MACSIS – MULTI-AGENCY COMMUNITY SERVICE INFORMATION SYSTEM

Board Operations Manual

HIPAA Member Section

(08/16/07 Version 4.0)

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I. Introduction to HIPAA Member Enrollment

This documentation is intended to guide the User through the process of enrolling and maintaining members in the MACSIS HIPAA[1] system. The enrollment of members into MACSIS is the first and most important step in the reimbursement process. Only those clients receiving behavioral health services funded in whole or in part with public funds administered through the boards should be enrolled in MACSIS. The enrollment request should be initiated as soon as a provider is aware that they will be delivering a service for which board reimbursement will be likely. However, the member only needs to be enrolled one time. Each board enrolls and maintains members that are residents of their own county. Boards can only enroll and maintain members who are enrolled in their groups and plans. They are then responsible for payment of the services provided while the member is in one of their plans.

This manual will attempt to walk you through the processes involved in enrolling and maintaining members. If you still have questions after reviewing this document and the reference documents, please contact MACSIS Support at 1-877-462-2747 or e-mail MACSIS Support at **MacsisSupport@mh.state.oh.us**.

II. Policies/Procedures Needed

The following is a checklist of policies/procedures that Boards need to develop related to the topic of Enrollment and Member Maintenance:

Internal to Board

- ☐ Routine enrollment process
- ☐ Special handling
- ☐ Clients unwilling/unable to sign disclosure
- ☐ Out of County
- ☐ Residency Dispute Determination (RDD)
- ☐ Provider appeals
- ☐ Member maintenance
- ☐ Working reports
- ☐ Retroactive Medicaid
- ☐ Transfers

For Provider

- ☐ Who to enroll
- ☐ Privacy/Disclosure issues
- ☐ Enrollment process
- ☐ Local use of plans/riders, etc.
- ☐ Enrollment Turnaround times
- ☐ Documentation required (financial, residency, etc.)
- ☐ When/how to communicate changes (i.e. Medicaid #, income level, etc.)
- ☐ How to handle out-of-county enrollments

[1] Throughout this document MACSIS HIPAA will be referred to as MACSIS.

III. Background

Providers are expected to collect the minimum data required on the enrollment form as well as information necessary to identify the county of residence. To assist providers, standard forms have been created for their use. Two of the most common forms consist of a data collection form (see **New Member Enrollment/UCI Request**) and a verification of residency form (see **MACSIS Residency Verification Form**). The provider is expected to verify the residency of the member to the best of their ability. The enrolling board will provide local definitions of certain data fields to ensure that the member is assigned to the correct plan that the appropriate disclosures are signed, and that income figures are collected, if applicable, to establish rider codes. This may involve ongoing training with provider staff so that the enrollment forms are completed correctly. This may also include ongoing communication with provider administrative staff so that they understand the board's expectation and the ramifications of bad data.

Board staff should establish and maintain a clear policy of how plans are assigned. This is especially critical at boards where there is an extensive choice of plans. Each plan requires a definition so that enrollment staff can readily select the correct plan code. Providers need to provide sufficient information on the enrollment forms so that enrollment staff can identify the appropriate plan for the member.

The MACSIS system attempts to identify and update Medicaid eligibility status automatically on a daily basis. In order to do this it is necessary to maintain a single Universal Client Identifier (UCI) for each member enrolled. Special emphasis is placed on the accuracy of potential members' Names, Dates of Birth, Social Security Numbers, and the Medicaid Identification numbers. Members that are enrolled with either invalid information or missing information for these fields may not have their Medicaid information updated correctly. Failure to collect valid information in these particular fields will eventually add a substantial maintenance burden to the local board and prevent them from fully utilizing federal Medicaid funds, which would enable the board's funds to cover other important services.

The board is encouraged to remind providers of the importance in notifying the board of changes, especially when the provider becomes aware that a member has been issued a new Medicaid number.

IV. Enrollment Process – Client Specific

Provider Process

The enrollment process begins at the provider level. When a client presents for service the provider determines whether the service will be funded in whole or part with public funds administered by the board. The provider completes the MACSIS enrollment form, determines the county of residence, and submits the enrollment form along with the residency verification, if applicable, to the appropriate board.

Providers should complete the residency verification form when:

1. The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).

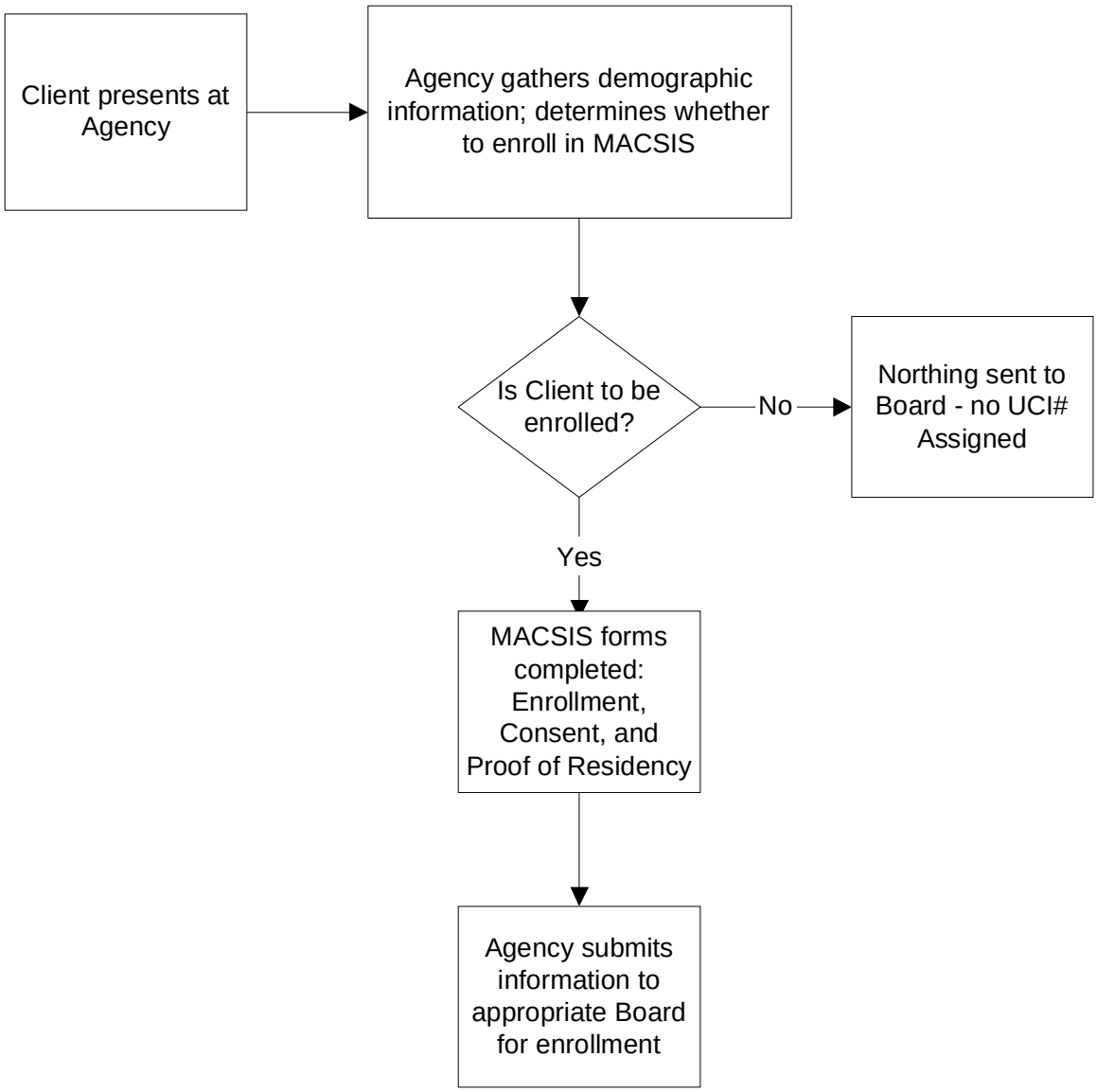
2. The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
3. The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the **Residency Guidelines**.

If at the time of enrollment the client is in crisis, the provider only needs to obtain the minimum required data elements: Last name, First name, date of birth (use default if unobtainable 07/04/1876), and gender. Provider should get the remaining information from the client once the client is out of crisis and forward the completed enrollment form and residency verification form to the appropriate board. **This does not mean crisis providers do not have to try to obtain this information.** Boards cannot refuse to enroll clients who are in crisis at the time of enrollment as long as providers indicate on the form that the client "is in crisis".

Boards are responsible for communicating with their providers how enrollment information should be submitted in accordance with the board's privacy practices.

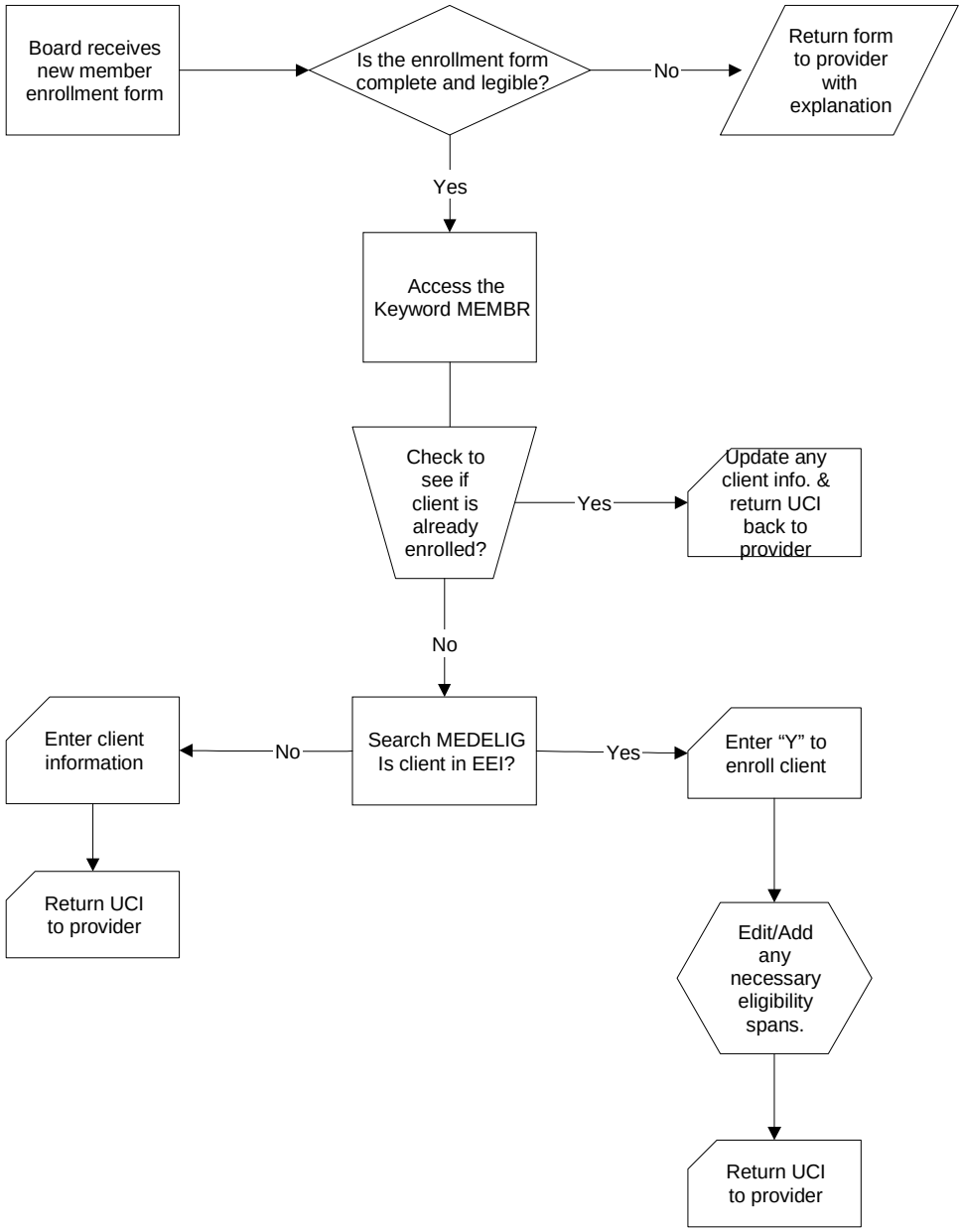
Provider Enrollment Process



Board Process

The board receives the enrollment form and reviews the form for completeness. If the form does not include the minimum data elements or is not legible, the board will return the form to the provider with an explanation. If the form is acceptable, the Board will proceed with enrolling the client.

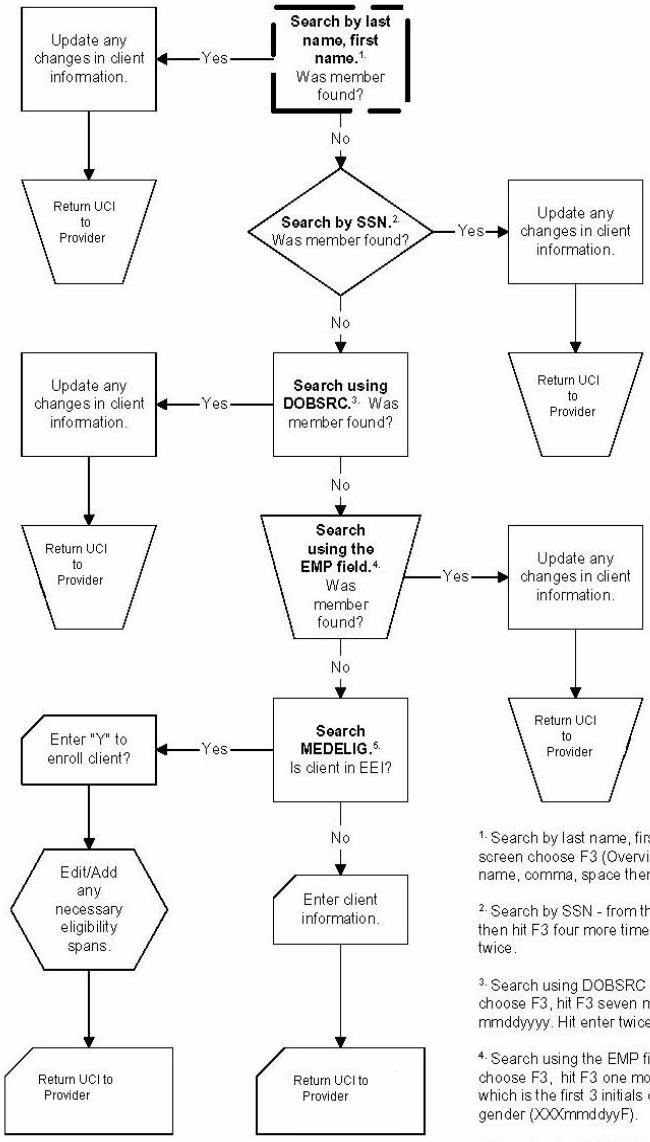
Board Enrollment Process



Searching for a Member in Diamond F3 Search

The board enrollment specialist will access the Diamond keyword MEMBR. Prior to enrolling a member, the enrollment specialist must verify that the member is not currently enrolled. It is essential that duplicate enrollments be avoided and boards take appropriate measures to ensure that duplicate members are not entered into Diamond. Potential members should be looked up through the Function Key “F3” overview screen. The common look up options include member name, social security number, date of birth, Medicaid #, etc. Boards should not limit their look up process to one search option. If the member is found through the F3 overview screen, the board will update any client information and return the UCI to the provider.

How to Search for a Member



[1] Search by last name, first name - from the member screen choose F3 (Overview scrn), in upper case enter last name, comma, space then first name. Hit enter twice.

[2] Search by SSN - from the member screen choose F3, then hit F3 four more times and enter the SSN. Hit enter twice.

[3] Search using DOBSRC - from the member screen choose F3, hit F3 seven more times. Enter date of birth like mmddyyyy. Hit enter twice.

[4] Search using the EMP field - from the member screen choose F3, hit F3 one more time. Enter the Employee # which is the first 3 initials of the last name, date of birth and gender (XXXmmddyyF).

[5] Search using MEDELIG - from the member screen choose F6 (SpecFuncts), then select X (External Eligibility Inquiry) then hit enter. If you have the Medicaid ID you can enter and search on that. If you do not have the Medicaid ID, it is best to search on the first two letters of their last name and date of birth. You can search on SSN only by entering a ? in the Medicaid ID field and the SSN.

Searching for a Member in Diamond Utilizing EEI

If the member is not found using the F3 Search function, the board will perform the external eligibility inquiry EEI by pressing F6-X (if accessing from the main Diamond menu – keyword EXINQ). Options for this inquiry includes Medicaid number (if known); first character of the last name and date of birth; or enter a question mark in the Medicaid number field and enter the client's social security number. If the client is in EXINQ and is already enrolled, the UCI number will be displayed in the UCI field. Access the UCI number through MEMBR, verify Medicaid eligibility, edit/add eligibility spans if necessary (see **Correcting/Changing Member's Eligibility Span**), and return UCI to provider.

Enrolling a New Member Utilizing EEI

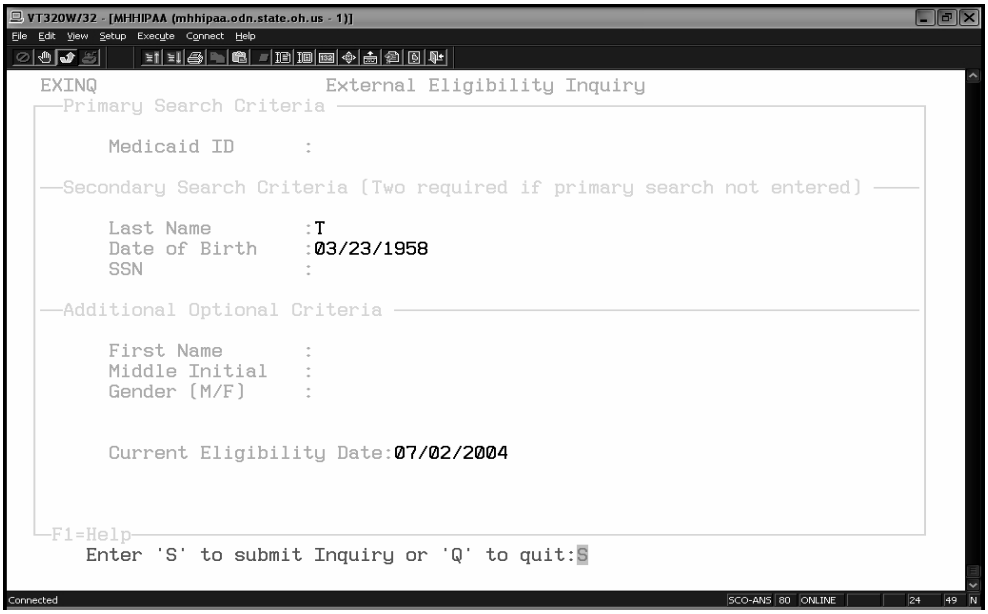
The board enrollment staff has determined that the member is not enrolled in Diamond but that the person is in EEI. To enroll the client using EEI:

1. Access the Diamond keyword MEMBR and make sure that the Sub ID field is blank.

2. Press F6 – X to access EEI.

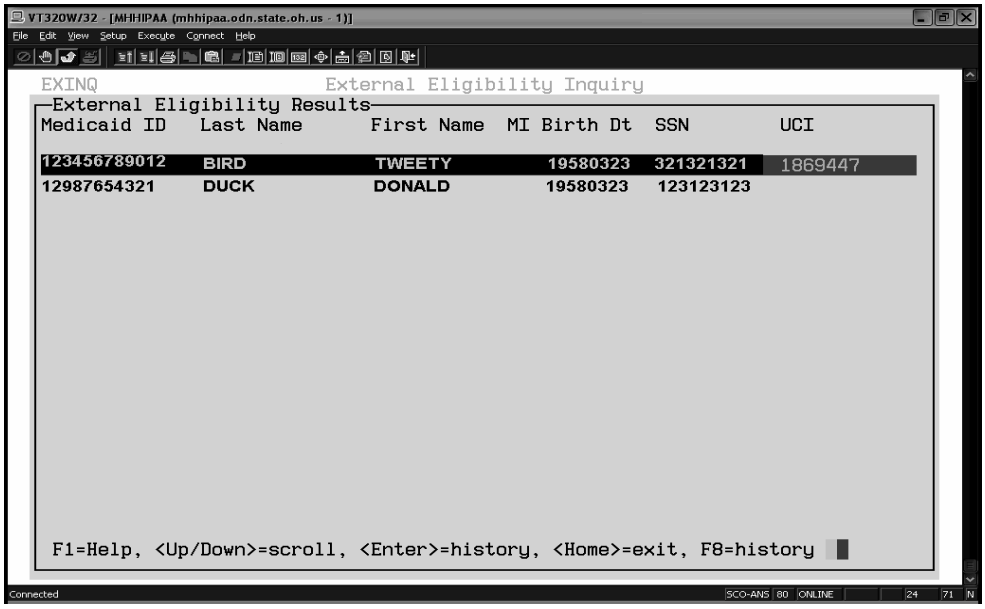
3. Enter the search criteria for the EEI lookup (see above). Press enter.

EEI Lookup Screen

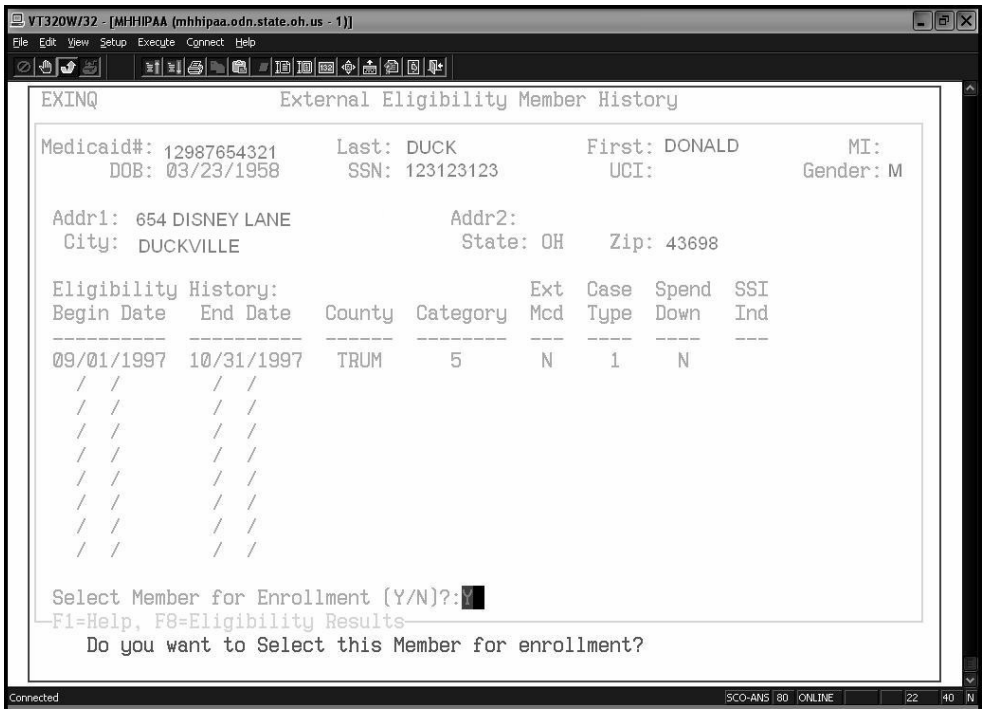


4. Highlight the person that you wish to enroll and press enter. (The information that will be displayed on the External Eligibility Inquiry Results screen will be based on the search criteria.)

EEI Lookup Result Screen



EEI Member History Screen



5. Verify the information on this screen to ensure this is the correct member to be enrolled. Select “Y” to enroll. This will take you back to the member screen. This process will make entering a new client faster and easier. The member screen will be populated with information from the MEDELIG file. This includes last name, first name, middle initial, date of birth, gender, address, Medicaid #, social security number, and current Medicaid eligibility information. For step-by-step instructions for completing the member screen when enrolling using EEI, see **Completing Member Screen using EEI**.

Completing Member Screen using EEI

Once the member you wish to enroll has been located using EEI/EXINQ and you have entered a "Y" in the "Do you want to Select this Member for enrollment?" field follow the steps below to complete the fields on the Member Screen:

1. **Sub ID:** Hit <enter> and the next UCI will automatically be assigned by the system.
2. **Person No:** Always enter 00 (zero, zero)
3. **Sub:** Defaults to 00. Hit <enter> and the default values will automatically be filled in.
4. **Last Nm:** This is populated automatically from EEI. Press <enter>.
5. **First:** This is populated automatically from EEI. Press <enter>.
6. **MI:** This is populated automatically from EEI. Press <enter>.
7. **DOB:** This is populated automatically from EEI. Press <enter>.
8. **Gndr:** This is populated automatically from EEI. Press <enter>.
9. **Rel:** Enter an O. Press <enter>.
10. **Addr 1:** This is populated automatically from EEI. Press <enter>.
11. **Addr 2:** This is populated automatically from EEI. Press <enter>.
12. **City:** This is populated automatically from EEI. Press <enter>.
13. **State:** This is populated automatically from EEI. Press <enter>.
14. **Zip:** This is populated automatically from EEI. Press <enter>.
15. **CTY:** Enter a Z here if you have put information in the Additional Member Information screen. This information can be accessed by pressing F6 (SpecFuncts) and then pressing Z.
16. **Country:** Not Used.
17. **RACE:** Enter the client's race (may add up to 5 codes, see **Race table**).
18. **ETHNIC:** Enter client ethnicity (may add up to 4 codes, see **Ethnicity Table**).
19. **DOBSRC:** Enter client's date of birth (format mmddyyyy). If this field is blank it will be created by the nightly maintenance.
20. **Hom Ph:** Enter client's home phone, area code followed by phone number (1234567890). Special characters are system generated.
21. **Bus Ph:** Enter client's work phone, area code followed by phone number (1234567890). Special characters are system generated.
22. **Sal:** This field is not used.
23. **Lang:** Enter client's primary language code (see **Language Table**).
24. **MAR:** Enter client's marital status: M=married, D=divorced, W=widowed, S=single.
25. **COB:** System generated.

26. **MedCare:** This field is used by the Boards to override what MEDELIG has for the last name, first name, and middle initial by placing a "Y" in the first character of the field.
27. **Medcaid[1]:** This is populated automatically from EEI. Press <enter>.
28. **SocSec:** This is populated automatically from EEI. Press <enter>.
29. **Emp:** Enter first 3 letters of client's last name, DOB and gender (format XXXmmddyyyG).
30. **MedRec:** Enter client's medical record number used to identify them at the provider.
31. **Security:** This field should always be left lank.
32. **Start:** This is populated automatically from EEI with the start date of the latest coverage if the client is Medicaid eligible. If client is not currently Medicaid eligible, no start date is displayed. Remember the start date needs to be the date the provider has requested.
33. **Term:** Leave this blank during manual enrollment; otherwise it is the termination date of the current displayed span of coverage.
34. **Elig Sts:** System default is the letter "E", press enter to continue. A value other than "E" will not allow claims to be paid correctly for the member. A value other than "E" will be removed during the Member Maintenance process.
35. **SeqNo:** System generated based on the order the spans were entered. The current span is always visible on the screen. (Does not necessarily reflect the number of eligibility spans for a client.)
36. **Group:** Enter the first four letters of the county responsible for this client. (see **County Code List**)
37. **Plan:** Enter the plan to which the client has been assigned (i.e. ADMCD48123). AD = Alcohol & Drug, MH = Mental Health, DF = Dual Funded; MCD = Medicaid, NON = Non-Medicaid, Board Number, and Board Plan Code.
38. **Riders:** Enter all the rider codes that are applicable to the client (see **Sample Sliding Fee Schedule** and **Rider Codes**)
39. **Panel:** Enter the panel code that defines the provider network (i.e. 25B, 48A). The panel code is the Board Identification number (see **Board Identification Numbers**) and the Board Type (B = Both AOD & MH, M = MH, A = AOD).
40. **PCP ID:** Not used by most boards.
41. **Prov2:** Enter the UPID of the enrolling provider.
42. **IPA and Hire DT:** Not used.
43. **McareSt:** This field stores the client's MCD recipient aid category, case type, spend down indicator, extended MCD indicator and whether they are eligible for the CHIP or BCCP program and will be updated by the state. (see **Medicaid Eligibility Information**)
44. **MiscSt:** Enter the number of individuals within the subscriber's family. (see **Definition of a Family**)

[1] Diamond refers to the Medicaid ID field in the Other Identification ID's section as Medcaid. When referenced throughout this document, it is referring to the Diamond field name.

45. **DEF3:** Updated by the state. County Number (2 characters) where the MCD card was issued. (see **County Identification Codes**)
46. **Term Rsn:** Reason the current eligibility span was terminated. (Usually left blank on manual enrollment.) (see **Term Reason Codes**)
47. **Salary:** Enter the adjusted gross income of the family. Enter $1000.00 as 100000.
48. **OvrrAmt, OverrTyp, OStep:** Not used.
49. **USERDEF:** USERDEF1 – This is automatically populated with the Medicaid ID number of the member whether they are Medicaid Eligible or not. Remember to remove the number if the member is not currently Medicaid Eligible.
50. **USERDEF:** USERDEF2 – is not used.
51. **Privacy:** Not used.
52. **Sales Rep:** Enter the first four letters of the county of residence for the client or OUTSTATE for members who are out of state.

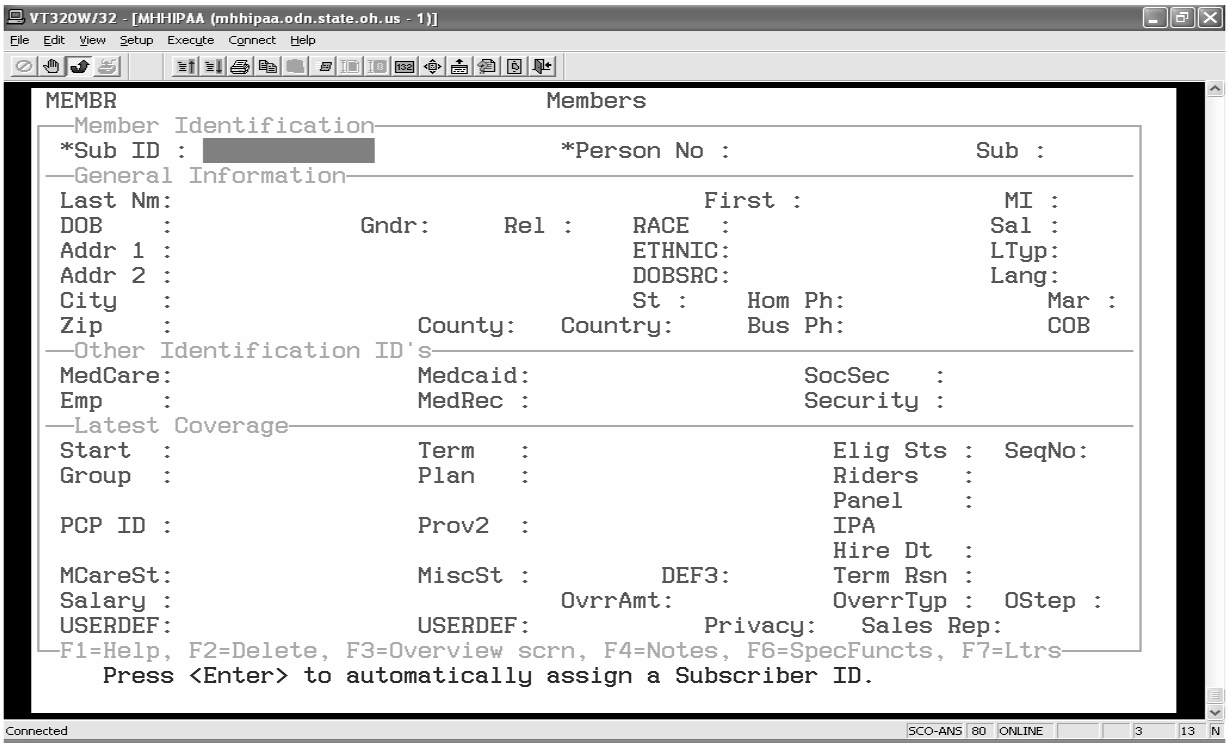
Enrolling a New Member in Diamond

The board's enrollment specialist has determined that the client is not currently enrolled in Diamond and the client is not in EEI.

Completing the Member Screen

1. **Sub ID:** Hit <enter> and the next UCI will automatically be assigned by the system.
2. **Person No:** Always enter 00 (zero, zero)

Member Screen



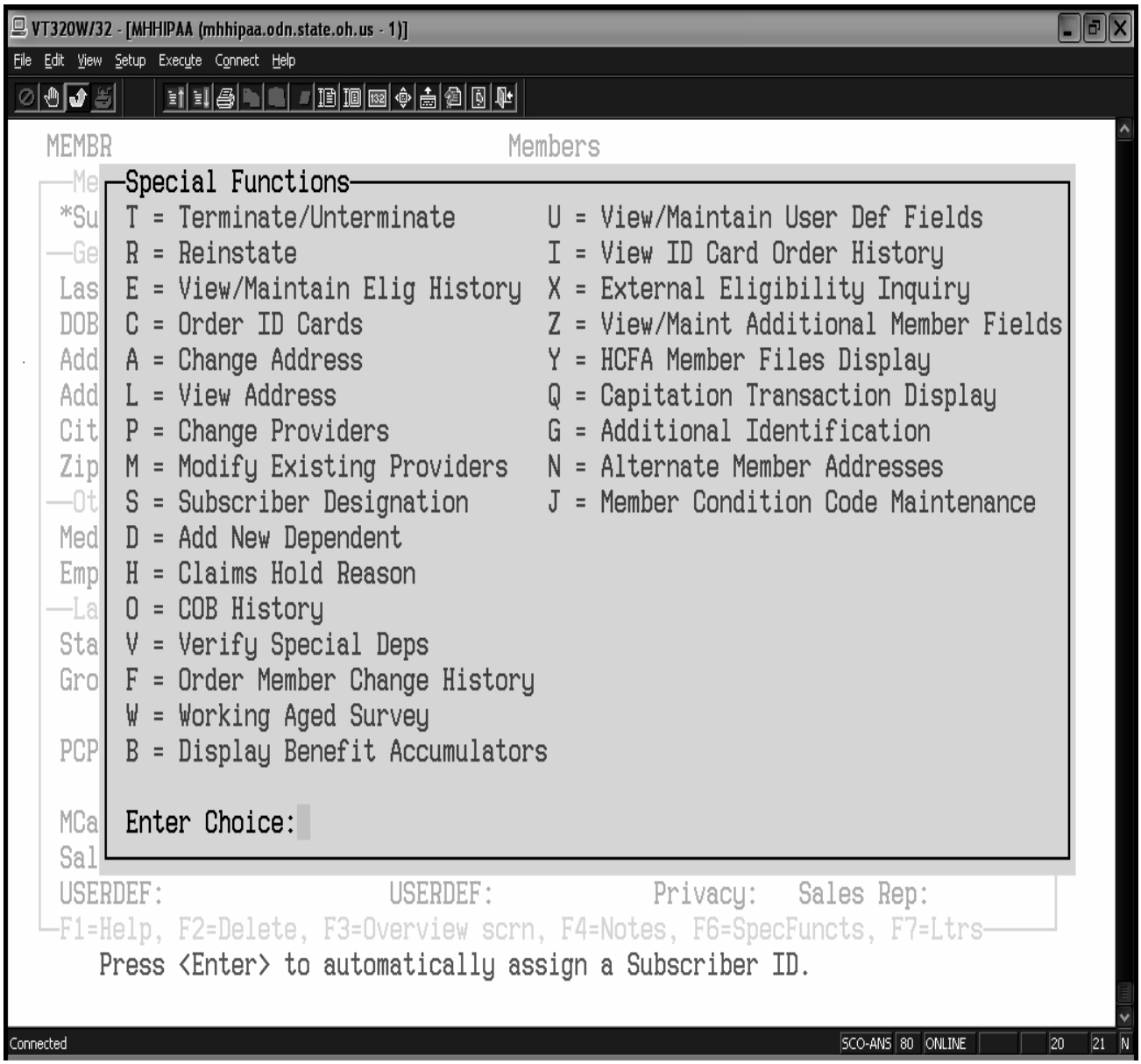
3. **Sub:** Defaults to 00. Hit <enter> and the default values will automatically be filled in

4. **Last Nm:** Enter the client's last name in all caps. Only special character allowed is a dash for hyphenated last names.
5. **First:** Enter the client's first name in all caps.
6. **MI:** Enter the client's middle initial in caps.
7. **DOB:** Enter client's date of birth in the following format - mmddyyyy.
8. **Gndr:** Enter M for male and F for female.
9. **Rel:** Enter an O.
10. **Addr 1:** Enter the first line of the client's residential address. If client is homeless, enter "Homeless".
11. **Addr 2:** Enter the second line of the client's residential address if needed.
12. **City:** Enter the client's city of residence. If homeless and living in a shelter, enter the shelter's city; otherwise enter the board's city.
13. **State:** Enter the abbreviation for the client's state of residence. If homeless and living in a shelter, enter the shelter's state abbreviation; otherwise enter the board's state abbreviation.
14. **Zip:** Enter client's residential zip code. If homeless and living in a shelter, enter the shelter's zip code; otherwise enter the board's zip code. In the event that the zip code is not immediately available, this field should be filled with "55555" as a default. The correct zip code should be entered as it is obtained.
15. **Cty:** Enter a Z here if you have put information in the Additional Member Information screen. This information can be accessed by pressing F6 (SpecFuncts) and then pressing Z.
16. **Country:** Not used.
17. **RACE:** Enter client's race (may add up to 5 codes see **Race Table**).
18. **ETHNIC:** Enter clients ethnicity (may add up to 4 codes see **Ethnicity Table**).
19. **DOBSRC:** Enter client's date of birth (format mmddyyyy). If this field is blank it will be created by the nightly maintenance.
20. **Hom Ph:** Enter client's home phone, area code followed by phone number (1234567890). Special characters are system generated.
21. **Bus Ph:** Enter client's work phone, area code followed by phone number (1234567890). Special characters are system generated.
22. **Sal:** This field is not used.
23. **Lang:** Enter client's primary language code (see **Language Table**).
24. **Mar:** Enter client's marital status: M=married, D=divorced, W=widowed, S=single.
25. **COB:** System Generated
26. **MedCare:** This field is used by the Boards to override what MEDELIG has for the last name, first name and middle initial by placing a Y in the first character of the field.
27. **Medcaid:** Enter client's MCD number.

28. **SocSec:** Enter client's social security number. If the client refuses or cannot provide an accurate social security number due to a crisis state, use the default of "555555555".
29. **Emp:** Enter first 3 letters of client's last name, DOB and gender (format: XXXmmddyyG).
30. **MedRec:** Enter client's medical record number used to identify them at the provider.
31. **Security:** This field should always be left blank.
32. **Start:** Enter the client's admission (enrollment) date from the provider. Never enter future dates. This will not allow the member's eligibility to be updated during the nightly maintenance program.
33. **Term:** Leave this blank during manual enrollment; otherwise, it is the termination date of the current displayed span of coverage.
34. **Elig Sts:** System default is the letter "E"; press enter to continue. A value other than "E" will not allow claims to be paid correctly for the member.
35. **SeqNo:** System generated based on the order the spans were entered. The current span is always visible on the screen. (Does not necessarily reflect the number of eligibility spans for a client.)
36. **Group:** Enter the first four letters of the county responsible for this client. (see **County Code Table**)
37. **Plan:** Enter the plan to which the client has been assigned (i.e. ADMCD48123). AD = Alcohol & Drug, MH = Mental Health, DF = Dual Funded; MCD = Medicaid, NON = Non-Medicaid, Board Number, and Board Plan Code.
38. **Riders:** Enter all the rider codes that are applicable to the client. (see **Sample Sliding Fee Schedule** and **Rider Codes**)
39. **Panel:** Enter the panel code that defines the provider network (i.e. 25B, 48A). (see **Board Identification Numbers**)
40. **PCP ID:** Not used by most boards.
41. **Prov2:** Enter the UPID of the enrolling provider.
42. **IPA and Hire DT:** Not used.
43. **McareST:** This field stores the client's MCD recipient aid category, case type, spend down indicator, extended MCD indicator and whether they are eligible for the CHIP or BCCP program and will be updated by the state. (see **Medicaid Eligibility Information**)
44. **MiscSt:** Enter the number of individuals within the subscriber's family. (see **Definition of a Family**)
45. **DEF3:** Updated by the state. County number (2 characters) where the MCD card was issued. (see **County Identification Codes**)
46. **Term Rsn:** Reason the current eligibility span was terminated. (Usually left blank on manual enrollment.) (see **Term Reason Codes**)
47. **Salary:** Enter the adjusted gross income of the family. Enter $1000.00 as 100000.
48. **OvrrAmt, OverrTyp, OStep:** Not used.
49. **USERDEF:** USERDEF1 - If the client is MCD eligible and in a MCD plan, enter the client's MCD ID.

50. **USERDEF:** USERDEF2 - is not used.
51. **Privacy:** Not used.
52. **Sales Rep:** Enter the first four letters of the county of residence for the client or OUTSTATE for members who are out of state.

V. Special Function Key – F6



The special function key – F6 can be accessed from the main member screen. The use of these options provides boards the ability to view additional information for that member or shortcuts to certain fields. The most commonly used ones include the following:

T = Terminate/Unterminate: This allows you to terminate or un-terminate a member's current eligibility span. For information on changing the term date of previous eligibility spans see the section on **Correcting/Changing Member's Eligibility Span**.

1. Access the Diamond keyword MEMBR.

2. Enter the UCI # and the Person No. of 00 (zero, zero) of the member you wish to term.

3. Press F6–T, this will take you to the term date.

4. If you are terming a member, enter the term date and press <enter>. The system will automatically take you to the term reason.

    a. Enter a valid term reason and press <enter>.

5. If you are un-terming a span, when it takes you to the term date, hit the <space bar> to remove the term date and press <enter>. You will then automatically be taken to the term reason field.

    a. Hit the <space bar> to remove the term reason. Hit <enter>.

6. Update (save your changes).

Note: If you are terming the member with other than MBDEC, MBINL, MBMOS, ERR01, EDUP1, EDUP2, OR EDUP3 you must enter a new span

R = Reinstate: This is used to establish a new eligibility span for members that have been termed with reason codes other than MBDEC, ERR01, EDUP1, EDUP2, OR EDUP3 (members termed with these reason codes need to have the termed spans corrected before reinstating/entering a new span). Make sure the information for the member you wish to reinstate is displayed in the member screen.

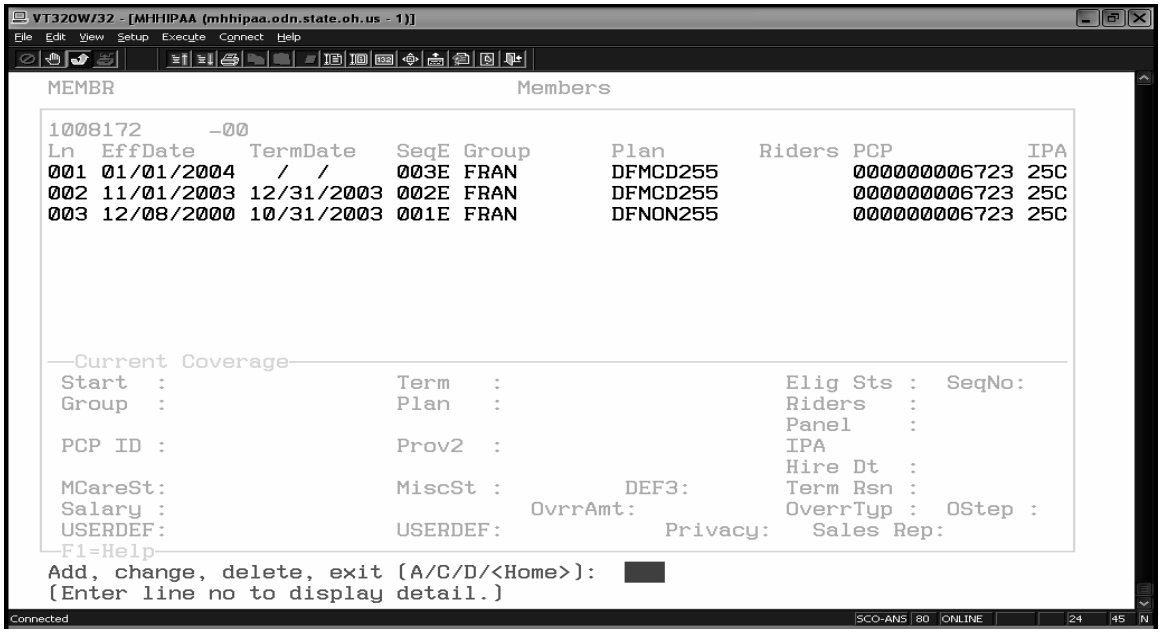
1. Press F6-R. MACSIS will automatically set the start date to the day following the previous term date.

2. Complete the remaining fields: Group, Plan, Riders (if applicable), Panel, Prov2, MiscSt, Salary, USERDEF (if applicable) and Sales Rep.

3. Make sure to save the record.

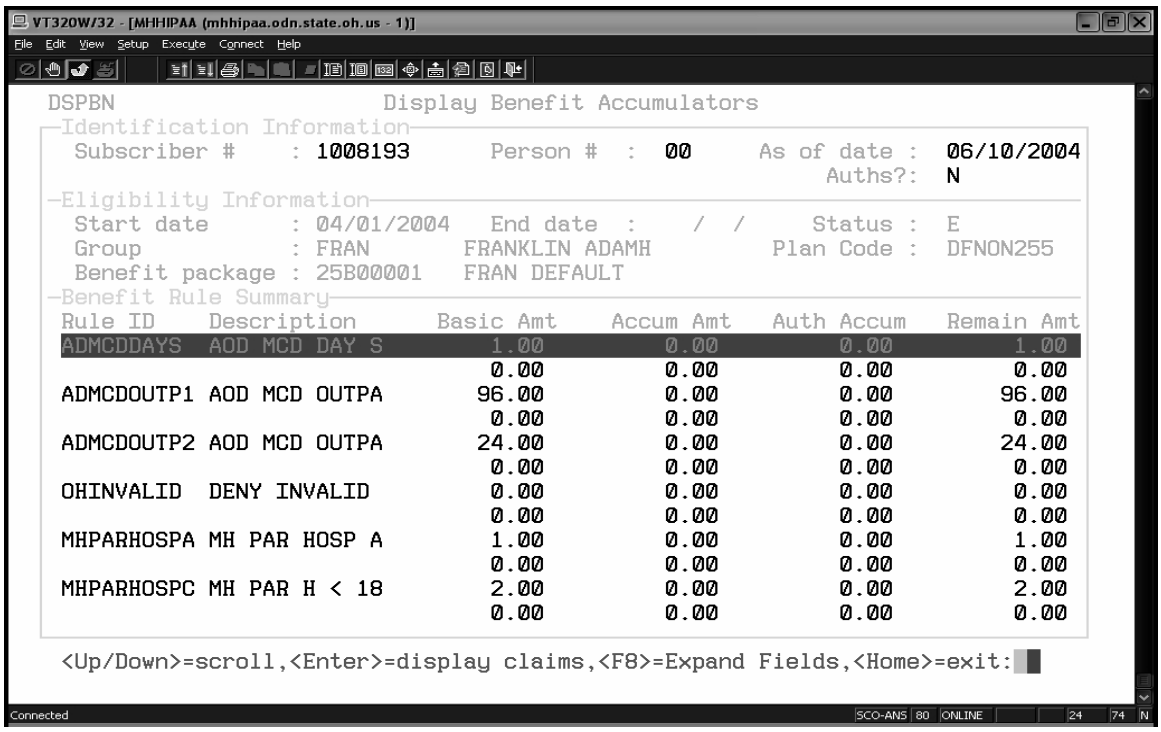
E = View/Maintain Eligibility History: This allows you to view all of the member's eligibility history. You can also add or change eligibility spans through this option.

F6 E Screen



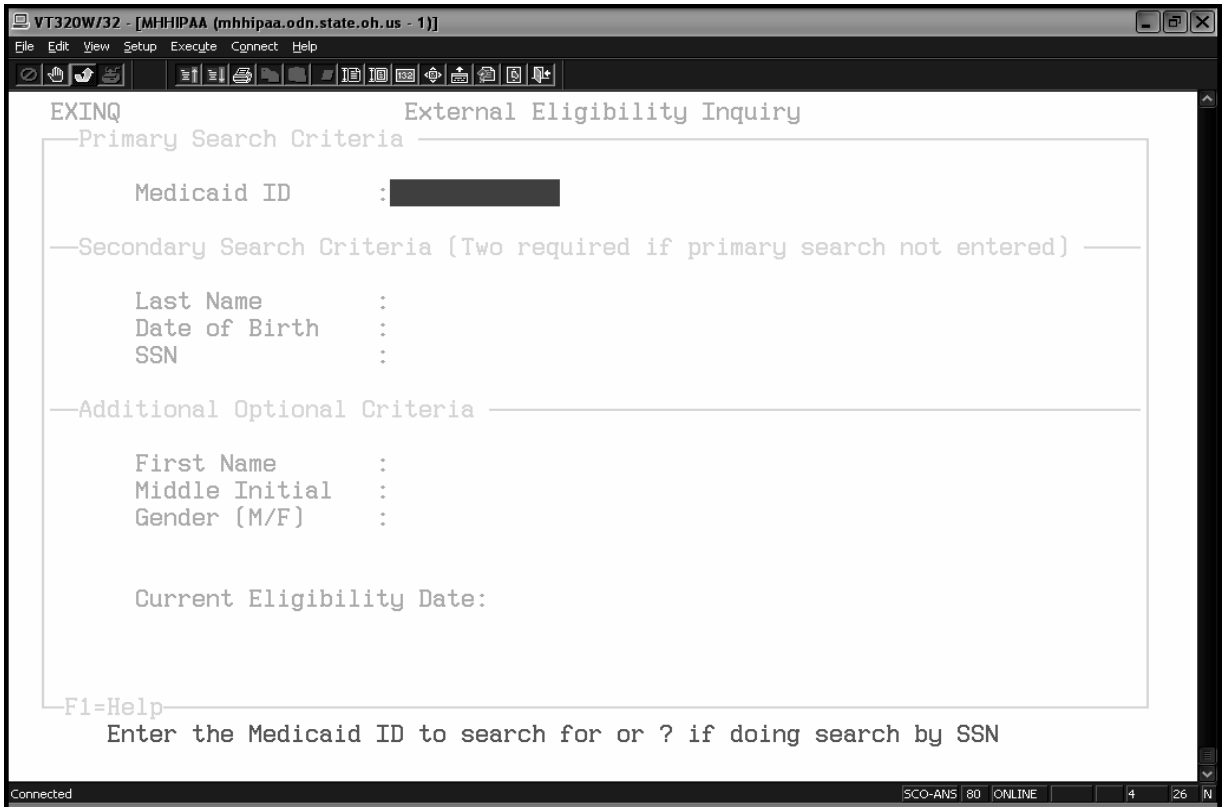
B = Display Benefit Accumulators: Displays benefit accumulation information applied through state or board defined benefit rules for a member as of a specified date.

Benefit Accumulators Screen



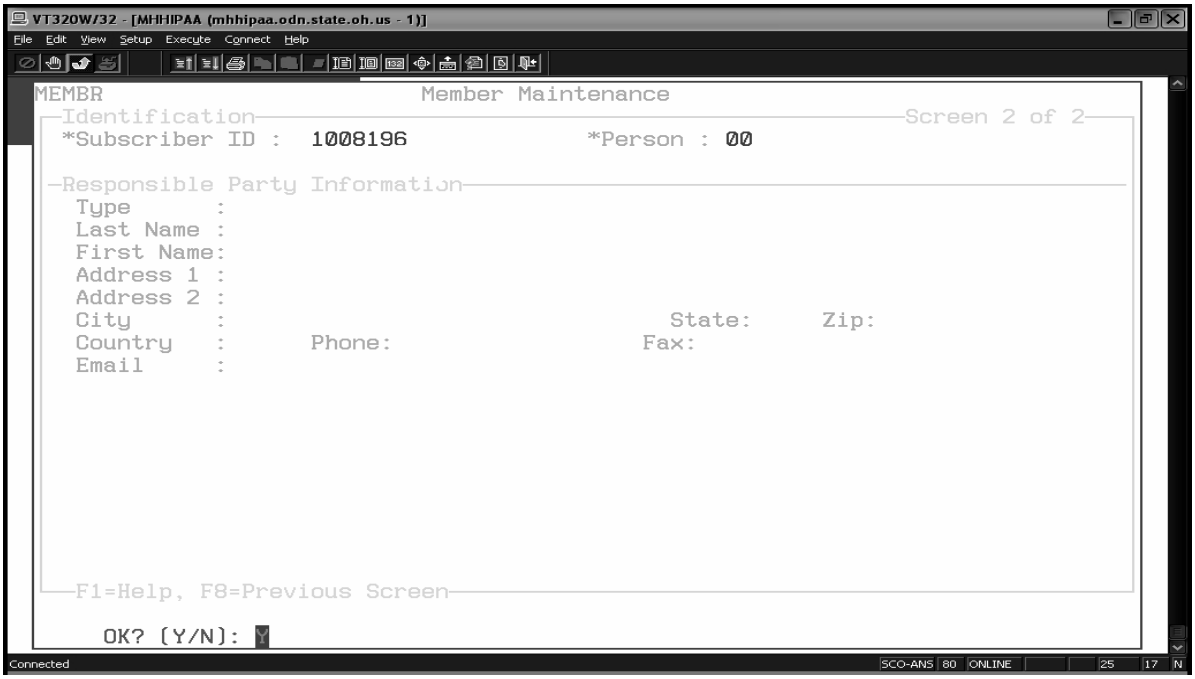
X = External Eligibility Inquiry: This function takes you to the EEI (EXINQ keyword), which will allow you to search for valid Medicaid numbers.

EXINQ Screen

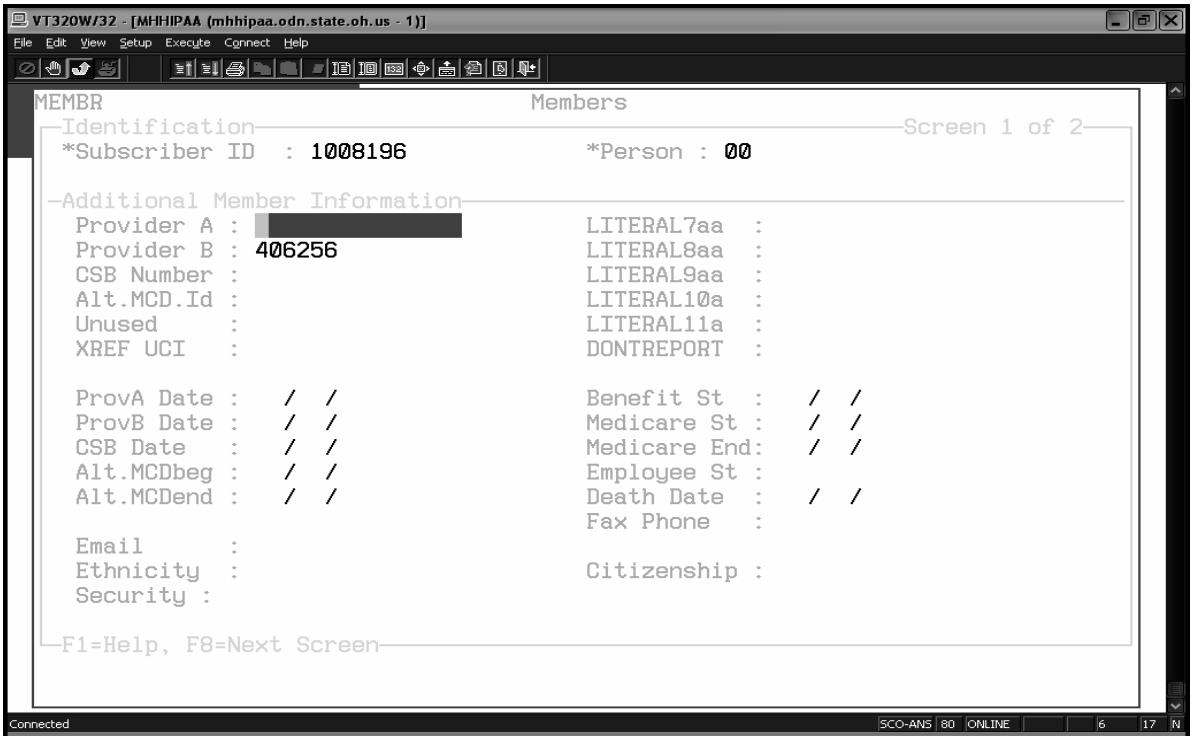


Z = View/Maint Additional Member Fields: This function will take you to the Alternative Member screen where additional fields allow storage of additional provider numbers, alternative Medicaid ID's, cross reference UCI numbers, etc. to be entered/maintained.

F6 Z Screen 1



F6 Z Screen 2



Shift F1: Can be used to reveal the date and initials of who created or made changes when looking at member screens.

F5: Whenever you see an F5 option at the bottom of the member screen this indicates that there is a listing of valid codes from which to choose. Press F5 and hit <Enter>; scroll through the list and select the appropriate choice by highlighting and hitting <Enter>.

VI. Correcting/Updating Members

There are three main types of member corrections that routinely need to be completed:

1. General information – demographic information such as address, DOB, race, etc.
2. Other identification ID's – Medicaid ID, SSN, MedRec, etc.
3. Latest Coverage – eligibility information such as rider, group, plan, etc.

Corrections or updates to the **General Information** or **Other Identification ID's** can be made by accessing the member screen, making the appropriate changes and saving those changes. Corrections or updates to the latest coverage or prior eligibility spans are made by accessing the **View/Maintain Elig History** screen from the member screen by selecting F6-E. (See **Correcting/Changing Member's Eligibility Span**, **Adding Member Eligibility Spans** or **Terming/Reinstating member's eligibility span (utilizing F6-E)**.)

Setting Medicaid Name Override

If the client has a Medicaid number and the information in Diamond is different from the information from ODJFS, the information from ODJFS will replace what is in Diamond during the nightly update process when the client becomes Medicaid eligible. If MEDELIG has the incorrect last name, first name or middle initial, boards can set the **Medicaid Name Override Flag** by placing a "Y" in the first character of the **MedCare** field that is in the Other Identification ID's section of the member screen. Setting this flag prevents the last name, first name and middle initial from being overwritten with the incorrect information from ODJFS. Make sure the information in Diamond is correct before setting the **Medicaid Name Override Flag.** The member's eligibility will continue to be updated, but last name, first name and middle initial will not be overwritten with the incorrect information from ODJFS.

Setting Medicaid Override

Sometimes the information from ODJFS will also include incorrect DOB and /or SSN. In this case, board staff should contact the MACSIS Support Desk and request that the **Medicaid Override Flag** be set. The **Medicaid Override Flag** keeps the nightly update from replacing last name, first name, M.I., DOB and SSN with the information on the RMF file that comes from ODJFS. Prior to making the request, board staff should make sure the correct information is in the member fields before requesting the **Medicaid Override Flag** be placed on a member record. The member's eligibility will continue to be updated, but last name, first name, middle initial, DOB and SSN will not by overwritten with the incorrect information from ODJFS.

Note: There is no flag that can be set to prevent the address from being overwritten with the information from the RMF file. When the information coming from ODJFS is incorrect, the only way to get the information corrected is by having the client work through their local county

Department of Job and Family Services. **Hint:** The use of F4 Notes will allow you to store the valid address and other information about the member.

Adding Member Eligibility Spans

There will be times when you will need to add an eligibility span due to a transfer of a member, retroactive MCD eligibility change, etc. The procedure for adding an eligibility span is outlined below:

1. At the Diamond main menu, type: **MEMBR** (members)
2. Enter the UCI number, the Patient No. of 00 (zero, zero) and hit <enter>.
3. Once the member information is displayed for the appropriate member, press F6–E and <enter> which will take you to the **View/Maintain Elig History** screen.
4. Type “A” (Add) and press <enter>.
5. Complete all the information for the span being added.

   Note: If you are adding a Medicaid span, be sure to enter the Medicaid number in the **USERDEF** field. If you do not, any claims for this eligibility period will not be able to be extracted and sent to ODJFS for reimbursement of the FFP. Always remember you can only have one open span, so if the span you are adding will become the most current, you will need to term the old span first.
6. Update. (Save the changes/corrections.)

Diamond will automatically put the span in the correct chronological order and will add the line number (Ln) and sequence number (SeqE). SeqE is assigned based on the order the spans were entered and LN is assigned based on the chronological order of the spans.

Correcting/Changing Member’s Eligibility Span

To correct or change a member’s eligibility span(s) or view the complete details of previous eligibility spans, you must access the member and use the special function F6-E.

To change an eligibility span:

1. At the Diamond main menu, type: **MEMBR** (members)
2. Enter the UCI number, the Patient No. of 00 (zero, zero) and hit <enter>.
3. Once the member information is displayed for the appropriate member, press F6–E and <enter> which will take you to the **View/Maintain Elig History** screen.
4. Select “C” (Change) and press <enter>.
5. Enter the line number of the span you wish to change and press <enter>.
6. Enter the information that needs corrected or changed.

   Note: Remember for Medicaid eligibility changes or corrections the Medicaid number must be entered in the **USERDEF** field.
7. Update. (Save the changes/corrections.)

To view the details of an eligibility span, enter the line number of the span you wish to view and press <enter>. Only state staff can delete eligibility spans.

Certain changes made to an eligibility span will require corrections to claims (plan, rider, panel, etc.) Refer to the MACSIS Claim Correction Policy/Procedure (see **Claim Corrections Policy** and **Claim Corrections Procedure**).

Never enter future eligibility spans. Future eligibility spans will be deleted by the state.

When moving a member into your group and plan, which is enrolled by another board, you need to notify the other board of the transfer. Refer to the "**Instructions for Completing Member/Claims Transfer**". This allows claims that are un-finalized to be sent to the responsible board.

Note: Changes, updates, transfers, and corrections can only be made to members who are enrolled in your group and plan.

Terming/Reinstating a Member's Eligibility Span (Utilizing F6-E)

To term a member's eligibility span:

1. At the Diamond main menu, type: **MEMBR** (members)
2. Enter the UCI number, the Patient No. of 00 (zero, zero) and hit <enter>.
3. Once the member information is displayed for the appropriate member, press F6–E and <enter> which will take you to the **View/Maintain Elig History** screen.
4. Enter a "C" and press <enter>.
5. Enter the span number that you are going to term - **001** and press <enter>.
6. Enter the term date then <enter>.
7. Enter the appropriate term reason then <enter> (see **Term Reason Codes**).
8. Next, open a new eligibility span for the member by choosing "A" and <enter>.
9. Enter all the eligibility information for the span being added and save.

Instructions to Terminate/Unterminate a member from the main member screen can be found at: **Terminate/Unterminate**. Reinstating a member from the main member screen can be found at: **Reinstate**.

VII. Member Maintenance (State Processes)

The MACSIS Membership Support Group runs various member maintenance programs to maintain the quality of the membership data in the MACSIS system and to ensure the member's Medicaid eligibility is up-to-date. Some programs are run nightly and others at scheduled intervals. It is a common practice for all of these programs to be called the **Nightly Update Process** even though some may be run weekly. Many of the processes generate reports that are distributed either to the boards or to state staff for correction. The purpose and action required for each report is detailed in the **Member Reports** section. Member Maintenance Reports are created and distributed to the boards weekly. Some of the reports are informational

only and not all reports are created each week if there are no members that meet the criteria for the report.

What is MEDELIG?

The "master" MEDELIG file was produced from the Recipient Master File (RMF) from the Ohio Department of Job and Family Services (ODJFS – formerly known as the Ohio Department of Human Services). The MEDELIG file is smaller than the RMF file because it only contains MEDICAID eligibility data for subscribers eligible for Medicaid on or after 7/1/1997 and it excludes spans for General Assistance, Disability Assistance, and Qualified Medicare Beneficiary.

An RMF file is received daily from ODJFS. The daily RMF is used to update the "master" MEDELIG file with the current demographic and eligibility changes. The nightly update programs use the updated MEDELIG file to perform various processes that verify Medicaid eligibility data.

The nightly update process checks all records within Diamond using Medicaid ID against the information in MEDELIG. If a match is found and the member is eligible today, the member's latest span in Diamond is updated with the current eligibility and demographic information from MEDELIG.

The nightly update process also looks for records within Diamond without a Medicaid ID and searches MEDELIG for an exact match on first six characters of the last name, DOB, social security number and gender. If an exact match is found and the member is eligible today, the member's current record in Diamond is updated with the current eligibility and demographic information from MEDELIG and the member's UCI number is then mapped back to MEDELIG. (If a potential match is found or more than one match is found, these are reported on the Member Maintenance Reports – see **Member Reports** section).

Another program looks for duplicate UCI's. Since a Medicaid number can only be associated with one UCI number and the UCI ties the member to the Medicaid ID in MEDELIG, it is vital that there only be one UCI for an individual. If there is more than one UCI for a member, one of the UCI numbers will be termed with a term reason of EDUP1, EDUP2 or EDUP3. If the UCI with the Medicaid ID is the one that is termed, the member's eligibility will not be updated. Members termed with these term reasons are reported on the **Daily Membership Maintenance – Electronic Duplicates** report.

- ☐ Members are termed with **EDUP1** when two records have the same SSN (other than all 5's) and the date of birth match.
- ☐ Members are termed with **EDUP2** when two records have the same SSN, same last name and one digit of the DOB is different.
- ☐ Members are termed with **EDUP3** when two records have the same first 8 characters of last name, same first 8 characters of the first name, same DOB and either of the two SSN's is equal to all 5's.

Members are termed with the term reason ERR01 if either the last name or first name is all spaces or any part of the DOB is equal to zeroes (i.e., month = 00, day = 00 or year = 0000), or the last name is less than 2 characters. Members termed with ERR01 appear on the **Daily Membership Maintenance – Critical Errors** report.

Another member maintenance process identifies Diamond members with no Medicaid ID that match the SSN on a record in MEDELIG. These potential Medicaid eligible clients are reported on the **Potential Medicaid Eligible Clients** report.

When the first 6 characters of the last name, date of birth, gender and SSN for a member match more than one Medicaid number in MEDELIG it is reported on the **Members with more than one RMF Medicaid Number** report.

Medicaid ID's that fail a check digit routine or are not found in MEDELIG are reported on the **MEDICAID Number Check Digit Error** report.

Diamond members with the same SSN but a different date of birth are identified and reported on the **Duplicate Records by SSN – as of DDMMMYY** report.

The member extract file is used to look for members with the same first 8 characters of the last name, same first character of the first name, same date of birth and gender. These are reported on the **Potential Duplicates – as of DDMMMYY** report.

When a Diamond member with a Medicaid ID has a DOB different from the DOB reported by ODJFS, they are reported on the **Medicaid/Diamond Comparison** report.

A program is run that looks for SSN with all 9's, zeroes or a pattern; they are automatically changed to all 5's. There is no report generated from this process.

The only valid reason for terming a Non-MCD client's eligibility span without creating a new span is if they have been termed with MBDEC (member is deceased), MBINL (member is ineligible due to income), MBMOS (member moved out-of-state), ERR01, EDUP1, EDUP2, and EDUP3. A program is run that looks for termed Non spans that do not have one of the above term reasons and re-opens the span by removing the term date and term reason. No report is generated from this process.

A report is created for internal use called the Weird Member Report. This report uses the member extract and reports the following information:

1. Members with the most eligibility spans – informational only.
2. UCI numbers that are not 7 characters in length – informational only.
3. Members with eligibility spans with a start date greater than 30 days from today – these spans are manually deleted or corrected by state staff and **are not** reported to the boards.
4. Member spans where the eligibility status is other than "E" – state staff changes the eligibility statues to "E" (the only acceptable value).

The nightly update process can only update the current (latest) span. If a change affects a prior eligibility period (not the most current), this is reported on the Medicaid Retro Reports that are created and distributed to the boards on a monthly basis by FTP'ing the files to the boards' /county/extract/ sub-directory. Members who have been termed with MBDEC, MBINL, MBMOS, ERR01, EDUP1, EDUP2, and EDUP3 will not be updated.

The eligibility and demographic changes made by the nightly update process may replace valid data in Diamond with invalid data from ODJFS. For the vast majority of records the data from

ODJFS is correct. Incorrect information from ODJFS can only be corrected by the member contacting their local JFS (Job and Family Services) office. ODMH and ODADAS staff cannot correct this information. There is a process to keep certain fields from being overwritten with invalid data. (Please see the section on **Correcting/Updating Members**.)

VIII. Member Reports

The member reports are mailed on a weekly basis to boards. The Member Maintenance Reports will only be produced for those boards where errors or exceptions occurred. Some of these reports are informational only. These reports include information where the member has more than one Medicaid number; more than one member has the same social security number, a name discrepancy between ODJFS and MACSIS, potential Medicaid eligible clients, electronic duplicates, and members whose date of birth do not match.

Members with more than one RMF Medicaid number report. The purpose of this report is to identify Diamond members with more than one Medicaid ID. Members are matched against the RMF file and any member that matches on the first 6 characters of the last name, date of birth, gender and SSN appear on this report. The member maintenance staff will put the Medicaid ID on the member screen when only one Medicaid ID has an open eligibility span. If both Medicaid ID's are valid, the board receiving the report needs to identify the appropriate Medicaid ID to use and enter that Medicaid ID in the members Medicaid field within Diamond. The board needs to review the changes made by the member maintenance staff and relay the information on to providers.

Medicaid number check digit error report. The purpose of this report is to report any Medicaid ID that fails a check digit routine or is not in MEDELIG. This is an informational only report. There usually are not any of these reports.

Duplicate records by social security number. The purpose is to identify Diamond members with the same social security number but have a different date of birth. The member maintenance staff verifies the social security number and makes corrections to the member records in Diamond. Board staff should review these corrections made by the member maintenance staff and relay the information on to provider staff.

Potential duplicate report. The purpose of this report is to identify Diamond members who match on the first 8 characters of the last name, first character of the first name, date of birth and gender. Boards need to review these reports for the corrections made by the member maintenance staff and communicate these on to provider staff as well.

Potential Medicaid eligible clients. The purpose of this report is to identify members in MACSIS with no Medicaid ID whose social security number matches with an individual in the RMF. This report shows two lines of information per individual. The first line contains the information from MEDELIG. The second line has the information from Diamond. The member maintenance staff will make corrections to the members once the information has been verified and determined to be the same individual. Board staff should review the changes made by the member maintenance staff. On reports where state staff could not make a determination, board staff needs to review the information and determine whether it is the same individual. If the person is determined to be the same, board staff would enter the Medicaid ID in Diamond so that the person would no longer be reported.

Daily membership maintenance – Critical Errors reports. The purpose of this report is to report members with a reason code of ERR01 (members missing last name or first name, any part of the date of birth equals zeros, or the last name is less than 2 characters). Board staff needs to review the reports and make corrections in Diamond when appropriate. The term date and term reason need to be cleared once the corrections have been made.

Electronic duplicates reports. The purpose of these reports is to notify boards when members have been termed with reason codes of EDUP1, EDUP2, or EDUP3. Members termed with a reason code of **EDUP1**, identifies members who have the same social security number (other than all 5's) and the same date of birth. Members termed with a reason code of **EDUP2**, identifies members who have the same last name, same social security number and one digit of the date of birth is different. Members termed with a reason code of **EDUP3**, identifies members with the same first 8 characters of the last name, the same first 8 characters of the first name, the same date of birth and either of the two social security numbers is all 5's.

Boards need to verify that the corrections made by state staff are correct. If not, make appropriate corrections and notify the providers of the valid UCI# to be used for claim submission. If a correction needs to be made by board staff, make sure you clear out any term date and term reason from the valid UCI number. If the member that was termed by state staff is the UCI number that truly should be valid and the member is Medicaid eligible, remember to remove the Medicaid ID from the Other Identification ID's section on the UCI number that needs to be termed and enter it in the Other Identification ID's section on the UCI number that is to be the valid UCI.

Medicaid/Diamond comparison report. The purpose of this report is to identify Diamond members with a Medicaid ID who have a different date of birth than reported by ODJFS. The member maintenance staff makes corrections to members when they are able to verify the date of birth. Boards need to review the corrections made by the member maintenance staff and communicate the changes on to the provider. Boards need to verify with providers which date of birth is correct for those records that member maintenance staff were not able to verify. If ODJFS has the incorrect date of birth, the board will need to request that the Medicaid override flag be set so that the information is not overwritten during the nightly update. **Keep in mind that state staff cannot change the information that ODJFS has for a client. The client must contact their local office of JFS in order to get the information corrected.**

The state also produces a member extract file that is distributed to boards on a weekly basis. For more information on the file layout, refer to the MACSIS web site (**http://www.mh.state.oh.us/ois/macsis/extracts/new.and.old.member.extract.layouts.pdf**).

IX. Other Member Keywords/Misc. Functions

F4 NOTES

The **F4** notes function is accessed from the member screen. Use of this function allows boards to add/update additional information on members such as address changes, additional provider information, or notes concerning pending information to be received about the member and links the note to that member as well as the **MEMBR** keyword. Once a note has been entered and linked to a member, the member screen will be flagged with "see note" in the upper right hand corner.

Notes can also be added from the main Diamond screen by typing the keyword "**NOTES**". Notes added from the main menu are not directly linked to specific keywords in Diamond. The note

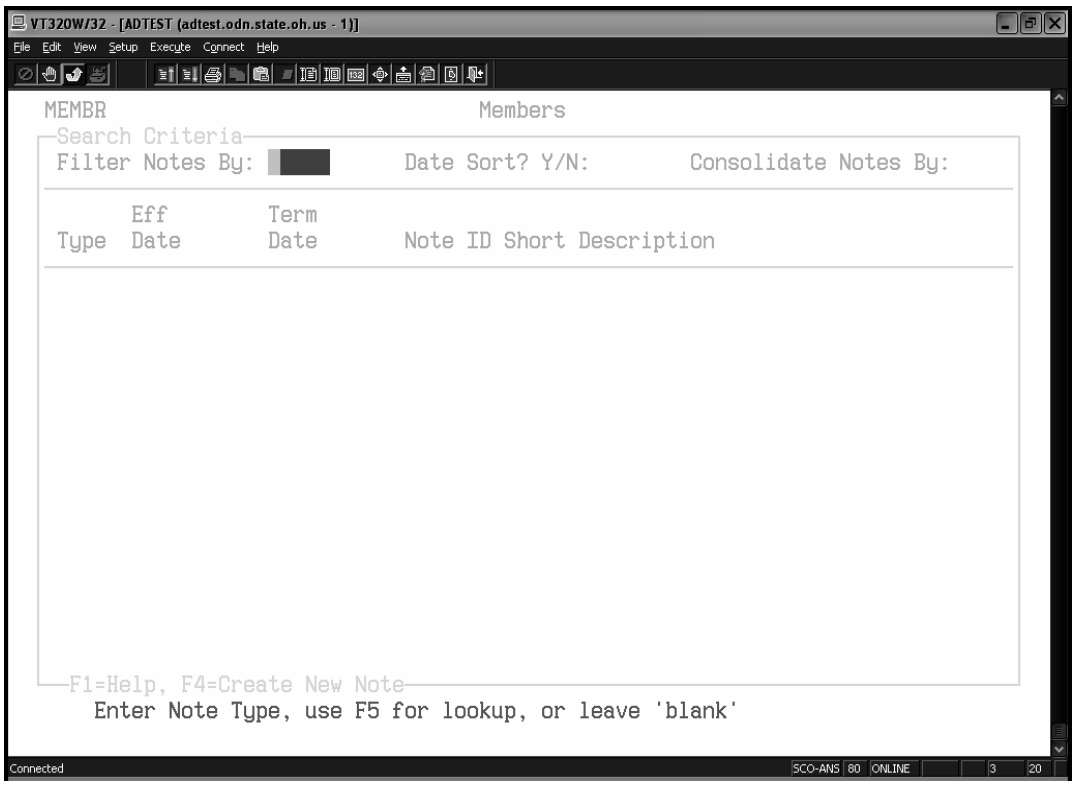
type will always be “Notes” when entered through this option. **If you want a note to be linked to specific member information, do not enter a note from the main menu.**

Entering Notes

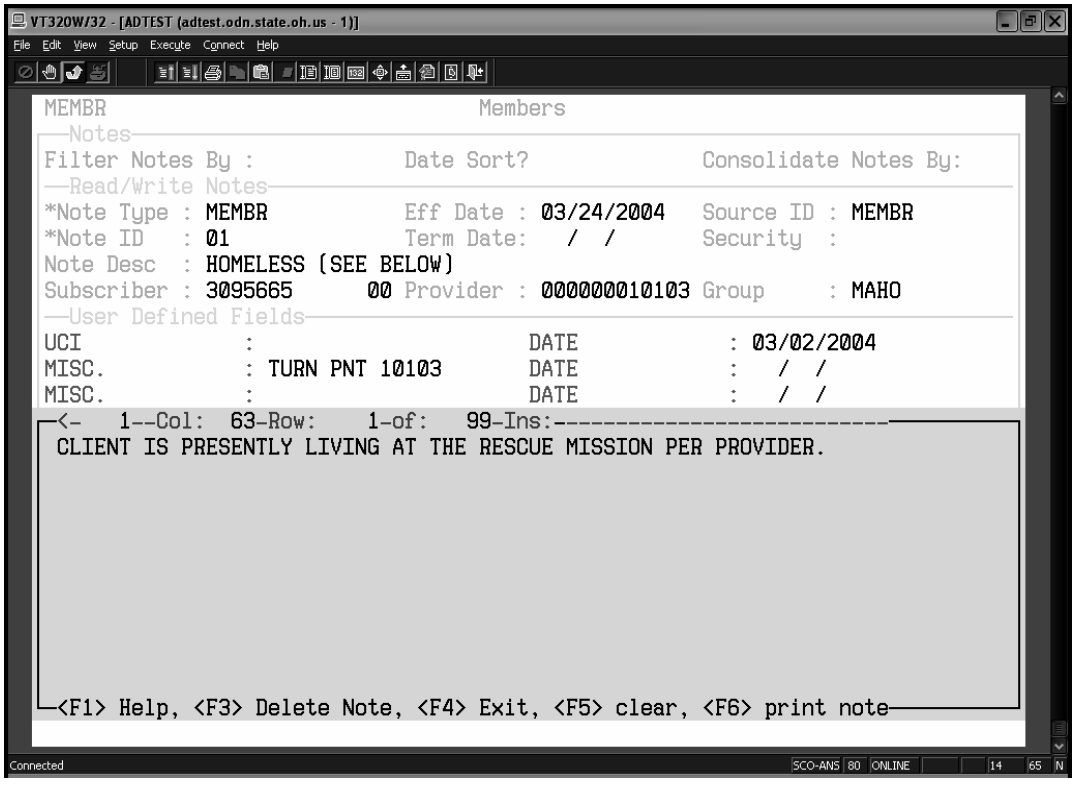
To enter a new note from the main MEMBR screen:

1. Enter the client’s UCI number and bring up the member information.
2. Hit F4 twice. (The Note Type, Subscriber, Provider, Source ID and Group will automatically be populated); hit <enter>. The Note ID field will be populated with the next available note number.
3. Enter a Note Desc if desired or hit <enter>.
4. The EFF Date will automatically populate with the current date (this can be overwritten with a different date if desired); term date and security code are optional.
5. Complete any relevant information in the User Defined Fields (you must enter through all of the User Defined Fields whether you are populating them or not, in order to bring up the text field).
6. Enter whatever information you want stored for that member in the text field (i.e. address, provider, additional information needed, etc).
7. When finished select F4 to exit the screen.
8. Enter “Y” to update (save) the note.

F4 Notes Screen 1



F4 Notes Screen 2



Editing Notes

To edit a note from the main MEMBR Screen:

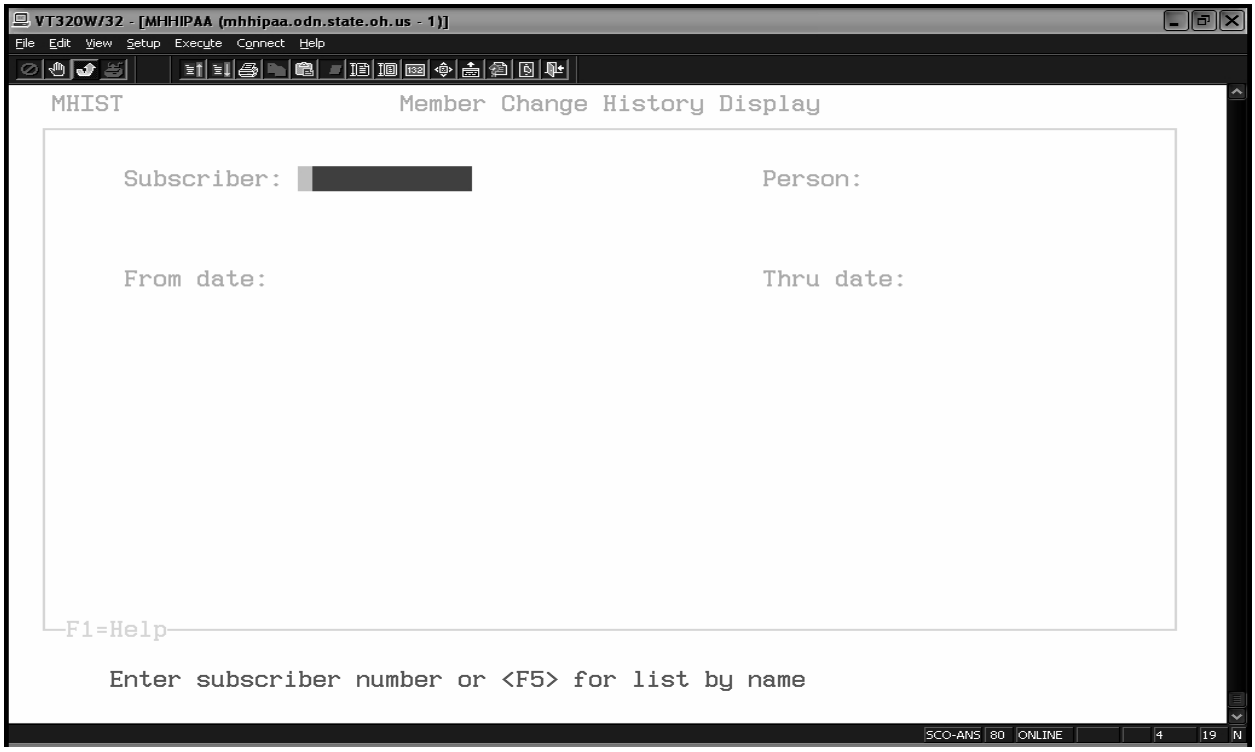
1. Enter the client's UCI number and bring up the member information.
2. Select F4 to go to the "Notes" screen.
3. Enter search criteria or press enter through the 3 search fields. If no search criteria was selected, a list of the current notes will be displayed.
4. Select the note you wish to edit and press <enter>.
5. Edit any information contained in the read/write notes section or the user-defined section.
6. Select <End> to edit/add information to the text field.
7. Press F4.
8. Enter "Y" to save changes.

MHIST

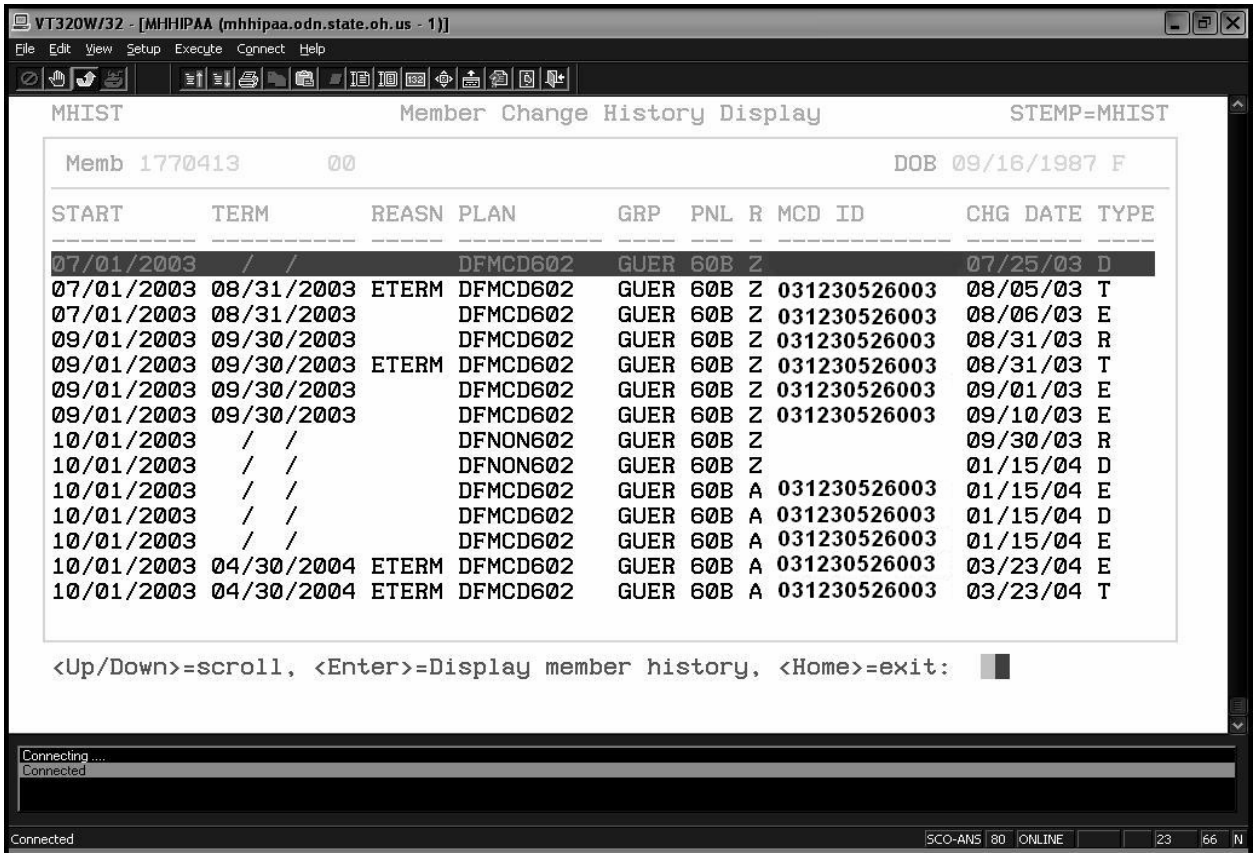
The keyword MHIST provides an audit trail of demographic and eligibility changes made to a member. This will show a listing of the changes made by date order. When you select and view any of the changes a date and initial stamp will show the date, the initials of the person who made the changes and the type of changes that were made. To access this information:

1. Type MHIST at the main Diamond menu.
2. Enter the client's UCI number and person number (00).
3. If there is a specific date range that you want to view, you enter those dates, otherwise hit <enter> and the system returns all the changes pertaining to eligibility or demographics for that member.
4. Highlight any date you wish to view and hit <enter>. The upper right hand corner will display the date the change was made, the initials of the person making the change and a letter which identifies the type of change made (R=Reinstate, D=Demographic, E=Eligibility and T=Terminated). **Keep in mind that not all changes are stored within MHIST.**

MHIST Screen 1



MHIST Screen 2



Shift + F1

Shift + F1 can be used to reveal the date and initials of who created or made changes when looking at member screens.

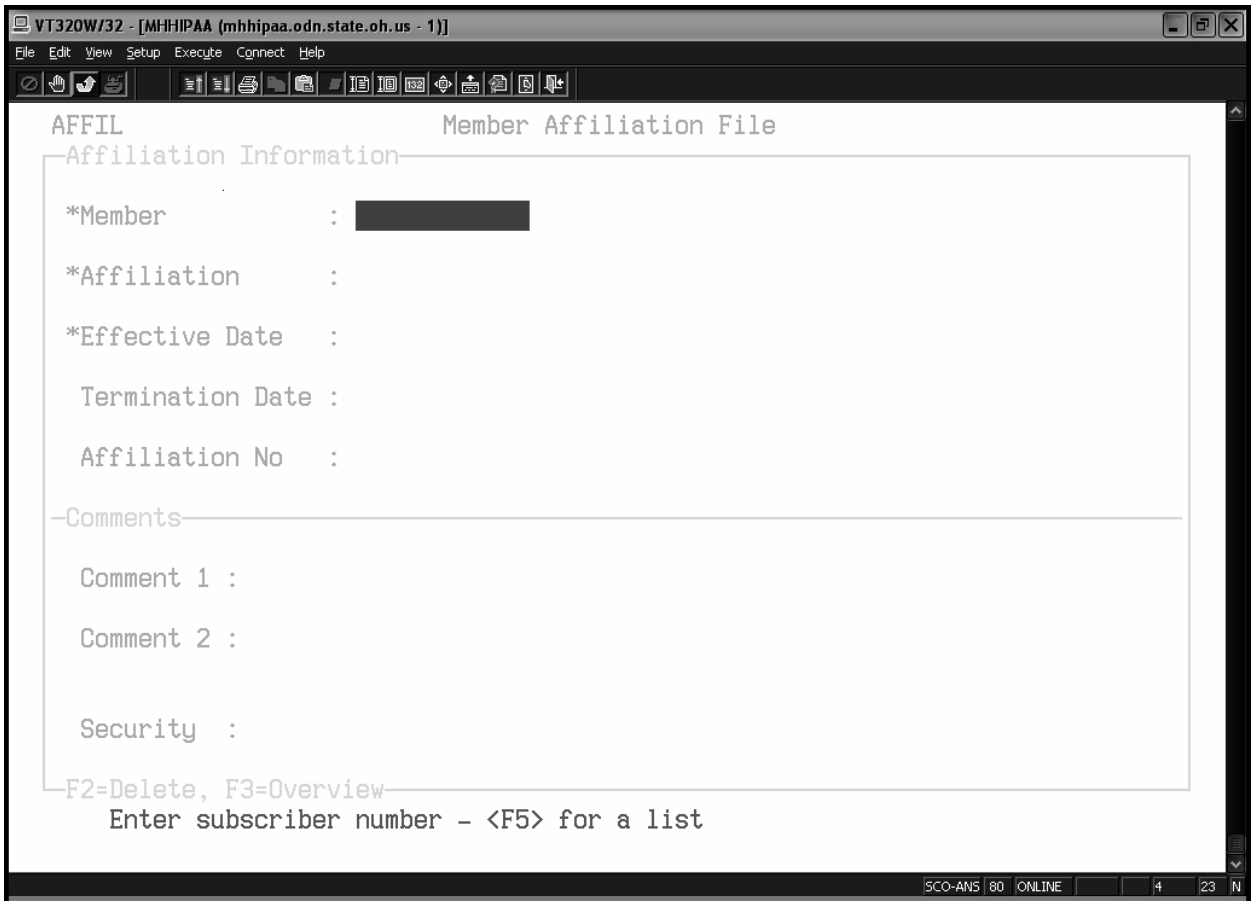
F5

Whenever you see an F5 option at the bottom of the member screen this indicates that there is a listing of valid codes from which to choose.

AFFIL

Affiliation Codes are optionally used in MACSIS to link groups with common membership characteristics (SMD, SED) and to track funding sources. This can be accessed through the MEMBR screen or Diamond keyword AFFIL. Affiliation Codes must be defined in the Diamond keyword AFFCD. To get an Affiliation Code entered please refer to the Change Control Policy (**http://www.mh.state.oh.us/ois/macsis/policies/change.control.pdf**). A special Affiliation extract is created by the state. This is created by request only. To request an extract email **MacsisSupport@mh.state.oh.us** .

Affiliation Screen



Entering an Affiliation Code from MEMBR

To enter an Affiliation Code from the MEMBR screen:

1. If the member is already in Diamond, enter the UCI number and the Patient No. 00 and hit <enter> to display the client information and hit the <End> key.
    a. If you are enrolling a new client, once the client information has been entered hit the <End> key.
2. Type “F” for Affiliation at the prompt.
3. The affiliation screen will appear and the client’s UCI, person number and name will automatically be populated.
4. Verify that the Affiliation Code has not already been entered by pressing “page down”.
5. Enter the appropriate Affiliation Code (or hit F5 then enter to view a list of current Affiliation Codes).
6. Enter the effective date.
7. Enter the appropriate security code.
8. Update the record (this returns you to the MEMBR screen).

Note: To view the affiliation code for a member bring up the member information, hit <End> and type “F” for affiliation. The affiliation screen will appear and the client’s UCI, person number

and name will automatically be populated. Hit <Page Down> and the affiliation records will be displayed. The client may have more than one affiliation record so you may need to page down more than one time.

Entering an Affiliation Code from the main screen

To enter an Affiliation Code from the main Diamond menu:

1. Enter the Diamond keyword AFFIL.
2. Enter the client's UCI number and the Person No. of "00".
3. The affiliation screen will appear and the client's name will automatically be populated.
4. Enter the appropriate Affiliation Code (or hit F5 then enter to view a list of current Affiliation Codes).
5. Enter the effective date.
6. Enter the appropriate security code.
7. Update (save) the record.

Note: To view the affiliation code for a member bring up the member information, hit <End> and type "F" for affiliation. The affiliation screen will appear and the client's UCI, person number and name will automatically be populated. Hit <Page Down> and the affiliation records will be displayed. The client may have more than one affiliation record so you may need to page down more than one time.

X. Special Topics

Electronic (computer generated) Updates

These updates are restricted to the most current eligibility span in Diamond. Old spans cannot be fixed, updated, deleted, etc. through any automated means. Never enter future dates for eligibility spans (start date). Board enrollment staff needs to be especially careful when entering eligibility dates in Diamond. Members that have been enrolled with a future date of eligibility will be deleted by the state.

Eligibility Period

When the line of business on the eligibility span is updated, future claims that post to the system will receive the changed line of business. However, previously posted claims for that same eligibility period are not automatically updated. Therefore, changes that affect prior eligibility spans may require manual re-processing of claims that have already been sent and posted into MACSIS. Given the impact that eligibility changes can have on claims processing it cannot be stressed enough that enrollment staff need to communicate these changes to claims staff on a timely basis.

Clients with two Medicaid Numbers

There are times when members have two active Medicaid numbers. The board will need to decide which Medicaid ID to place on the member record. The choice can be made by choosing the Medicaid number that has an open end date; or the one with the earliest start date; or the one with the most recent end date; or the one with the largest eligibility period. In some cases, the Medicaid case type may be the determining factor, i.e. CHIP, BCCP indicator or foster care. To change the Medicaid ID on the member screen access the keyword MEMBR, enter the

Medicaid ID in the Medicaid field located in the middle of the screen under Other Identification ID's. If you are changing the Medicaid number on a previous eligibility span, you must use the F6-E function. See section on **Correcting/Changing** members.

Retroactive Medicaid Eligibility

Retroactive Medicaid eligibility refers to a member's eligibility span(s) that was originally non-Medicaid but due to an eligibility change by ODJFS is now Medicaid eligible for that eligibility period(s). The Ohio Department of Job and Family Services is the party responsible for determining Medicaid eligibility for recipients. The most common occurrence you will see for retroactive Medicaid is when ODJFS has determined that the member is in fact eligible for Medicaid for a prior period in time. However, ODJFS can also take Medicaid eligibility away from a member. Some of the reasons a member could become Medicaid eligible retroactively includes: appeal filed by the recipient; change in income or number of dependents within the recipient's household; backlog in eligibility determinations by ODJFS caseworker, etc.

Retroactive changes can only be applied electronically if it is the most current eligibility span. Retroactive eligibility changes to prior spans must be entered manually whether it is for Medicaid or non-Medicaid.

The state runs a program on a monthly basis to identify retroactive Medicaid eligible members as well as any claims that have been paid as non-Medicaid that could now be billed as Medicaid. There are three files created from this process and placed in your /county/extract/ directory and these files are all inclusive.

- ☐ **hmondd.ret.clm.group_bd** - This file contains claims that can be fixed immediately.
- ☐ **hmondd.ret.mbr.group_bd** - This file contains member records that have eligibility spans that need corrected before correcting the claims.
- ☐ **hmondd.ret.clmfxmbr.group_bd** - This file contains claims to correct after the member eligibility spans have been corrected.

Boards are required to pay previously denied non-Medicaid claims when the member has been determined to be retroactively Medicaid eligible. It is financially beneficial for Boards to work these retroactive Medicaid files. Once the member's eligibility spans and claims have been fixed, the board will receive the FFP portion from ODJFS, therefore, reducing the amount of levy or other local funds that had been applied to those services that were previously paid as non-Medicaid. This may also mean more money for providers (i.e. Out of County services denied as non-Medicaid and not crisis, Medicaid only providers, etc.). Please refer to the Board Operations Manual HIPAA Claims Section for complete instructions on claims corrections. **http://www.mh.state.oh.us/ois/macsis/manuals/hipaa.claims.manual.pdf**

To correct the member eligibility (hmondd.ret.mbr.group_bd):

1. Access the member record
2. F6-E to access the eligibility maintenance screen
3. Select "C" (change) then press enter
4. Select the appropriate span

5. Change the member's plan to Medicaid

6. Enter the Medicaid ID in the USERDEF field

7. Update (save) the changes

NOTE: Be sure to correct all incorrect eligibility spans.

Backdated Enrollment Procedures

When a board receives an enrollment form with a backdated start date they must enroll the member but are not required to backdate the enrollment more than 365 days prior to the date the enrollment form was received from the provider. Example: provider sends an enrollment form to a board requesting a start date of April 1, 2005 and the board receives the enrollment form on July 1, 2006, the board enrollment staff would enter July 1, 2005 as the member's start date. Manual entry of Medicaid eligibility spans will be necessary for these types of enrollment requests.

Confidentiality

The following state and federal laws address confidentiality and related notice requirements imposed upon Providers, Boards, ODADAS and ODMH in conjunction with their roles in the public community mental health system:

Ohio Revised Code (ORC) Chapter 1347 applies to state and local agencies that deposit personally identifying information into a database. The statute mandates notice to persons whose data is input into the system, and adoption of measures to protect the confidentiality and integrity of information input into the system.

ORC 5122.31 (see also Ohio Administrative Code, OAC 5122-27-08), imposes limitations on the disclosure of personally identifying information relating to a recipient of mental health care or treatment.

42 Code of Federal Regulations (CFR) Part 2 (Re: Alcohol or Drug (AOD) Confidentiality)

AOD Policy – Consent for Release of Information

- ☐ Federal law (42 CFR 2.12 (d) (2)) requires releases of information relating to AOD treatment (with limited exceptions)
- ☐ Notice regarding prohibition on re-release of information also required
- ☐ Requires client signature
- ☐ Applicable to AOD treatment/services

45 CFR Part 164 (HIPAA) imposes limitations on the use and disclosure of protected health information. HIPAA applies to health plans, clearinghouses and health care providers, and, through mandated contracts, their business associates.

Out of County Enrollments

Board enrollment staff will work with provider staff in counties all over Ohio when one of the board's members presents for service at a provider in another county. Part of the ongoing training with providers should cover what documentation they need to collect to show proof of residency for enrollment in the appropriate board.

It is the provider's responsibility to determine county of residence. The information that a provider obtains in order to verify county of residence will vary across the state.. When the provider has sufficient evidence that the person is an out of county client, the provider needs to have the client sign a Residency Verification Form. For out of county clients, boards cannot request additional proof of residence. The signed Residency Verification Form is all that is required.

Note: Medicaid cards reflect the county that issued the card not necessarily the client's county of legal residence. Therefore, Medicaid cards should not be used to determine residency.

Once the provider has determined the residency of the client, the provider must submit the enrollment form to that board's enrollment center. Board enrollment contact and fax numbers can be obtained on the MACSIS web page (**http://www.mh.state.oh.us/ois/macsis/mac.con.mu.county.html)**. The provider must indicate on the enrollment form that releases have been obtained for the specific board area and whether or not the client is/was in crisis at the time of enrollment. Provider needs to include a **Residency Verification Form** signed by the client or legal guardian.

Upon receipt of an enrollment form from a provider that is treating a client who is a resident of that board area, the board's enrollment center should look up the client, enroll the client if not currently enrolled in MACSIS, and then return to the provider the client's UCI, plan assignment and rider information. If there are points of clarification, the board is responsible for making contact with the provider to resolve any questions.

It is recommended that no more than 5 business days should separate the submission of the enrollment form from the provider to the board and the receipt of the UCI by the provider. However, board's have up to 10 business days to return a UCI number to the provider before providers contact the MACSIS Support Desk. The provider will then use the UCI to bill for services. Medicaid clients receiving Medicaid certified services will be paid and non-Medicaid clients and non-Medicaid services will be subject to the Out of County Guidelines.

Disputed Enrollment Process (for Providers)

If the provider has followed the proper enrollment procedure for out of county and has not received a UCI number and the deadline of 10 business days is approaching, the provider can contact the board to inquire as to the status of the issuance of the UCI number. If the board of residency refuses to enroll the client or fails to provide a UCI within 10 business days, then the provider should contact the MACSIS Support Desk. (Refer to the **Guidelines Pertaining to the Implementation of MACSIS under HIPAA, Topic 8. Residency Guidelines, Item D: Disputed Enrollment Process (for Providers)**

The MACSIS Support desk will follow the **Enrollment Procedures through the Support Desk** when enrolling a client or providing a UCI number to the provider.

Note: Providers should be aware that out-of-county non-Medicaid clients that are not in crisis WILL NOT be enrolled (mental health only).

Residency Dispute Determination (RDD) Process

For those instances where boards cannot agree on the residency (hence, financial responsibility) of a specific member, the residency dispute determination process has been developed to review documentation submitted and make a final determination. The process is detailed on the RDD page of the MACSIS website (**http://www.mh.state.oh.us/ois/macsis/mac.pol.rdd.html**) Refer to Topic 8 of the Guidelines to the Implementation of MACSIS under HIPAA.

Residency issues will be governed by the ODMH and ODADAS definitions as incorporated in the **Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards**.

Member Transfer between Boards

A member transfer between boards occurs when a Board assumes financial responsibility of a member who is currently enrolled in MACSIS in another board's group and plan. This transfer can be the result of a member moving from one county to another, local contract with jail systems, homeless clients, etc.

The board that is transferring the member into their group and plan will access the member screen, term the current span by choosing F6-T with a term reason of MBMOV (member has moved out-of-county) and reinstate the member by choosing F6-R enter your board's group, plan, panel, rider, etc. If the transfer date is prior to the current eligibility span, follow the instructions for **correcting eligibility spans**. They will then notify the other board that they have transferred the member into their group and plan by following the procedure established by the member and claims users groups. Refer to the **Instructions for Completing Member/Claims Transfer**. Complete instructions on how to term a member can be found under the section **Correcting/Updating Members**. It is extremely important that boards follow the procedures as set forth due to the claims process involved and potential for creating mismatch claims.

Removal of Client Data from MACSIS

The information contained within MACSIS is client specific and under the terms of HIPAA is considered protected health information. There have been guidelines established to address the issue of removal of protected health information in MACSIS. There are conditions when client information can or cannot be removed from MACSIS, MH Outcomes and the Behavioral Health Module.

Client information can be removed if:

- Client is enrolled but there are no claims
- Client is enrolled and has received services but they have **not** been paid in whole or part with public funds

Client information cannot be removed if:

- Client is enrolled and has received services that have been paid in whole or part with public funds

The request to have a member's information removed from MACSIS can come from a board or provider on behalf of the client. Please refer to the MACSIS policies and guidelines for the complete procedure and form for such a request (see **Removal of Client Data from MACSIS** and **Request to Remove Client from MACSIS Form**).

Enter key

Whenever you enter a value in any Diamond field you must press the enter key in order for that information to be stored. If you make changes to a field, press the end key, and save, rather than pressing <enter> the information will be lost.

XI. Enrollment Process – Non-Client (Pseudo) Specific

A non-client specific service is a service that is not limited to a single member at a time. Services such as community education or drug and alcohol prevention might fall into this category. Pseudo UCI numbers are not intended to be utilized when clients refuse to provide or are unable to provide certain information so that they can be enrolled into MACSIS.

The board staff must enter all the fields that are mandatory for pseudo UCI numbers. To enter a pseudo UCI:

1. **UCI** – The UCI for these services will fall outside the normal range. The naming convention (BBBBTXXXXXPP) will begin with the four letter county code for the board in question (BBBB). The county code number for a multi-county board is the four-letter County ID where the board headquarters is located. For instance, the Clark-Greene-Madison Board headquarters is located in Clark County. Therefore, the Board uses CLAR for Clark County as the four letter county code.

   The fifth character (T) will designate the type of board. Split boards will use either A = Alcohol & Drug or M = Mental Health and combined boards will use B = Both.

   The next five digits (XXXXX) are used to contain the MACSIS UPID (provider ID).

   The last two digits (PP) will identify the service population codes as described in the table below titled "**Service Population Codes**".

2. **Name** – These three fields (First, Last & MI) should be used by the boards for identification purposes.

3. **Gender** – If the program is gender specific, the gender should be set to reflect the appropriate gender. Otherwise, it should be set to "U". This is the only time when "U" is appropriate for the gender field.

4. **DOB** – This field must be filled with "07/01/2000".

5. **Rel** – This field should always be “O”.

6. **SSN** – Social Security number for pseudo-clients should always be “111111111”.

7. **Start Date** – Because it is used to pay claims, this field should be the effective date of the program.

8. **Elig Sts** – This field should always be “E”.

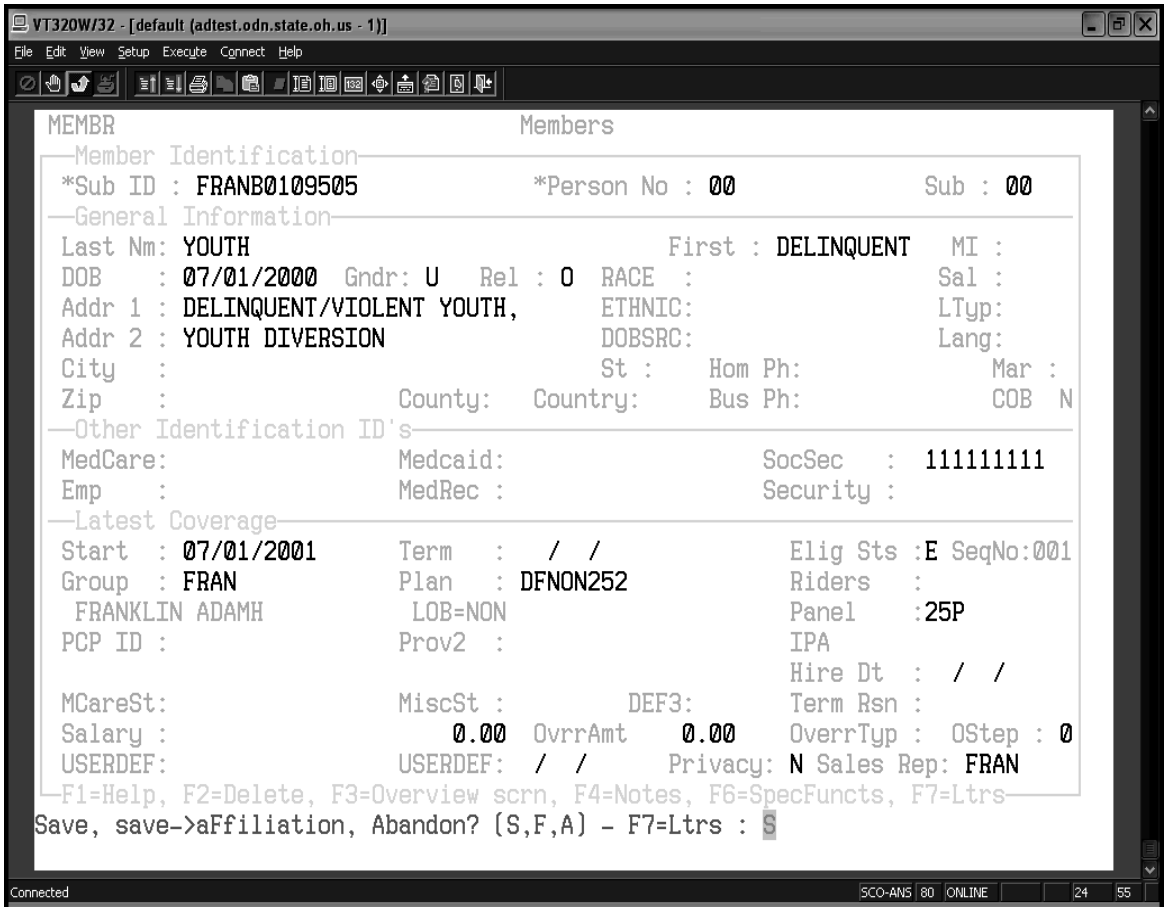
9. **Group** – This field should be the first four letters of the board in the UCI number for the pseudo client.

10. **Plan** – Enter the plan for which pseudo UCI’s are to be assigned (i.e. DFNON252). AD = Alcohol Drug, MH = Mental Health, DF = Dual Funded; NON = Non-Medicaid, Board Number, and Board Plan Code.

11. **Panel** – This field should reflect the panel the pseudo UCI is a member of (most boards only have one panel – if your board uses more than one panel make sure you enter the correct one because panel is used in claims pricing and adjudication).

12. **Sales Rep** – Enter the first four letters of the county of residence.

Example of UCI for Non-Specific Client:



FRANB0109505 Delinquent/Violent Youth

LUCAM4211307 Older Adults

LUCAA2345112 High School Students

NOTE: For certain procedure codes, ODADAS requires claims to be submitted using a Pseudo UCI only. Please refer to the listing of ODADAS procedure codes for more information (http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf)

Service Population Codes

1	Business and Industry	21	Preschool Students
2	Civic Groups/Coalitions	22	Prevention/Treatment Professionals
3	College Students	23	Religious Groups
4	(COSAs) Children of Substance Abusers	24	School Dropouts
5	Delinquent/Violent Youth	25	Teachers/Administrators
6	Economically Disadvantaged Youth/Adults	26	Youth/Minors
7	Older Adults	27	Law Enforcement/Military
8	Government/Elected Officials	28	Gays/Lesbians
9	Elementary School Students	29	HIV/AIDS, General
10	General Population	30	Hotline, General
11	Health Professionals	31	Crisis, General
12	High School Students	32	Jail Population, General; other than Law Enforcement (27)
13	Homeless/Runaway Youth	33	Other Forensic, General; other than Jail (32) or Law Enforcement (27)
14	Middle/Junior H.S. Students	34	Housing, General
15	Parents/Families	35	Tobacco, General
16	People Using Substances	36	Problem Gambling, General
17	People with Disabilities	37-49	Reserved
18	People with Mental Health Problems	50	Circle of Recovery
19	Physically/Emotionally Abused People	51-97	Board Assigned (other than above)
20	Pregnant Females/Women of Childbearing Age	98	Other
		99	Not Applicable (Default code)

Definitions

Business and Industry – Individuals who manage or work in for-profit businesses or industry. Examples are small business, companies, corporations, industrial plants, and unions. Use Code 01.

Civic Groups/Coalitions – Members of civic organizations, nonprofit organizations, and community coalitions. Examples are men's and women's state or local civic groups, nonprofit agency boards of directors or staff, community or statewide coalition members, community partnership groups, and community task forces, alliances, and similar community organizations. Use Code 02.

College Students – Youth and adults enrolled in public or private institutions of higher education, including enrollees in universities, colleges, community colleges, technical colleges, and other institutions for advance education. Use Code 03.

COSAs/Children of Substance Abusers – Youth and adults who are children of substance abusers. Examples are adult children of alcoholics, children whose parents' abuse alcohol or other drugs, and children raised in or chronically exposed to situations involving substance abuse. Use Code 04.

Delinquent/Violent Youth – Youth who display risk factors for delinquency or violence or who have been determined to be delinquent or violent. Examples are youth declared delinquent by a state child welfare system, youth who have been arrested for juvenile delinquent behavior, youth who are chronically truant, and youth who display chronic or periodic violent behavior,

including youth who display antisocial behavior (e.g. chronic fighting, hitting, using weapons). Use Code 05.

Economically Disadvantaged Youth/Adults – Youth and adults considered underprivileged in material goods due to poor economic conditions. Examples are youth and adults living in poor housing conditions or who are enrolled in State or Federal public assistance programs. Use Code 06.

Older Adults – Adults considered being older (in general, persons over 65 years of age). Examples are older persons who are living independently or residing in a nursing home or an assisted living facility. Use Code 07.

Government/Elected Officials – Individuals holding government positions, including those who are elected to public office. Examples are government workers; mayors, city administrators, city or county commissioners, supervisors, freeholders, or other elected officials; state legislators and staff; and members of the U.S. Congress and their legislative staff. Use Code 08.

Elementary School Students – Youth enrolled in public or private elementary schools in kindergarten through grade five. Use Code 09.

General Population – Youth and adult citizens of a state rather than a specific group within the general population. Use Code 10.

Health Professionals – Individuals employed by or volunteering for health care services. Examples are physician, nurses, medical social workers, medical support personnel, medical technicians, and public health personnel. Use Code 11.

High School Students – Youth enrolled in public or private high schools (generally grades 10 through 12) and home study youth in these grades. Use Code 12.

Homeless/Runway Youth – Youth (and adults) who do not have a stable residence or who have fled their primary residence. Examples are street youth (and adults), youth (and adults) in homeless shelters, and youth in unsupervised living situations. Use Code 13.

Middle/Junior High School Students – Youth enrolled in public or private middle schools or junior high schools including grades 6 through 8, 6 through 9, or 7 through 9, sixth-grade and seventh-grade centers, and home-study youth in comparable groups. Use Code 14.

Parents/Families – Parents and families, including biological parents, adoptive parents, and foster parents; grandparents, aunts and uncles, or other relatives in charge of or concerned with the care and raising of youth; nuclear families; and mixed families. Use Code 15.

People Using Substances – Youth and adults who may have used or experimented with alcohol, tobacco, or other drugs. Examples are youth or adults charges with driving under the influence (DUI), driving while intoxicated (DWI), or being a minor in possession (MIP); social or casual users of illicit substances; and youth and adults who smoke tobacco or consume alcoholic beverages but who are not yet in need of treatment services. Use Code 16.

People with Disabilities – Youth and adults who have disabilities. Examples are individuals who are physically handicapped, hearing impaired, speech impaired, or visually impaired. Use Code 17.

People with Mental Health Problems – Youth and adults with mental health problems. Examples are persons with diagnosable mental illness such as depression, severely emotionally disturbed youth, and the educable mentally retarded. Use Code 18.

Physically/Emotionally Abused People – Youth and adults who have experienced physical or emotional abuse. Examples are victims of physical abuse, sexual abuse, incest, emotional abuse, and domestic abuse. Use Code 19.

Pregnant Females/Women of Childbearing Age – Women who are of the physiological age to bear children and for whom the intent of prevention services is to ensure healthy newborns. Use code 20.

Preschool Students – Youth enrolled in, or of an age to be enrolled in, public or private preschool programs. Examples are youth enrolled in preschool programs, child day care, and Head Start programs and other children aged 4 or younger. Use Code 21.

Prevention/Treatment Professionals – Individuals employed as substance abuse prevention or treatment professionals. Examples are counselors, therapists, prevention professionals, preventionists, clinicians, prevention or treatment supervisors, and agency directors. Use Code 22.

Religious Groups – Individuals involved with, employed in religious denominations, or organized religious groups such as churches, synagogues, temples, or mosques. Examples are members, deacons, elders, clergy, religious associations, ministerial associations, ecumenical councils or organizations, lay leaders, and religious education staff. Use code 23.

School Dropouts – Youth under the age of 18 who have not graduated from school or earned a general educational development certificate and/or who are not enrolled in a public or private learning institution. Use Code 24.

Teachers/Administrators/Counselors – Individuals employed in the education field. Examples are teachers, coaches, deans, principals, faculty, and counselors. Use Code 25.

Youth/Minors – Children under age 18 who are not otherwise counted within one of the school grade categories. Examples are youth in recreation programs (camps, summer programs), youth in employment programs, and youth in clubs or recreation centers. Use Code 26.

Law Enforcement/Military – Individuals employed in law enforcement agencies or in one of the U.S. Armed Services. Examples are police, sheriffs, state law enforcement personnel, and members of the National Guard, Army, Navy, Marines, Air Force, and Coast Guard. Use Code 27.

Gays/Lesbians – Individuals who identify themselves as emotionally and physically attracted to others of the same gender. Use Code 28.

HIV/AIDS, General – Provision of services to non-identified individuals affected by HIV or Aids. Use Code 29.

Hotline, General – Provision of a program's capacity to respond to telephone calls, often anonymous, made to a program for crisis and/or emergencies on a 24-hour per day, seven days a week. Use Code 30.

Crisis, General - Provision of face-to-face emergency services in a non-client identified manner. Use Code 31.

Jail Population, General; Other than Law Enforcement – Provision of non-client identified services to persons within a jail setting. Use Code 32.

Other Forensic, General; Other Than Jail (32) or Law Enforcement (27) – Provision of non-client identified services for persons identified under ORC 2945.371G3, 475.38B, 40/38B, 402A38B, H402/38B, 39A/38B, etc. Use Code 33.

Housing, General – Provision of non-treatment housing to non-client specific population. Use Code 34.

Tobacco, General – Provision of education and prevention services to non-identified clients or groups of clients covering addiction to tobacco and tobacco related products. Use Code 35.

Problem Gambling, General – Provision of services to non-identified clients or groups of individuals to train, identify, educate or develop services to persons suffering from gambling addiction and/or problems because of ones gambling. Use Code 36.

Reserved – Codes 37 – 49.

Circle of Recovery – Provision of non-treatment Re-Entry relapse prevention services for African American male ex-offenders under the supervision of local Adult Parole Authorities. Use Code 50.

Board Assigned (other than above) – Codes 51 – 97.

Other – Individuals or organizations who do not fit any of the above definitions or who represent a special population on which a particular state wishes to capture prevention services data. Use Code 98.

Not Applicable – Used for prevention services not directed at a specific population (e.g. community drop-in centers, community teams).

XII. Reference Documents

These are the most current version of the reference documents that are included in this section. Please check the MACSIS Website periodically for any updates that may become available (**http://www.mh.state.oh.us/ois/macsis/macsis.index.html**).

MACSIS Client (Member) Enrollment Form Completion Procedures

Within the MACSIS system, the term Member is used to represent those enrolled in the system and receiving services from providers being reimbursed by the system. Since the MACSIS screens and documentation utilize Member when describing those enrolled and receiving services through the system, we have adopted the term when we refer to client information contained in MACSIS to reduce the confusion.

In completing the form it is imperative that the person completing the form to remember to write legibly.

For those that are entering the data into Diamond it is important to remember that all data entered into MACSIS is to be done in CAPITAL LETTERS.

1. **ADAMH/ADAS/CMH Board Consortium:** This is the name of the board to which the enrollment form is forwarded.
2. **MACSIS UCI:** Required upon change to existing member. This field will be completed by the board designated enrollment staff after the form has been processed for new members. A form prepared to change data on an existing member must have this field completed.
3. **FORM TYPE:** Required. This indicates whether this form is being completed for enrolling a new member, updating, or correcting information on a currently enrolled member. The UCI is required in order for the form to be considered as a change.
4. **Submitting Provider:** Required. Enter the name of the agency providing the service.
5. **Date Faxed to Enrollment Center:** Enter the date the form was faxed to the enrollment center.
6. **Submitting Provider UPI:** Required. Enter the MACSIS Universal Provider ID for your agency.
7. **Contact Person:** Required. Enter first and last name of the person at your agency that the board designated enrollment staff should contact in case there are questions about the data reported on this form. In most cases, this will be the name of your agency's enrollment contact person.
8. **FAX Number:** Required. This is the secured agency fax number to which completed enrollment forms should be faxed back to the submitting provider.
9. **Contact Phone number:** Required. Enter the phone number at which the "Contact Person" may be reached during business hours.
10. **Last Name:** Required. This is the member's second or family name. It must be upper case alphabetic. The only non-alphabetic character allowed is a dash, used in hyphenated last names.
11. **First Name:** Required. This is the member's legal first name.
12. **Middle Initial:** This refers to the member's middle initial as his/her second given name. Use one character. If member has no middle name leave blank.
13. **DOB:** Required**.** Enter the member's Date of Birth as a two number month, two number day of the month and four number year (example: 03/15/1956). If not obtainable, use 07/04/1876.
14. **Sex:** Required. Indicate the member's gender.

15. **Address 1:** Required. Indicate the first line of member's physical address. If the member is homeless, write "HOMELESS".

16. **Address 2:** Indicate second line of member's physical address. If there is no second line, leave blank.

17. **City:** Required. Indicate the member's physical city of residence. If the member is homeless and living in a shelter, enter the shelter's city; otherwise, enter the board's city.

18. **State:** Required**.** Indicate the member's physical state of residence. If the member is homeless and living in a shelter, enter the shelter's state abbreviation; otherwise enter "OH".

19. **ZIP:** First five digits are required**.** Indicate the member's physical address zip code (ZIP + 4). If you do not know the last four digits, leave the last four spaces blank. If the member is homeless and living in a shelter, enter the shelter's zip code. If the zip code is unknown, enter "55555".

20. **Race:** Required. Indicate the member's self-report of his/her race, selecting all appropriate code(s).

    The official policy of the State of Ohio is to use the stated codes for all information entries to the race field. All blanks and entries that do not conform to the code list will be changed to 'U'.

    The following codes will be used as the standard for maintaining, collecting, and presenting data on race for all Federal-reporting purposes. *****

Code	Race	Definitions (for documentation purposes)
N	American Indian	A person having origins in any of the original peoples of North (excluding Alaska) and South America (including Central America), and who maintains tribal affiliation or community attachment.
M	Alaskan Native	A person having origins in any of the original peoples of Alaska, and who maintains tribal affiliation or community attachment
A	Asian	A person having origins in any of the original peoples of the Far Eat, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
B	Black or African American	A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "negro" can be used in addition to "Black or African American."
P	Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands [which includes: Carolinian, Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese), and Yapese.]
W	White	Aperson having origins in any of the original peoples of Europe, the Middle East, or North Africa.
U	Unknown	This code should be used only if the race of the member is unknown.

***** The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as

determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race by Federal agencies.

21. **Ethnicity:** Required. Indicate the member's self-report of his/her ethnicity, selecting all appropriate code(s).

    The official policy of the State of Ohio is to use the stated codes for all information entries to the ethnicity field. All blanks and entries that do not conform to the code list will be changed to E.

    The following codes will be used as the standard for maintaining, collecting, and presenting data on ethnicity for all Federal-reporting purposes. *****

Ethnicity Codes and Definitions	
Code	**Ethnic Designation**
A	Puerto Rican
B	Mexican
C	Cuban
D	Other Hispanic
E	Not Hispanic or Latino

    ***** The categories in this classification are social-political constructs and should not be interpreted as being either scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on ethnicity by Federal agencies. Although OMB only requires the "header classification," Hispanic and Not Hispanic, SAMHSA will continue to require the same breakdown for ethnicity. Instead, they will collapse down to OMB.

22. **Home Phone Number:** Indicate the member's home phone number including the area code. If not known or member prefers not to provide this information leave field blank.

23. **Business Phone Number:** Indicate the member's business phone number including the area code. If not known or member prefers not to provide this information leave field blank.

24. **Non-English Language Code:** Enter the code if the member's primary language is not English. If the member's primary language is English, leave blank. Non-English language codes are located on the back of the form.

25. **Marital Status:** Required. Select the appropriate code for the marital status of the member. Do not fail to select one of the categories. If the member is "separated", check "married".

26. **Medicaid Number:** If you know the member's 12-digit Medicaid Recipient number, enter it here.

27. **Social Security Number:** Required. Enter the nine-digit social security number for the member. This information is crucial to determination of the member's eligibility for Medicaid, and for identifying if they are currently enrolled in MACSIS. Value to "555555555" if unobtainable (report as soon as found).

28. **Client ID at Provider (medical record no.):** Enter the client ID in your provider system that you use for the member.
29. **Start Date:** Required. This is the date that the member is admitted to your agency (Admission Date). This date must be equal to or before the first date of service provided as identified on your claim. This information should be entered in the following format: Two number month, two number day of the month, and four number year (example: 07/13/1998).
30. **Family Size (01-99):** Required. In this field, enter the number of individuals, including the member, who live in the home and are dependent upon the family income. The number of dependents in the family is determined, as it would be on the federal income tax return. If unobtainable, value to "01".
31. **Adjusted Gross Monthly Income:** Required. Enter the family's Adjusted Gross Monthly Income.
32. **County of Residence:** Required. Enter the first four characters of the county responsible for adjudicating the client's behavioral health claims or check "out of state". The Residency Determination Guidelines outline how to determine the county responsible for adjudication, including for special populations such as foster children, out-of-county clients, college students, homeless clients, migrant workers, out-of-state clients, adults in specialized institutions and forensic clients.

Please note that a Residency Verification Form is required along with the enrollment form in the following circumstances:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (ex. domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

A Residency Verification Form is not required for adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories. The latter populations require proof of residency as outlined in the Residency Determination Guidelines.

County Table

ADAM	ADAMS	**ALLE**	ALLEN	**ASHL**	ASHLAND
ASHT	ASHTABULA	**ATHE**	ATHENS	**AUGL**	AUGLAIZE
BELM	BELMONT	**BROW**	BROWN	**BUTL**	BUTLER
CARR	CARROLL	**CHAM**	CHAMPAIGN	**CLAR**	CLARK
CLER	CLERMONT	**CLIN**	CLINTON	**COLU**	COLUMBIANA
COSH	COSHOCTON	**CRAW**	CRAWFORD	**CUYA**	CUYAHOGA
DARK	DARKE	**DEFI**	DEFIANCE	**DELA**	DELAWARE
ERIE	ERIE	**FAIR**	FAIRFIELD	**FAYE**	FAYETTE
FRAN	FRANKLIN	**FULT**	FULTON	**GALL**	GALLIA
GEAU	GEAUGA	**GREE**	GREENE	**GUER**	GUERNSEY
HAMI	HAMILTON	**HANC**	HANCOCK	**HARD**	HARDIN
HARR	HARRISON	**HENR**	HENRY	**HIGH**	HIGHLAND

HOCK	HOCKING	**HOLM**	HOLMES	**HURO**	HURON
JACK	JACKSON	**JEFF**	JEFFERSON	**KNOX**	KNOX
LAKE	LAKE	**LAWR**	LAWRENCE	**LICK**	LICKING
LOGA	LOGAN	**LORA**	LORAINE	**LUCA**	LUCAS
MADI	MADISON	**MAHO**	MAHONING	**MARI**	MARION
MEDI	MEDINA	**MEIG**	MEIGS	**MERC**	MERCER
MIAM	MIAMI	**MONR**	MONROE	**MONT**	MONTGOMERY
MORG	MORGAN	**MORR**	MORROW	**MUSK**	MUSKINGUM
NOBL	NOBLE	**OTTA**	OTTAWA	**PAUL**	PAULDING
PERR	PERRY	**PICK**	PICKAWAY	**PIKE**	PIKE
PORT	PORTAGE	**PREB**	PREBLE	**PUTN**	PUTNAM
RICH	RICHLAND	**ROSS**	ROSS	**SAND**	SANDUSKEY
SCIO	SCIOTO	**SENE**	SENECA	**SHEL**	SHELBY
STAR	STARK	**SUMM**	SUMMIT	**TRUM**	TRUMBULL
TUSC	TUSCARAWAS	**UNIO**	UNION	**VANW**	VAN WERT
VINT	VINTON	**WARR**	WARREN	**WASH**	WASHINGTON
WAYN	WAYNE	**WILL**	WILLIAMS	**WOOD**	WOOD
WYAN	WYANDOT				

For data items 33 through 45, some of this information may not be pertinent. Contact the board you contract with to determine need for and specific instructions for completing these fields.

33. Plan Type: Select the appropriate plan type.

34. Sliding Fee Percentage: Enter the percentage as required per the provider's contract with the enrolling board. If no contract with the enrolling board, leave blank.

35. Member Copay: This amount is the amount that the member is required to pay. Enter the amount as required per the provider's contract with the enrolling board. If no contract with the enrolling board, leave blank.

MEMBER DISCLOSURE STATEMENT SECTION

This section confirms that the member has been notified that for billing purposes, information will be released to the appropriate board, the State of Ohio and other entities necessary to recoup the cost of services provided. These documents will be kept in the member's clinical record at the provider agency. If the member is unable to sign these forms, follow your policy on documentation of such situations.

36. Client is potentially SMD/SED? Check the yes box if you feel it is likely that the client will qualify as "severely mentally disabled" (SMD) or "severely emotionally disabled" (SED) per the definitions published by the Ohio Department of Mental Health. For clients receiving only AOD services, check "no". The answer to this question may or may not be used to determine the designation of a plan by the enrolling board.

37. AOD release of information signed (AOD only)? Required for AOD or dual-diagnosis clients. Check the yes box if the AOD release of information was signed. If not applicable, do not check either box.

38. Consent for treatment signed? Required. Check the yes box if the member has signed the consent for treatment document.

39. **Client refused to sign consent for treatment (MH only)?** Required for MH or dual-diagnosis clients only. Check the yes box if the client refused to sign the consent for treatment to receive mental health services.
40. **In crisis at enrollment?** Required. Check the yes box if the member is crisis and is not able to sign the Consent to Treatment at the time of enrollment. If the box is checked "yes", then the enrolling board must accept the enrollment request, if the provider has included, at a minimum, the client's last name, first name, gender (best guess) and actual or "default" date of birth on the enrollment form. Every effort should be made by the provider to subsequently obtain complete enrollment information.
41. **Referred to Provider Name:** Enter the name of the lead provider agency to which the member has been referred for further treatment.
42. **Referred to UPI:** Enter the provider agency's MACSIS UPI (Universal Provider ID).
43. **Other 1:** This field may also be used to indicate plan, panel or affiliation codes as instructed by your contracting board.
44. **Other 2:** Same as "Other 1" field.
45. **Other 3:** Same as "Other 1" field.

Items Completed by the Enrollment Staff

Items below the line titled "Items Completed by the Enrollment Staff" on the form, do not need to be completed by the provider. Contact your contracting board/boards to know how to interpret information returned to you in these fields.

Group Level 3:

46. **Plan:**
47. **Panel:**
48. **Riders:**
49. **Term Date:**
50. **Term Reason:**
51. **Staff Entering Data:**
52. **Date Entered:**
53. **Date Faxed to Provider:**

New Member Enrollment/UCI Request Form

* = Required Field

NEW MEMBER ENROLLMENT/UCI REQUEST

ADAMH/ADAS/CMH Board Consortium

*MACSIS UCI No. (Req'd on change only)

*Form Type
N = New Member
C = Change/Correction

PROVIDER INFORMATION

*Submitting Provider		Date Faxed to Enrollment Center	*UPI
*Contact Person	*Fax No.	*Phone No. (include ext.)	

CLIENT INFORMATION

*Last Name: *First: MI:

*DOB: *Gender: M F

*Address 1:

Address 2:

*City: *State: *Zip: –

*Race ("X" all that apply): A - Asian; B - Black/African American; M - Alaskan Native; N - Native American/American Indian; P - Native Hawaiian/Other Pacific Islander; W - White; U - Unknown

*Ethnicity ("X" all that apply): A - Puerto Rican; B - Mexican; C - Cuban; D - Other Hispanic; E - Not Hispanic or Latino

Home Phone: Business Phone:

Non-English Language Code codes from A-Z (see reverse):

*Marital Status: S - Single; M - Married; D - Divorced; W - Widowed

Medicaid No.: *SSN: Client ID at Provider (medical record no.):

*Start Date: – – *Family Size: *Adjusted Gross Mo. Income: .

*County of Residence (1st 4 letters of co.): Out of State

Plan Type: MH - Mental Health; AD - Alcohol and Other Drugs; DF - Dual Funded

Client is potentially SMD/SED? Yes No

*AOD release of information signed (AOD only)? Yes No

*Consent for treatment signed? Yes No

*Client refused to sign consent for treatment (MH only)? Yes No

*In crisis at enrollment? Yes No

Sliding Fee Percentage	Member Copay

Referred to

Provider Name	UPI	Other 1	Other 2	Other 3

Prohibition on Redisclosure: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse and/or mental health treatment. State and Federal law prohibit redisclosure of this information without the client's consent. With respect to clients receiving alcohol and other drug addiction treatment, this information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ITEMS COMPLETED BY ENROLLMENT STAFF

Group - Level 3: Plan: Panel:

Riders: Term. Date: Term. Reason:

Staff Entering Data	Date Entered	Date Faxed to Provider

(Rev. 1/04) (codes on reverse)

MACSIS Residency Verification Form

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? ☐ Yes ☐ No **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

DMH-MACSIS-001 (Rev. 3/02)

Residency Guidelines

1. The purpose of these guidelines and operating principles is to clarify what is to take place, in terms of board responsibilities and residency determinations, when clients seek services outside their service district of residence.

    a. Nothing contained in this document should be interpreted to reduce in any way the obligation of boards set forth in ORC Section 5122.01 (S) to deal with crisis/emergency situations which occur within their service districts and to respond to essential client service needs while residency questions are being resolved.

    b. Regardless of residency determination, nothing contained in this document should be interpreted to constrain the freedom of clients to seek services wherever they wish. Rather, it is intended to clarify which board is to deal with such requests and under the auspices of which Board's Mutual Systems Performance Agreement – M-SPA (i.e., the Community Mental Health Plan) they are to be considered.

2. For the purposes of MACSIS, the county of assigned residency determines into which board's service system (i.e. group and plan) an individual is to be enrolled. In special circumstances, a client may live in a board area which differs from that to which residency/enrollment has been legitimately and appropriately assigned.

3. A fundamental tenet that is to guide residency policy and its interpretation is that continuity-of-care is paramount and that responsibility to ensure this in instances of out-of-district placement or referral should rest ultimately with the "home" board from which the client came. A board should not be in a position to shift this responsibility by facilitating the relocation of clients to facilities or services which lie outside its service district. The "home" board to which a client's residency is assigned should carry the following responsibilities (some of which may be delegated to another entity):

    a. Assuring reasonable client access to the services called for in the board's M-SPA in a fair and equitable manner.

    b. Enrolling eligible persons in its benefit plans in accordance with the applicable business rules and providing for the provision and management of these benefits.

    c. Serving as the local authority for funding, contracting, coordinating, monitoring, and evaluating services. These responsibilities include clinical oversight and utilization review responsibilities as authorized by Chapters 340 and 5122 of the Ohio Revised Code.

    d. Providing the necessary financial resources (to the extent such resources are available to the board).

    e. Taking in the initiative to negotiate and implement workable solutions when problems involving residency arise.

4. Residency determinations are to be based upon the following:

    A. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which reads as follows:

    "Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.30, 2945.40, 2945.401 [2945.40.1], or

2945.402 [2945.40.2] of the Revised Code, residence means the county where the criminal charges were filed.

B. For alcohol/drug clients, the definition of residency established by ODADAS, which reads as follows:

"Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

5. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, ODMH and ODADAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" board because of a client's placement in a special residential program or facility or because of other unusual circumstances.
6. The provisions of ORC Section 5122.01 (S) and the ODADAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:
   a. A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).
   b. The type of facilities encompassed includes hospitals, nursing homes, ODMH-licensed and ODADAS certified residential facilities, Ohio Department of Health (ODH) licensed Adult Care Facilities, mental retardation group homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), rest homes, drug/alcohol residential programs, crisis shelters, foster-care homes, etc.
   c. The term "mental health services" is to be construed broadly to encompass all those items contained in OAC 5122-25-02(B) and ORC Section 340.09 and the term "alcohol or other drug addiction services" shall include all those alcohol/drug services identified in OAC 3793:2-1-08 through 17.
   d. The phrase "receiving (MH or AOD) services at a program/facility" is to be understood to mean "while on the rolls of the program/facility." It is not necessary either for the services to be provided "on the premises of the program/facility" or "by an employee of the program/facility." Likewise, it is not necessary for said services to be officially certified for the purposes of residency determination.
   e. There is to be no "statute of limitations" on designated residency remaining with the "home" board for persons placed in specialized residential programs/facilities that lie outside its service district.
   f. Designated residency shall remain with the "home" board regardless of whether it was directly involved in facilitating placement in an out-of-district specialized program/facility.
   g. Residency shall not remain with the "home" board in those situations where a client is placed for an indefinite period in a facility for reasons having nothing to do with mental health or alcohol/drug needs and then develops such problems subsequent to placement. However, no discharge directly from a state hospital to a facility shall cause a change in residency, regardless of the reasons for the discharge.

7. The interpretation of the provisions of ORC Section 5122.01(S) and the ODADAS definition of residency in regard to "intent to remain" shall be guided by the following:

   a. "Intent to remain" is to be interpreted to mean a person's expressed intent, **as documented by completing and signing the Residency Verification Form,** to remain in the county, with the exception of persons in specialized treatment facilities. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose. The Residency Verification Form should be completed when:

      1. The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county)
      2. The physical address of the client as noted on the enrollment form does not match the legal county of residency of the client (ex. Domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county)
      3. The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

   b. Boards may request from in-county, contracting providers one of the following forms of documentation that is current to assess whether a person's actions demonstrate intent to be a resident. The contract between a provider and board may dictate the form of documentation required for cases not outlined in section 7.a. above.

      1. mailing address
      2. voting
      3. car registration
      4. job or other vocational efforts
      5. payments of taxes
      6. location of family
      7. general conduct
      8. signed Residency Verification form

         (**http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf**)

         - Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.
         - Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-à-vis residency.
         - For out-of-county, non-contracting providers, a signed Residency Verification Form shall suffice as proof of residency.

8. Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a Children Services Board (CSB), Ohio Department of Youth Services (ODYS), etc.), residency should remain with the "home" board of the county where the court which ruled maintains jurisdiction. **Completion**

and signing of the Residency Verification Form shall provide residency documentation for children.

a. This guideline is not intended to resolve boundary issues between the responsibilities of boards versus those of CSB's, juvenile courts, ODYS, etc. Rather, it is intended to clarify that it is the responsibility of the "home" board to work through such matters for its clients.

b. Persons with handicapping conditions who consequently may remain in the custody of a CSB, etc., through their 21st year shall be considered to be children for the purposes of these guidelines.

9. The interpretation of these residency provisions for children is to be guided by the provisions of ORC Sections 3313.64(A) (1 and 4), 3313.64(C) (2), and 2151.35, which deal with the determination of local responsibility within the educational system.

10. For clients committed pursuant to ORC Section 2945.38, 2945.39, 2945.40, 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised Code, residency shall remain with the board of the service district in which the charges were filed only for as long as the client remains in a forensic status. If and when the client's status reverts to a civil commitment, at that point the client's residency shall be changed to that to which it would be for non-forensic clients (i.e. the "home" board from which the client originally came). For those clients who may be in a non-hospital setting when their commitment status changes, residency should be determined by type of facility and/or intent, depending upon the circumstances. When residency shifts because of a change in forensic status, the board from which residency is being shifted is to give timely notice to the new board of residency.

11. Where special circumstances, such as result from unusual geographic boundaries, create situations where the applicability of the residency criteria in the law may be especially problematic, the boards involved may negotiate a "Memorandum of Understanding" as to how various issues will be addressed, rather than repeatedly disputing individual cases.

12. A board (directly or through its contract agencies) may receive requests for services from a client whose residency rests with the board of another service district (with this encompassing clients involved in emergencies while away from home, clients wishing to travel to receive non-emergency services from a provider in another district, and clients placed in a specialized residential facility who seek additional services beyond that which the facility itself may provide). Such requests for services from non-residents should be dealt with as follows:

    a. Emergency/crisis situations are to be addressed by the board and/or designated agency where the crisis occurs, regardless of the client's official residency assignment.

        1. To the extent that commitment/probate matters may be involved in addressing the crisis, the boards involved shall be guided by item #10 of this guideline.

        2. For mental health, non-Medicaid services, the board providing the service is responsible for crisis intervention services up to three days.

            For ODADAS, non-Medicaid services out of county/emergency/clinically appropriate services are the Level I services (Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis; (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient services) plus Level III and Level IV ambulatory detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend

beyond three days, the out of county placement must be approved by the home board. It is essential collaborative efforts be made between providers and boards to establish arrangements for a client's continued care.

3. When an enrollee of a board receives crisis services [as defined above in paragraph (2)] outside his/her service district and under the auspices of another board's service system, financial responsibility for these crisis services shall be borne by the board in which the client is enrolled. The rate for said services shall be that contained in the contract of the local board under whose auspices the services are being provided.

4. A board which is providing crisis/emergency services for an individual who is enrolled in another board's plan shall contact that other board (or it designee) within one business day, to notify it that one of its members is involved in a crisis situation and to consult on the disposition of the case.

    a. The board in which a client is enrolled shall have no financial responsibility for the provision of out-of-district crisis services beyond three days without its concurrence. In the event it is anticipated that the three-day limit shall be exceeded, the board/agency involved in the provision of crisis services to an out-of-district party shall be responsible for contacting the board of residency/enrollment to establish appropriate arrangements for payment or to provide for the orderly transfer of the client to a provider selected by the home board.

    b. Services other than emergency/crisis services and Medicaid-billable services should remain the sole responsibility of the "home" board of residency, with this responsibility understood to encompass the items listed in section #2 of this document.

    c. The Chief Clinical Officer (or designee) of the "home" board should be responsible for determining what services may be clinically necessary and appropriate for an individual seeking services outside of his/her "home" district. The "home" board should bear ultimate responsibility for overseeing and supporting the provision of appropriate out-of-district services (to the extent they are approved as being consistent with the board's M-SPA and sufficient financial resources are available).

    d. For non-Medicaid services, a board may have "preferred providers" (i.e. its contract agencies) and expect residents seeking board-subsidized services to use these organizations.

    e. Non-emergency services may be provided to out-of-district clients by either the "home" board of residence or the board from which the client is seeking services. However, no board should be expected or assumed to provide ongoing, non-emergency services to out-of-district clients without its explicit consent and without a mutually agreeable reimbursement mechanism having been negotiated. All boards should adopt official policies and procedures which layout how it will respond to requests of its residents who seek services outside the board's service district.

    f. Anytime a severely mentally disabled (SMD) client is placed in an out-of-district residential facility with the involvement of the public community mental health system, the "home" board should notify the board where the facility is located and work out matters of service coordination and continuity-of-care.

g. Contract agencies are free to serve whomever they wish with funds other than those provided pursuant to a contract with a board.

13. A person incarcerated in an out-of-district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary reassignment of a jail inmate to a plan of the local board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original board of residence.

14. Residency disputes are to be addressed as follows:

    a. Ultimate responsibility for resolving residency disputes shall rest with ODMH and ODADAS, whose decisions shall be binding.

    b. ODMH and ODADAS shall officially adopt and distribute these "Guidelines and Operating Principles" (along with any subsequent modifications), with the explicit understanding that they are to be followed in the determination of residency.

    c. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.

    d. As the initial step in the formal dispute resolution process, the board which believes that an individual's residency has been inappropriately determined is to contact the board it believes is the proper board to which residency should be assigned. This is to be done in writing and, unless there are extenuating circumstances, is to take place within ten working days of the time a board first becomes aware that a residency assignment may need to be questioned.

    e. After receipt of the written statement initiating the residency dispute process, the two boards shall have five additional working days to agree upon the appropriate residency designation. If the matter remains unresolved, either board may refer the matter to ODMH or ODADAS (depending upon the circumstances) for final resolution. This shall be done in writing and shall occur immediately upon expiration of the five working days during which the boards are to attempt to resolve the matter between themselves. The Director of ODMH/ODADAS (or his/her designee) shall make a final determination about residency within ten additional working days, during which time the boards involved in the dispute and other relevant parties (including, where appropriate, the client) are to be contacted. A written determination, including the rationale for the decision, is to be provided to both boards.

15. While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a board other than the board which paid for the services is the appropriate board of residence then the board which paid for the cost of service will invoice the board of residence. The board of residence will be expected to pay the board of service within a reasonable amount of time.

    {For Medicaid purposes only, while the residency dispute process is taking place, the automatic contracting and payment of Medicaid reimbursable services is not to be interrupted or delayed in any way. This is to say that no changes are to be made to the MACSIS "plan" the client is enrolled in, Medicaid reimbursable services are to be continued to be provided and paid for and, if necessary, the "Secondary" Medicaid Contract is to be

established within the 30-day limit. For MACSIS purposes, ODMH/ODADAS reserve the right to take any action deemed necessary to assure this process is strictly adhered to.}

16. No board is to alter an individual's residency/plan assignment within MACSIS without the explicit approval of the other affected board or a formal ODMH/ODADAS resolution of a residency dispute. (Normal practice should be for the receiving board to effect a residency change in MACSIS.)

17. Nothing in this document should be interpreted as precluding two boards from affecting a transfer of residency responsibilities when they mutually determine this to be in the best interest of a client.

    a. These guidelines deal only with inter-board residency issues and are not intended to address situations where individuals may be placed or seek services across state lines. It is felt that the issues involved are enough different to warrant separate consideration.

A. <u>Guidelines to be used in determining the county of residency for College Students, Homeless Clients and Migrant Workers.</u>

Please note: these guidelines address county of residency determinations for MACSIS enrollment/plan/panel assignment and not State Hospital county of residency issues.

1. ***College Student Guideline***

   As referenced in item #8 the residency for children is to be determined by the residency of the parent(s)/or guardian(s) and should change when the parent(s)/guardian(s) move (even when the move occurs in the middle of a hospitalization or residential placement).

   The primary question to use in determining whether or not this guideline is applicable is: "Is the student an IRS (Internal Revenue Service) Tax Dependent?" If the student is, then the board area in which the parent(s)/guardian(s) reside is the child's county of residence. The student is to be enrolled in one of that county's plan(s)/panel(s).

   If the student is not considered an IRS Tax Dependent, then the following is to be taken into consideration for county of residency determination:

   Is the student emancipated?

   Is this a graduate level student?

   Does this student have dependent children?

   Students who fall within these criteria should have further screening to determine actual county of residency. Please reference item #4. Has the client/student established residency or expressed the intent to remain? If the client has, then the Board must enroll that student as a resident of their county.

   If it is an out of state college student, enrollment criteria should be developed and implemented by the local Board. These students should be enrolled using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field.

2. ***Homeless Client Guideline***

   These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

   Example:

   The client was originally enrolled in a plan/panel of the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board. This client subsequently presents in Montgomery County for

services and claims to be homeless (please note that this client can claim an address of homeless or an address of a homeless shelter). The Montgomery County ADAMH Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. If this client continues their journey and presents for services in Butler County two months later and again claims to be homeless, the Butler County Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. Please note, it is intended for MACSIS to track this type of client to assist in identifying such populations and their need for continuity of care.

How to process enrollments/transfers in MACSIS:

a. Client not previously enrolled. Board area in which the client presents as homeless should enroll immediately for benefits. Note: A client in this situation should **NEVER** be terminated for benefits prior to another board assuming responsibility.

b. Client previously enrolled. If the client is already enrolled in another Board's plan/panel, then the Board in which the client has presented for services and stated homelessness **MUST** immediately transfer the client into one of their plan/panel combinations. As previously noted above, a client in this situation should **NEVER** be terminated for benefits prior to another board assuming responsibility.

3. ***Migrant Worker Guideline***

The following guideline is applicable to Legal Migrant Workers. (Illegal Migrant workers are still under discussion, however, it was noted that boards should be utilizing the "Out of County Service Matrix" when dealing with these clients.)

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Please reference the "Homeless Client Guideline" above.

4. ***Out of State Client Guideline***

How to handle the enrollments within MACSIS:

a. If the Client has a valid Ohio Medicaid card, then the Board in which the client has presented for service should enroll the client in one of their plan/panel combinations or if the client has previously been enrolled, immediately transfer the client to one of their plan/panel combinations.

b. If the client does **NOT** have a valid Ohio Medicaid card, then the Board could exercise their local option to enroll these clients for service. (Please reference the enrollment guideline for out of state college students.)

5. ***Criminal Justice System and Residence Determinations***

As part of the Multi-Agency Community Services Information System (MACSIS) implementation by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH), many questions have arisen concerning how to determine the "county of residence" for a client who has recently been under the auspices of the Ohio Department of Rehabilitation and Correction (ODRC) system and is in need of alcohol and other drug or mental health services.

A workgroup, consisting of representatives of ODADAS, ODMH, ODRC, and Alcohol and Drug Addiction Services (ADAS) Boards, Community Mental Health Boards (CMHB), Alcohol, Drug Addiction and Mental Health (ADAMH) Boards and in conjunction with provider input, believes the basic residency guidelines outlined above are adequate for

determining county of residence in this situation. Former offenders should be treated, for residence determination purposes, in the same manner as any other individual in the State of Ohio. Primacy for determining county of residence shall be upon the individual's statement (i.e., expressed intent to remain) and/or upon the individual's statement becoming a charge of the ODRC system.

The applicable section of the residency determination guidelines can be found in item #6. a. and b. ODRC will bear the financial responsibility for necessary drug and alcohol and/or mental health services provided to Transitional Control inmates housed in halfway houses contracted with ODRC. When a person transitions from an inmate status to a non-inmate status, eligibility for and the financial responsibility for alcohol and other drug and/or mental health services should be determined, as it would be for any other Ohioan. The attached documents, including an inmate versus non-inmate status matrix developed by ODRC and shared and reviewed by the workgroup, should be used in determining when an individual's services are the responsibility of ODRC and when the individual's services become the responsibility of the community alcohol and drug and/or mental health system.

Inmate Status	**Non-Inmate Status**
Halfway House Population: Transitional Control Offender (ODRC Jurisdiction) Prison (ODRC Jurisdiction)	Halfway House Population: Parole/Post –Release Control/Probation/Community Control
CBCF (County/Court Jurisdiction Jail (County/Sheriff Jurisdiction)	Non-Halfway House Population: Parole/Post Release Control

a. Jails and CBCF's (Community-Based Correctional Facilities)

A person in a jail is considered an inmate.

- ODRC does not provide MH or AOD funding for jails but does set standards by which jails are to provide substance abuse and/or mental health treatment services.
- A person in a CBCF is considered an inmate of a correctional institution and is under the jurisdiction of a common pleas court.
- Either of these persons is still a resident of his/her home county.

- In many communities the local ADAS/ADAMHS/CMH Board has traditionally, through a voluntary collaborative arrangement with the local Judicial Corrections Board, made arrangements for the CBCF to utilize local AOD and MH agencies for the provision of needed services.
- These scenarios are covered by item #10 above.
- A person incarcerated in an out-of-district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

b. Halfway house

ODRC currently contracts with 24 halfway houses throughout the state. All of these facilities house individuals who are considered non-inmates, with the exception of those facilities which serve Transitional Control offenders. Transitional Control (or furlough) clients are considered inmates and their services are the responsibility of ODRC. At which time an offender is no longer under Transitional Control status and is transferred to another status, such as parole or post-release control, and expresses an "intent to remain" in the county, the offender may be referred to community agencies and is eligible for services as any other resident of that county.

B. Normal Out of County Enrollment Process

Step 1 Provider determines client's county of residence.

It is the Provider's responsibility to obtain sufficient documentation to determine the client's county (Board) of residence. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence.

Step 2 Provider completes enrollment form

Step 3 Provider submits form to enrollment center for the board where the client resides.

Once the Provider has determined the residency of the client, the Provider must submit the enrollment form to that Board's enrollment center per the Board's submission requirements to begin the enrollment process. The Provider must indicate on the enrollment form the releases have been obtained for that specific Board area.

Step 4 Board enrolls the client or works with the provider to clarify questions.

Upon receipt of an enrollment form from a Provider that is treating a client who is a resident of that Board area, the Board's enrollment center should look up the client, enroll the client if not already in MACSIS, and then return to the provider the client's UCI, plan assignment and rider information. If there are points of clarification, the Board is responsible for making contact with the Provider to resolve any questions.

Step 5 Board returns UCI to provider.

It is recommended that no more than 5 business days **(1)** should separate the submission of the enrollment form from the provider to the board and the receipt of the UCI by the provider. The provider will then use the UCI to bill for services. Medicaid

clients receiving Medicaid certified services will be paid and non-Medicaid clients and non-Medicaid services will be subject to the Out of County guidelines.

C. Disputed Enrollment Process (for Providers)

Step 1 Provider follows Normal Enrollment Process.

In all cases, the Provider should follow the process established for a normal out of county enrollment. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence. Examples of documentation that can be used to establish a client's residency include:

Driver License

State ID Card

Lease Agreement

Adoption or Custody Papers

Statement from Client (Signed and Witnessed) Indicating Residency

Step 2 Board of Residency Refuses to Enroll an Out of County Client

If the Board (where the Provider determines the client resides) refuses to enroll the client or fails to provide a UCI within ten business days, the provider should contact the MACSIS Support Desk.

Step 3 MACSIS Support Desk Enrolls Client

The Provider will provide the MACSIS Support Desk with copies of the enrollment form and all supporting information that was provided to the Board. As soon as the proper documentation has been received, the MACSIS Support Desk staff will send an email to the affected board and wait one working day before doing the enrollment. This is to provide time for the affected board to become aware of the issue. **(2)**

The MACSIS Support Desk staff will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Desk will follow the rules as outlined in the Summary Matrix outlined below.

Note: Providers should be aware that non-Medicaid clients that are not in Crisis WILL NOT be enrolled per the Summary Matrix included in this notice.

The MACSIS Support Desk staff will then electronically notify both the Board where the client has been enrolled and the provider that is treating the client, with the enrollment information.

Step 4 Residency Dispute Claim Submitted.

If the board where the client is enrolled disputes the residency determination and action taken by the MACSIS Support Desk, the Board may file a formal residency dispute following the established residency dispute determination (RDD) Guidelines.

(1) The expectation remains that the majority of enrollments will occur within two (2) to five (5) days. It is understood, however, that exceptional circumstances will occur, particularly with out-of-county enrollments. In no event, however, should any enrollment, in-county or out-of-county, take longer than ten (10) days.

(2) The MACSIS Support Desk is not responsible for settling residency disputes and therefore, should not be expected to respond to board disputes which might result

from the email notification. They will continue, as outlined in this procedure (i.e., enrolling the client) and the disputing board must then file the appropriate dispute as noted in the RDD Guidelines.

D. Clarification of Requirements for Out-of-County MACSIS enrollment

Mental Health Services

1. Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.

In these circumstances, such persons must be enrolled with the appropriate Board of residence per the MACSIS enrollment guidelines. The reason enrollment is required, is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

2. Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in emergency situations.

In these circumstances, such persons must be enrolled with the appropriate Board of residence pursuant to the MACSIS enrollment guidelines. The reason enrollment is required, is the Board of residence is responsible for paying non-Medicaid claims for Crisis Intervention services in emergency situations for a period up to 72 hours.

3. Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in non-emergency situations.

In these circumstances the provider organization is not required to enroll such persons. However, the provider organization should refer such persons to the Enrollment Center for the person's Board of residence in order to be linked with the appropriate provider organization. The out-of-county provider organization should offer the person assistance in contacting the Enrollment Center for the person's Board of residence. Such assistance in referral will better ensure appropriate continuity of care.

Alcohol and Drug Addiction Services

Medicaid

1. Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.

In these circumstances such persons must be enrolled with the appropriate Board of residence pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

Non-Medicaid

1. ODADAS recognizes non-Medicaid services, out-of-county services, emergency services or clinically appropriate services as:

- Level I Services (Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient Services, plus)

- Levels III and IV Ambulatory Detoxification Services

Non-Medicaid clients who present for services out-of-county are eligible for Board funding under the same considerations as if the clients presented for services in their home county. Level I services and Levels III and IV ambulatory detoxification services may be provided for three days or until linkage to treatment is established in the "home county." If out-of-county treatment is to extend beyond three days, the out-of-county placement must be approved by the home board. It is essential that collaborative efforts occur between providers and boards to establish arrangements for a client's continued care.

Out-of County MACSIS Enrollment Summary Matrix

CIRCUMSTANCES	MH	AOD
Medicaid eligible person – emergency or non-emergency	Enrollment: Must enroll. Services: Any Medicaid covered service.	Enrollment: Must enroll. Services: Any ODADAS Medicaid covered service.
Non-Medicaid eligible person – emergency	Enrollment: Must enroll. Services: Crisis Intervention services for up to three days (72 hours).	Enrollment: Must enroll. Services: Level I Services – assessment, individual counseling, group counseling, crisis intervention, case management, alcohol/drug urinalysis (lab analysis of specimens for presence of alcohol and/or drugs), medical/somatic, intensive outpatient and methadone administration plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county."
Non-Medicaid eligible person – non-emergency	Enrollment: Not required. Services: Not required to pay for services.	Enrollment: Must enroll. Services: Level I services plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county."

Race Table

The following codes will be used as the standard for maintaining, collecting, and presenting data on race for all Federal reporting purposes[1].

Code	Race	Definitions (for documentation purposes)
N	American Indian	A person having origins in any of the original peoples of North (excluding Alaska) and South American (including Central America), and who maintains tribal affiliation or community attachment.
M	Alaskan Native	A person having origins in any of the original peoples of Alaska, and who maintains tribal affiliation or community attachment.
A	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
B	Black or African American	A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”
P	Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands (which includes: Carolinian, Fijian, Korean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese), and Yapese.)
W	White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
U	Unknown	This code should be used only if the race of the member is unknown.

Note: Those with nationality or ancestry of Mexico are usually classified for federal reporting purposes as White, or American Indian depending on whether the individual feels that they are maintaining tribal affiliation or community attachment.

[1] The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race by Federal agencies.

Ethnicity Table

Reports are run on a periodic basis to ensure data integrity. All blanks and entries that do not conform to the code list will be changed to E.

The official policy of the State of Ohio is to use the stated codes for all information entries to this field. All blanks and entries the do not conform to the code list will be changed to E.

The following codes will be used as the standard for maintaining, collecting, and presenting data on ethnicity for all Federal-reporting purposes.[1]

Ethnicity Codes and Definitions	
Code	**Ethnic Designation**
A	Puerto Rican
B	Mexican
C	Cuban
D	Other Hispanic
E	Not Hispanic or Latino

[1] The categories in this classification are social-political constructs and should not be interpreted as being either scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on ethnicity by Federal agencies. Although OMB only requires the "header classification," Hispanic and Not Hispanic, SAMHSA will continue to require the same breakdown for ethnicity. Instead, they will collapse down to OMB.

Language Table

Any value from A-Z or a blank is valid. Any other character will be replaced with a blank.

The official policy of the State of Ohio is to use the stated codes for all information entries to this field. If the primary language is English, leave the field blank.

The following table shows the language codes available for use on the Member screen. This list was developed based on the distribution of residents in Ohio whose primary language is not English.

Alphabetical Language Code List for Member Record			
Code	**Language**	**Code**	**Language**
A	ASL American Sign Language	N	Mon-Khmer (Cambodian)
B	Arabic	O	Pennsylvania Dutch
C	Chinese	P	Polish
D	Croatian	Q	Rumanian
E	Dutch	R	Russian
F	Fresh	S	Serbian
G	German	T	Serbo-Croatian
H	Greek	U	Slovak
I	Hindi	V	Slovene
J	Hungarian	W	Spanish
K	Italian	X	Thai (Laotian)
L	Japanese	Y	Ukrainian
M	Korean	Z	Vietnamese

County Code Table

ADAM	ADAMS	**ALLE**	ALLEN	**ASHL**	ASHLAND
ASHT	ASHTABULA	**ATHE**	ATHENS	**AUGL**	AUGLAIZE
BELM	BELMONT	**BROW**	BROWN	**BUTL**	BUTLER
CARR	CARROLL	**CHAM**	CHAMPAIGN	**CLAR**	CLARK
CLER	CLERMONT	**CLIN**	CLINTON	**COLU**	COLUMBIANA
COSH	COSHOCTON	**CRAW**	CRAWFORD	**CUYA**	CUYAHOGA
DARK	DARKE	**DEFI**	DEFIANCE	**DELA**	DELAWARE
ERIE	ERIE	**FAIR**	FAIRFIELD	**FAYE**	FAYETTE
FRAN	FRANKLIN	**FULT**	FULTON	**GALL**	GALLIA
GEAU	GEAUGA	**GREE**	GREENE	**GUER**	GUERNSEY
HAMI	HAMILTON	**HANC**	HANCOCK	**HARD**	HARDIN
HARR	HARRISON	**HENR**	HENRY	**HIGH**	HIGHLAND
HOCK	HOCKING	**HOLM**	HOLMES	**HURO**	HURON
JACK	JACKSON	**JEFF**	JEFFERSON	**KNOX**	KNOX
LAKE	LAKE	**LAWR**	LAWRENCE	**LICK**	LICKING
LOGA	LOGAN	**LORA**	LORAINE	**LUCA**	LUCAS
MADI	MADISON	**MAHO**	MAHONING	**MARI**	MARION
MEDI	MEDINA	**MEIG**	MEIGS	**MERC**	MERCER
MIAM	MIAMI	**MONR**	MONROE	**MONT**	MONTGOMERY
MORG	MORGAN	**MORR**	MORROW	**MUSK**	MUSKINGUM
NOBL	NOBLE	**OTTA**	OTTAWA	**PAUL**	PAULDING
PERR	PERRY	**PICK**	PICKAWAY	**PIKE**	PIKE
PORT	PORTAGE	**PREB**	PREBLE	**PUTN**	PUTNAM
RICH	RICHLAND	**ROSS**	ROSS	**SAND**	SANDUSKEY
SCIO	SCIOTO	**SENE**	SENECA	**SHEL**	SHELBY
STAR	STARK	**SUMM**	SUMMIT	**TRUM**	TRUMBULL
TUSC	TUSCARAWAS	**UNIO**	UNION	**VANW**	VAN WERT
VINT	VINTON	**WARR**	WARREN	**WASH**	WASHINGTON
WAYN	WAYNE	**WILL**	WILLIAMS	**WOOD**	WOOD
WYAN	WYANDOT				

Sample Sliding Fee Schedule

For the most recent schedule, go to **http://aspe.hhs.gov/poverty/poverty.htm**

Family Size	5% From	5% Thru	10% From	10% Thru	15% From	15% Thru	20% From	20% Thru
1	$ 776	$ 892	$ 893	$ 1,009	$ 1,010	$ 1,126	$ 1,127	$ 1,243
2	$ 1,041	$ 1,157	$ 1,158	$ 1,274	$ 1,275	$ 1,391	$ 1,392	$ 1,508
3	$ 1,306	$ 1,422	$ 1,423	$ 1,539	$ 1,540	$ 1,656	$ 1,657	$ 1,773
4	$ 1,571	$ 1,687	$ 1,688	$ 1,804	$ 1,805	$ 1,921	$ 1,922	$ 2,038
5	$ 1,836	$ 1,952	$ 1,953	$ 2,069	$ 2,070	$ 2,186	$ 2,187	$ 2,303
6	$ 2,101	$ 2,217	$ 2,218	$ 2,334	$ 2,335	$ 2,451	$ 2,452	$ 2,568
7	$ 2,366	$ 2,482	$ 2,483	$ 2,599	$ 2,600	$ 2,716	$ 2,717	$ 2,833
8	$ 2,631	$ 2,747	$ 2,748	$ 2,864	$ 2,865	$ 2,981	$ 2,982	$ 3,098

Family Size	25% From	25% Thru	30% From	30% Thru	35% From	35% Thru	40% From	40% Thru
1	$ 1,244	$ 1,360	$ 1,361	$ 1,477	$ 1,478	$ 1,594	$ 1,595	$ 1,711
2	$ 1,509	$ 1,625	$ 1,626	$ 1,742	$ 1,743	$ 1,859	$ 1,860	$ 1,976
3	$ 1,774	$ 1,890	$ 1,891	$ 2,007	$ 2,008	$ 2,124	$ 2,125	$ 2,241
4	$ 2,039	$ 2,155	$ 2,156	$ 2,272	$ 2,273	$ 2,389	$ 2,390	$ 2,506
5	$ 2,304	$ 2,420	$ 2,421	$ 2,537	$ 2,538	$ 2,654	$ 2,655	$ 2,771
6	$ 2,569	$ 2,685	$ 2,686	$ 2,802	$ 2,803	$ 2,919	$ 2,920	$ 3,036
7	$ 2,834	$ 2,950	$ 2,951	$ 3,067	$ 3,068	$ 3,184	$ 3,185	$ 3,301
8	$ 3,099	$ 3,215	$ 3,216	$ 3,332	$ 3,333	$ 3,449	$ 3,450	$ 3,566

Family Size	45% From	45% Thru	50% From	50% Thru	55% From	55% Thru	60% From	60% Thru
1	$ 1,712	$ 1,828	$1,829	$ 1,945	$ 1,946	$ 2,062	$ 2,063	$ 2,179
2	$ 1,977	$ 2,137	$2,138	$ 2,254	$ 2,255	$ 2,371	$ 2,371	$ 2,488
3	$ 2,242	$ 2,358	$2,359	$ 2,475	$ 2,476	$ 2,592	$ 2,593	$ 2,709
4	$ 2,507	$ 2,623	$2,624	$ 2,740	$ 2,741	$ 2,857	$ 2,858	$ 2,974
5	$ 2,772	$ 2,888	$2,889	$ 3,005	$ 3,006	$ 3,122	$ 3,123	$ 3,239
6	$ 3,037	$ 3,153	$3,154	$ 3,270	$ 3,271	$ 3,387	$ 3,388	$ 3,504
7	$ 3,302	$ 3,418	$3,419	$ 3,535	$ 3,536	$ 3,652	$ 3,653	$ 3,769
8	$ 3,567	$ 3,683	$3,684	$ 3,800	$ 3,801	$ 3,917	$ 3,918	$ 4,034

Family Size	65% From	65% Thru	70% From	70% Thru	75% From	75% Thru	80% From	80% Thru
1	$ 2,180	$ 2,296	$ 2,297	$ 2,413	$ 2,414	$ 2,530	$ 2,531	$ 2,647
2	$ 2,489	$ 2,605	$ 2,606	$ 2,722	$ 2,723	$ 2,839	$ 2,840	$ 2,956
3	$ 2,710	$ 2,826	$ 2,827	$ 2,943	$ 2,944	$ 3,060	$ 3,061	$ 3,177
4	$ 2,975	$ 3,091	$ 3,092	$ 3,208	$ 3,209	$ 3,325	$ 3,326	$ 3,442
5	$ 3,240	$ 3,356	$ 3,357	$ 3,473	$ 3,474	$ 3,590	$ 3,591	$ 3,707
6	$ 3,505	$ 3,621	$ 3,622	$ 3,738	$ 3,739	$ 3,855	$ 3,856	$ 3,972
7	$ 3,770	$ 3,886	$ 3,887	$ 4,003	$ 4,004	$ 4,120	$ 4,121	$ 4,237
8	$ 4,035	$ 4,151	$ 4,152	$ 4,268	$ 4,269	$ 4,385	$ 4,386	$ 4,502

Family Size	85% From	85% Thru	90% From	90% Thru	95% From	95% Thru	100% Above	
1	$ 2,648	$ 2,664	$2,665	$2,781	$2,782	$2,898	$2,899	
2	$ 2,957	$ 3,073	$3,074	$3,190	$3,191	$3,307	$3,308	
3	$ 3,178	$ 3,294	$3,295	$3,411	$3,412	$3,528	$3,529	
4	$ 3,443	$ 3,559	$3,560	$3,676	$3,677	$3,793	$3,974	
5	$ 3,708	$ 3,824	$3,825	$3,941	$3,942	$4,058	$4,059	
6	$ 3,973	$ 4,089	$4,090	$4,206	$4,207	$4,323	$4,324	
7	$ 4,238	$ 4,354	$4,355	$4,471	$4,472	$4,588	$4,589	
8	$ 4,503	$ 4,619	$4,620	$4,736	$4,737	$4,853	$4,854	

For family units with more than 8 members, add $265 for each additional member.
Last Update 5/12/2004

Rider Codes

A-T, Z Sliding Fee Scale at 5% Increments

A = 5%	F = 30%	K = 55%	P = 80%
B = 10%	G = 35%	L = 60%	Q = 85%
C = 15%	H = 40%	M = 65%	R = 90%
D = 20%	I = 45%	N = 70 %	S = 95%
E = 25%	J = 50%	O = 75%	T = 100%

Z = 0%

Board Identification Numbers

02	Allen-Augl-Hard	28	Geauga	68	Preble
03	Ashland	31	Hamilton	69	Putnam
04	Ashtabula	39	Huron	70	Richland
05	Athens-Hock-Vint	41	Jefferson	71	Ross-Pike-Pick-Faye-High
07	Belmont-Harr-Monr	43	Lake	73	Scioto-Adams-Lawr
09	Butler	45	Licking-Knox	76	Stark
12	Clark-Gree-Madi	47	Lorain	77	Summit
13	Clermont	48	Lucas	78	Trumbull
15	Columbiana	50	Mahoning	79	Tuscarawas-Carroll
18	Cuyahoga	51	Marion-Crawford	81	Van Wert-Merc-Paul
21	Delware-Morr	52	Medina	83	BHG
22	Erie-Ottawa	55	Miami-Dark-Shel	84	Washington
23	Fairfield	57	Montgomery	85	Wayne-Holmes
25	Franklin	60	Muskingum Joint	86	Williams
27	Gallia-Jack-Meig	67	Portage	87	Wood

Medicaid Eligibility Information

The Medicaid recipient aid category, case type, spend down indicator, extended Medicaid indicator and an indication of whether they are eligible within the CHIP program (federal Children's Health Insurance Program) can be found in the McareSt field.

The information from MEDELIG can be broken down as follows:

Aid Category
1-Aged, 2-Blind, 3-Disabled, 4-ADC Regular, 5-ADC Unemployed. 6-Crippled Children, 7-Foster Care, 8-Adoption Assistance

Case Type
A-General Assistance, C-Catastrophic Illness, D-Disability assistance, G-concurrent GR+ADC, H-Healthy Start, I-Healthy Start Expanded, J-Children's Health Insurance Program – income eligible, P-Presumptive eligibility, S-Child Support, V-Vendor Payment ADC Case.

1-Regular; 2-Medical only; 3-Medicaid only; 5-ACD MCD <21 no custody; 6-day care; 7-Medical Social Security; 9-ADC MED <21 custody.

Spend Down Indicator
Recurring (Eligible 1st day of the month)
Delayed (Medicaid eligible because they met their spend down)
N (not eligible have not met spend down).

Extended Medicaid Indicator
Y indicated there is private insurance coverage
N (or space) indicates there is no 3rd party coverage
Unused (space filled)

6-9 CHIP Designation.
If person is eligible for CHIP program this filed contains "CHIP". If not eligible for CHIP program field contains spaces. CHIP indicates person is eligible for higher FFP reimbursement.

10-11 Unused (space filled).

Definition of Family

Family means one or more adults and children related by blood, law, and residing in the same household. Where adults, other than spouses, reside together, each shall be considered a separate family. Emancipated minors and children living together under the care of individuals not responsible for their care shall be considered one-person families. Adult means an individual who is aged 18 or older, or an emancipated minor (as determined by state law). Individuals aged 18 to 21 who are attending high school are considered children unless otherwise emancipated. Physically and mentally handicapped persons aged 18 to 21, who are not otherwise emancipated, are considered children. Stepparent living with his/her spouse and his/her spouse's children shall be considered as one family. The income of the stepparent shall be included in determining the income eligibility of the entire family including the stepparent, the stepparent's spouse, and any minor children of either spouse who reside in the household.

Individuals legally responsible for the care of a child are the natural or adoptive parents of the child. Adoptive parents assume legal responsibility at the point the adoption becomes finalized by court decree.

Children living with unrelated adults or with relatives other than their natural or adoptive parents; and children in the temporary or permanent custody of a licensed child agency shall be considered a one-person family and each shall have his own social service case.

County Identification Codes

01 ADAM ADAMS	02 ALLE ALLEN	03 ASHL ASHLAND
04 ASHT ASHTABULA	05 ATHE ATHENS	06 AUGL AUGLAIZE
07 BELM BELMONT	08 BROW BROWN	09 BUTL BUTLER
10 CARR CARROLL	11 CHAM CHAMPAIGN	12 CLAR CLARK
13 CLER CLERMONT	14 CLIN CLINTON	15 COLU COLUMBIANA
16 COSH COSHOCTON	17 CRAW CRAWFORD	18 CUYA CUYAHOGA
19 DARK DARKE	20 DEFI DEFIANCE	21 DELA DELAWARE
22 ERIE ERIE	23 FAIR FAIRFIELD	24 FAYE FAYETTE
25 FRAN FRANKLIN	26 FULT FULTON	27 GALL GALLIA
28 GEAU GEAUGA	29 GREE GREENE	30 GUER GUERNSEY
31 HAMI HAMILTON	32 HANC HANCOCK	33 HARD HARDIN
34 HARR HARRISON	35 HENR HENRY	36 HIGH HIGHLAND
37 HOCK HOCKING	38 HOLM HOLMES	39 HURO HURON
40 JACK JACKSON	41 JEFF JEFFERSON	42 KNOX KNOX
43 LAKE LAKE	44 LAWR LAWRENCE	45 LICK LICKING
46 LOGA LOGAN	47 LORA LORAINE	48 LUCA LUCAS
49 MADI MADISON	50 MAHO MAHONING	51 MARI MARION
52 MEDI MEDINA	53 MEIG MEIGS	54 MERC MERCER
55 MIAM MIAMI	56 MONR MONROE	57 MONT MONTGOMERY
58 MORG MORGAN	59 MORR MORROW	60 MUSK MUSKINGUM
61 NOBL NOBLE	62 OTTA OTTAWA	63 PAUL PAULDING
64 PERR PERRY	65 PICK PICKAWAY	66 PIKE PIKE
67 PORT PORTAGE	68 PREB PREBLE	69 PUTN PUTNAM
70 RICH RICHLAND	71 ROSS ROSS	72 SAND SANDUSKEY
73 SCIO SCIOTO	74 SENE SENECA	75 SHEL SHELBY
76 STAR STARK	77 SUMM SUMMIT	78 TRUM TRUMBULL
79 TUSC TUSCARAWAS	80 UNIO UNION	81 VANW VAN WERT
82 VINT VINTON	83 WARR WARREN	84 WASH WASHINGTON
85 WAYN WAYNE	86 WILL WILLIAMS	87 WOOD WOOD
88 WYAN WYANDOT		

Term Reason Codes

The following is a listing of valid term reason codes that can be used within MACSIS to term a member's eligibility span. When terming a member's eligibility span a new Non-MCD span must be created unless one of the following term reason codes is used: **MBMOS** (member moved out of state), **MBDEC** (member deceased), or **MBINL** (member income ineligible).

The termination error codes **ERR01**, **EDUP1**, **EDUP2**, and **EDUP3** are, in most cases, generated by the nightly maintenance programs and indicate that the member's eligibility spans are no longer maintained by eligibility maintenance programs. Eligibility spans with the above termination codes do not require a new Non-MCD span.

If a member's eligibility span is terminated with other than MBMOS, MBDEC, MBINL, ERR01, EDUP1, EDUP2 or EDUP3, and a new Non-MCD span has not been created, the termed span will be reopened (term reason and term date removed).

EDUP1	Electronic Duplicate – Same SSN/D.O.B.
EDUP2	Electronic Duplicate – Invalid D.O.B.
EDUP3	Electronic Duplicate – Invalid SSN
ERR01	Invalid Required Field
ETERM	Member Terminated Electronically
IPUCI	Invalid Pseudo UCI Code[1]
MBDEC	Member Deceased
MBINL	Member Ineligible
MBMOS	Member Moved Out of State
MBMOV	Member Left Service Area/Moved
MBPLC	Plan Changed Manually By Board
RIDER	Rider Change

[1] Pseudo client eligibility spans are not subject to the above rules concerning termination of spans.

Member Reports

The MACSIS Membership Support Group generates a series of reports to be used to maintain the quality of the membership data within the MACSIS system.

The Member Maintenance Reports will only be received if there were errors or exceptions which would cause the reports to be created.

The following are samples of the Member Error Reports.

O.D.M.H. – O.I.S. MEMBERSHIP REPORT GROUP
MEMBERS WITH MORE THAN ONE RMF MEDICAID NUMBER
FOR MAY 3, 2004

---------- PANEL=02B ----------

BOARD	UCI	DIAMOND LAST NAME	DATE OF BIRTH	SEX	SSN	DIAMOND FIRST NAME	MEDICAID ID	ELIGIBLE START DATE	ELIGIBLE END DATE	MEDICAL RECORD NUM	PROV2	NOREPT
21	3294084	JONES	07/09/1994	M	382312434	ROGER	027001504590	10/01/98	10/30/98	34566	001051	
21	3294084	JONES	07/09/1994	M	382312434	ROGER	157849511200	09/01/98	09/30/98	34566	001051	
21	3292811	HAROLD	10/06/1987	F	213446580	EVELYN	046003610490	11/01/98	11/30/98	29188	001051	
21	3292811	HAROLD	10/06/1987	F	213446580	EVELYN	028654874120	11/01/98		29188	001051	
21	3293710	CROSBY	02/08/1982	M	265593122	HOSKINSON	028451400370	07/01/98		14342	001051	
21	3293710	CROSBY	02/08/1982	M	265593122	HOSKINSON	027001654750	08/01/98		14342	001051	

IEL007R1

EXPLANATION: Records in Diamond that do not have a Medicaid ID are matched with the MEDELIG file using 1st 8 characters of the last name, DOB, Gender, and SSN. The records on this report indicate that during this process more than one exact match was found. This implies that Medicaid has issued more than one valid Medicaid ID. MACSIS Operations Management cannot automatically post Medicaid eligibility information t this record until a single Medicaid number can be associated with this person. Claims for this UCI will not be billed to Medicaid until a valid Medicaid ID with eligibility for the period covering the claim is entered.

ACTION: If both Medicaid Numbers are valid for the same period of time, someone must manually enter one of the Medicaid ID's to allow the eligibility changes to be processed. The report identifies each Medicaid ID for an individual that has not had any Medicaid ID entered. The eligibility start and end dates from the MEDELIG file are also reported.

OHIO DEPARTMENT OF MENTAL HEALTH
OFFICE OF INFORMATION SERVICES
MEMBERSHIP SUPPORT GROUP
MEDICAID NUMBER CHECK DIGIT ERROR REPORT
FOR JULY 12, 2004

---------- PANEL 76M ----------

OBS	UCI	DIAMOND LAST NAME	DIAMOND FIRST NAME	MEDICAID ID	USER DEF. MEDICAID ID	PLAN	MEDICAL REC. NO.	PROV2
1	5411231	MONAHAN	ERIC	840761548405		DFMCD7611	03412587	003570

IEL010R1

EXPLANATION: This report contains records with Medicaid ID's that are not valid; either it does not comply with a check digit routine or it is not on the MEDELIG file. NOTE: Many records on the RMF were not placed on the MEDELIG file if they did not have valid Medicaid spans beyond 07/01/1997. The Medicaid ID has already been replaced with spaces to prevent incorrect Medicaid Id's from being left on the file.

ACTION: The report is a notification, no further action is required, though you may want to review the source of the bad Medicaid ID and see if it was written incorrectly and needs to be updated with the right number.

OHIO DEPARTMENT OF MENTAL HEALTH
OFFICE OF INFORMATION SERVICES
MEMBERSHIP SUPPORT GROUP
DUPLICATE RECORDS BY SSN - AS OF 04JULY12

SSN=041762099

OBS	SSN	DATE OF BIRTH	UCI	TERM. REASON	LAST NAME	FIRST NAME	PLAN	MEDICAID	USERDEF1
1	041762099	07/01/1975	1933655		HATTER	HAROLD	DMMON255 Exp	102370221399	
2	041762099	07/15/1975	1455864		HATTERJR	HAROLD	DMMCD253	122370958549	122370958549

OBS	PROV2	PANEL	SADDR1	SCITY	HHHOME	CRDATE	CRUSIT	UPDATE	UPUSIT
1	010364	25C	123 MAIN ST	BELLE CENT		20020617	CAC	20020825	MDM
2	006723	25B	321 S FINDLAY	MINISTER		20001102	LAT	20001102	LAT

IEW035R1

EXPLANATION: This report contains records that have the same SSN but a different DOB. The member maintenance staff verifies the social security number and makes corrections to the member records in Diamond.

ACTION: Board staff needs to review the corrections and relay the information on to provider staff.

OHIO DEPARTMENT OF MENTAL HEALTH
OFFICE OF INFORMATION SERVICES
MEMBERSHIP SUPPORT GROUP
POTENTIAL DUPLICATES - AS OF 04JUL12
MATCHKEY = LAST NAME(8)+FIRST NAME(4)+DOB+GENDER

---------- MATCHKEY=WINDHEIM STEV222604 ----------

OBS	UCI	MATCHKEY		SSN	LAST NAME	FIRST NAME	PLAN	MEDICAID	USERDIF1
1	1932255	WINDHEIM	STEV222604	388766992	WINDHEIMER	STEVEN	DEMO0255	Edupl	
2	1457740	WINDHEIM	STEV222604	386756950	WINDHEIMER	STEVE	DEMO0253	122370958549	

OBS	PROV2	PANEL	SADD1	SCITY	PHONE	CRDATE	CRUSIT	UPDATE	UPUSIT
1		JJB	331 STCANDE DR	AKRON		20000612	SSS	20000612	SSS
2		JJB	331 STCANDE	AKRON		20001102	TAI	20001101	TAC

NOTE: IF SOCIAL SECURITY NUMBER WAS CHANGED AFTER CHECKING SOCIAL SECURITY VERIFICATION SYSTEM, THEN THE HIGHER NUMBER UCI (LATEST ONE ADDED) WILL AUTOMATICALLY BE TERMINATED AND THE TERM REASON SET TO EDUP1 BY THE NIGHTLY MEMBER MAINTENANCE PROCESS.

EXPLANATION: This report contains a list of records that might be duplicates. It uses the last eight (8) characters of the last name and the first four (4) characters of the first name. When a duplicate is identified, the record with the incorrect SSN should be marked as EDUP1.

ACTION: Board staff needs to review the corrections made by the Member Maintenance Staff and communicate updates and changes to provider staff.

IEL030BL

THE SAS SYSTEM
ODMH/OIS - MEMBERSHIP SUPPORT GROUP
POTENTIAL MEDICAID ELIGIBLE CLIENTS
PANEL - 11B

AS OF 12JUL04
PAGE 1

***PLEASE NOTE: THESE CLIENTS ARE ELIGIBLE TODAY

	UCI OR MEDID	LAST NAME	FIRST NAME	DOB	SOC.SEC.#	GEN	PLAN	PANEL NOKEPT
MEDELIG =	2104903107 99	SHANNAN	ANNE	12/31/85	321905918	F		
DIAMOND =	9349927	SHANNON	ANNE	12/31/85	321905918	F	DFMCN11	11B
MEDELIG =	10514273559	SPRATTSB	JACK	07/05/72	382643932	M		
DIAMOND =	9255882	SPRATT	JACK	06/05/72	382643932	M	DFMCN11	11B

mof

EXPLANATION: For each record there are two lines reported. The first line contains information from the MEDELIG file. The second line contains information from Diamond. This report identifies records that do not have a Medicaid ID in Diamond but have a Social Security Number in MEDELIG that matched the Social Security Number in Diamond.

ACTION: Review the information on the report and determine whether the individuals are the same. If the individuals are truly the same, add the Medicaid ID to the member screen in Diamond.

07/12/04

OHIO DEPARTMENT OF MENTAL HEALTH
OFFICE OF INFORMATION SERVICES
MEMBERSHIP SUPPORT GROUP
DAILY MEMBERSHIP MAINTENANCE - CRITICAL ERRORS

---------- 25M ----------

OBS	UCI	SSN	DATE OF BIRTH	LATE NAME	FIRST NAME	PLAN	ROV2	EFFECT. DATE	TERM DATE	TERM REASON
1	1035664	277454193	04/06/1974	JOHNSON	RAYMOND	MHMCD25K	020024	08/04/2004	07/12/2004	ERRO1
2	1080922	000000000	06/04/1997	WILLIAMS	DANIEL	DFMCD252	002364	07/03/2004	07/12/2004	ERRO1
3	1073443	284504339	08/12/1973	WORTH	JANELLE	DFNON253	004589	09/04/2004	07/12/2004	ERRO1

IEL045R1

EXPLANATION: This report identifies member records that contain a critical error. They have been terminated with a term reason of ERRO1 and the termination date is the date the error was identified. The critical errors include:

- Missing first or last name
- Invalid social security number (invalid pattern, invalid characters, not enough characters, etc.)
- Effective date was a date greater than the day it was encountered (future date).

ACTION: Identify the critical error, correct the field(s) in Diamond, remove the Term Date and Term Reason to reactivate the member.

IEL046RL

OHIO DEPARTMENT OF MENTAL HEALTH
OFFICE OF INFORMATION SERVICES
MEMBERSHIP SUPPORT GROUP
DAILY MEMBERSHIP MAINTENANCE - ELECTRONIC DUPLICATES

AS OF 12JUL04

	VALID RECORD	TERMINATED RECORD
UCI	10083701	1090020
PERSON NO.	00	00
LAST NAME	DANSEN	DANSEN
FIRST NAME	ROBERT	ROBERT
MIDDLE INIT.		K.
BIRTH DATE	03/05/1963	03/05/1963
GENDER	M	M
RELATIONSHIP	O	C
MARITAL ST.	S	S
LANG. CODE		
RACE	B	B
ETHNICITY	E	
MCARE NO.	19830805M	
MCAID NO.	189576016605	189576016605
SOC SEC. NO	247565252	247565252
EMPL. NO.	DAN030563M	
MED REC NO	DANSM1	
HOME PHONE		2165558929
BUS PHONE		
ADDRESS 1	3131 MAPLE AVE	6122 WEST BROAD
ADDRESS 2	C/O VIM GROUP HOME	
CITY	AKRON	AKRON
STATE	OH	OH
ZIP CODE	45115	45115
SECURITY FLAG		
SEQUENCE NO.	02	01
EFFECTIVE DATE	08/01/1997	07/03/2004
TERM DATE		07/12/2004
PLAN	MHMCD76S	MHMCD76S
COUNTY CODE	76	76
RIDER		Z
MCARE STATUS	45NN	
FAMILY SIZE	1	
ELIG STATUS	E	E
TERM REASON		EDUP1
PROV2		010048
PANEL	76S	76S
SALARY		
USERDEF1	189576016605	
COUNTY OF RES	STAR	STAR

EXPLANATION: This report identifies member records that have been terminated as duplicates. The termed record has a term date of when the duplicate record was identified. The first record listed on the report is the valid record. Records with a term reason of EDUP1 identify records that have the same SSN (other than all 5's) and the same DOB; EDUP2 identify records that have the same SSN, same last name, and one digit of the DOB is different; EDUP3 identify records that have the same first 8 characters of the last name, same first 8 characters of the first name, same DOB and either of the two SSN's is equal to all 5's. Most generally, the lowest valued UCI is the record kept as valid.

ACTION: Review the information on the termed record. Verify the corrections made by state staff. If corrections were not appropriate, board needs to make the appropriate corrections, remove the term date and term reason, notify providers of the valid UCI to be used.

IEL010RL

ODMH/OIS - MEMBERSHIP SUPPORT GROUP
MEDICAID/DIAMOND COMPARISON ERRORS
PANEL - 04B

AS OF 12JUL04

		UCI	MEDICAID ID	LAST NAME	FIRST NAME	DOB	SSN	PANEL
1	MEDELIG =			FISHBURN	JOHN	08/05/1947	254842339	
	DIAMOND =	1414141	10101010101	FISHBURN	JOHN	08/15/1947	254842339	04B
2	MEDELIG =			SMITHSON	RALPH	07/05/1947	354477829	
	DIAMOND =	1515151	20202020202	SMITHSON	RALPH	02/15/1945	254842339	04B

Explanation: The report identifies a Diamond member with a different DOB than the DOB in MEDELIG. This is based on matching Medicaid IDs.

Action: Boards need to verify with provider which date of birth is correct. If Diamond has the correct date of birth the board needs to request to have the Medicaid override flag set. Request the provider to have the client go to the local JFS office to get the information corrected.

Enrollment Procedures through the Support Desk

Provider determines client's county of residence and follows normal enrollment process, but Board of residence refuses to enroll the client or supply the provider with the client's UCI within ten (10) business days.

1. **Client is Medicaid eligible on the date they received services from the provider and is currently enrolled in MACSIS:**

   The provider should contact the MACSIS Support Desk and provide them with copies of the enrollment form and all supporting information that was provided to the Board. Once the proper documentation is received, the MACSIS Support Desk will notify the Board (where the client is currently enrolled) via email and wait one working day before giving the UCI number to the provider. If the Board where the client is currently enrolled feels the client is no longer a resident of their board area, the Board may file a residency dispute. In order to facilitate the resolution and tracking of all Residency Disputes, please copy the MACSIS Support Desk on all RDD Filings.

2. **Client is Medicaid eligible on the date they received services from the provider and is not currently enrolled in MACSIS:**

   The provider should contact the MACSIS Support Desk and provide them with copies of the enrollment form and all supporting information that was provided to the Board. Once the proper documentation is received, the MACSIS Support Desk will notify the affected Board via email and wait one working day before doing the enrollment. The MACSIS Support Desk will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Desk will then notify the Board where the client has been enrolled and the provider that is treating the client of the UCI number and any other pertinent information. If the Board where the client has been enrolled feels the client is not a resident of their board area, the Board may file a residency dispute. In order to facilitate the resolution and tracking of all Residency Disputes, please copy the MACSIS Support Desk on all RDD filings.

3. **Client is non-Medicaid eligible on the date they received services from the provider and is currently enrolled in MACSIS:**

   If the client is receiving emergency services (see the matrix below) the provider should contact the MACSIS Support Desk and provide them with copies of the enrollment form and all supporting information that was provided to the Board. Once the proper documentation is received, the MACSIS Support Desk will notify the Board (where the client is currently enrolled) via email and wait one working day before giving the UCI number to the provider. If the Board where the client is currently enrolled feels the client is no longer a resident of their board area, the Board may file a residency dispute. In order to facilitate the resolution and tracking of all Residency Disputes, please copy the MACSIS Support Desk on all RDD filings.

4. **Client is non-Medicaid eligible on the date they received services from the provider and is not currently enrolled in MACSIS:**

   If the client is receiving emergency services (see the matrix below) the provider should contact the MACSIS Support Desk and provide them with copies of the enrollment form

and all supporting information that was provided to the Board. Once the proper documentation is received, the MACSIS Support Desk will notify the affected Board via email and wait one working day before doing the enrollment. The MACSIS Support Desk will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Desk will then notify the Board were the client has been enrolled and the provider that is treating the client of the UCI number and any other pertinent information. If the Board where the client has been enrolled feels the client is not a resident of their board area, the Board may file a residency dispute. In order to facilitate the resolution and tracking of all Residency Disputes, please copy the MACSIS Support Desk on all RDD filings.

CIRCUMSTANCES	MH	AOD
Medicaid eligible person – emergency or non-emergency	Enrollment: Must enroll. Services: Any Medicaid covered service.	Enrollment: Must enroll. Services: Any ODADAS Medicaid covered service.
Non-Medicaid eligible person – emergency	Enrollment: Must enroll. Services: Crisis Intervention services for up to three days (72 hours).	Enrollment: Must enroll. Services: Level I Services – assessment, individual counseling, group counseling, crisis intervention, case management, alcohol/drug urinalysis (lab analysis of specimens for presence of alcohol and/or drugs), medical/somatic, intensive outpatient and methadone administration plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county."
Non-Medicaid eligible person – non-emergency	Enrollment: Not required. Services: Not required to pay for services.	Enrollment: Must enroll. Services: Level I services plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county."

Please refer to these reference documents that may be found on the MACSIS web site:

Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards

(1) While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the Board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which Board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a Board other than the Board which paid for the services is the appropriate Board of residence then the Board which

paid for the cost of service will invoice the Board of residence. The Board of residence will be expected to pay the Board of service within a reasonable amount of time.

> [For Medicaid purposes only, while the residency dispute process is taking place, the automatic contracting and payment of Medicaid reimbursable services is not to be interrupted or delayed in any way. This is to say that no changes are to be made to the MACSIS "plan" the client is enrolled in, Medicaid reimbursable services are to be continued to be provided and paid for and, if necessary, the "Secondary" Medicaid Contract is to be established within the 30 day limit. For MACSIS purposes, ODMH/ODADAS reserve the right to take any action deemed necessary to assure this process is strictly adhered to.]

Out of County Enrollment Process and Residency Dispute Process Guideline

(2) The MACSIS Support Desk is not responsible for settling residency disputes and therefore, should not be expected to respond to board disputes which might result from the email notification. They will continue, as outlined in this procedure (i.e., enrolling the client) and the disputing board must then file the appropriate dispute as noted in the RDD guidelines.

Residency Dispute Determination Process (MACSIS) Instructions for Executive Directors of ADAMHS & CMH Boards

Instruction for Completing Member/Claims Transfer

I. Enrollment/Membership Transfer Communication Protocol

A. There will be times in which a county (County "A") is in need of taking over membership rights from another county (County "B"). As having gone over in the Enrollment Users Group, once County "A" has determined that a client is now a resident of their county; County "A" can assume responsibility for that client. County "A" can terminate the current client record from County "B" and then appropriately reinstate into their county group and plan.

B. Finally, and most importantly, County "A" must then properly notify County "B" that they have assumed membership responsibility for the client. Once County "B" receives notification from County "A", it is important that their Enrollment Staff notify the Claims Staff of this transaction.

C. NOTE: During this initial UCI notification process, it is important that County "A" instruct County "B" if they prefer to have any potential outstanding claims they will be receiving from County "B" placed on hold. Otherwise, all boards can assume that once they refresh and adjudicate the claim for the other board involved, they **DO NOT** have to place claims involved on hold. (This corresponds to step II B detailed below.)

II. Appropriate Handling of Claims

A. Upon notification of client transfer, the Claims Staff of County "B" should check claims history through PSDSP for any claims incurred from timeframe of transfer to present. If claims have been paid (in the claims processing status of finalized "F" or paid "P"), then a manual invoice can be created billing County "A".

B. However, while checking PSDSP, should you find that claims are not paid (in the claims processing status of "U"), then the claims can be switched over for County "A" to pay. Appropriate action to take:

1. Pull a listing or screenshot from PSDSP as to the claims involved.

2. In OCPLM, pull up claim(s) involved and refresh the claim header (F6 function key and option F to refresh the member's eligibility). After refreshing the claims header, you will notice that the membership will change from your County's group and plan to County "A's" group and plan.

3. Next, go to end of claim and enter "A" to adjudicate the claim. Once in the claims detail, pull up line 001. Next, you should re-price and re-adjudicate the claims detail (F6 function key and option B to both price and adjudicate). Once completing, you will notice that the claim will then price and adjudicate according to County "A's" benefit package. Next, press <end> to end and enter "Y" to update the claims detail. If requested, place claim on hold for County "A".

4. Finally, hit home, enter to bottom of claims header screen, and change from your security code to County "A's" security code. Enter "S" to save changes. This claim will then become the responsibility of County "A"."

C. Finally, county “B” should then notify County “A” that claims have been switched over to their security code. This will help County “A” to review claims for appropriate adjudication prior to APUPD.

III. Claims Security Issues

If there is not proper enrollment notification and claims handling, there are potential claims problems that will be incurred by both Boards involved in the UCI transfer situation:

A. Just security code placed on claims – no other action taken:

- ☐ Claims header and detail problem incurred if only a new security code is attached and then claim is taken through APUPD. Security code will be of one county “A” with all other detail belonging to other county “B”.

B. Claim header refreshed but detail is not re-priced and re-adjudicated:

- ☐ Claims header (Company Code and Plan) mismatch with claims detail if detail is not re-priced and re-adjudicated to new plan information. (Header will be for County “A”, but detail remains for County “B”).

Member Transfer Form

XXXX XXXXXXXXX
XXXX OH XXXXX
Phone: XXX-XXX-XXXX extension
Fax: XXX-XXX-XXXX

XXXX Board Enrollment Department

Fax

To:	[Click here and type name]	From:	XXXX Enrollment, Specialist
Fax:	[Click here and type fax number]	Date:	June 28, 2004
Phone:	[Click here and type phone number]	Pages:	[Click here and type number of pages]
Re:	Member Transfer	CC:	[Click here and type name]

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

UCI: _____ **Effective Date:** ____/____/____

Name: _____

Message: The _____ County Board has determined that the above listed member(s) having previously been enrolled in your Group and Plan are now residents of this county. This courtesy notice is provided to inform you that we have terminated your Board's Group and Plan and opened a new _____ County Group and Plan eligibility span. This Board is assuming financial responsibility for these members as of the effective date above.

Claims Security Release Request: One or more of _____ County agencies may have submitted claims for services prior to this change in MACSIS. Please search for any claims with payment status "UNPOSTED," and if found, refresh each claim header (s), and re-adjudicate each claim detail. Lastly, change your Board's security code to our security code "___" so these claims will adjudicate properly. Upon completion, return this form via fax immediately listing of the associated claims. Please DO NOT place these claims on hold.

If there are questions or concerns, please contact me. Thank you for your cooperation.

UCI Number	Last Name	First Name	Date of Service	Claim Number

6. Topic: Removal of Client Data from MACSIS

The purpose of these guidelines is to establish the criteria and process for removing protected health information (PHI) from MACSIS, Mental Health (MH) Outcomes and the Behavioral Health Module and to establish ODMH, ODADAS and board responsibilities.

A. Conditions

The following matrix illustrates various scenarios of when it is and is not permissible under applicable federal and state statutes and policies for the State to delete protected health information (PHI) from the ODMH and ODADAS systems.

Scenario	Delete	Comments
Client enrolled but has no claims	Yes	Follow process below
Client has received services(s) paid in whole or part with public funds	No	Information needs to be maintained in accordance with Business Records retention schedule
Client has received services but they have NOT been paid in whole or part with public funds.	Yes	MACSIS Guidelines – Topic 2 indicates that only those clients receiving services funded in whole or in part with public funds administered through the boards will be enrolled in MACSIS.

B. Process

1. The MACSIS Support Desk, hereinafter referred to as State, will timely process requests submitted by the board to remove client information from MACSIS.

2. Documentation to substantiate request to remove client information should be maintained at the local level (board and/or provider) and not routinely submitted to the State. The State reserves the right to request information as necessary to timely process the request.

3. Boards or providers can initiate a request on behalf of the client by completing the **Request to Remove Client from MACSIS form**. Reason for request must be documented and approved by board prior to submission to the State. Board approval process should include but not be limited to the following:

    - Exploration to assure client has not received services paid in whole or part with funds administered through requesting board. Board should verify this by checking to make sure that a net amount of zero is not the result of benefit rules, rider codes or 100% withhold (i.e. clients served in Women's Set-Aside Grant Program shall not be submitted for deletion).

4. State will verify client has not received services in other boards areas

5. If MACSIS has claims paid by a board other than from the requesting board then the State will work with those board(s) prior to removing client from database to assure

services were not funded in whole or part with public funds (i.e. even if netted to zero)

6. State will take action to remove member and claims information from the MACSIS on-line system. Information archived (on-line) or on back-up tapes will not be modified.

7. State will take action necessary to remove client information from Outcomes database.

8. Board(s) will be responsible for notifying provider of action taken by State.

9. Provider(s) must submit a delete record to ODADAS in accordance with Behavioral Health Instruction Manual to delete client information from BH module.

10. Boards and providers should take necessary action to remove client information from local databases and files.

Request to Remove Client from MACSIS Form

REQUEST TO REMOVE CLIENT FROM MACSIS

Please complete the following information for the client you wish to have removed from MACSIS.

UCI #:_____ **DOB:**_____ **First 3 letters of last name:**_____

Reason for request:

- ☐ **Client is enrolled in MACSIS and has no claims in the system.**
- ☐ **Client is enrolled in MACSIS and has services in the system but they were not paid in whole or part by public funds.**

Request initiated by:

- ☐ **Client**
- ☐ **Provider :**_____ **UPI #:**_____
  Contact Person:_____ **Phone #:**_____
  Fax #:_____
- ☐ **Board:**_____ **Board #:**_____
  Contact Person:_____ **Phone #:**_____
  Fax #:_____

If Client/Provider initiated, date sent to Board: _____

Date received by Board: _____

Action Taken by Board:

- ☐ **Request denied**
  Comments/reason:_____
  - ☐ **Provider notified**
- ☐ **Request approved. Date sent to State:** _____

Date received by State:_____ **Rec'd By (Staff Initials):**_____

Action Taken by State:

- ☐ **Client deleted**
  Date Deleted:_____ **Staff Initials:**_____
- ☐ **Claims for services that were not paid by public funds were deleted.**
  Date Deleted:_____ **Staff Initials:**_____
- ☐ **Forwarded to Outcomes staff** **Date:**_____
- ☐ **Outcome records deleted:**
  Date Deleted:_____ **Staff Initials:**_____
- ☐ **Notification of action taken sent to Board.**
  Date Deleted:_____ **Staff Initials:**_____

Claim Corrections Policy within MACSIS

Claim Corrections in MACSIS (For Claims with Dates of Service Beginning July 1, 2003)

Source: MACSIS Policy Team

To establish guidelines and specific procedures for when and how boards may make claim corrections within MACSIS for erroneously billed services. All corrections must be made in accordance with the "Procedure for Claim Corrections within MACSIS".

Policies:

Only the following claim errors may be corrected in MACSIS:

- Finalized MH Medicaid and non-Medicaid claims
- Un-finalized MH Medicaid and non-Medicaid claims
- Finalized AOD Medicaid and non-Medicaid claims
- Un-finalized AOD Medicaid and non-Medicaid claims
- The wrong number of units were billed (i.e., straggler claim, incorrect units)
- The billed amount was incorrect
- Incorrect procedure code
- Incorrect modifier
- Incorrect third party amounts
- Wrong date of service
- Incorrect UCI
- Date of service on claim is over 365 days old when received in MACSIS
- OHIO claims
- Mismatch claims
- Claims that have been reported on the OHEXT Error Report
- Client has retroactive Medicaid eligibility
- Denied claims with missing information

Note: "Denying" a claim for payment within MACSIS because it had been billed twice is not the same as "denying" a client treatment. The term "denial" in this document refers to the denial of payment, not the denial of treatment.

1. This guideline is not to be used to reverse claims paid before a resolution to a residency dispute. This is because the provider is not responsible for creating a residency dispute and therefore their funds should not be retracted accordingly. As noted in appendix 44, "ODADAS-ODMH Guidelines Pertaining to the Implementation of MACSIS under HIPAA", Topic 8, section 16. Boards are to resolve monies owed due to residency dispute resolutions outside of MACSIS.
2. All claims adjusted/reversed/denied/etc. **MUST** have a reason code.
3. This Guideline is **NOT** to be used to adjust Medicaid rates. Medicaid rate changes are assigned an effective date based on the day they are input into Diamond by ODMH/ODADAS. Therefore, neither boards nor providers are to use the claims correction procedure to retroactively update Medicaid rate(s). In instances where boards maintain separate rates for non-Medicaid, the claims correction procedure may be used to correct non-Medicaid claims due to an incorrect or retroactive rate change.

4. To ensure consistency across provider and board areas, both ODMH and ODADAS will allow correcting of Medicaid claims and non-Medicaid claims regardless of claim status.
5. All claims (whether AOD or MH) will be corrected following the "Procedure for Claim Corrections within MACSIS".

    - Boards may require claims that were originally denied in Diamond (missing/invalid modifier/diagnosis code) due to provider error to be resubmitted electronically.
    - Boards cannot require providers to resubmit claims electronically if the claims were originally denied in Diamond due to board error, unless mutually agreed to.

    No other claims may be corrected by resubmission. Claims denied as duplicates (e.g., straggler claims) must be corrected following the "Procedure for Claim Corrections within MACSIS".
6. **DO NOT** reverse Medicaid claims which 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.
7. Boards **MUST** pay claims when they have been finalized and documented on the 835(s) (even if corrections are going to be made). The erroneous claims must then be "worked" following the "Procedure for Claim Corrections within MACSIS".

    The ODJFS' adjudication deadline is 365 days from the date of service. If the date of service on the Medicaid claim is 366 days or older when it is received in MACSIS, (based on the received date in Diamond) the board may deny the claim or may allow the claim to be submitted to ODJFS for adjudication.
8. Boards and providers are responsible for identifying claims billed in error to ODJFS in a timely manner.
9. Boards and providers must use the Claims Correction Form to identify erroneously billed claims. Exception: 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. Boards and providers MUST maintain a copy of this form (or mutually agreed upon report) to serve as written documentation that a service was or was not erroneously billed.
10. Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond.
11. 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 from the provider within 30 days, boards may reverse a finalized claim or deny an un-finalized claim.

12. Boards are required to process corrections with little delay after receipt of a **Claims Correction Form** or a provider response to a **Claims Correction Form**.
13. The actual, year-end Medicaid cost reconciliation will be handled according to ODADAS' or ODMH's Medicaid Reconciliation Guidelines.
14. Boards **MUST** "work" the OHEXT Error Report and correct Member eligibility spans to resolve claims which are being paid as Medicaid but are not being extracted and sent to ODJFS.
15. Boards **MUST** "work" the OHIO claims, the Mismatch claims, and the Retroactive Medicaid claims in a timely manner.

***The MACSIS Claim Correction Policy is adopted as phase I of ODADAS' re-engineering of Medicaid reconciliation. Phase I represents movement toward alignment of current Medicaid reconciliation processes with MACSIS technology.**

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 an erroneously 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 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**

[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**.

- **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**
- **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. <u>Claim Is a Duplicate</u>

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. <u>Billed Amount, Units of Service, Procedure Code, Modifier, Place of Service or Third Party Amount are Incorrect</u>

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. <u>Original Claim is Denied</u>

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 since the original claim was denied, not reversed.

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.

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 reasons 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 or the date of service on the claim detail line is different from the date of service on the claim header (primary date).

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. 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 and 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 "ODADAS-ODMH Guidelines" "Topic 10: 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. hmondd.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. hmondd.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>hmondd.ret.clmfxmbr.group_bd</u> (ex: jul20.clmfxmbr.group_25b)

This file 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. <u>Correcting Retroactive Medicaid Eligibility and Claims</u>

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. <u>Correct Member Eligibility (hmondd.ret.mbr.group_bd)</u>

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. <u>Correct the Claims that Should have been Billed as Medicaid</u>

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.

ODADAS - ODMH
Guidelines Pertaining to the Implementation of MACSIS under HIPAA
Effective July 1, 2003
Last Updated January 27, 2005

INTRODUCTION

These Guidelines contain information related to the Multi-Agency Community Services Information System (MACSIS) and should be used in conjunction with the detailed information found in the Claims and Member manuals. Boards and providers should review this information carefully so that timely and accurate reimbursement can be made.

If there are questions about these guidelines, please contact the MACSIS Support Desk at: 614-466-1562 or 1-877-462-2747.

GUIDELINE UPDATING

These guidelines may require periodic additions and changes as a result of policy development, and or changes in State and Federal laws. All policy communication should be reviewed by the originator to determine if there are any impacts to these guidelines. If there are implications, the originator should email changes to the guidelines by completing information required in the Revision History and any supporting documentation to be included in the guidelines to MacsisSupport@mh.state.oh.us concurrent with distribution of the policy communication. These updates will be recorded in the Revision History portion at the back of these Guidelines and will include the Change, Section Revised, Date of Revision and the person or entity authorizing the change.

GENERAL

1. Topic: Change Control Procedures

This topic documents the steps needed for requesting or initiating system changes and the procedures for initiating the changes.

A. General Information

The MACSIS Operations Management (MOM) Team will be used as the primary gatekeeper for approving and monitoring system build changes and related procedures to ensure compliance with Medicaid and other State and Federal rules and requirements. Such changes fall into categories relating to member and benefits within Diamond, as well as changes to existing schedules and policies for claims electronic data interchange (EDI), accounts payable update (APUPD), and data extracts/reports.

All change requests must be submitted via email to MacsisSupport@mh.state.oh.us.

Requests received by close of business on Friday afternoons will be discussed at the next MOM meeting, typically held every Tuesday from 8-10 am. The email request must contain all requisite information needed to evaluate and implement the changes as outlined below **in bold typeface** for each type of change. For the most part, changes to the Diamond build will be entered into the system by State staff based on information received from the requesting board.

Most changes can be accommodated with a 30-day notification; unless the change impacts other boards or is so complex that additional time is needed (e.g. adding a new plan or changes to benefits). Those keywords that boards can change without prior notification are also listed under the appropriate change category.

Requests for types of changes not listed below should be sent to MACSIS Support for evaluation.

B. Changes to Diamond Files

1. Membership

- Adding a New Panel: Boards may add new panels without prior notification to the State. Panel naming conventions can be found in the MACSIS Naming Conventions document. Boards will need to add the new panel code to Diamond Keyword PANEL, and also create a new group/panel affiliation (GRUPP) record for each group and panel. **Boards should notify MACSIS Support of changes made since member reports are distributed by PANEL and State staff will need to add the new panel to the distribution list. Additionally, boards will need to build new Non-Medicaid provider contracts (PROVC) for the new panel(s) and must supply the necessary documentation for the State to build the Medicaid contracts.**
- Adding a New Affiliation Code: Boards need to request the addition of a new code. Use of affiliation codes must comply with HIPAA regulations and can only be used when the information is essential to paying a claim. **The request should list the business reason for adding a new code and a recommended 5-character code.**
- Adding a new Plan Code: Boards need to request the addition of a new plan code (PLANC) code. This type of addition is a very complex build change and should be requested only after all other possible avenues have been explored to meet the business need. Changes and additions to general ledger assignments (GLASS), general ledger references (GLREF), benefit packages and rules (BENEF, BRULE) and group detail (GRUPD) are required when a new plan is added, and extensive claims testing must also occur to ensure that claims adjudicate properly**. Boards will need to submit comprehensive documentation outlining the business need for such a substantial change, and will also need to work with State staff in determining the changes needed for the ancillary keywords mentioned above.** Adding a new plan actually requires two new plan codes, one for Medicaid and one for Non-Medicaid. This type of change requires 90 days notice, and will be implemented only twice per year for the following January 1 or July 1 start date. No retroactive changes can be made. Please refer to the Benefit Packages section below for additional information and requirements. Once the build is complete, boards will be required to manually move and enter clients into the new plan; the State cannot move clients electronically into a new plan due to limitations in the nightly member update programs.

2. Implementing Rider Codes

Boards that need to implement the use of rider (RIDER) codes to control benefits can do so by creating the necessary group premium detail (GRUPD) records. Please note that actually

triggering the rider codes is accomplished through the use of Benefit Rules thus **boards will also need to follow the procedures outlined below for BRULEs**. The new rider codes must be manually added to the member record. There is no need to terminate the old span and open a new span with the new rider code since the rider will be effective as of the date entered into the BENEF package.

3. ***Diamond Reason Codes***

Boards need to request the addition of a new code. The request should indicate the reason code type, recommended 5 character codes, the business reason for the change, and the recommended corresponding 835 Health Care Claim/Payment Advice claim adjustment reason category and code.

4. ***Diagnosis Codes***

Diamond contains the 647 ICD-9-CM (International Classification of Diseases, Version 9, Clinical Modification) diagnosis codes approved by Ohio Department of Job and Family Services (ODJFS) for Medicaid billing. These codes can only be changed by State staff when notified by ODJFS of adjustments made at the State or Federal level. See the list of MACSIS Behavioral Health ICD-9-CM Codes Considered for Payment under HIPAA, Health Insurance Portability and Accountability Act of 1996, (http://www.mh.state.oh.us/ois/macsis/codes/bhcare.icd9cm.codes.payment.hipaa.pdf) for a complete list.

5. ***Benefits***

- Adding/Changing Benefit Rules: Boards need to request additions and changes to benefit rules (BRULE). Typical changes include adding a rider code, applying or removing a copay or coinsurance, denying services, holding claims for some services, and limiting the quantity or dollar amount of services**. Boards should submit a request that describes the intent of the rule and provide a name for the rule that follows the naming conventions found in the MACSIS Naming Conventions document. A comprehensive list of all the medical definitions and appropriate rider codes that will be covered by the rule must also be submitted, along with the effective date of the new rule and the termination date of any old rules if applicable**. Adding a new rule requires 30 days notice due to the extensive testing needed, and will be implemented only twice per year for the following January 1 or July 1 start date. No retroactive additions or changes can be made.
- Terminating a Benefit Rule: Boards need to request the termination of a rule. This process is less complex than adding or changing rules so **the email only needs to include the rule name and the termination date, which cannot be retroactive**. Rules can be terminated without 30 days prior notice and such a change is not restricted to January or July.

C. Changes to Claims EDI

1. Changes in Provider Software:

Boards must follow the MACSIS HIPAA EDI Claims File Testing and Approval Policy and Procedure, Tier 1 and Tier 2 testing (http://www.mh.state.oh.us/ois/macsis/claims/hipaa.edi.claims.file.test.policy.pdf and http://www.mh.state.oh.us/ois/macsis/claims/procedure.submit.macsis.hipaa.edi.claim.file.pdf), for any providers who upgrade or change claims processing software before submitting production claims files. The test file submitted should contain sufficient claims to ensure that all contracted procedure codes are pricing and adjudicating correctly.

2. Changes to Production Claims Reports:

With the exception of the Outpatient List Report (OPLST, 102), all Edit and Post reports are Diamond proprietary formats and cannot be changed. For changes to the 102 report, please refer to Section D below.

3. Changes to Production Claims Schedule:

To request a second production run during the week, or permanently change the scheduled date or time, **a request should be sent to MACSIS Support indicating the adjustment needed. Requests for claims runs outside of the normal time period will be accommodated based on volume for the week.** Every attempt will be made to reschedule a run, however high volume weeks may preclude a second run due to system resource limitations.

D. Changes to Extracts and Reports

All change requests should be submitted to MACSIS Support. **Include the file/report name and specify in detail the proposed changes.** Since any adjustments to file structures will affect all boards, MOM will evaluate the change and determine which user groups must be involved in the decision to accommodate the requested change. Typically, volunteers from the appropriate committees will be solicited to meet or confer via phone in order to evaluate the impact and efficacy of the change being requested.

CLIENTS

2. Topic: Clients Enrolled and Services Reported in MACSIS

MACSIS is a Client Centered information system. Only those clients receiving behavioral health services funded **in whole** or **in part** with public funds administered through the boards will be enrolled in MACSIS.

Boards are responsible for assigning clients enrolled in MACSIS a Unique Client Identifier (UCI). Providers must have a valid UCI for public clients to receive payment or credit for services provided.

Pseudo Client Identifiers are available for non-client specific services and are addressed in Topic 44 of this document. MACSIS can ONLY receive data for clients that have been enrolled.

3. Topic: New Member Enrollment/UCI Request Process

A standard Member Enrollment Form can be used to initiate enrollment for a client in MACSIS. This statewide standard form (http://www.mh.state.oh.us/ois/macsis/forms/new.member.enrollment.pdf) includes the maximum number of data elements which can be collected at enrollment.

Boards may choose to design their own enrollment forms but must adhere to the following guidelines:

- No data element beyond what is stored in the MACSIS Member Data File can be collected on any MACSIS enrollment form, with the exception of questions designed to prompt the provider to ensure the proper procedures are being followed in their office.
- Boards must accept the State standard form or any other board's form from any provider (in-county or out-of-county) as long as the required data elements are completed on the form, the data has been verified by the provider for accuracy, the data elements are in the standard form order and the form is legible. This includes accepting forms which are system-generated and meet the preceding criteria. See Member Enrollment Form Completion Instructions for further details about what data elements are required and when (http://www.mh.state.oh.us/ois/macsis/forms/mbrfrmin.pdf)
- Boards may refuse to process an enrollment form where a required data element is not labeled or valued on the form (i.e., null or blank value). Simply leaving a data element off a system-generated form or leaving a value blank will not be interpreted as a "no" or completed response. Providers must label and value every required field. If the enrollment form indicates that the client is in crisis (i.e., the "In crisis at enrollment?" is marked "Yes"), then the provider must at a minimum provide the client's last name, first name, gender (best guess) and real or "default" date of birth. Every attempt should be made by the provider to subsequently obtain the required information.
- Boards cannot require a provider to mail an enrollment form, if a faxed copy is legible. However, they can require the provider fax the enrollment form to a confidential fax number, if the number is made available to the provider in advance.
- Providers must complete the physical address where the client is residing on the enrollment form, but the "county" should be the legal county of residence. The Residency Verification Form (http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf) should be used to communicate further legal county of residency information, if different.
- Required data elements will be flagged with an "asterisk" on the Standard MACSIS Enrollment Form and will appear in the required order. Boards are encouraged to similarly flag the standard required data elements on their forms with an "asterisk" for clarity and consistency. Please note that some data elements are only required if specifically stated in the board/provider contractual agreement. The latter data elements will not be marked with an "asterisk".

4. Topic: Confidentiality

The following state and federal laws address confidentiality and related notice requirements imposed upon Providers, Boards, ODADAS and ODMH in conjunction with their roles in the public community mental health system:

- Ohio Revised Code (ORC) Chapter 1347 applies to State and local agencies that deposit personally identifying information into a database. The statute mandates notice to persons whose data is input into the system, and adoption of measures to protect the confidentiality and integrity of information input into the system.
- ORC 5122.31 (see also Ohio Administrative Code, OAC 5122-27-08), imposes limitations on the disclosure of personally identifying information relating to a recipient of mental health care or treatment.
- 42 Code of Federal Regulations (CFR) Part 2 (Re: Alcohol or Drug (AOD) Confidentiality)

  AOD Policy – Consent for Release of Information

  - Federal law (42 CFR 2.12 (d)(2)) requires releases of information relating to AOD treatment (with limited exceptions)
  - Notice regarding prohibition on re-release of information also required
  - **Requires client signature**
  - Applicable to AOD treatment/services

- 45 CFR Part 164 (HIPAA) imposes limitations on the use and disclosure of protected health information. HIPAA applies to health plans, clearinghouses and health care providers, and, through mandated contracts, their business associates.

5. Topic: Sliding Fee Scales and Co-Payments

The purpose of this guideline is to establish business rules and specify procedures for the assessment of consumer fees and appropriate billing for services to members whose adjusted annual income and number of dependents fall within the fee scale established by the local Board. With the implementation of MACSIS, sliding fee scale is referred to as co-insurance. Co-payments refer to flat-rate minimum fees and residential fees.

A. Sliding Fee (Co-Insurance)

- MACSIS will be used to capture the patient sliding fee percentage (referred to in MACSIS business rules as co-insurance). When claims are processed through MACSIS, the percentage share to be paid by the member will be calculated based on the allowed amount, deducted from the total billed amount and the net amount will be paid by the board. It is the provider's responsibility to collect the balance from the client. Sixteen (16) rider codes (A - S) have been set aside for sliding fee. These rider codes correspond to 5% increments beginning with five (5%) and ending with 95%. A single rider code (A – S) will be attached to the client and to a benefit rule for each **non-Medicaid reimbursable service**. An additional rider code (Z) has been created when a client is responsible for 0% (i.e. Board pays 100%).

- If/when a client's status changes, such that it changes the appropriate sliding fee scale percent, the rider code will need to be updated. This must be done manually by the Board with a new effective and termination date.
- All enrolled clients should have a sliding fee percentage (i.e., rider code) assigned (e.g. data collected includes family size and income). Not only is there the possibility of a client's eligibility moving from Medicaid to non-Medicaid but Medicaid does not pay for all services. Therefore, by design, a Medicaid client can receive non-Medicaid eligible services. The sliding fee can be applied to any non-Medicaid eligible service although there are many cases were clients are eligible for 100% reimbursement.
- Per ORC 340.03 (9), each board will establish its own sliding fee scale.
    - Since a client can only have one effective rider code associated with a sliding fee or copayment, a board must implement a uniform fee schedule with all contract agencies.
- Processes should be developed to update clients' sliding fee percentages routinely. Untimely processing may result in clients' rights issues.
- Sliding fee amounts and/or copayments (see below) should not be deducted from the claim billed amount. Since the client amounts due are calculated in MACSIS, deducting the amount in advance could result in a double deduction.

B. Co-payments (minimum fee)

MACSIS could be used to compute co-payments. When claims are processed through MACSIS, the flat-rate amount to be paid by the member will be deducted from the total billed amount, and the net amount will be paid by the Board. It is the provider's responsibility to collect the balance from the client. MACSIS can compute monthly co-pay fees through the use of up to 16 rider codes. *For example: a Board could determine that it wants the increments to begin with $10 and end with $550.* The appropriate rider code (1 - 9 and T - Z) will be attached to the client and to a benefit rule (BRULE) for each **non-Medicaid reimbursable service**.

6. Topic: Removal of Client Data from MACSIS

The purpose of these guidelines is to establish the criteria and process for removing protected health information (PHI) from MACSIS, Mental Health (MH) Outcomes and the Behavioral Health Module and to establish ODMH, ODADAS and board responsibilities.

A. Conditions

The following matrix illustrates various scenarios of when it is and is not permissible under applicable federal and state statutes and policies for the State to delete protected health information (PHI) from the ODMH and ODADAS systems.

Scenario	Delete	Comments
Client enrolled but has no claims	Yes	Follow process below
Client has received services(s) paid in whole or part with public funds	No	Information needs to be maintained in accordance with Business Records retention schedule
Client has received services but they have NOT been paid in whole or part with public funds.	Yes	MACSIS Guidelines – Topic 2 indicates that only those clients receiving services funded in whole or in part with public funds administered through the boards will be enrolled in MACSIS.

B. Process

The MACSIS Support Desk, hereinafter referred to as State, will timely process requests submitted by the board to remove client information from MACSIS.

Documentation to substantiate request to remove client information should be maintained at the local level (board and/or provider) and not routinely submitted to the State. The State reserves the right to request information as necessary to timely process the request.

Boards or providers can initiate a request on behalf of the client by completing the Request to Remove Client from MACSIS form. Reason for request must be documented and approved by board prior to submission to the State. Board approval process should include but not be limited to the following:

- Exploration to assure client has not received services paid in whole or part with funds administered through requesting board. Board should verify this by checking to make sure that a net amount of zero is not the result of benefit rules, rider codes or 100% withhold (i.e. clients served in Women's Set-Aside Grant Program shall not be submitted for deletion).

State will verify client has not received services in other boards areas

If MACSIS has claims paid by a board other than from the requesting board then the State will work with those board(s) prior to removing client from database to assure services were not funded in whole or part with public funds (i.e. even if netted to zero)

State will take action to remove member and claims information from the MACSIS on-line system. Information archived (on-line) or on back-up tapes will not be modified.

State will take action necessary to remove client information from Outcomes database.

Board(s) will be responsible for notifying provider of action taken by State.

Provider(s) must submit a delete record to ODADAS in accordance with Behavioral Health Instruction Manual to delete client information from BH module.

Boards and providers should take necessary action to remove client information from local databases and files.

7. Topic: County of Residence

Residency issues will be governed by the ODMH and ODADAS definitions as incorporated in the Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards (http://www.mh.state.oh.us/ois/macsis/mac.pol.rdd.html).

8. Topic: Residency Guidelines

1. The purpose of these guidelines and operating principles is to clarify what is to take place, in terms of Board responsibilities and residency determinations, when clients seek services outside their service district of residence.
   a. Nothing contained in this document should be interpreted to reduce in any way the obligation of Boards set forth in ORC Section 5122.01(S) to deal with crisis/emergency situations which occur within their service districts and to respond to essential client service needs while residency questions are being resolved.
   b. Regardless of residency determination, nothing contained in this document should be interpreted to constrain the freedom of clients to seek services wherever they wish. Rather, it is intended to clarify which Board is to deal with such requests and under the auspices of which Board's Mutual Systems Performance Agreement – M-SPA (i.e., the Community Mental Health Plan) they are to be considered.
2. For the purposes of MACSIS, the county of assigned residency determines into which Board's service system (i.e. group and plan) an individual is to be enrolled. In special circumstances, a client may live in a Board area which differs from that to which residency/enrollment has been legitimately and appropriately assigned.
3. A fundamental tenet that is to guide residency policy and its interpretation is that continuity-of-care is paramount and that responsibility to ensure this in instances of out-of-district placement or referral should rest ultimately with the "home" Board from which the client came. A Board should not be in a position to shift this responsibility by facilitating the relocation of clients to facilities or services which lie outside its service district. The "home" Board to which a client's residency is assigned should carry the following responsibilities (some of which may be delegated to another entity):
   a. Assuring reasonable client access to the services called for in the Board's M-SPA in a fair and equitable manner.
   b. Enrolling eligible persons in its benefit plans in accordance with the applicable business rules and providing for the provision and management of these benefits.
   c. Serving as the local authority for funding, contracting, coordinating, monitoring, and evaluating services. These responsibilities include clinical oversight and utilization review responsibilities as authorized by Chapters 340 and 5122 of the Ohio Revised Code.

d. Providing the necessary financial resources (to the extent such resources are available to the Board).

e. Taking the initiative to negotiate and implement workable solutions when problems involving residency arise.

4. Residency determinations are to be based upon the following:

   a. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which read as follows:

      "Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residence means the county where the criminal charges were filed.

   b. For alcohol/drug clients, the definition of residency established by ODADAS, which reads as follows:

      "Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

5. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, ODMH and ODADAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" Board because of a client's placement in a special residential program or facility or because of other unusual circumstances.

6. The provisions of ORC Section 5122.01(S) and the ODADAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:

   a. A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).

   b. The type of facilities encompassed includes hospitals, nursing homes, ODMH-licensed and ODADAS certified residential facilities, Ohio Department of Health (ODH) licensed Adult Care Facilities, mental retardation group homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), rest homes, drug/alcohol residential programs, crisis shelters, foster-care homes, etc.

   c. The term "mental health services" is to be construed broadly to encompass all those items contained in OAC 5122-25-02(B) and ORC Section 340.09 and the term "alcohol or other

drug addiction services" shall include all those alcohol/drug services identified in OAC 3793:2-1-08 through 17.

d. The phrase "receiving (MH or AOD) services at a program/facility" is to be understood to mean "while on the rolls of the program/facility." It is not necessary either for the services to be provided "on the premises of the program/facility" or "by an employee of the program/facility." Likewise, it is not necessary for said services to be officially certified for the purposes of residency determination.

e. There is to be no "statute of limitations" on designated residency remaining with the "home" Board for persons placed in specialized residential programs/facilities that lie outside its service district.

f. Designated residency shall remain with the "home" Board regardless of whether it was directly involved in facilitating placement in an out-of-district specialized program/facility.

g. Residency shall not remain with the "home" Board in those situations where a client is placed for an indefinite period in a facility for reasons having nothing to do with mental health or alcohol/drug needs and then develops such problems subsequent to placement. However, no discharge directly from a state hospital to a facility shall cause a change in residency, regardless of the reasons for the discharge.

7. The interpretation of the provisions of ORC Section 5122.01(S) and the ODADAS definition of residency in regard to "intent to remain" shall be guided by the following:

   a. "Intent to remain" is to be interpreted to mean a person's expressed intent, **as documented by completing and signing the Residency Verification Form,** to remain in the county, with the exception of persons in specialized treatment facilities. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose. The Residency Verification Form should be completed when:

      1) The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county)

      2) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (ex. domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county)

      3) The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

   b. Boards may request from in-county, contracting providers one of the following forms of documentation that is current to assess whether a person's actions demonstrate intent to be a resident. The contract between a provider and board may dictate the form of documentation required for cases not outlined in section 7.a. above.

      1. mailing address
      2. voting
      3. car registration
      4. job or other vocational efforts

5. payment of taxes
6. location of family
7. general conduct.
8. signed Residency Verification Form (http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf)

- Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.
- Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-à-vis residency.
- For out-of-county, non-contracting providers, a signed Residency Verification Form shall suffice as proof of residency.

8. Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a Children Services Board (CSB), Ohio Department of Youth Services (ODYS), etc.), residency should remain with the "home" Board of the county where the court which ruled maintains jurisdiction. **Completion and signing of the Residency Verification Form shall provide residency documentation for children.**
   a. This guideline is not intended to resolve boundary issues between the responsibilities of Boards versus those of CSB's, juvenile courts, ODYS, etc.. Rather, it is intended to clarify that it is the responsibility of the "home" Board to work through such matters for its clients.
   b. Persons with handicapping conditions who consequently may remain in the custody of a CSB, etc., through their 21st year shall be considered to be children for the purposes of these guidelines.
9. The interpretation of these residency provisions for children is to be guided by the provisions of ORC Sections 3313.64(A)(1 and 4), 3313.64 (C)(2), and 2151.35, which deal with the determination of local responsibility within the educational system.
10. For clients committed pursuant to ORC Sections 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residency shall remain with the Board of the service district in which the charges were filed only for as long as the client remains in a forensic status. If and when the client's status reverts to a civil commitment, at that point the client's residency shall be changed to that to which it would be for non-forensic clients (i.e. the "home" Board from which the client originally came). For those clients who may be in a non-hospital setting when their commitment status changes, residency should be determined by type of facility and/or intent, depending upon the circumstances. When residency shifts because of a change in forensic status, the Board from which residency is being shifted is to give timely notice to the new Board of residency.
11. Where special circumstances, such as result from unusual geographic boundaries, create situations where the applicability of the residency criteria in the law may be especially

problematic, the Boards involved may negotiate a "Memorandum of Understanding" as to how various issues will be addressed, rather than repeatedly disputing individual cases.

12. A Board (directly or through its contract agencies) may receive requests for services from a client whose residency rests with the Board of another service district (with this encompassing clients involved in emergencies while away from home, clients wishing to travel to receive non-emergency services from a provider in another district, and clients placed in a specialized residential facility who seek additional services beyond that which the facility itself may provide). Such requests for services from non-residents should be dealt with as follows:

    a. Emergency/crisis situations are to be addressed by the Board and/or designated agency where the crisis occurs, regardless of the client's official residency assignment.

        1. To the extent that commitment/probate matters may be involved in addressing the crisis, the Boards involved shall be guided by item #10 (page 14) of this guideline.

        2. For mental health, non-Medicaid services, the board providing the service is responsible for crisis intervention services up to three days.

            For ODADAS, non-Medicaid services out of county/ emergency/ clinically appropriate services are the Level I services (Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis; (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient services) plus Level III and Level IV ambulatory detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend beyond three days, the out of county placement must be approved by the home board. It is essential collaborative efforts be made between providers and Boards to establish arrangements for a client's continued care.

        3. When an enrollee of a Board receives crisis services [as defined above in paragraph (2)] outside his/her service district and under the auspices of another Board's service system, financial responsibility for these crisis services shall be borne by the Board in which the client is enrolled. The rate for said services shall be that contained in the contract of the local Board under whose auspices the services are being provided.

        4. A Board which is providing crisis/emergency services for an individual who is enrolled in another Board's plan shall contact that other Board (or its designee) within one business day, to notify it that one of its members is involved in a crisis situation and to consult on the disposition of the case.

            a. The Board in which a client is enrolled shall have no financial responsibility for the provision of out-of-district crisis services beyond three days without its concurrence. In the event it is anticipated that the three-day limit shall be exceeded, the Board/agency involved in the provision of crisis services to an out-of-district party shall be responsible for contacting the Board of residency/enrollment to establish appropriate arrangements for payment or to provide for the orderly transfer of the client to a provider selected by the home Board.

            b. Services other than emergency/crisis services and Medicaid-billable services should remain the sole responsibility of the "home" Board of residency, with this

responsibility understood to encompass the items listed in section #2 of this document.

c. The Chief Clinical Officer (or designee) of the "home" Board should be responsible for determining what services may be clinically necessary and appropriate for an individual seeking services outside of his/her "home" district. The "home" Board should bear ultimate responsibility for overseeing and supporting the provision of appropriate out-of-district services (to the extent they are approved as being consistent with the Board's M-SPA and sufficient financial resources are available).

d. For non-Medicaid services, a Board may have "preferred providers" (i.e. its contract agencies) and expect residents seeking Board-subsidized services to use these organizations.

e. Non-emergency services may be provided to out-of-district clients by either the "home" Board of residence or the Board from which the client is seeking services. However, no Board should be expected or assumed to provide ongoing, non-emergency services to out-of-district clients without its explicit consent and without a mutually agreeable reimbursement mechanism having been negotiated. All Boards should adopt official policies and procedures which layout how it will respond to requests of its residents who seek services outside the Board's service district.

f. Anytime a severely mentally disabled (SMD) client is placed in an out-of-district residential facility with the involvement of the public community mental health system, the "home" Board should notify the Board where the facility is located and work out matters of service coordination and continuity-of-care.

g. Contract agencies are free to serve whomever they wish with funds other than those provided pursuant to a contract with a Board.

13. A person incarcerated in an out-of district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

14. Residency disputes are to be addressed as follows:

a. Ultimate responsibility for resolving residency disputes shall rest with ODMH and ODADAS, whose decisions shall be binding.

b. ODMH and ODADAS shall officially adopt and distribute these "Guidelines and Operating Principles" (along with any subsequent modifications), with the explicit understanding that they are to be followed in the determination of residency.

c. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.

d. As the initial step in the formal dispute resolution process, the Board which believes that an individual's residency has been inappropriately determined is to contact the Board it believes is the proper Board to which residency should be assigned. This is to be done in writing and,

unless there are extenuating circumstances, is to take place within ten working days of the time a Board first becomes aware that a residency assignment may need to be questioned.

e. After receipt of the written statement initiating the residency dispute process, the two Boards shall have five additional working days to agree upon the appropriate residency designation. If the matter remains unresolved, either Board may refer the matter to ODMH or ODADAS (depending upon the circumstances) for final resolution. This shall be done in writing and shall occur immediately upon expiration of the five working days during which the Boards are to attempt to resolve the matter between themselves. The Director of ODMH/ODADAS (or his/her designee) shall make a final determination about residency within ten additional working days, during which time the Boards involved in the dispute and other relevant parties (including, where appropriate, the client) are to be contacted. A written determination, including the rationale for the decision, is to be provided to both Boards.

15. While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the Board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which Board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a Board other than the Board which paid for the services is the appropriate Board of residence then the Board which paid for the cost of service will invoice the Board of residence. The Board of residence will be expected to pay the Board of service within a reasonable amount of time.

    [For Medicaid purposes only, while the residency dispute process is taking place, the automatic contracting and payment of Medicaid reimbursable services is not to be interrupted or delayed in any way. This is to say that no changes are to be made to the MACSIS "plan" the client is enrolled in, Medicaid reimbursable services are to be continued to be provided and paid for and, if necessary, the "Secondary" Medicaid Contract is to be established within the 30-day limit. For MACSIS purposes, ODMH/ODADAS reserve the right to take any action deemed necessary to assure this process is strictly adhered to.]

16. No Board is to alter an individual's residency/plan assignment within MACSIS without the explicit approval of the other affected Board or a formal ODMH/ODADAS resolution of a residency dispute. (Normal practice should be for the receiving Board to effect a residency change in MACSIS.)

17. Nothing in this document should be interpreted as precluding two Boards from effecting a transfer of residency responsibilities when they mutually determine this to be in the best interest of a client.

    a. These guidelines deal only with inter-Board residency issues and are not intended to address situations where individuals may be placed or seek services across state lines. It is felt that the issues involved are enough different to warrant separate consideration.

A. Guidelines to be used in determining the county of residency for College Students, Homeless Clients, Migrant Workers and Out-of-State Clients.

Please note: these guidelines address county of residency determinations for MACSIS enrollment/plan/panel assignment and not State Hospital county of residency issues.

1. ***College Student Guideline***

As referenced in item #8 (page 14) the residency for children is to be determined by the residency of the parent(s)/or guardian(s) and should change when the parent(s)/guardian(s) move (even when the move occurs in the middle of a hospitalization or residential placement).

The primary question to use in determining whether or not this guideline is applicable is: "Is the student an IRS (Internal Revenue Service) Tax Dependent?" If the student is, then the board area in which the parent(s)/guardian(s) reside is the child's county of residence. The student is to be enrolled in one of that county's plan(s)/panel(s).

If the student is not considered an IRS Tax Dependent, then the following is to be taken into consideration for county of residency determination:

Is the student emancipated?
Is this a graduate level student?
Does this student have dependent children?

Students who fall within these criteria should have further screening to determine actual county of residency. Please reference item # 4 (page 11-12). Has the client/student established residency or expressed the intent to remain? If the client has, then the Board must enroll that student as a resident of their county.

If it is an out of state college student, enrollment criteria should be developed and implemented by the local Board. These students should be enrolled using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field.

2. ***Homeless Client Guideline***

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Example:

The client was originally enrolled in a plan/panel of the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board. This client subsequently presents in Montgomery county for services and claims to be homeless (please note that this client can claim an address of homeless or an address of a homeless shelter). The Montgomery County ADAMH Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. If this client continues their journey and presents for services in Butler county two months later and again claims to be homeless, the Butler County Boards should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. Please note, it is intended for MACSIS to track this type of client to assist in identifying such populations and their need for continuity of care.

How to process enrollments/transfers in MACSIS:

a. Client not previously enrolled. Board area in which the client presents as homeless should enroll immediately for benefits. Note: A client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

b. Client previously enrolled. If the client is already enrolled in another Board's plan/panel, then the Board in which client has presented for services and stated homelessness MUST immediately transfer the client into one of their plan/panel combinations. As previously noted above, a client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

3. ***Migrant Worker Guideline***

The following guideline is applicable to Legal Migrant Workers. (Illegal Migrant workers are still under discussion, however, it was noted that boards should be utilizing the "Out of County Service Matrix" (page 24) when dealing with these clients.)

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Please reference the "Homeless Client Guideline" above.

4. ***Out of State Client Guideline***

How to handle the enrollments within MACSIS:

a. If the client has a valid Ohio Medicaid card, then the Board in which the client has presented for service should enroll the client in one of their plan/panel combinations or if the client has previously been enrolled, immediately transfer the client to one of their plan/panel combinations.

b. If the client does NOT have a valid Ohio Medicaid card, then the Board could exercise their local option to enroll these clients for service. (Please reference the enrollment guideline for out of state college students.)

B. Criminal Justice System and Residence Determinations

As part of the Multi-Agency Community Services Information System (MACSIS) implementation by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH), many questions have arisen concerning how to determine the "county of residence" for a client who has recently been under the auspices of the Ohio Department of Rehabilitation and Correction (ODRC) system and is in need of alcohol and other drug or mental health services.

A workgroup, consisting of representatives from ODADAS, ODMH, ODRC, and Alcohol and Drug Addiction Services (ADAS) Boards, Community Mental Health Boards (CMHB), Alcohol, Drug Addiction and Mental Health (ADAMH) Boards and in conjunction with provider input, believes the basic residency guidelines outlined on pages 11-17 are adequate for determining county of residence in this situation. Former offenders should be treated, for residence determination purposes, in the same manner as any other individual in the State of Ohio. Primacy for determining county of residence shall be upon the individual's statement (i.e.,

expressed intent to remain) and/or upon the individual's county of residence prior to becoming a charge of the ODRC system.

The applicable section of the residency determination guidelines can be found on page 12, item #6. a. and b. ODRC will bear the financial responsibility for necessary drug and alcohol and/or mental health services provided to Transitional Control inmates housed in halfway houses contracted with ODRC. When a person transitions from an inmate status to a non-inmate status, eligibility for and the financial responsibility for alcohol and other drug and/or mental health services should be determined as it would be for any other Ohioan. The attached documents, including an inmate versus non-inmate status matrix developed by ODRC and shared and reviewed by the workgroup, should be used in determining when an individual's services are the responsibility of ODRC and when the individual's services become the responsibility of the community alcohol and drug and/or mental health system.

Inmate Status	Non-Inmate Status
Halfway House Population: Transitional Control Offender (ODRC Jurisdiction) Prison (ODRC Jurisdiction)	Halfway House Population: Parole/Post-Release Control/Probation/Community Control
CBCF (County/Court Jurisdiction) Jail (County/Sheriff Jurisdiction)	Non-Halfway House Population: Parole/Post Release Control

*A. **Jails and CBCF's (Community-Based Correctional Facilities)***

- A person in a jail is considered an inmate.
- ODRC does not provide MH or AoD funding for jails but does set standards by which jails are to provide substance abuse and/or mental health treatment services.
- A person in a CBCF is considered an inmate of a correctional institution and is under the jurisdiction of a common pleas court.
- Either of these persons is still a resident of his/her home county.
- In many communities the local ADAS/ADAMHS/CMH Board has traditionally, through a voluntary collaborative arrangement with the local Judicial Corrections Board, made arrangements for the CBCF to utilize local AoD and MH agencies for the provision of needed services.
- These scenarios are covered by item 10 (page 14).
- A person incarcerated in an out-of-district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected.

Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

B. Halfway House

ODRC currently contracts with 24 halfway houses throughout the state. All of these facilities house individuals who are considered non-inmates, with the exception of those facilities which serve Transitional Control offenders. Transitional Control (or furlough) clients are considered inmates and their services are the responsibility of ODRC. At which time an offender is no longer under Transitional Control status and is transferred to another status, such as parole or post-release control, and expresses an "intent to remain" in the county, the offender may be referred to community agencies and is eligible for services as any other resident of that county.

C. Normal Out of County Enrollment Process

Step 1 Provider determines client's county of residence.
It is the Provider's responsibility to obtain sufficient documentation to determine the client's county (Board) of residence. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence.

Step 2 Provider completes enrollment form

Step 3 Provider submits form to enrollment center for the board where the client resides.
Once the Provider has determined the residency of the client, the Provider must submit the enrollment form to that Board's enrollment center per the Board's submission requirements to begin the enrollment process. The Provider must indicate on the enrollment form that releases have been obtained for that specific Board area.

Step 4 Board enrolls the client or works with the provider to clarify questions.
Upon receipt of an enrollment form from a Provider that is treating a client who is a resident of that Board area, the Board's enrollment center should look up the client, enroll the client if not already in MACSIS, and then return to the provider the client's UCI, plan assignment and rider information. If there are points of clarification, the Board is responsible for making contact with the Provider to resolve any questions.

Step 5 Board returns UCI to provider.
It is recommended that no more than 5 business days (1) should separate the submission of the enrollment form from the provider to the board and the receipt of the UCI by the provider. The provider will then use the UCI to bill for services. Medicaid clients receiving Medicaid certified services will be paid and non-Medicaid clients and non-Medicaid services will be subject to the Out of County guidelines.

D. Disputed Enrollment Process (for Providers)

Step 1 Provider follows Normal Enrollment Process
In all cases, the Provider should follow the process established for a normal out of county enrollment. It is in everyone's best interest for the provider to obtain as much information as

possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence. Examples of documentation that can be used to establish a client's residency include:

Driver License
State ID Card
Lease agreement
Adoption or custody papers
Statement from Client (Signed and Witnessed) Indicating Residency

Step 2 Board of Residency Refuses to Enroll an Out of County Client
If the Board (where the Provider determines the client resides) refuses to enroll the client or fails to provide a UCI within ten business days, the provider should contact the MACSIS Support line.

Step 3 MACSIS Support Line Enrolls Client
The Provider will provide the MACSIS Support line with copies of the enrollment form and all supporting information that was provided to the Board. As soon as the proper documentation has been received, the MACSIS Support Line staff will send an email to the affected board and wait 1 working day before doing the enrollment. This is to provide time for the affected board to become aware of the issue. (2)

The MACSIS Support Line staff will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Line will follow the rules as outlined in the Summary Matrix outline on page 24.

Note: Providers should be aware that non-Medicaid clients that are not in Crisis WILL NOT be enrolled per the Summary Matrix included in this notice.

The MACSIS Support line Staff will then electronically notify both the Board where the client has been enrolled and the provider that is treating the client, with the enrollment information.

Step 4 Residency Dispute Claim Submitted
If the board where the client is enrolled disputes the residency determination and action taken by the MACSIS Support Line, the Board may file a formal residency dispute following the established residency dispute determination (RDD) Guidelines.

(1) The expectation remains that the majority of enrollments will occur within two (2) to five (5) days. It is understood, however, that exceptional circumstances will occur, particularly with out-of-county enrollments. In no event, however, should any enrollment, in-county or out-of-county, take longer than ten (10) days.

(2) The MACSIS Support Line is not responsible for settling residency disputes and therefore, should not be expected to respond to board disputes which might result from the e-mail notification. They will continue, as outlined in this procedure (i.e., enrolling the client) and the disputing board must then file the appropriate dispute as noted in the RDD guidelines.

E. Clarification of Requirements for Out-of-County MACSIS Enrollment

Mental Health Services

1. **Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.**

   In these circumstances, such persons must be enrolled with the appropriate Board of residence per the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

2. **Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in emergency situations.**

   In these circumstances, such persons must be enrolled with the appropriate Board of residence pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying non-Medicaid claims for Crisis Intervention services in emergency situations for a period up to 72 hours.

3. **Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in non-emergency situations.**

   In these circumstances the provider organization is not required to enroll such persons. However, the provider organization should refer such persons to the Enrollment Center for the person's Board of residence in order to be linked with the appropriate provider organization. The out-of-county provider organization should offer the person assistance in contacting the Enrollment Center for the person's Board of residence. Such assistance in referral will better ensure appropriate continuity of care.

Alcohol and Drug Addiction Services

Medicaid

1. **Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.**

   In these circumstances such persons must be enrolled with the appropriate Board residence of pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

Non-Medicaid

1. **ODADAS recognizes non-Medicaid services, out-of-county services, emergency services or clinically appropriate services as:**

- Level I Services (Assessment, Individual counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient Services, plus)

- Levels III and IV Ambulatory Detoxification Services

Non-Medicaid clients who present for services out-of-county are eligible for Board funding under the same considerations as if the clients presented for services in their home county. Level I services and Levels III and IV ambulatory detoxification services may be provided for three days or until linkage to treatment is established in the "home county." If out-of-county treatment is to extend beyond three days, the out-of-county placement must be approved by the home board. It is essential that collaborative efforts occur between providers and Boards to establish arrangements for a client's continued care.

Out-of-County MACSIS Enrollment Summary Matrix

Circumstances	MH	AOD
Medicaid eligible person - emergency or non-emergency	Enrollment: Must enroll. Services: Any Medicaid covered service.	Enrollment: Must enroll. Services: Any ODADAS Medicaid covered service.
Non-Medicaid eligible person - emergency	Enrollment: Must enroll. Services: Crisis Intervention services for up to three days (72 hours).	Enrollment: Must enroll Services: Level I Services:(assessment, individual counseling, group counseling, crisis intervention, case management, alcohol/drug urinalysis (lab analysis of specimens for presence of alcohol and/or drugs), medical /somatic, intensive outpatient and methadone administration) plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county".
Non-Medicaid eligible person - non-emergency	Enrollment: Not required. Services: Not required to pay for services.	Enrollment: Must enroll Services: Level I services plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county"

9. Topic: Spend Down

The client's eligibility status will be updated when the client's spend down amount has been met according to ODJFS eligibility files. The revised Medicaid eligibility status will be transmitted to MACSIS during the nightly update process. If a client is Medicaid eligible the McareSt field (on the MACSIS Member screen) will contain a spend down indicator. The codes and meanings are as follows:

R for Recurring (eligible 1st day of month); D for Delayed (Medicaid eligible because they have met their spend down), and N for Not eligible have not met spend down).

The Spend Down information for people not Medicaid eligible is not maintained in the MACSIS MEDELIG (nightly Medicaid eligibility update) file (subset of the ODJFS Recipient Master file).

10. Topic: Retroactive Medicaid Eligibility

For MACSIS purposes, retroactive eligibility occurs when the initial coverage changes at a later point in time.

A client will be assigned a UCI number at the point when the agency expects payment in part or in whole from a Board, whether Medicaid eligible or not. When a client subsequently gains or loses his/her Medicaid eligibility status, the UCI will remain the same, but his/her affiliated benefit plan in MACSIS will be updated to reflect CURRENT Medicaid eligibility status.

The problem is that if a change occurs that affects an eligibility period that is not the current eligibility period there is no automated means of making the correction. The system is set up to identify changes that affect today. If a change affects today (and previous days in the same span) the change can be automatically updated in MACSIS.

The following instances will require the board to make manual adjustments:

- Changes to the retroactive MACSIS member eligibility period from a previous point in time (as described in above paragraph)
- Claims adjudicated before retroactive eligibility changes are processed must be manually adjusted by the Board and then resubmitted by the Departments to ODJFS as long as it is within 365 days.

FINANCIAL

11. Topic: Use of Company Codes in Diamond

Company code will be used to identify a board or group of boards in MACSIS (Diamond).This policy will allow each board to operate as a separate company (in Diamond terms) or as a board consortium, depending on accounts payable and general ledger assignment needs.

While this procedure will allow for multiple companies to be formed, it is imperative that this policy not be confused with the use of security codes. If a board elects to become a part of a consortium or break away from a consortium, a separate discussion regarding use of security codes will need to take place and will require approval by the State MACSIS Team.

12. Topic: MACSIS Unique Provider Identifier (UPI) and Vendor Numbers

All AOD and MH service providers who intend to submit claims through the MACSIS system must be assigned a MACSIS UPI and VENDR number as defined below.

Definition of MACSIS VENDR Number:

MACSIS Vendor Number. It is a five digit number assigned to the legal owner of a provider as identified by the tax identification number on the MACSIS Provider Registration Form and as verified against the provider's AOD and MH certification records. Please note the following:

- The number will be assigned by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in cooperation with the Ohio Department of Mental Health (ODMH).
- For non-governmental entities the long name linked to the MACSIS VENDR number will be the name associated to owner's charter number as registered and verified with the Ohio Secretary of State, Business Services Division.
- The address associated with the MACSIS VENDR number is where the provider wants remittance information distributed.
- There can only be one MACSIS VENDR Number per Tax-ID.

Definition of MACSIS UPI:

Unique Provider Identifier. It is a five digit number assigned to the entity providing AOD or MH services at a physical location within the State of Ohio. The UPI number is linked to the legal owner via the MACSIS Vendor Number. Please note the following:

- The number will be assigned by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in cooperation with the Ohio Department of Mental Health (ODMH).
- The long name associated with the UPI will be the name of the provider as recorded in the AOD and MH certification records.
- All AOD entities will be registered by the Ohio Department Alcohol and Drug Addiction Services (ODADAS) with the Substance Abuse and Mental Health Services Administration (SAMHSA) federal agency.
- There can be multiple UPI's assigned to a MACSIS VENDR Number if services are provided at distinct, certified physical locations.

Exceptions:

To attach a UPI to a VENDR number other than the legal owner, the board and provider must submit legal documentation to MACSIS (TPA/BAA) indicating that the proposed VENDR accepts complete financial responsibility for the attached provider.

Transferring UPI Numbers:

A UPI will only be transferred from one MACSIS VENDR number (i.e., legal owner) to another MACSIS VENDR number if the owner submits documentation via the board attesting to the legal and financial obligation transferring from one owner to another. It shall be the policy of MACSIS to not reassign UPIs of entities no longer submitting claims to MACSIS.

- It should be noted that an entire board-combined weekly claim file could reject, if an existing UPI number for a provider in the file is transferred from one VENDR number to another and

the file contains claims for prior dates of service. This is because both the VENDR and the Tax ID information are not date sensitive in Diamond.

Please use the MACSIS Provider Request/Modification Form to add or change information regarding a provider.

13. Topic: Medicaid Pricing

In the MACSIS system, Medicaid pricing (rates) will be:

- State maintained as fully described in the MACSIS procedural manual.
- The contracted rate for Medicaid will be applicable to all Medicaid clients served by a provider regardless of county of residence.
- Providers will be reimbursed at 100% of the Medicaid contracted rate.
- If a providers' rates are not revised at the beginning of a new state fiscal year, the most recent rates will be used to pay claims until rates are revised.

14. Topic: Diamond Contract Process

The original MACSIS Finance and Contracts Team initially created an overall approach to how contracts are built and administered in Diamond that address the Medicaid Contract issue and the Default Contracts for both Medicaid and Non-Medicaid. This basic conceptual approach was expanded for contracts beginning July 1, 2003, to accommodate changes due to HIPAA EDI requirements and in the Diamond HIPAA compliant software.

A. Standard Diamond Contracts

Standard Diamond Contracts (PROVC) will be built for each Provider + Line of Business (LOB) + Panel combination that reflects contracts between the Boards and Providers. The pricing of actual claims is affected by the price schedules, regions and contract details associated with each contract. The standard contracts include:

1. *Medicaid Standard Contracts*

   Medicaid Standard contracts (LOB=MCD) are used to control pricing for services provided by certified Medicaid providers to Medicaid eligible clients in MACSIS. A separate Medicaid Standard contract (PROVC) will be created and maintained by the State for each Provider + MCD + panel combination. The price region on these contracts will always be "OH".

   - The primary price schedule(s) associated with the Medicaid Standard Contract will control pricing for the Medicaid eligible services provided to Medicaid eligible clients The alternate price schedule(s) associated with the Medicaid Standard Control will control pricing for the Non-Medicaid eligible services provided to Medicaid eligible clients. The "home" board, defined as the Board that holds the primary Medicaid contract with the provider, will dictate the services included in the alternate price

schedule. If any other board wishes to contract with the same provider, the State will assign the next available alternate price schedule for use by the other board.

2. *Non-Medicaid Standard Contracts*

   Non-Medicaid Standard contracts (LOB=NON) are used to control pricing for services provided to Non-Medicaid eligible clients in MACSIS. A separate Non-Medicaid Standard contract (PROVC) will be created by the State but maintained by the Board for each Provider + NON + panel combination. The price region on these contracts will either be "OH" or the Board's price region.

   - If the Board that is contracting with this provider chooses to use the same prices as linked to the Medicaid Standard contracts, then the price region "OH" would be used. If the Board has negotiated different rates or a different range of services for their Non-Medicaid clients, the price region must be changed to the Board's.

3. *Medicaid Default Contracts*

   Medicaid Default contracts are used to control pricing for services provided by out-of-county Medicaid providers to Medicaid eligible clients. Medicaid Default contracts will be created and maintained by the State for each Provider + MCD combination. The price region on these contracts will always be "OH".

   - The decision was made to not use any Alternate Price Schedule for Medicaid Default Contracts. The affect of this configuration is that no Non-Medicaid eligible services will be priced and in fact all Non-Medicaid eligible services claims that reach this contract will be denied. Boards that choose to pay for these services have the option to override Diamond on a one by one basis or to create a Standard Contract and re-adjudicate these claim lines.

4. *Non-Medicaid Default Contracts*

   Non-Medicaid Default contracts are used to control pricing for services provided by out-of-county providers to Non-Medicaid eligible clients. Non-Medicaid Default contracts will be created and maintained by the State for each Provider + NON combination. The price region on these contracts will always be "OH".

   - The primary price schedules associated with the Non-Medicaid Default Contracts will price and place on hold all Medicaid eligible services provided to Non-Medicaid clients in an out-of-county setting. However, the Boards' will only be liable for up to three days of crisis services per current policy. The alternate price schedules associated with the Non-Medicaid Default Contracts will price and place on hold services which are being contracted with the home Board. Boards will then choose which services to pay and will have the option to override each claim on a one by one basis.

B. Price Schedules

Each provider will be assigned five price schedules as follows:

- **Primary Price Schedule P0 (0xx)** – This price schedule will control pricing for Medicaid eligible services with the exception of MH group services and/or AOD individual counseling.
- **Primary Price Schedule P1 (1xx)** – This price schedule will control pricing for AOD individual counseling services.
- **Primary Price Schedule P2 (2xx)** – This price schedule will control pricing for MH Group Counseling and/or Community Support (CSP) services.
- **Alternate Price Schedule A0 (Axx)** – This price schedule will control pricing for Non-Medicaid eligible services with the exception of AOD Hotline services. Note: If any other board wishes to contract with the same provider, the State will assign the next available alternate price schedule for use by the other board.
- **Alternate Price Schedule A1 (Bxx)** – This price schedule will control pricing for AOD Hotline services.

C. Provider Contract Detail

In addition to the assigned price schedules above, each provider will be assigned three provider address records which control the pricing for "shared" procedure codes under HIPAA.

- Main Address (000) – This address record will control pricing for all services except AOD individual counseling, AOD Hotline and MH Group Counseling and/or CSP services.
- AODINDIV Address (001) – This address record will control pricing for AOD individual counseling and AOD Hotline services.
- MHGROUP Address (002) – This address record will control pricing for MH Group and/or CSP services.

15. Topic: Title XX of the Social Security Act (Block Grants to States for Social Services)

MACSIS is developed to capture all publicly funded behavioral healthcare services. However, it is only designed to distinguish Medicaid funded services and non-Medicaid funded services (General Revenue Fund (GRF), Title XX, local levy, etc.). As a result, Title XX claims can be billed thru MACSIS as a non-Medicaid funded service, but they will not be uniquely identified in MACSIS. Consistent with current reporting requirements, Boards and Providers will need to continue to report Title XX funds for the total expenditures and total recipients, (adult, children/adolescents, total) by service, by eligibility category outside of MACSIS.

As a reminder, when clients receive services paid for with Title XX funds, in most cases, it is considered payment in full and the client should not be required to pay a co-pay or sliding fee amount. To conform with this Federal requirement, it is recommended that the amount or percentage share that MACSIS automatically deducts be set to zero (see Topic 5 of this document). Any copayment that is charged must be consistent with the Title XX eligibility criteria established by the county Job and Family Services

Department. In no instance should a copayment be collected for Title XX recipients eligible for free services.

16. Topic: Out-of-County Provider Reimbursement

Definition of Residency: Residency issues will be governed by the ODMH and ODADAS definitions as incorporated in: Topic 8: Residency Guidelines.

- **For ODMH and ODADAS Medicaid reimbursable services provided to Medicaid eligible clients**, Boards will be responsible for paying Medicaid services from any agency in Ohio, which has a Medicaid Agreement in effect with another Board.
- F**or ODADAS Medicaid reimbursable services provided to non-Medicaid clients,** boards are responsible for out-of-county, emergency, clinically appropriate Level I services plus Level III and Level IV Ambulatory Detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend beyond three days, the out of county placement must be approved by the home board. It is essential collaborative efforts be made between providers and Boards to establish arrangements for a client's continued care.
    - Level I services include Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis (Lab Analysis of Specimens for Presence of Alcohol and/or Drugs), Medical/Somatic, Methadone Administration including levomethadyl acetate (LAAM) and Intensive Outpatient services
- **For out-of-county, non-Medicaid eligible services,** boards may pay or deny claims per their own business rules except in emergency situations, in which case emergency/crisis services should be covered for 72 hours.

17. Topic: ODADAS Women's Set Aside Programs

A. Purpose

This guideline is intended to provide uniform directions and assistance for ADAMH/ADAS Boards regarding grants to women's set-aside programs.

B. Basic Assumptions

1. Grants to women's set-aside providers are to be paid in full on a regular monthly basis.
2. Services provided by these programs must be recorded in MACSIS in a consistent manner. The current inability to consistently report such services places Ohio at a significant disadvantage. Reports lack credibility as both dollars and services are not counted correctly or uniformly across board areas. Also, it is consistent that Boards are to pay from the 835 Health Care Claim Payment Advice/Electronic Remittance Advice (ERA) and it is acceptable for Boards to compare the actual value of the Women's Program (HD) modified claims against the award amount for monitoring purposes. Finally, Boards are also reminded

that MACSIS is not designed to be an accounting system. It is recommended that Boards separate the patient accounting function from the fund accounting function of reconciling funds. ODADAS hopes to create a mutually beneficial situation: providers continue their ability to receive all the grant dollars awarded and the Boards and State obtain the ability to document adequately and account for services to these programs.

C. Background

Initially the State established a "90W" plan and/or panel in an attempt to meet the requirements above. Lack of uniformity in implementation left some services being denied when paid by grant funds, others being valued at zero dollars and other combinations that did not allow for any reasonable analysis of the data. The implementation of HIPAA uniform procedure coding and the ability to add modifiers to the new 837 Professional Version 4010 Claim File format provide an opportunity for a solution to this issue.

D. Implementation Plan

Provider requirements for billing Women's Set Aside Services each Women's Set-Aside grant award will include a requirement stating that all women's services will be billed through MACSIS and that these services will have "HD" modifier in the modifier two position. The "HD" modifier identifies services provided under a "Women's Program."

Board Requirements for Adjudicating Women's Set-Aside Services in MACSIS

1. *For Services Provided by Contracting Providers*

   The net paid amount for Women's Set-Aside services covered under the grant must be equal to the contracting provider's Medicaid or Non-Medicaid rate for those services. Boards cannot deny these claims in Diamond and/or use a 100% copay to force the net paid amount to zero.

2. *For Services Provided by Out-of-County Providers*

   For services provided under the Women's Set-Aside Program by a non-contracting, out-of-county provider to a Non-Medicaid client, these claims will automatically go on hold in MACSIS. When correcting or adjusting claims, Boards need to correct these claims by making the "withhold amount" equal to the "allowed amount" and by adding the adjustment reason code of "**ADWSA"** (Alcohol/Drug Women-Set-Aside) to the claim in Diamond.

   - Please note that Diamond Reason Codes do not appear on the 835 Health Care Claim Payment Advice, only the national standard claim adjustment reason codes will appear. However, the modifier 2 will be included on the 835 and it will be an obvious indicator as to why these services were withheld.

Board Requirements for Disbursing Funds for Women's Set-Aside Services

Whatever the value of the claims, the provider must still be paid the 1/12 value of the grant, assuming the board provides the funds in twelve monthly installments. To be consistent with the directive that Boards are to pay from the 835/ERA, boards should remit payment for services at

the time the 835/ERA is produced and then reconcile to the grant funds on a monthly basis. Examples on how to do this are provided below.

To facilitate this process for smaller boards which do not have the systems in place to analyze the 835/ERA, ODADAS modified the printed remittance advice (RA) to show Modifier 2 and developed a subtotal reflecting the net pay amount for all eligible services with a non-Medicaid medicaid definition (MCD Flg = N) and the HD modifier on the RA. Since the printed RA is a busy document, ODADAS removed the first four positions (currently all zeros) of the MACSIS Claim Number to make room for the placement of modifier 2.

Example: Provider A has a annual Women's Set Aside Award for $120,000 starting July 1, 2003. Provider also has a board contract for $50,000 for services budgeted from State GRF and Federal Block Grant dollars under the board control. Provider submits claims totaling $15,000 for month of July. Weekly 835/RA's for the month shows subtotal of HD claims at $8,000 and other non-Medicaid at $5,000.

Outside Diamond, the board monitors the transfer of dollars to its providers. Board voucher request shows a draw of $8,000 for HD claims value and $2,000 for grant value (subtotal of $10,000 which is 1/12 of the grant award) and $5,000 from levy, Block Grants or whichever source the board has identified for that provider. Whether the Board provides the Women's Set-Aside program their offsetting grant value weekly or monthly is the board's option.

If the provider outperforms its monthly Women's dollars amount, the board may choose to reimburse more than the 1/12 in any given month but the provider must understand that the total of the Women's Grant Award will not exceed 12/12 or whatever the provider's Women's Set-Aside Award equals.

CLAIMS PROCESSING

18. Topic: Benefit Plans, Medical Definitions, and Default BRULES

Benefit Rules (BRULE) in Diamond are used to automatically adjudicate claims according to a Board's funding policies. In general, benefit rules and benefit packages (BENEF) are used to automatically hold or deny certain claims, deduct copayments and coinsurance based on client income and family size, and limit selected services to a maximum number of units or dollars in a specified time period. Please refer to Topic 1: Change Control Procedures for additional information on procedures for adding, changing, and terminating benefit packages.

Benefit rules are based on Medical Definitions (MEDEF) that are determined by combinations of procedure code , modifier 1, modifier 2, and place of service (for MH only) codes. Medical Definitions are an essential component in claims adjudication and are used to determine (1) which claims will be submitted to Medicaid, (2) which claims are subject to copayments, limits, exclusions, out-of-pocket maximums, etc., (3) G/L payment source (MH Mcd, AoD Mcd, MH non-Mcd, AoD non-Mcd, etc.) and (4) which claims should be denied as duplicates. Invalid claims (missing critical information or plan-procedure mismatches for split MH/AoD boards) are assigned non-billable medical definitions and denied automatically during adjudication.

Each board must create at least one benefit package and must include, at a minimum, the statewide rules that restrict service utilization for selected services discussed below. Boards can use the statewide default rules for non-billable medical definitions or construct their own if their policies are not fully covered by the statewide rules.

Statewide rules that MUST be attached to all benefit packages are as follows:

- **ADMCDDAYS** (AOD MCD DAY SVC LIMIT): This rule limits AOD Medicaid eligible services, such as ambulatory detoxification (H0014) and intensive outpatient (H0015), to one per day.
- **ADMCDOUTP1** (AOD MCD OUTPAT 15MIN): This rule limits AOD Medicaid eligible 15-minute services, such as individual counseling (H0004) and group counseling (H0005), to 96 units per day.
- **ADMCDOUTP2** (AOD MCD OUTPAT 24 HRS): This rule limits AOD Medicaid eligible 60-minute services to 24 units per day.
- **OHINVALID**: This rule will cause claims with invalid medical definitions to deny (ex. invalid procedure and modifier code combination).
- **MHPARHOSPA:** This rule limits MH partial hospitalization services (S0201) for adults to 1 unit per day.
- **MHPARHOSPC:** This rule limits MH Partial Hospitalization (S0201) for children to two units per day.

19. Topic: MACSIS System Access

A. Board Notification Responsibilities

In accordance with the HIPAA Security Regulations regarding Information Access Management (42 CFR Part 164.308 (a4)), boards are responsible for monitoring system access requirements to minimize risks for unauthorized access to protected health information (PHI). In addition, since MACSIS is a system supported by ODMH staff, it is subject to the ODMH Administration Services Information System policy in regards to passwords and User IDs. The latter policy dictates requirements around notification of changes in system access due to termination or job function.

Therefore, boards are required to notify the MACSIS team of changes in system access as follows:

- For involuntary termination – must notify prior to termination or within one hour
- For retirement or resignation – must notify at effective date
- For changes of responsibility (affecting system access) – must notify at effective date

The process by which boards should notify the MACSIS team of changes is outlined below.

B. Obtaining MACSIS On-Line Access

1. To obtain access for employees to the MACSIS on-line system, the Board/Consortium MACSIS Administrator must complete and submit a MACSIS Account Request Form, a TCP/IP Access Form and a Disclosure of Information Notice to the following location:

   Ohio Department of Mental Health
   C/O MACSIS Account Coordinator
   Suite 1010
   30 East Broad Street
   Columbus, OH 43266-0414
   Or fax to: 614-752-6474

2. All forms must be completed in full, dated and signed by responsible authorizer (CEO, CIO, supervisor, etc.). Incomplete forms will be returned to requesting board without MACSIS on-line access being granted. All completed forms which have been processed will be filed by the MACSIS Account Coordinator and the OIS Billing Supervisor.

C. Modifying MACSIS On-Line Access

To modify access, the Board/Consortium MACSIS Administrator must re-submit a MACSIS Account Request Form to the above location indicating a change in access. Once the change is complete, the Board/Consortium MACSIS Administrator will be notified accordingly and a copy of the form will be filed by the MACSIS Account Coordinator.

D. Terminating MACSIS On-Line Access

1. To terminate access, the Board/Consortium MACSIS Administrator must re-submit a MACSIS Account Request Form indicating termination

2. Once received, the following steps will be taken:
   a. The user's access to Diamond will be terminated within four hours.
   b. DAS will be notified to terminate the user's TCP/IP Access.
   c. The Disclosure of Information Notice will be discarded by the OIS Billing Reimbursement Supervisor.
   d. The related forms will be stored on file by Board/Consortium and a copy retained by the MACSIS Account Coordinator.
   e. The MACSIS Support Desk will and Board MACSIS Administrator will be notified.

E. Routine Review of Employee Access

To encourage routine review of user system access, the MACSIS Technical Team will distribute of list of all active MACSIS Accounts on a semi-annual basis to the Board MACSIS Administrator. Accounts which have been inactive for over 90 days will be marked for removal. Boards are required to review and respond with changes within 30 days.

F. E-Mail Group Distribution Lists

If an employee needs to be added, updated or removed from a MACSIS-related email distribution list, the Board MACSIS Administrator should send an email to the MACSIS Support Desk (macsissupport@mh.state.oh.us) and indicate exactly which e-mail distribution lists need to be updated. This list includes but is not limited to the following:

MACSIS Claims Users Group – Macsis_claims@odadas.mh.state.oh.us
MACSIS Member Users Group – Macsis_members@odadas.mh.state.oh.us
MACSIS MIS Users Group – Macsis_mis@odadas.mh.state.oh.us
MACSIS Finance Users Group – Macsis_finance@odadas.mh.state.oh.us
MACSIS Project and Operations (POP) – Macsis_pop@odadas.mh.state.oh.us
MACSIS HIPAA Production Claims Reports – MACHIPAA GroupWise List

⇒ Note: Boards can self-subscribe or unsubscribe to the HIPAA Community List Service via http://www.mh.state.oh.us/ois/macsis/mac.join.html . To unsubscribe, type "unsubscribe" in place of subscribe.

It is the Board's responsibility to ensure changes or deletions in e-mail addresses are reported in a timely manner.

CLAIMS EDI (Electronic Data Interchange)

40. Topic: General EDI Policies

A. Effective Date

The HIPAA EDI policies outlined in this document are effective July 1, 2003 for all Boards or MACSIS Administrators[1] submitting claims via MACSIS. Please refer to Topic 2, "Clients Enrolled and Services Reported in MACSIS" for further explanation of the scope of claims to be submitted.

B. Formats and Versions Supported

1. *Electronic Claims Submission*

   The HIPAA-mandated, Accredited Standards Committee (ASC X12N) 837 Professional Claim (837P) Transaction Version 4010 is required for submitting claims electronically via MACSIS , except as noted in Section C1 below. These files will only be supported in a batch, not real-time mode, as recommended in the standard HIPAA implementation guide.

2. *Electronic Remittance*

[1] MACSIS Administrators are Boards or Board Consortiums who perform MACSIS-related system or administrative functions on behalf of another Board.

The HIPAA-mandated, ASC X12N 835 Health Care Claim Payment/Advice Version 4010 format is provided by MACSIS to the Boards or MACSIS Administrators by agency remitted in batch mode. MACSIS will continue to provide the existing MACSIS Electronic Remittance Advice (ERA) file by agency and by Board to supplement the new 835 files, until its continued need and use can be further evaluated.

Due to the operational efficiency issues surrounding disbursement of electronic remittance information to non-contracting providers, MACSIS will provide print-image files of the existing MACSIS Remittance Advice Report and MACSIS/ODJFS Reject Report to the Boards or MACSIS Administrators. It would be the Board's or MACSIS Administrator's responsibility to determine which file types (835, print-image, etc.) should be initially disbursed to non-contracting providers within HIPAA guidelines and on what medium. If, however, a non-contracting provider requests an electronic 835 file, the Board or MACSIS Administrator must comply with that request regardless of file size per HIPAA regulations.

3. *Electronic Reimbursement to Boards via ODJFS and MACSIS*

   Agency Reimbursement Accounting Reports (ARAs) are provided via print image in the designated Board or MACSIS Administrator file transfer protocol (FTP) directories as currently done.

4. *ASC X12N Addenda*

   The Health and Human Services (HHS) Secretary adopted the X12N addenda changes (Version 004010X098A1) proposed in October 2002. Therefore, MACSIS has implemented the applicable addenda changes for both the 837P and the 835 files.

C. Implementation Issues

Board Technical Evaluation and Modification to Support HIPAA-Mandated Transactions

Boards or MACSIS Administrators must evaluate their technical infrastructure to determine which modifications and additions are necessary to perform and support EDI functions in compliance with the Board-State Business Associate/Trading Partner Agreement. The evaluation should include analysis of telecommunication hardware and software, EDI translation software if needed, any business system applications used to support claims processing, including pre-scrubbing, reporting (electronic, paper or via web), general accounting interface or remittance update programs.

D. General File Transfer Policies

1. *File Transfer Overview*

   Boards or MACSIS Administrators are provided a special "FTP" account on a designated "FTP" server also referred to as the MHHUB AIX server. Each Board's account is provided with its own unique password and secure, distinct storage area.

   Once FTP account access is established, Boards have access to an assigned set of directories for file drop-off and/or pick-up. The list of available directories is not static, depending on the evolving needs of the Boards or MACSIS Administrators.

For more information about the "FTP" server directories and process, please refer to the MACSIS Technical Support Documentation, FTP Accounts (http://www.mh.state.oh.us/ois/macsis/technical/macsis.ftp.and.dir.updated.2.pdf)

When a Board or MACSIS Administrator "drops off" files anywhere into their designated sub-directories, these files are available to the Board or MACSIS Administrator FTP account (as owner) and the "staff" (or MACSIS) group. There are no world or other access rights enabled.

2. *Board Technical Account/Security Liaison*

   Each Board or MACSIS Administrator must designate a MACSIS Technical Account/Security Contact person to be responsible for the following:

   - File Transfers to/from MACSIS
   - EDI Security Issues
   - Resolving FTP/Unix Account access issues

   This person must be familiar with basic Unix commands and the file transfer (FTP) process.

3. *File Transfer Protocol Accounts (FTP)*

   Once designated, the MACSIS Technical Account/Security Contact must have on file or submit a "Request for TCP/IP" form that can be found at http://www.mh.state.oh.us/ois/macsis/forms/tcpip.form.pdf for the MACSIS Account Coordinator to gain FTP access to the MACSIS server where electronic files may be dropped off or retrieved. The contact should indicate on the form that they are responsible for the "FTP" account for their Board or MACSIS Administrator.

   TCP/IP (Transmission Control Protocol/Internet Protocol) Request Forms can be mailed or faxed to the following location:

   Ohio Department of Mental Health
   C/O MACSIS Account Coordinator
   Suite 1010
   30 East Broad Street
   Columbus, Ohio 43266-0414
   Or fax to: 614-752-6474

   Upon receipt of the form, the MACSIS Technical Support Team will assign an FTP account and password and will notify the Board MACSIS Technical/Security Contact accordingly.

   FTP account passwords are in a standard AIX style and will change every 57 days. When the passwords are changed, the Board's Technical Account/Security Contact is informed. If you have questions about the current password on your account, contact the MACSIS Technical Support Team.

4. *File Transfer Account Termination Policy*

The Board's or MACSIS Administrator's MACSIS Technical Account/Security Contact or Privacy Officer must notify the MACSIS Technical Team of any changes in staffing or responsibilities related to TCP/IP access within one business day.

5. *Required File Transfer Process*

   Boards or MACSIS Administrators may use their FTP software of choice, but must adhere to the following file transfer process.

   For "raw" data files, such as non-compressed 837 claim files, transfer or retrieve files in the **ASCII mode** (American Standard Code for Information Interchange) of FTP.

   - Please note Boards or MACSIS Administrators must transfer 837 claim files as non-compressed (i.e., non-zipped) files to MACSIS. Compressed or "zipped" 837 files will not be processed.

   For compressed ("zipped"), word processing or spreadsheet files, transfer or retrieve files in **BINARY mode of FTP**. An example of a compressed file is the Board's weekly extract files.

   There are many software programs on the market that make file transferring as easy as "drag and drop". MACSIS supports Ipswitch's WS_FTP Pro software. Electronic claim files submitted via portable media (diskette, CD-ROM, tape, etc.) will not be processed by MACSIS.

6. *Required File Characteristics*

   MACSIS requires consistent use of segment, element and component delimiters to ensure proper adjudication of electronic claims data. The delimiters are defined as follows:

   - Segment Delimiter (i.e., End of Line Marker)
     - For Windows-based operating systems, use carriage return, line feed, hexadecimal '0D0A'x
     - For Unix-based operating systems, use line feed, hexadecimal '0A'x
     - For Mac-based operating systems, use carriage return, hexadecimal '0D'x
   - Element Delimiter – Use * (asterisk)
   - Component Delimiter – Use : (colon)

   Additionally, any of the delimiters noted above should not be used in the content of a text/alphanumeric data element within an ASC X12N transaction sent to MACSIS. It is also recommended that other special characters such as "&" or "/" not be used in text/alphanumeric data elements. Please note that the delimiter values are also defined in the Interchange Acknowledgement Envelope (ISA) of the ASC X12N transactions.

7. *"FTP" Server Purge Policy*

   The MACSIS Team reserves the right to erase any file on the "FTP" server that is more than thirty days old. If a Board or MACSIS Administrator has a strong business need for storage on the server of over thirty days, the designated Board Technical Account/Security Contact

must contact the MACSIS Technical Support Team for special permission. If space is available, this may be granted on a short-term basis.

41. Topic: Becoming a Business Associate/Trading Partner

A. Getting Started

1. Business Associate/Trading Partner Agreement

   Each board must have a signed MACSIS Business Associate/Trading Partner agreement (http://www.mh.state.oh.us/ois/macsis/policies/final.macsis.baa-tpa.pdf) on file with ODMH and ODADAS before HIPAA-compliant claim files can be processed in a Production environment on behalf of a board. Testing between MACSIS and a Board can begin prior to receiving a signed BAA/TPA agreement; however, no production claims will be processed until a signed agreement is on file. Boards will be responsible for negotiating TPAs between themselves and their providers.

   The Board-State BAA/TPA document, should be signed by the Board Executive Director and the Directors of ODMH and ODADAS. Signed BAA/TPA agreements should be returned to the Legal Counsel Department at ODMH.

2. Sender and Receiver Identification Numbers

   The ASC X12N formats require use of identification numbers assigned to both the sender and receiver of electronic claim files to identify these parties on the file being transmitted.

   Since the receiver of the 837 professional claims file (ex., home Board) may be different than the entity ultimately identified as responsible for adjudicating a claim (ex. out-of-county Board), the sender and receiver identification numbers for the 837 will not necessarily match the sender and receiver identification numbers for the 835 Health Care Claim Payment/Advice files.

   - 837 Professional Claim File

     a. Sender Identification Numbers

        For providers, the MACSIS-assigned Unique Provider Identifier (UPI), Vendor or MACSIS Value Added Network (VAN) ID's will serve as the sender's respective identification number. For example, if Agency "X" with UPI number 10045 is submitting a claim file to their contracting Board, their sender identification number is "10045" and will remain that number when the file is forwarded to MACSIS.

        There are several possible scenarios where the sender may be a vendor submitting on the behalf of multiple agencies with different UPI numbers or the sender may be a clearinghouse. The following information clarifies how the sender identification numbers should be valued:

- If the MACSIS Provider UPI and MACSIS Vendor Number are the same and the provider is the creator of the file, the sender identification number is the MACSIS UPI number.
- If the MACSIS Provider UPI and MACSIS Vendor Number are different, the sender identification number is either the MACSIS UPI number or the MACSIS Vendor Number depending on who created the file.
- If a clearinghouse is the creator of the file, the sender identification number is the MACSIS-assigned VAN ID. See section 3 below for more information.

- 835 Health Care Claim Payment/Advice File

  a. Sender Identification Numbers

  The sender identification number will be the five character MACSIS-assigned Board company code. This code identifies the Board responsible for the adjudicated claim(s).

  b. Receiver Identification Numbers

  The receiver identification number will be the five digit MACSIS Unique Provider Identifier (UPI) assigned to the agency being remitted. Refer to section 43-D (ASC X12N 835 Health Care Claim Payment/Advice Return Policies, File Content) for more information as to why this number will be used as the receiver identification number.

3. Obtaining MACSIS VAN (Clearinghouse) ID

Providers who intend to use a clearinghouse or Value Added Network (VAN) to submit HIPAA-compliant claim files must notify their contracting board to obtain a MACSIS-assigned VAN ID for their clearinghouse or VAN. . The board should then email the MACSIS Support Desk at macsissupport@mh.state.oh.us. to obtain the assigned number. The e-mail must include the full name, address, contact name, phone and fax number for the Clearinghouse or VAN as well as a list of the MACSIS-assigned UPI numbers the VAN will be supporting.

B. EDI Testing Policies

1. 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)

2. ***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 .

3. **Constituent Responsibilities*:***

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.

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.

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.

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

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.

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.

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.

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.

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.

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[2] 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[3].	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[4].	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.	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

[2] 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.
[3] 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.
[4] See http://www.mh.state.oh.us/ois/macsis/mac.provf.top.html to verify address information as stored in MACSIS.

42. Topic: ASC X12N 837 Professional Claim File Submission Policies

A. File Naming Conventions

Incoming production claim files should be named Axxxxxx#.julyy, where "xxxxxx" = the MACSIS UPI or Vendor number on behalf of whom the claims are being sent (right-justified, zero-filled), "#" is a sequential number to identify separate and distinct file transmissions being sent on the same day, "jul" is the julian date the file was created and "yy" is the year the file was created.

> Ex. A0010431.31402 would be the file name for the first file sent to MACSIS from provider UPI # 001043 on November 10, 2002.

Incoming test claim files should be named similar to the production files, only the first character should be a "J" instead of an "A".

B. File Data Change Policy

Boards or MACSIS Administrators will not be permitted to change the contents of claims data submitted by a provider before forwarding the file to MACSIS. This is a State Auditor requirement.

C. File Transaction Limits

Boards or MACSIS Administrators must submit a provider-combined minimum of 100 service lines (2400 loops) per week to ensure processing of claims in a particular claim run. If the provider-combined claim volume for a given Board continues to be less than 100 service lines for a month, those claims will be processed in a special run. A provider-combined maximum of 50,000 service lines (2400 loops) per weekly claim run per Board will be processed.

D. File Acknowledgement

MACSIS will not be returning a 997 Functional Acknowledgement Transaction upon receipt of a file or files from a Board or MACSIS Administrator. Boards or MACSIS Administrators, however, may choose to return a 997 functional acknowledgement transaction to their respective providers if they can and want to create the transaction themselves.

E. File Validation Edits

Incoming claim files will be checked for basic MACSIS 837 Professional Claim Implementation Guide compliance, including but not limited to:

- Correct File Naming Convention Used
- Non-Duplicate File Name Submitted
- Basic 837P v4010 File Format Compliance
- Proper Use of Delimiters
- Proper Use of Loops and Segments
- One Service Line Per Claim Present
- Provider Approved to Submit Services via 837P

Only files passing basic MACSIS HIPAA compliance validation will be processed into MACSIS. Boards must not reject an entire claim file for reasons other than the specific criteria applied at the State level (examples noted above) unless the provider and board mutually agree it is in the provider's best interest to resubmit the file.

F. Processing Schedule

1. Timeliness of Billing File Posting By Board or MACSIS Administrator

If a provider specifically requests an acknowledgement that their home Board received their claim file(s), the Board or MACSIS Administrator must honor that request within two business days of the request for acknowledgement. The Board and provider must mutually agree via their trading partner agreement (TPA) how file acknowledgement will be provided. For example, it can be provided via the recommended HIPAA-standard 997 functional acknowledgement transaction as supported by the Board/MACSIS Administrator or via another method such as e-mail.

If acknowledgement is handled via the 997 Functional Acknowledgement transaction, the standard data elements on that transaction will dictate the information exchanged between the Board and provider.

If acknowledgement communication is handled via email or fax, the provider must specify in their request to the Board or MACSIS Administrator the submitted file(s) name, total billed amount, number of claims and the date submitted. The Board or MACSIS Administrator should reply with the submitted information attached, indicate if the file was received and provide an estimated date of when the file will be loaded into MACSIS. Providers must understand the date provided is only an estimate and may change if the file is later found to reject from MACSIS due to format or content errors and/or unforeseen problems with the MACSIS system.

All Boards or MACSIS Administrators are required to notify their providers within seven business days of receiving a claim file if the file was accepted and processed into MACSIS and the corresponding MACSIS batch number under which it was processed or if the file was rejected. If the file was rejected, the Board or MACSIS Administrator must indicate the generic reason why and what action the provider is expected to take accordingly.

Boards or MACSIS Administrators may choose to communicate status of received and/or processed files via a website accessible to their providers. The return of standard reports to

the provider, such as the Claim Error Report, Claim Processing Reports or other Board-produced reports clearly indicating that the file was processed into MACSIS and/or rejected and why would suffice as acknowledgment to the provider, if sent to the provider within seven business days of submission of the file.

Boards or MACSIS Administrators may not choose to process files only monthly or semi-monthly. If files have been submitted, they must be processed weekly unless there are MACSIS system problems preventing the State or Board/MACSIS Administrator from processing files. If the latter occurs, the Boards or MACSIS Administrator will notify their submitting providers of the problem and status. (Please note that the posting of a provider's file may be delayed, if the total number of claims received by a Board for a particular week is under 100 claims.) Boards or MACSIS Administrators are also required to ensure a tracking system is in place to ensure provider files are submitted timely and accurately to MACSIS.

Providers are encouraged to submit claim files on a routine, timely basis and to not submit claim files less frequently than once a month. This will help to ensure the timely adjudication of provider claims.

2. *MACSIS Processing Schedule*

Boards or MACSIS Administrators will be assigned a designated day per business week when their claims will be processed into the MACSIS system. The assigned day may shift due to holidays, mutual agreement between the Board/MACSIS Administrator and MACSIS staff, scheduled or unscheduled system downtime. To view current monthly MACSIS schedules, see http://www.mh.state.oh.us/ois/macsis/mac.sched.index.html.

G. MACSIS 837 Professional Claim Informational Guide

A technical information guide is available to provide further information on recommended values for specific loop, segment and data elements on the 837 Professional Claim transaction to ensure proper adjudication of claims in MACSIS. This is only a guide and not intended to instruct the submitter as to what *must* or *must not* be provided on the transaction. The guide includes further information for required fields and only those situational fields which MACSIS will use for adjudication purposes. All other data elements are not included, but can be submitted by the provider within HIPAA guidelines. Refer to http://www.mh.state.oh.us/ois/macsis/claims/837.prof.claim.guide.pdf for a copy of the 837 Informational Guide.

43. Topic: ASC X12N 835 Health Claim/Payment Advice Return Policies

A. File Compliance

1. 100% Payment for Medicaid Services

Per the ODJFS/ODMH interagency agreement and the Board's M-SPA, please note the following:

- **Beginning in FY 2000, State and local public fund match verification will no longer occur at the community mental health (CMH) agency level. Rather, the Board now must be able to verify that each valid Medicaid claim is fully paid from State or Local public funds prior to claiming federal financial participation payments (FFP).** The sole exception is where a governmental entity is the CMH agency. The Board will need to be able to document the expenditure of eligible public matching funds prior to claiming FFP.

- There is agreement within the departments that when a Board goes live on MACSIS, providers will receive 100% of the Medicaid contracted rate by a Board when the service is billed minus amounts of ACTUAL payments received from other carriers as reported in Loop 2320 (Other Subscriber Information), COB Amount Segment.

- Payment will be made at the time of adjudication in MACSIS, contingent upon the interface/interactions between the Board and the County Auditor.

- Medicaid claims that meet criteria to submit to ODJFS will be extracted from MACSIS and submitted to ODJFS for adjudication. This process is more informally known as the double loop process where the first loop represents the Board provider contract relationship and the second loop represents the State to ODJFS to Board relationship. If a Board has paid a claim and then the claim is denied by ODJFS, the double loop process automatically reverses the claim and recovers the payment the next time claims are adjudicated by the Board. If a claim is submitted with Medicaid as a secondary payor, then the following process will be used to ensure the proper amount is submitted to ODJFS.

- The ASC X12N 837 Professional Claim Format contains two data elements used to reflect the liability of the primary carrier for coordination of Benefits (Loop 2320, Field AMT02 (COB Amount) and Loop 2330A, Field REF02, Other Insured Additional Identifier). Using this data, MACSIS will automatically deduct the amount paid from the Allowed amount. If the claim is Medicaid reimbursable then this Net Amount will be extracted from MACSIS and submitted to ODJFS through the Double Loop process.

- Payment to the provider must be disbursed no later than 30 calendar days from the claim being included on a State-Produced ASC X12N 835 Health Care Claim/Payment Advice. A copy of the electronic remittance advice file must accompany payment and/or be disbursed prior to receipt of the payment.

2. *Disbursement of Remittance Advice*

At least initially, the State will create both a standard ASC X12N 835 Health Care Claim/Payment Advice as well as the existing Electronic Remittance Advice (ERA) proprietary format. Boards or MACSIS Administrators may add additional information to the proprietary ERA format only in the designated Board area. Boards or MACSIS

Administrators may not modify the ASC X12N 835 Health Care Claim/Payment Advice file as provided by MACSIS prior to disbursing it to the provider.

Due to the operational efficiency issues surrounding disbursement of electronic remittance information to non-contracting providers, MACSIS will continue to provide print-image files of the existing MACSIS Remittance Advice Report and MACSIS/ODJFS Reject Report to the Boards or MACSIS Administrators. It would be the Board's responsibility to determine which file types (835, print-image, etc.) should be initially disbursed to non-contracting providers within HIPAA guidelines and on what medium. If, however, a non-contracting provider requests an electronic 835 file, the Board or MACSIS Administrator must comply with that request regardless of file size per HIPAA regulations. Boards are not required to provide both a paper remittance advice and an electronic remittance advice file. Only the latter is required per HIPAA regulations.

Further information regarding the format of the existing Electronic Remittance Advice (ERA) proprietary format and any print-image remittance advice reports can be found at http://www.mh.state.oh.us/ois/macsis/mac.pay.paper.remit.reports.index.html .

3. *Timeliness of Payment*

Boards must remit 100% payment from non-Federal funds to the provider for Medicaid services within 30 calendar days of the claim being included on a State-produced ASC X12N 835 Health Care Claim/Payment Advice. Remitting payment means actually disbursing the check and the 835 file within the 30-day timeframe. The 835 file may precede the check or accompany the check, but cannot be disbursed after the check. This federal requirement applies to both in-county and out-of-county provider payments.

The 30-day timeframe is based on OAC 5101:3-1-19.7, which requires providers to be paid prior to the FFP reimbursement from ODJFS being received by the Departments. Thirty calendar days is the estimated timeframe by which the FFP will be received by the Departments. Many Boards or MACSIS Administrators disburse HIPAA-compliant remittance data much sooner than 30 calendar days after the creation of the State-produced ASC X12N 835 Health Care Claim/Payment Advice, which is acceptable and, in fact, encouraged. However, a 30-day timeframe has been established to also permit paper disbursements of remittance advices as requested by providers, which requires more time than electronic disbursements, and to accommodate, when possible, some provider's requests to receive the remittance advice and checks at the same time rather than separately.

Boards must also disburse an ASC X12N 835 Health Care Claim/Payment transaction to their providers for non-Medicaid services within 30 calendar days of the distribution of the State-produced ASC X12N 835 Health Care Claim/Payment Advice which includes the claim. If a Board has contractually agreed to pay a provider for non-Medicaid services on a fee-for-service (FFS) basis and/or the Board is using federal funds to pay for the non-Medicaid services, a check must also be disbursed in this timeframe.

Boards or MACSIS Administrators must disburse an ASC X12N 835 Health Care Claim/Payment file to a provider, even if all of the claims on the file are denied. Boards or MACSIS Administrators should check every Monday for 835 files in their Unix directory because they may have claims they are responsible for paying which came into the system via another Board.

B. File Naming Conventions

ASC X12N 835 Health Care Claim Payment/Advice files will be named according to the format Abbbxxxxxx.julyy. An example is A25B001043.31402, where:

- "A" is a constant used to identify the file as an ANSI-compliant file. (Note: ANSI is American National Standards Institute.)
- "bbb" equals the remitting Board's number and type code (ex. 25B for Franklin ADAMH).
- "xxxxxx" equals the provider's MACSIS-assigned UPI number (ex. "001043")
- "jul" equals the julian date the file was created (ex. 314 for November 10th)
- "yy" equals the year the file was created (ex. 02 for 2002)

The supplemental, existing proprietary ERA format naming convention will remain the same (ex. 25B01043.314). If test 835 files are disbursed during the testing process, then the test 835 files will named according to the convention noted above, except the first character will be a "J" instead of an "A".

- A weekly 835 Summary File will be made available to Boards to audit and balance to the individual 835 Health Care Claim Payment/Advice files created. These files will be named Sbbb835Summary.julyy (ex. S25B835Summary.31402)

- If an ERA or 835 file needs to be recreated at the request of a Board or due to a system problem, the naming convention for the recreated file will be the same as noted above, except "R" will be added to the end of the file extension (ex., A25B001043.31402R or 25B01043.314R). The julian date of the recreated file will remain the date the file was originally created.

- Please note that ARA files returned to the Boards via the Double Loop process will be named PRbbb351.ASC (MH) and PRbbb451.ASC (AOD) for claims processed in the new HIPAA environment (ex. PR25B351.ASC).

C. File Transaction Limits

There are no applicable file transaction limits at this time.

D. File Content

The ASC X12N 835 Health Care Claim/Payment Advice will encompass the following:

- The 835 Health Care Claim Payment/Advice file will be produced as a "notification only" file (see Segment BPR01, Transaction Handling Code for more information). The reason for this decision is because the actual payment funding method associated with claim payment transactions on an 835 file are determined individually by Board outside of the MACSIS system process. For this reason and the fact that some providers sharing the same MACSIS vendor information use disparate computer systems, the State will be producing one 835 file per provider (i.e., UPI), not MACSIS Vendor. The 835 file will, however, contain both provider and MACSIS vendor information in the appropriate loops and segments.

- Only paid or denied claims will be included on the ASC X12N 835 Health Care Claim/Payment Advice, not held or pended claims.

- "Negative Balance Due" claims (i.e., claims where the net total due back from the provider is a negative or debit balance) will be included on the ASC X12N 835 Health Care Claim/Payment Advice. This information is provided on the existing supplemental MACSIS electronic remittance advice (ERA) files as preferred by the majority of Boards and providers.

E. MACSIS Processing Schedule

The State-produced ASC X12N 835 Health Care Claim/Payment Advice files and supplemental proprietary ERA files are estimated to be produced approximately one week following the date the claim is finalized in the MACSIS system (also referred to as the "AP Date"). Files are generally produced over the weekend and made available to the Boards or MACSIS Administrators by Monday afternoons, unless there is scheduled or unscheduled system downtime or other system issues prohibiting production. To view current monthly MACSIS schedules, see http://www.mh.state.oh.us/ois/macsis/mac.sched.index.html.

Boards and providers can monitor the amount of claims finalized by week, month or fiscal year using the reports available on the MACSIS webpage. (See http://www.mh.state.oh.us/ois/macsis/mac.rpts.index.html).

F. MACSIS 835 Health Care Claim Payment/Advice Informational Guide

A technical information guide is available to provide further information regarding the anticipated values for specific loop, segment and data elements on the 835 Health Care Claim Payment/Advice transaction as claims are adjudicated in MACSIS. This is only a guide and not intended to limit the values which may or may not be provided on the transaction. The guide includes further information for required fields and only those situational fields which MACSIS will use for adjudication purposes. All other data elements conditionally available for use under HIPAA but not intended for use under MACSIS are not included. Refer to http://www.mh.state.oh.us/ois/macsis/claims/835.claim.pay.advice.pdf for a copy of the 835 Informational Guide.

44. Topic: Data Content Policies

A. One Service Line per Claim

For claims submitted on an 837P file, there can only be one service line per claim to ensure proper adjudication within MACSIS. It will be necessary to repeat the claim information for each service line in the claim file.

1. *Medicaid Implications*

   To maximize potential Medicaid revenue, only one detail service line can be submitted per claim. The MACSIS program used to extract Medicaid services for further adjudication by ODJFS only reads the first line of service on the claim. Additionally, MACSIS adjudicates all service lines associated with a claim based on the eligibility status of the member as determined by the primary date on the claim. For example, if a client has not previously been Medicaid eligible, all claim lines may adjudicate as non-Medicaid when in fact eligibility may have changed during the time period covered by the detail service lines. For these reasons, any 837P file that contains more than one detail service line per claim will be rejected.

2. *MACSIS Definition of a Medicaid claim*

   When a Medicaid covered service is provided, MACSIS will automatically determine if a service unit(s) is billable to Medicaid by checking the service code, service date, modifier(s), place of service, and client's Medicaid eligibility on that day of service.

B. Non-Client Specific Services

(Examples: BH Hotline – H0030, MH Prevention – M4110, MH Education – M4140, AOD Training- H0021, AOD Prevention – A0610/A0660, AOD Transportation – A0750)

The MACSIS Member team has developed a recommendation to track non-client specific services that is fully documented in the Member User Documentation (http://www.mh.state.oh.us/ois/macsis/manuals/hipaa.member.manual.pdf). In short, this will be accomplished by creating a pseudo-client number that can be used to capture services that are not limited to a single identified member at a time. Services such as MH - Community Education or Alcohol and other Drug Addiction Prevention fall into this category. AoD Services designated as "non-client specific" must use a pseudo UCI and are marked with an "*" on the ODADAS Procedure Code Table at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf . MH services are not designated as "non-client specific" but do allow pseudo UCIs to be used when appropriate and in accordance with parameters established in the Member Manual.

All pseudo-clients must be entered manually by the Board staff and meet format requirements. Please note that claims pertaining to non-client specific services, if submitted electronically, must still be submitted via the ASC X12N 837 Professional claim format as outlined in this document.

For AOD prevention services (Information Dissemination: A0610, Education: A0620, Community-Based process: A0630, Environment: A0640, Problem Identification and Referral: A0650, and Alternatives: A0660) providers should pass service delivery information in the control number fields on the 837 professional claims file (Loop 2300, CLM01 or Loop 2400, REF02). The service delivery information identifies the population characteristics of those who received the prevention service and should be formatted as follows:

- Delimited, not fixed-length format
- Delimiters are letters which identify the values immediately following the letters
- Order of delimiters is:
  - U, S or I to indicate "universal, selected or indicated" statistics, M = # of Males, F = # of Females, S = # under the age of 21, T = # between ages of 21 and 44, U = # between ages of 45 and 64, V = # 65 and over, W = # of Whites, Not Hispanic, B = # of Blacks, Not Hispanic, N = # of Native Americans, A = # of Asian or Pacific Islander, H = # of Hispanic/Latino
- Examples:
  - Universal, 20 males, 100 Females, 75 under 21, 45 age 24-44, 65 White, 40 Black, 15 Mexican would be sent as : UM20F100S75T45W65B40H15
  - Selected, 25 males, 0 Females, 25 65 and Over, 25 White would be sent as: SM25V25W25
- As a matter of explanation, one can apply the IOM framework to an adolescent population:

  Universal - all students at Smith High School
  Selected - survey results show that the transition from 8th-9th grade is often accompanied by increased ATOD use, so the program targets all freshmen (at risk).
  Indicated - freshmen who have violated school ATOD policies.
- If one were to apply the IOM framework to an adult population:

  Universal - all senior citizens living in Smith City
  Selected - all senior citizens living in Smith City who take prescription medications
  Indicated - all senior citizens living in Smith City who drink alcohol and take prescription medications

If prevention services are provided, for example, to two elementary classes, once in the morning and once in the afternoon, the control number should be calculated with the number of attendees totaled. Please note that the submission of service data delivery via the 837P file replaces the requirement to submit minimum data set (MDS) data separately.

NOTE: To accommodate the use of the 837P control number fields for both service delivery data and provider-assigned control numbers, prevention providers have the option of placing a "Z" between the service delivery data and their provider-assigned control number. For example in the above case, the program would report:

UM20F100S75T45W65B40H15Z##### where ##### provides uniqueness to the provider-assigned control number. This information will be returned to the provider on the 835 Health Care Claim/Payment Advice file in the appropriate control number data elements.

C. Procedure Codes

To assure proper adjudication, claims must include the procedure codes contained in the MACSIS Procedure Code table for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf or ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf.

1. Service Units Rounding Conventions

ODMH and ODADAS require the following rounding conventions to be used when reporting service units. The appropriate OAC will be modified to reflect proposed changes in the billable unit policy. Please refer to the procedure code taxonomy for definition of appropriate billing units.

a. 15 Minute Service Unit (1 unit = 15 minutes)

- APPLIES TO THE FOLLOWING SERVICES:

  BH Counseling and Therapy (H0004, MH and AOD)
  Community Psychiatric Supportive Treatment (H0036)
  MH Self-Help/Peer Services (H0038)
  Alcohol and/or Other Drug Service Group Counseling (H0005)
  Alcohol and/or Substance Abuse Service Family/Couple Counseling (T1006)

- Services that are measured in 15 minute increments should be billed in whole units. If these claims are submitted with less than one unit of service or for partial units, they will be denied.

- Services exceeding seven minutes must be rounded to the nearest whole unit in accordance with the following table:

TIME SERVICE PROVIDED	UNITS TO BILL
0 minutes to 7 minutes	Not billable
8 minutes to 22 minutes	1
23 minutes to 37 minutes	2
38 minutes to 52 minutes	3
53 minutes to 67 minutes	4
68 minutes to 82 minutes	5
83 minutes to 97 minutes	6

- If the same service is legitimately provided on the same day to the same client, the service minutes must be summed for the date of service, then rounded according to the table as noted above and submitted as one service line on the claim.

- Actual minutes must be accurately reflected in the clinical records. Each encounter for the day should be recorded separately in the clinical record. You must either a) record the start and end time of each encounter or b) record the start time and duration (in minutes) of each encounter.

Scenario:

MH Community Psychiatric Supportive Treatment (H0036) is provided face-to-face by the same agency three times during a single day to the same client. This provider bills MH Community Psychiatric Supportive Treatment at $50 per unit of 15-min. service. When the "sum and round" methodology is used, the units of service on the bill would be calculated as follows:

Clinician (Staff)	**Date of Service**	**Client**	**Duration**	**Start Time**	**Billable Service**	**Billable Units**	**Billable Rate**
Clinician A	7/5/03	Joe Client	7 min.	9:00 am	H0036	---	---
Clinician B	7/5/03	Joe Client	23 min.	11:00 am	H0036	---	---
Clinician C	7/5/03	Joe Client	3 min.	4:00 pm	H0036	---	---
TOTAL BILLED as one line item	***7/5/03***	***Joe Client***	***33 min***	***----***	***H0036***	***2***	***$100***

b. Hourly Based Service Units

- APPLIES TO THE FOLLOWING SERVICES

BH Hotline (H0030)
Crisis Intervention – MH services (S9484)
MH Assessment, Non-physician (H0031)
Psychiatric Diagnostic interview – Physician (90801)
Pharmacologic Mgt (90862)
Occupational Therapy (M1430)
Adjunctive Therapy (M1440)
School Psychology (M1530)
Adult Education (M1540)
Social & Recreational (M1550)
Employment/Vocational (M1620)
Consumer Operated Service (M3120)
MH Svcs, Not otherwise specified - Healthcare (H0046)
Other MH Svcs – Non healthcare (M3140)
Prevention (M4110)
Consultation (M4120)
MH Education (M4140)
Information and Referral (M4130)

Alcohol and/or Other Drug Service Assessment (H0001)
Alcohol and/or Other Drug Service Case mgt (H0006)
Alcohol and/or Other Drug Service Crisis Intervention (H0007)
Alcohol and/or Other Drug Service Medical/Somatic (H0016)

Alcohol and/or Other Drug Service Consultation (A0560)
Alcohol and/or Other Drug Service Intervention (H0022)
Alcohol and/or Other Drug Service Referral and Information (A0510)
Alcohol and/or Other Drug Service Training (H0021)
BH Outreach (H0023)
Alcohol and/or Other Drug Svc Prevention Environmental Svcs (A0640)
Alcohol and/or Other Drug Prevention Problem Id & Referral (A0650)
Child Sitting services for children of the individual receiving alcohol and/or substance abuse services (T1009)
Alcohol and/or Substance Abuse Services, Not Otherwise Classified (T1011)

- If the same service is legitimately provided on the same day to the same client, the service minutes must be summed for the date of service, then rounded according to the table below and submitted as one service line on the claim.

- All hourly based services require the following rounding conventions to be used when reporting service units. Hourly-based services should be rounded to the nearest tenth as follows:

Time Service Provided	*Units to Bill*
0 minutes to 7 minutes	Not Billable
8 minutes	.1 Units
9 minutes to 14 minutes	.2 Units
15 minutes to 20 minutes	.3 Units
21 minutes to 26 minutes	.4 Units
27 minutes to 32 minutes	.5 Units
33 minutes to 38 minutes	.6 Units
39 minutes to 44 minutes	.7 Units
45 minutes to 50 minutes	.8 Units
51 minutes to 56 minutes	.9 Units
57 minutes to 62 minutes	1.0 Units
63 minutes to 68 minutes	1.1 Units

- Actual minutes must be accurately reflected in the clinical records. Each encounter for the day should be recorded separately in the clinical record. You must either a) record the start and end time of each encounter or b) record the start time and duration (in minutes) of each encounter.

Progress Note (and implication for billing)

Service Date	Actual Time	Service name	Service Time	Units of Service
7/27/03	8:05 – 8:15	Crisis Intervention	10	--
7/27/03	12:00–12:05	Crisis Intervention	5	--
7/27/03	3:45 – 4:00	Crisis Intervention	15	.--
	Total Billed as one line item		**30**	**.5**
7/31/03	9:00 – 9:27	Pharmacologic Mgt	27	--
7/31/03	11:15 – 11:20	Pharmacologic Mgt	5	--
7/31/03	2:00 – 2:05	Pharmacologic Mgt	5	--
	Total Billed as one line item		**37**	**.6**

c. Day- Based Services

- APPLIES TO THE FOLLOWING SERVICES:

  MH - Partial Hospitalization (S0201)
  MH Residential services that do include Room and Board: (See http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.housing.table.pdf for more information about MH Residential service code definitions and examples.)

  Crisis Care (M2280)
  Temporary Housing (M2290)
  Residential Care(M2200)
  Foster Care (M2250)
  Respite Care (M2270)
  Subsidized Housing (M2260 – Daily or Monthly)
  Community Residence (M2240 – Daily or Monthly)
  Temporary Housing (M2290)

  Alcohol and/or Other Drug Service Intensive Outpatient (H0015)
  Alcohol and/or Other Drug Service Ambulatory Detox (H0014)
  Alcohol and/or Other Drug Medical Cmty Res Treatment Hosp Setting (A1210)
  BH Medical Cmty Res Treatment (H0017)
  Alcohol and/or Other Drug Service Medical Cmty Res Treatment
  Non-Hospital setting - includes Room & Board (A0230)
  BH Alcohol and/or Other Drug Service Medical Cmty Res Treatment
  Non-Hospital setting - without Room & board (H0018)

Alcohol and/or Other Drug Service Non-Medical Cmty Res Treatment includes Room & Board (A1220)
BH Non-medical Cmty Res Treatment -without Room & Board (H0019)
Alcohol and/or Other Drug Service Observation or inpatient hospital care for a patient who is admitted and discharged on the same date with a presenting problem of high severity (99236)
Alcohol and/or Other Drug Service Sub-Acute Detox (H0012)
Alcohol and/or Other Drug Service Acute Detox – Hosp inpatient (H0009)
Room and Board (A0740)

- Effective July 1, 2001, a client no longer has to be in the MH - partial hospitalization program (S0201) at least three hours in order to bill for the service. However, agencies must bill fractional units of a partial hospitalization program day if the client is not in the program for the entire program day. The agency must bill the percentage of the program day that the client attends the program for a given day. For example, if the client is in the program two out of three hours of the agency's partial hospitalization program day, the agency can bill 2/3's of a unit (.67 of a unit). However, the agency will need to round to the nearest tenth of a percent of a unit (.7) to bill through MACSIS. All of the fractional units of partial hospitalization should be rounded to the nearest tenth of a unit. Please remember, however, that the edits are still in place in MACSIS to allow a maximum of one unit of partial hospitalization a day for adults and two for children.
- Actual time must be accurately reflected in case records
- MACSIS will only accept a maximum of 1.0 unit per day for all day based services EXCEPT Children's Partial Hospitalization where MACSIS will accept 2 units.

2. ***Multiple Rates/Sites For Same Service***

If a provider offers different programs that fall under the same procedure code and these different programs have different rates or unit costs or are provided at different sites, the Board has the option of requiring the provider to use one of the following solutions:

The rates may be blended based on the expected volume and cost of each service;

If the programs are provided at different CERTIFIED sites, a second Unique Provider Identifier (UPI) could be issued, and the two separate programs would be billed under the same procedure code, but separate UPIs or;

If the programs are in the same physical location, the Board will assign one of the nine alternate procedure codes where the 5th position of the **MACSIS-DEFINED** procedure code would be used to distinguish multiple rates/sites for **same NON-HEALTHCARE service**. This distinction is not permitted with HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) codes used to capture nationally recognized healthcare services. Please refer to the procedure code table for additional clarity.

For example: If a MH provider offers two **EMPLOYMENT** programs with different rates, that provider would have a single UPI and bill using two separate procedure codes: where M1620 is the standard code and could be used for one program and the second program could use **M1621.**

3. ***Other Mental Health Services***

Board and agencies may determine the exact procedure code used to capture certified Other Mental Health services. There is an option to identify services as other healthcare versus other non-healthcare services based on whether the specific certified service falls into a healthcare versus a non-healthcare category as determined by the boards and agencies.

- **MH Services, not otherwise specified – Health care (H0046)**: is to be used for healthcare services that have been certified by ODMH as "Other". It is important to recognize if the national standard code is used, the rate for the service would have to be a blended rate for all healthcare services falling under the "other mental health" category.

- **Other Mental Health - non health care (M3140)**: is to be used for non-healthcare services that have been certified as "Other" by ODMH. If this option is used, position 5 in the procedure code could be used to identify specific programs and bill by program cost instead of a blended rate.

4. ***Rates for Shared Procedure Codes***

Separate rates will be possible under MACSIS for services that share the same procedure code (ex., H0004 for BH Counseling and Therapy, Individual or Group for MH and Individual BH Counseling and Therapy for AOD). Modifier 1 will be used to distinguish which type of service is provided and will the drive the rate accordingly.

D. Modifier Codes

When a modifier is applicable to a claim, the code must be one of the nationally defined modifier codes contained in the modifier code table available for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/mh.hipaa.modifier.code.table.pdf and for ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/aod.hipaa.modifier.code.table.pdf and valued in the order outlined in that same table to assure proper adjudication.

1. ***Modifier Coding Guidelines***

It is essential Modifiers be valued in accordance with ODMH and/or ODADAS Modifier tables noted above. Please note the following:

- Modifier 1 will be required to ensure proper pricing in MACSIS
- Modifier 2 may be necessary to ensure proper adjudication in MACSIS
- Modifiers 1 and 2 will be used for duplicate claim checking
- Modifier positions 3 and 4 do not affect pricing and adjudication but are reserved for board use.
- For MH services, the use of "GT" (Telephone) for MH Medicaid covered services or for Housing and Residential services in modifier 3 or 4 will result in a denied claim.

- For MH Medicaid covered services, if "HS" (Family/couple without client present) is in modifier 3 or 4, and "UK" is not in modifier 2, the claim will be denied.
- Some vendors require modifier values in consecutive positions
    - If required, place "99", which means "Multiple Modifiers", in modifier 2 or 3 as needed.
    - If not required, modifier 2 may be left blank
    - A blank or "99" modifier are treated the same within MACSIS and must be summed for same-day services (see Section 44I for more details about the same day service reporting policies).

2. ***Identifying Other Fund Sources For Non-Healthcare Services***

   Board(s) may determine the exact procedure code used to capture service information that is paid for with public dollars from other fund sources for Non-Healthcare Services. Each Board has the option to identify other payer sources via national standard modifiers for health care services. For non-healthcare services, it is recommended that the Board instruct their providers to value the third or fourth modifier to the appropriate national standard value to identify funding sources if necessary and as available.

3. ***Clients Treated in an Institution For Mental Disease- IMD (POS = 51) or Treated While in the Penal System (POS = 99)***

   Services provided while the client is in an IMD or while the patient is in the penal system will no longer be identified via the use of modifier codes. This is because national standard modifier codes do not exist to identify these instances.

   For clients treated in an IMD, services should be submitted with a place of service code of "51 – Inpatient Psychiatric Facility" on the claim. For more information about what constitutes an IMD, refer to 42CFR 435.1009. For clients treated while in the penal system, services should be submitted with a place of service code of "99 – Other Unlisted Facility" on the claim.

   Please note the following:

   - Even though Medicaid eligible services provided to Medicaid eligible clients in the penal system (based on eligibility reflected in MACSIS at the time the claim is processed) will be identifiable via the place of service code "99", these services will be adjudicated as "paid" in MACSIS and forwarded to ODJFS to make the final determination about the client's eligibility at the time of service.
   - Medicaid eligible services to Medicaid eligible clients 21 or under or 65 and older with Place of service code 51 (Inpatient Psychiatric Facility) will be sent to ODJFS for final adjudication.
   - There are two locations on the 837 Professional Claim Transaction where place of service information can be provided. Loop 2300, Field CLM05-1, Facility Code Value (required) or Loop 2400, Field SV105, Place of Service Code (situational). Since there should be one Loop 2300 for each Loop 2400, if both are valued, technically, both place of service codes should match. However, if both are valued and they do not match, the

place of service code in Loop 2400 will be used for adjudication purposes. If Loop 2400 is not valued, the place of service code in Loop 2300 will be used.

- Through the use of benefit rules, Boards will have the flexibility to pay, hold or deny these services provided to non-Medicaid eligible clients

4. ***Clients Treated Via the Telephone***

If clients are treated via the telephone, providers should specify modifier "GT –Interactive Telecommunications" in Modifier 1 for MH Individual Community Psychiatric Supportive Therapy (H0036) and MH Crisis Intervention (S9484). Please note that only MH Individual Community Psychiatric Supportive Therapy (H0036) is permissible via the telephone under Medicaid Policy and will be forwarded to ODJFS for adjudication. Although this modifier may also be used for MH Crisis Intervention, it is not a Medicaid reimbursable service when done via telephone. The "GT" modifier should not be used with other procedure codes, including MH Hotline.

5. ***Services Provided to Significant Others, Other Professionals or Family When the Client is NOT Present***

Modifier "UK" (services provided on behalf of the client to someone other than the client) should be used to capture services provided to Significant Others, Other Professionals or Family when the client is NOT present. The use of modifier UK should only occur when Medicaid covered services are provided when the client is NOT present . Do not use "UK" with other MH services.

Examples:

Scenario	**Procedure Code**	**Mod 1**	**Mod 2**	**POS**	**Units**
Service in School ○ BH Counsel. & Therapy ○ 20-min at School ○ Family/ client Present	Round minutes to whole units per table *H0004*	HE		03	1
Service w/probation officer ○ BH Counsel. & Therapy ○ 20-min at office ○ client NOT Present	Round minutes to whole units per table *H0004*	HE	UK	03	1
Service in School and at home ○ BH Counsel. & Therapy ○ 30-min at School with teacher, client NOT present ○ 60-min at client's home with Family/ client Present in p.m.	Round minutes to whole units per table *Submit 2 claims:* *H0004* *H0004*	HE HE	UK	03 12	2 4

E. Place of Services Codes (a.k.a. Facility Value Codes)

1. *General Provisions*

   The place of service codes are nationally defined as opposed to locally defined (as previously done) and can be found at http://www.mh.state.oh.us/ois/macsis/mac.codes.macsis.pos.codes.html. Under the ANSI standards, they are referred to both as Place of Service codes or Facility Value codes. The codes are similar to those used today, but not exactly the same. MACSIS will only refer to the place of service code for MH Medicaid reimbursable service adjudication purposes when valued to "51 – Inpatient Psychiatric Facility" (for IMD) or for clients treated while in the penal system, when valued as place of service code of "99 – Other Unlisted Facility".

2. *Clients Treated in an Institution For Mental Disease - IMD (POS = 51) or Treated While in the Penal System (POS = 99)*

   Please refer to Section D. Modifier Codes part 3.

3. *Recommendations*

   - If the actual Place of Service (POS) does not have a defined code use "11 – Office".
   - For same-day services, if there are multiple POS and they are not POS – 51 or POS – 99, the services must be summed and linked to one of the acceptable place of service codes. If the same-day services are all provided in the penal system or IMD (ex. all "99"), then the same-day services must still be summed with POS code "99" or "51" accordingly.

F. Diagnosis Codes

1. *General Provisions*

   HIPAA requires use of the most current published version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes for professional claims submission. Although providers may submit any current ICD-9-CM code, MACSIS will consider for payment claims containing only those diagnosis codes outlined in the Behavioral Health ICD-9-CM-Code Table at http://www.mh.state.oh.us/ois/macsis/codes/bhcare.icd9cm.codes.payment.hipaa.pdf.

   - Not all services require diagnosis codes to be considered for payment. To determine if a service requires a diagnosis code, refer to the MH and/or AOD procedure code tables (http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf and http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf
   - Claims submitted with diagnosis codes not included in the table noted above will be denied in MACSIS.
   - One of the AOD diagnosis codes listed in the diagnosis table must be provided when reporting AOD residential or AOD Detox services.

- Several diagnoses codes can be submitted at the claim level in Loop 2300, Segment HI – Health Care Diagnosis Codes, but MACSIS will only adjudicate a specific service based on the primary billing diagnosis code associated with the service line as indicated by Loop 2400, Field SV107-1 (Diagnosis Code Pointer = 1). Please note that if a claim is submitted with out a diagnosis code indicated in Loop 2300, Segment HI, but the diagnosis code pointer in Loop 2400, Field SV107-1 is valued, the claim will deny.

G. Reporting Other Carrier Information

Other carrier (i.e., payer) information is required on the 837P format, if other payers are known to potentially be involved in the paying of the claim. Please refer to the national standard HIPAA 837P implementation guide for further information regarding all of the other payer data that is required. MACSIS will only retrieve certain data elements from the required data set for adjudication purposes as noted in the MACSIS 837 Professional Claim Informational Guide http://www.mh.state.oh.us/ois/macsis/claims/837.prof.claim.guide.pdf.

For MACSIS purposes, it is important to note the following:

- All third party payers must be billed before MACSIS.
- If no response is received from a third party payer after 90 days from the date of service, a claim can be billed to MACSIS.
- Other payer paid amounts must be reported in Loop 2320, Other Subscriber Information, AMT segment with Amount Qualifier Code "D". The payer paid amount can be valued to zero.
- MACSIS uses only the first iteration of other payer information (Loops 2320 and 2330A) for adjudication purposes. This is due vendor system limitations and limitations within the current interface to ODJFS.
- If another payer paid amount is reported in Loop 2320, the total claim charge amount (Loop 2300, CLM02) and the line item charge amount (Loop 2400, SV102) should still reflect the provider's total billed amount. MACSIS will subtract the other payer paid amount and other system-derived deductions from the billed amount to determine the net paid amount..
- Other payer paid amounts cannot include patient paid amounts per HIPAA EDI regulations. Patient paid amounts must be reported separately on the 837P file and will not be used by MACSIS for adjudication purposes.
- The ODJFS COB Indicator will be required if a payer paid amount is reported in Loop 2320. The ODJFS COB Indicator must be submitted on the 837P file in Loop 2330A, Other Subscriber Name in field REF02, Other Insured Additional ID per ODJFS guidelines. The allowable values for the COB indicator remain the same:

  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.

H. Resubmitting Claims

1. **Resubmitting corrected claims on EDI File** - If a previously denied or rejected claim is resubmitted it will not be denied as a "duplicate" claim, although the claim may deny for other reasons. Boards and providers should refer to Topic 45: Claim Corrections within MACSIS and the "Procedure for Claim Correction within MACSIS" (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.proc.pdf) to determine when resubmission of claims is appropriate.

I. Duplicate Claims Policies

Consistent with pre-MACSIS Community Medicaid rules and to assure ODJFS that providers are not billing for the same service episode twice, MACSIS has been configured to check for duplicate claims as described below. Duplicate checking for manual claims and EDI transactions will be treated in the same manner as described below.

1. *Same-Day Service Reporting*

   Procedures have been implemented that require valid "same-day" services (i.e., same services provided to the same client on the same day by the same provider) to be rolled up to one service line on the claim before submitting to MACSIS. Consequently, MACSIS has been configured to automatically adjudicate, deny and not hold a non-rolled up "duplicate" service. (Note: MACSIS previously created a "warning" and held these services, so the Boards could or could not deny the service on a line-by-line basis.)

   "Same service" means the combination of UPI, UCI, date of service, procedure code, and modifier codes 1 and 2. These combinations result in the same medical definition (i.e., adjudication category) in MACSIS.

   - Same-day MH Medicaid reimbursable services with the place of service codes of "99" or "51" should not be summed with other place of service codes.
     - Note: If the same-day MH Medicaid reimbursable services are all provided in the penal system or IMD (ex. all "99"), then the same-day services should be summed with POS code "99" or "51" accordingly.
   - Modifier codes "99" and blank are treated the same within MACSIS. Therefore, same-day services with modifier codes "99" or blank in modifier position 2 should be summed.
   - For more information, please refer to the Roll-Up Category Matrix for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.rollup.pdf and for

ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.rollup.pdf which includes healthcare and non-healthcare procedures.

Scenario	Procedure Code	Mod 1	Mod 2	POS	Units
Same-Day Inpatient Psych Facility • MH Assessment • Non-Physician • 20-min at CMHC in a.m. • 30-min at State Hospital in evening	Submit two separate claims *H0031* *H0031*	 HE HE		 53 51	 .3 .5
Same-Day Nurse/Physician MedSomatic • Pharmacologic Mgmt • 7-min at CMHC by physician in a.m. • 7-min at CMHC by nurse in p.m.	Submit one claim. "Sum" then round minutes to partial units per table *90862*	 HE		 53	 .2

2. *Service Rounding Conventions*

   Rounding conventions outlined in Section 44C of this document should be applied to episodes of treatment occurring on the same day after summing the total number of service minutes. Refer to the example provided in Section 44C for Individual MH Community Support (CSP) for more information.

3. *Pre-Checking Policy*

   Boards or MACSIS Administrators will no longer be required to perform various levels of duplicate claim checking prior to the submission of a provider claim file to MACSIS. However, they should make every effort to ensure whole claim files are not submitted twice inadvertently to MACSIS.

45. Topic: Claim Corrections in MACSIS

Purpose:

To establish guidelines and specific procedures for when and how Boards may make claim corrections within MACSIS for erroneously billed services. All corrections must be made in accordance with the "Procedure for Claim Corrections within MACSIS".

Policies:

Only the following claim errors may be corrected in MACSIS:

- Finalized MH Medicaid and non-Medicaid claims

- Un-finalized MH Medicaid and non-Medicaid claims
- Finalized AOD Medicaid and non-Medicaid claims
- Un-finalized AOD Medicaid and non-Medicaid claims
- The wrong number of units were billed (i.e., straggler claim, incorrect units)
- The billed amount was incorrect
- Incorrect procedure code
- Incorrect modifier
- Incorrect third party amounts
- Wrong date of service
- Incorrect UCI
- Date of service on claim is over 365 days old when received in MACSIS
- OHIO claims (i.e., Company Code = OHIO)
- Mismatch claims
- Claims that have been reported on the OHEXT (Ohio Medicaid Extract) Error Report
- Client has retroactive Medicaid eligibility
- Denied claims with missing information

Note: "Denying" a claim for payment within MACSIS because it had been billed twice is not the same as "denying" a client treatment. The term "denial" in this document refers to the denial of payment, not the denial of treatment.

1. This guideline is not to be used to reverse claims paid before a resolution to a residency dispute. This is because the Provider is not responsible for creating a residency dispute and therefore their funds should not be retracted accordingly. As noted in the "ODADAS - ODMH Guidelines Pertaining to the Implementation of MACSIS", Topic 8, section 16. Boards are to resolve monies owed due to residency dispute resolutions outside of MACSIS.
2. All claims adjusted/reversed/denied/etc. **MUST** have a reason code.
3. This Guideline is **NOT** to be used to adjust Medicaid rates. Medicaid rate changes are assigned an effective date based on the day they are input into Diamond by ODMH/ODADAS. Therefore, neither Boards nor Providers are to use the claims correction procedure to retroactively update Medicaid rate(s). In instances where Boards maintain separate rates for non-Medicaid, the claims correction procedure may be used to correct non-Medicaid claims due to an incorrect or retroactive rate change.
4. To ensure consistency across provider and board areas, both ODMH and ODADAS will allow correcting of Medicaid claims and non-Medicaid claims regardless of claim status.
5. All claims (whether AOD or MH) will be corrected following the "Procedure for Claim Corrections within MACSIS" (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.proc.pdf).
    - Boards may require claims that were originally denied in Diamond (missing/invalid modifier/diagnosis code) due to provider error to be resubmitted electronically.
    - Boards cannot require Providers to resubmit claims electronically if the claims were originally denied in Diamond due to Board error, unless mutually agreed to.

6. **DO NOT** reverse Medicaid claims which 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 accounts payable (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.

7. Boards **MUST** pay claims when they have been finalized and documented on the 835(s) (even if corrections are going to be made). The erroneous claims must then be "worked" following the "Procedure for Claim Corrections Within MACSIS".

8. Currently ODJFS' adjudication deadline is 365 days from the date of service. If the date of service on the Medicaid claim is 366 days or older when it is received in MACSIS (based on the received date in Diamond), the Board may deny the claim or may allow the claim to be submitted to ODJFS for adjudication.

9. Boards and Providers are responsible for identifying claims billed in error to ODJFS in a timely manner.

10. Boards and Providers must use the **Claims Correction Form** (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.form.pdf) to identify erroneously billed claims. See http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.form.instruct.pdf for detailed instructions on how to complete the form.

    - Exception: 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**. Boards and Providers **MUST** maintain a copy of this form (or mutually agreed upon report) to serve as written documentation that a service was or was not erroneously billed.

11. Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond.

12. 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 from the Provider within 30 days, Boards may reverse a finalized claim or deny an un-finalized claim.

13. Boards are required to process corrections with little delay after receipt of a **Claims Correction Form** or a Provider response to a **Claims Correction Form**.

14. The actual, year-end Medicaid cost reconciliation will be handled according to ODADAS' or ODMH's Medicaid Reconciliation Guidelines.

15. Boards **MUST** "work" the OHEXT Error Report and correct Member eligibility spans to resolve claims which are being paid as Medicaid but are not being extracted and sent to ODJFS.

16. Boards **MUST** "work" the OHIO claims, the Mismatch claims, and the Retroactive Medicaid claims in a timely manner.

***The MACSIS Claim Correction Policy is adopted as phase I of ODADAS' re-engineering of Medicaid reconciliation. Phase I represents movement toward alignment of current Medicaid reconciliation processes with MACSIS technology.**

History of Document Revision

Change	Topic Revised or added	Date of Revision	Originator of Change
1. Added Topic 12.	MACSIS Unique Provider Identifier (UPI) and Vendor Numbers	4/20/04	P. Eichner
2. Removed Topic 19.	Claims in "Held" Status	4/20/04	P. Eichner
3. Updated Topic 43 to include file naming conventions for recreated files.	ASC X12N 835 Health Care Claim/Payment Advice Return Policies	5/19/04	P. Eichner
4. Added New Topic 19.	MACSIS System Access	1/27/05	P. Eichner
5. Updated Topics 40-43 to removed pre-HIPAA references.	Claims EDI	1/27/05	P. Eichner
6. Updated Topic 9	Spend Down – removed invalid references to spend down amount on member record.	08/31/05	K. Cluggish

Glossary of Acronyms

Acronym	Definition
835	Health Care Claim Payment Advice (Electronic HIPAA Format)
837P	Professional Claim Transaction (Electronic HIPAA Format)
ACPAY	Accounts Payable Records (Diamond Term)
ADAMH	Alcohol, Drug and Mental Health Board
AOD	Alcohol or Drug
APUPD	Accounts Payable Update (Diamond Term)
ASC	Accredited Standards Committee, X12N - Insurance Sub-Committee
ASCII	American Standard Code for Information Interchange
ANSI	American National Standards Institute
BENEF	Benefit Package Records (Diamond Term)
BRULE	Benefit Rule Records (Diamond Term)
CBCF	Community Based Correctional Facility
CFR	Code of Federal Regulations
CMH	Community Mental Health
CMHB	Community Mental Health Board
CMIA	Cash Management Improvement Act
COB	Coordination of Benefits
CPT	Common Procedural Terminology
CSB	Children Services Board
CSP	Community Support
EDI	Electronic Data Interchange
ERA	Electronic Remittance Advice (Pre-HIPAA Format)
FFP	Federal Fund Participation Payment
FFS	Fee-For-Service
FTP	File Transfer Protocol
GLASS	General Ledger Assignment Records (Diamond Term)
GLREF	General Ledger Reference Records (Diamond Term)
GRF	General Revenue Fund
GRUPD	Group Detail Records (Diamond Term)
GRUPP	Group/Plan Affiliation Records (Diamond Term)
HCFA	Health Care Financing Administration renamed Centers for Medicare and Medicaid Services (CMS)
HCPCS	Healthcare Common Procedure Coding System
HD	Women's Program Modifier under HIPAA
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-9-CM	International Classification of Disease, Version 9, Clinical Modification
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institution for Mental Disease
IRS	Internal Revenue Services
LAAM	Levomethadyl Acetate

Acronym	Definition
LOB	Line of Business (Diamond Term)
MACSIS	Multi-Agency Community Services Information System
MDS	Minimum Data Set
MEDEF	Medical Definition (Diamond Term)
MEDELIG	Nightly Medicaid Eligibility File
MH	Mental Health
MOM	MACSIS Operations Management Team
M-SPA	Mutual Systems Performance Agreement (Board/State Agreement)
OAC	Ohio Administrative Code
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODRC	Ohio Department of Rehabilitation and Corrections
ODYS	Ohio Department of Youth Services
OHEXT	Ohio Medicaid Extract
OHIO	Claims adjudicating under the Company Code of OHIO (Diamond Reference)
ORC	Ohio Revised Code
PHI	Protected Health Information
PLANC	Plan Codes (Diamond Term)
POS	Place of Service Code
PROVC	Provider Contract Records (Diamond Term)
RA	Remittance Advice (Hard-copy, Pre-HIPAA Format)
RDD	Residency Dispute Determination
RIDER	Rider Codes (Diamond Term)
SFY	State Fiscal Year (for Ohio July 1 through June 30)
SMD	Severely Mentally Disabled
SNIP	Strategic National Implementation Planning Committee (HIPAA EDI)
TCP/IP	Transmission Control Protocol/Internet Protocol
Title XX	Title XX of the Social Security Act (Block Grants to States for Social Services)
UCI	Unique Client Identifier
UPI	Unique Provider Identifier
VAN	Value Added Network (e.g., clearinghouse)

Claims Correction Form

MACSIS CLAIMS CORRECTION FORM

For reporting erroneous claims

Sending Organization Name:____________________________
Receiving Organization Name:__________________________
Provider MACSIS Unique Provider Identifier (UPI): __________
Date Received: _____________
Date Completed:_____________

Person Reporting Errors: _____________________
Phone Number: __________________________
Return Form to Attn: _________________________
Errors Apply to Fiscal Year: ____________________

	UCI #	DOS	MACSIS Claim #	Billed Amount	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Units	POS	COB Amt	Cob Ind[1]	Prov Pt Ctrl #
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*

[1] Must use one of the allowable ODJFS COB Indicator values: 2-6, R, P, F, L S, E, X

[2] Denote reason for error: wrong patient, date of service, units, procedure, modifier, 3rd party pmt/indicator, etc. or MACSIS Reason Code

Provider Representative Signature (required): ____________________________________ Date (required): ____________
If submitting via electronic media, type name above; add electronic signature: (check box) ☐