**MACSIS 835 Health Care Claim/Payment Advice Report Documentation**

## I. Purpose of Report

To report remittance information to Providers for claims which have been adjudicated and finalized through MACSIS. This report is provided to Boards for disbursement to their Providers as a courtesy to those Providers who do not contract with the Board responsible for payment and/or who do not have the capability to accept or review the federally-mandated 835 Health Care Claim/Payment Advice electronic file. It is not required under HIPAA.

Per Topic #43 of the Guidelines Pertaining to MACSIS Under HIPAA, if a Provider requests an electronic 835 file in lieu of this report, the remitting Board must comply with that request regardless of the size of the file per HIPAA regulations.

## II. Report Print Image File Name

RA.bbbxxxxx.julyy where:

- "bbb" is the remitting board number and type (ex., 25B for Franklin)
- "xxxxx" is the Provider's MACSIS-assigned Unique Provider Identifier (UPI)
- "jul" is the three byte julian date representing the date when the report was created
- "yy" is the year the report was created

## III. Frequency

This report is generated by Provider (UPI) by remitting Board and disbursed to the Board along with the 835 and ERA electronic files every Monday for Providers whose claims finalized in MACSIS the prior Monday. The remitting Board is responsible for disbursing the remittance information to the Provider. Providers should refer to HIPAA Alert #12 for information about how to track remittance advices due from a Board.

## IV. Inclusion/Exclusion Criteria

All claims finalized in MACSIS the prior week are included on this report, including any claims reversed and finalized through the ODJFS "Double Loop" process. The report does not include claims on hold or which have not yet finalized through the MACSIS Accounts Payable Process.

## V. Sort Order

Remittance transactions are grouped by patient and print in ascending order by the MACSIS Universal Client Identifier (UCI). Within UCI, transactions appear by

MACSIS claim number within date of service. A separate line will appear under each claim for every adjustment applied to that claim.

## VI. Subtotals

Base level subtotals are provided by UCI. Report level subtotals summarize claim and dollar amounts by Medicaid and Non-Medicaid funded services. The latter is determined by the medical definition in MACSIS and is reflected on the claim line under the Claim Filing Indicator (a value of "MC" for Medicaid and "13" for Non-Medicaid).

A summary of the number of claims and adjustment amounts by 835 Claim Adjustment Reason Code is also provided at the end of the report. This is so providers can assess the total amount of dollars adjusted due to denied reasons, differences between billed and allowed amounts, withheld dollars, etc.

For Alcohol and Drug service providers, subtotals will be provided for services adjudicated under the Women's Set Aside program. The latter is reflected on the claim line under Modifier 2 (a value of "HD" for Women's Program).

For providers with Medicaid reconciliation adjustments, the adjustment will appear as a dummy claim on the report prior to the pseudo-clients. Starting in the Patient Control # column, "ODADAS (ODMH) Reconciliation For Fiscal Year (FFP) ** 835 PLB" will appear with the associated retracted amount displayed under the "Payment Amount" column.

## VII. Data Dictionary

For a complete list and explanation of the data elements on the report, see the Remittance Data Dictionary.