State of Ohio
MACSIS System Implementation
Electronic Remittance Advice Specification
Version 1.04

I. Purpose

This specification outlines the file format, which will be produced by the boards to provide their agencies with the ability to post payments from the MACSIS system electronically. Each board will produce the file independently via data from the MACSIS system; however, they have all agreed to use the same format when extracting the data and providing it to their agencies. To allow the boards the flexibility to provide fund source and other board-specific information not stored in MACSIS, additional data elements may be provided at the end of the standard file format.

II. File Protocols

A. File Type

All files will be in an ASCII, fixed-length format. All text files will be in uppercase.

B. File Naming Conventions

Each **provider** specific file will be named according to the format, YyyXxxxx.zzz. An example is 25B01043.314, where:

Yyy = Board's county code (ex. "25" for Franklin) followed by board type ("M" for mental health, "A" for alcohol and drug and "B" for both).
Xxxxx = Equals the vendor's number. This will be the same as the UPI, if the provider is the vendor (ex. "01043").
Zzz = File creation date in julian form (ex. 314 is November 10, 1998)

Each **company** specific file will be named according to the format, Yyyyy.zzz. An example is FRANB.314, where:

Yyyyy = 1st 4 letters of board or group of boards followed by board type ("M" for mental health, "A" for alcohol and drug and "B" for both).
Zzz = File creation date in julian form (ex. 314 is November 10, 1998)

C. File Medium

Agencies should work with their local boards to determine the medium for submitting the file (FTP, diskette, etc.). E-mailing remittance advice files as attachments is not permitted per HCFA guidelines.

D. File Content

Only paid or denied claims will be included on the file, not pended or held claims. Each file must be condensed (i.e., zipped) and include the following prohibition of redisclosure notice, either as a comment on the zipped file or included in the zipped file:

> 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 prohibit 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.

E. File Sort

The file will be sorted by Provider Patient Control Number within Universal Provider ID (UPI).

III. File Layout

Below is a table describing each field in the order in which it will appear on the electronic file. The value of certain fields will repeat for multiple records in the file. For example, the UPI will repeat for each service being remitted associated with a particular agency.

#	Name	Description	From	Thru	Len	Type	Source Variable
1	Universal Provider ID (UPI)	The number assigned by the board to identify the agency who provided the service.	1	12	12	N	CAPROVIDER$
2	Provider Name	The name of the agency who provided the service.	13	42	30	A	PANAME1$
3	Vendor Number	The number assigned to the organization where checks should be remitted. This will be the same as the UPI number in most cases; however, it may be different if the agency is a subsidiary of another organization.	43	57	15	A	CAVENDOR$
4	Vendor Name	The name of the organization where checks should be remitted.	58	84	27	A	FENAME1$
5	Universal Client Identifier (UCI)	The number assigned to the client during enrollment in MACSIS.	85	96	12	A	CASUBNO$
6	Client Lastname	The lastname of the client as enrolled in MACSIS.	97	116	20	A	AALASTNM$
7	Client Firstname	The firstname of the client as enrolled in MACSIS.	117	128	12	A	AAFNAME$
8	Client Middle Initial	The middle initial of the client as enrolled in MACSIS.	129	129	1	A	AAMI$
9	Client Date of Birth	The date of birth of the client as recorded in MACSIS.	130	137	8	N	AADOB$
10	Medicaid Recipient Number	The client's Medicaid Recipient Number active at the time of the service being remitted.	138	152	15	A	ABUDEF1$
11	CHPS Indicator	Positions 6-9 of this field will contain "CHIP", if the client is enrolled in the Children's Health Insurance Program.	153	163	11	A	ABMSTAT$
12	County of Residence	The county of the client's primary residence at the time	164	171	8	A	ABREP$

#	Name	Description	From	Thru	Len	Type	Source Variable
		the service was provided. This field will contain OUTSTATE if primary residence is out-of-state or UNKNOWN if unknown.					
13	Plan Code	The "benefit" plan assigned to the client at the time of the service being remitted. Positions 1-2 denote the type of service (AD=Alcohol and Drug, MH=Mental Health, DF=Dual-Funded). Positions 3-5 denote the line of business (MCD=Medicaid, NON=Non-Medicaid). Positions 6-7 denote the county code of the board who responsible for the client. Positions 8-10 are reserved for local board use.	172	181	10	A	CAPLANCODE$
14	Line of Business	Identifies if the client was enrolled in a Medicaid ("MCD") or Non-Medicaid ("NON") plan at the time of the service being remitted.	182	184	3	A	CALOB$
15	Client Gender	The gender of the client. "M" for male. "F" for female. "U" for unknown will exist on "generic" enrollment records (i.e., used to record non-client specific services).	185	185	1	A	CASEX$
16	Primary Diagnosis	The primary ICD-9-CM code provided by the agency for the service being remitted. The decimal point is included. Refer to the Electronic Claims Submission Manual for a complete list of valid codes.	186	191	6	A	CADX1$
17	Provider Patient Control Number	The number provided by the agency during claims submission, which identifies the client or the client's episode of service within the provider's system.	192	206	15	A	CAUD2$
18	Claim Number	The number assigned to the claim within MACSIS.	207	222	16	A	CBCLAIM$
19	Check Number	The number of the check as	223	230	8	A	FJCHECKNO$

#	Name	Description	From	Thru	Len	Type	Source Variable
		assigned within MACSIS to remit payment for the service.					
20	Check Run Date	The date the check was produced.	231	238	8	N	FJENTDATE$
21	Procedure Code	The MACSIS service code as provided during claims submission, which identifies the type of service being remitted. Position 1 denotes the type of service (A=Alcohol and Drug, M=Mental Health). Remaining positions contain numbers. Refer to the Electronic Claims Submission Manual for a complete list of valid codes.	239	246	8	A	CBPROCCODE$
22	Procedure Description	The description associated with the MACSIS service code.	247	274	28	A	FCSHDESC$
23	Modifier	The MACSIS modifier as provided during claims submission, which identifies the modality of the service being remitted (ex. service provided face-to-face, via telephone, in group setting, etc.) Refer to the Electronic Claims Submission manual for a complete list of valid codes.	275	276	2	A	CBMODIFIER$
24	Units of Service	The units of service as provided during claims submission. A decimal point will be in the fifth position.	277	282	6	N	CBQUANT
25	Date of Service	The date the service was provided as noted during claims submission.	283	290	8	N	CBSERVDATE$
26	Claim Status	An indicator denoting the adjudication status of the claim. Allowable values include: A=Adjustment,C=Capitated,D =Denied,I=Informational,N=A	291	291	1	A	CBCLAIMSTAT$

#	Name	Description	From	Thru	Len	Type	Source Variable
		djustment-No check, P=Payable,S=Staff					
27	Company Code	A code identifying the board, group of boards, county or group of counties responsible for the remittance. The fifth position contains a "M" for Mental Health Boards/Counties, "A" for Alcohol and Drug Boards/Counties, and "B" for Both.	292	296	5	A	CBCOMPANY$
28	Billed Amount	The amount billed from the agency for the service being remitted. This amount should equal the agency's Uniform Financial Management System (UFMS) budgeted rate for the service.	297	307	11	N	CBBILLED
29	Allowed Amount	The amount of the agency's contracted rate for the service being provided.	308	318	11	N	CBALLOWED
30	Allowed Reason Code	A code denoting the source or reason for the allowed amount (ex. FEESC - derived from fee schedule).	319	323	5	A	CBALLOWRSN$
31	Allowed Reason Description	The description associated with the allowed reason code.	324	373	50	A	FGDESC$
32	Copayment Amount	The amount due from the client for the service provided. This amount is based on the client's sliding fee scale percentage assigned at the time of enrollment.	374	384	11	N	CBCOPAY
33	Copayment Reason Code	The code identifying the reason a copayment was applied (ex. 20%SF – 20% Sliding Fee Scale).	385	389	5	A	CBCOPAYRSN$
34	Copayment Reason Description	The description associated with the copayment reason code.	390	439	50	A	FGDESC$
35	Deductible Amount	The amount due from the client to meet their periodic deductible.	440	450	11	N	CBDEDUCT$
36	Deductible Reason Code	The code identifying the reason a deductible was applied.	451	455	5	A	CBDEDUCTRSN$

#	Name	Description	From	Thru	Len	Type	Source Variable
37	Deductible Reason Description	The description associated with the deductible reason code.	456	505	50	A	FGDESC$
38	Other Carrier Amount	The amount paid by a third party for the service being remitted as provided by the agency during claims submission.	506	516	11	N	CBOCAMT
39	Other Carrier Reason Code	The code which categorizes the third party who paid a portion of the claim (ex. 4=Employer or Union). Refer to the Electronic Claims Submission Manual, FA0 Record, COB Indicator for a complete list of valid codes.	517	521	5	A	CBOCRSN$
40	Other Carrier Reason Description	The description associated with the other carrier reason code.	522	571	50	A	FGDESC$
41	Withhold Amount	The amount withheld from the amount due, due to prior disbursements, such as block grants or pre-payments to agencies.	572	582	11	N	CBWITHHOLD
42	Not Covered Amount	The amount not covered due to the client or service not being eligible for payment via their assigned plan.	583	593	11	N	CBNOTCOV
43	Not Covered Reason Code	A code denoting the reason why the not covered amount was applied (ex.PCINV – Procedure code invalid or non-specific).	594	598	5	A	CBNOTCOVRSN$
44	Not Covered Reason Description	The description associated with the not covered reason code.	599	648	50	A	FGDESC$
45	Net Amount Paid	The net amount paid for the service being remitted. It should equal Allowed Amount - (Not Covered + Copayment/Coinsurance + Other Carrier Amount + Withhold).	649	659	11	N	CBNET

#	Name	Description	From	Thru	Len	Type	Source Variable
46	Medicaid Flag	Medicaid Indicator with value of 'M' for medicaid claim and 'N' for non-medicaid claim based on the MEDDEF value.	660	660	1	A	Based on MEDDEF value
47	Line Number	Line number of claim	661	663	3	A	CBLINE$
48	Reversal/ Adjustment Indicator	Value of 'R' for reversal, 'A' for an adjustment and blank for regular claim.	664	664	1	A	CBSUBLINE$
49	Adjustment Reason Code	A code denoting the reason for an adjustment to the claim.	665	669	5	A	CBADJUSTRSN$
50	Error Code 1	A code denoting the error occurring when claim is rejected by Human Services.	670	672	3	A	RRERROR1$
51	Error Code 2	A code denoting the error occurring when claim is rejected by Human Services.	673	675	3	A	RRERROR2$
52	Error Code 3	A code denoting the error occurring when claim is rejected by Human Services.	676	678	3	A	RRERROR3$
53	Carrier ID 1	Identification of first Insurance carrier of claim rejected by Human Services.	679	683	5	A	RRCARRIERID1$
54	Carrier ID 2	Identification of second Insurance carrier of claim rejected by Human Services.	684	688	5	A	RRCARRIERID2$
55	Policy 1	First insurance policy covering claim rejected by Human Services.	689	703	15	A	RRPOLICY1$
56	Policy 2	Second insurance policy covering claim rejected by Human Services.	704	718	15	A	RRPOLICY2$
57	Group 1	Group identification of first insured person causing claim rejected by Human Services.	719	730	12	A	RRGROUP1$
58	Group 2	Group identification of second insured person causing claim rejected by Human Services.	731	742	12	A	RRGROUP2$
59	Insured 1	Person named on first insurance policy causing rejection of claim by Human Services.	743	757	15	A	RRINSURED1$
60	Insured 2	Person named on second insurance policy causing	758	772	15	A	RRINSURED2$

#	Name	Description	From	Thru	Len	Type	Source Variable
		rejection of claim by Human Services.					
61	Post Date	Date of Diamond's APUPD Process. (YYYYMMDD)	773	780	8	A	CBPOSTDT$
62	Remittance File Name	This field will contain the file name of the electronic remittance associated with the service. The format is described in section II, B of this document. It is provided to allow a cross-reference between MACSIS and the provider system for purposes of tracking and problem resolution.	781	792	12	A	See section II, B
63	Fund Source Code	Code which identifies the source of funds used to pay for the service being remitted. This field is optional and may not be provided by the board.	793	802	10	A	Varies by board
64	Fund Source Description	The description associated with the fund source code. This field is optional and may not be provided by the board	803	832	30	A	Varies by board
65	Board-Specific Data	The remaining positions of the file may be used by the board to include information not in the standard layout, which their agencies have requested.	833	882	50	A	Varies by board
	Optional Data Fields						
		Batch Number	833	841	9	A	
		Modifier 2	842	843	2	A	
		Modifier 3	844	845	2	A	
		Modifier 4	846	847	2	A	
		Board-Specific Data	848	882	35	A	