

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.