

**SUBJECT:** MACSIS Claims Processing  
**IDENTIFIER:** 03.01.01  
**EFFECTIVE DATE:** 08/01/2006  
**FORMAL REVIEW DATE:** 08/01/2006  
**SUPERSEDES:** All policies adopted prior to effective date  
**AUTHORITY:** Governance Policies C-1, "Delegation to the Executive Director" and D-4  
"Financial Condition"  
**OACBHA STANDARD:** I-A.5 and I-C.7

**PURPOSE:** To insure compliance with the HIPAA Claims Section of the Board Operations Manual as published by ODMH and ODADAS.

**POLICY:** Claims Processing shall comply with the requirements established by ODMH and ODADAS in the HIPAA Claims Section of the MACSIS Board Operations Manual. This manual is located at:  
<http://www.mh.state.oh.us/ois/macsis/manuals/hipaa.claims.manual.pdf>

**RULES:**

- A. Board personnel shall comply at all times with the requirements of the current HIPAA Claims Section of the Board Operations Manual.
- B. Providers may submit 837p claim files to the Board at any time either via FTP to the designated server of the Board Network or on a physical disk/CD. No paper claims will be accepted.
- C. Board staff shall submit the agency claim files to MACSIS via FTP as they are received. All claim files received during any given week shall be submitted by the end of business on each Friday so long as the files were received prior to that time and the appropriate notification is provided by the submitting agency.
- D. Providers must notify the appropriate Board staff of all files submitted, including the file name, the number of claims in the file and the total amount of the claims in the file.
- E. The Operations Supervisor shall maintain a record of all claims files that are submitted to the Board showing when each file is uploaded to MACSIS.
- F. Denied claims are communicated to the providers on the standardized MACSIS output reports. A weekly report of held claims is provided to any agency that has claims that are held for any reason.
- G. Providers may appeal adverse determinations for claims other than Medicaid eligible claims by submitting in writing a list of the claims they wish to appeal and the reason for the appeal. These appeals are dealt with according to the terms of the provider contract. Appeals regarding Medicaid eligible claims must be handled according to the governing Ohio Medicaid Contract, ORC and Administrative Rules.
- H. The Board shall reimburse all valid Medicaid covered claims to any out of county provider per the requirements of the ODMH Medicaid Agreement. Emergency mental health services not covered by Medicaid may also be paid.
- I. Payment to providers shall be based upon the ERA data provided each week from MACSIS operations. Payments shall be made in a timely manner and shall be paid within the constraints of the provider agreements. All eligible reimbursements shall be made within 30 days of the date of the receipt by the Board of the ERA file.

**PROCEDURE:**

Provider notifies Board that an 837 claim file has been placed on the Board ftp site to be uploaded to ODMH ftp site for processing. Board verifies that file name, number of claims and total amount matches submitted information. Board ftp's all claim files to ODMH. ODMH batch processes on Monday all claim files submitted by the Board for the previous week. ODMH notifies Board when batch has been processed via email and existence of Pre-edit reports to be downloaded by the Board. Board downloads reports and generates Critical error reports and places reports on providers ftp site. Providers must resubmit all claims on Critical Error report. Board instructs ODMH to post week's batch of claims to MACSIS. ODMH posts batch and notifies Board that Post reports are on Board ftp site. Board downloads Post reports, loads into claims database, generates error and Out of county reports and places reports on providers ftp site. Providers can indicate corrections to these reports and fax signed reports to the Board. Operations Supervisor will access the claims in MACSIS, make corrections and re-adjudicate the claims.

Weekly the Board receives Caution reports. These reports are placed on the provider ftp site and they must be signed and returned to the Board verify validity of claims. Weekly the Operations Supervisor downloads from ODMH an extract of all members and claims pertaining to this Board and generates reports to determine all claims on hold, all claims outside the contract parameters per providers, all Medicaid claims over 365 days. The Operations Supervisor accesses MACSIS and removes hold, indicates whether claim is allowed, indicates reason and releases claim. All claims over 365 days are denied. All claims outside of the parameters of provider contracts are denied with appropriate reason codes. Weekly Mismatch reports require the Operations Supervisor to determine if the claims have finalized or if another Board should be contacted in order to correct the status of group and plan on indicated claims.

Monthly ODMH processes a report of all Medicaid Retro claims. Board staff updates Medicaid eligibility of all clients on Medicaid retro eligibility report. Staff reverses and splits all POS claims on Medicaid Retro report according to guidelines in the MACSIS claims processing manual. Providers may submit corrections to claims by submitting a MACSIS Correction Form. The form must be signed by provider personnel and indicate the information necessary to make the requested corrections. Upon receipt of the MACSIS correction form, the Operations Supervisor accesses the system and reverses and splits the claim based on this information.

Weekly the Board is notified that remittance reports are in their ftp folder. Board downloads and processes all remittance reports. Board generates reports to determine funds available by account for remittances to be paid. Board generates invoices based on funds available report. Board generates vouchers and recap reports which are audited and signed by the Operations Supervisor and the Director of Operations. These vouchers and recaps are presented to Auditor's office for payment. Board receives payments from Auditor's office. The payment along with corresponding documentation is sent to the providing agency. The Accounting Specialist files a copy of all documentation by vendor.

**RESPONSIBILITY:**

The **Director of Business Operations** shall be responsible for ensuring compliance with this procedure.

**FORMS:** Claims Correction Form

**AUTHORIZATION:**

  
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Charles Neff, Director of Business Operations

8-1-2006  
Date