MACSIS Communication
5010 Provider Testing
Sent on: November 9, 2011

Background:

Starting Friday, November 18, 2011, providers may submit test claim EDI files for MACSIS approval using the HIPAA-mandated format. The provider should discuss with their local Board how they expect to receive and/or be notified of test file submissions. This procedure will vary by Board depending on the file transfer arrangements they have made for their providers. Boards should make sure they have entered/updated the provider's Non-Medicaid rates and contracts in MACSIS.

Starting, November 21, 2011, the MACSIS staff will run submitted test files through the Claims EDI process. Due to the number of test files being submitted at one time, existing provider test files will only be verified whether the file was accepted by Diamond. For new providers, and those that request additional testing, the MACSIS staff will review the PREDI-Edit and Post reports to determine why records created critical and noncritical errors, why warnings were created, if the procedures priced as expected, and if all benefit rules were applied appropriately.

Once approved, providers may submit production 837P claim files starting December 12th, 2011, using the approved naming convention described in the procedures below.

Board Action Required:

1. Once a test file is received by the Board, the Board should at a minimum, verify that the file follows the appropriate test file naming convention as noted under the provider procedures.

   - Boards have the option and are encouraged to verify that test files pass additional requirements by verifying HIPAA form, structure and syntax compliance as well as checking for the MACSIS-specific requirements outlined in the Guidelines Pertaining to MACSIS under HIPAA. If errors are found, the Board can communicate the errors to the provider prior to any involvement by the MACSIS staff, however the Boards are not encouraged to actually change the provider file before submitting it onto the MACSIS staff.

   - If the Provider or the Board would like rates checked in MACSIS, the Board should complete the HIPAA Service Rate Forms(s) pertaining to the State Fiscal Year being tested for the Departments under which the provider will be submitting claims (ODMH and/or ODADAS)

   - Boards should make sure they have entered/updated the provider's Non-Medicaid rates and contracts in MACSIS.

2. The Board should FTP the file to the MACSIS mhhub server to the /county/<Board designation>/hipaa/test/ subdirectory. The Board should then complete the MACSIS EDI Claims Testing Form (and the HIPAA Service Rate Form if rates are being checked) and email it/them to macsistesting@mh.state.oh.us.

    - It is very important for the Boards to complete all requested information on EDI Claims Test form, the HIPAA Service Rate form (if rates are being checked), and to submit both forms at the same time the test file is made available. Emailing the form in MS Word format is the preferred method. If the Board does not have MS Word, a PDF version of the form is available and can be faxed to 614-752-6474. If faxing, please make sure the information is legible.

    - It is important to check the correct box in the Type of Test section according to the type of file being submitted, otherwise there is a risk the file could be rejected based on the incorrect information being submitted on the form.

3. Once received, the MACSIS staff will make sure the test environment is a current copy of Production and will run the test file through the Claims EDI process in the test environment.

4. If the file meets the acceptance criteria as determined per the policy, the provider will be approved for submission of 837P v5010A1 claim files for Production. A copy of the final Testing Request Form will then be emailed back to the Board indicating the provider has been approved for production claim submission.

    - If the file does not pass the acceptance criteria due to problems with the source file, the Board should contact the provider, who will need to correct their file creation program and resubmit a new file beginning with step 1.

    - If the file does not pass the acceptance criteria due to problems with the Diamond benefit, contract and pricing tables, the Board will need to follow appropriate change control procedures to correct the Diamond tables. Changes to PANEL, PLAN, BENEF, and BRULE records should be submitted to the MACSIS Support Desk. The Board should then submit a new test form (when ready) to request the process begin starting at step 3.

    - The Board is responsible for changes to the PROVC or PROCP records pertaining to the provider's non-Medicaid agreement. If changes need to be made to either the Medicaid provider contracts or Medicaid PROCP records, the provider must contact Debbie Downs to make the needed updates before proceeding.

    - Boards should wait three business days after the submission of a test file to the MACSIS staff before inquiring about the status. Inquiries about the test file status should be sent to the MACSIS Support Desk.

Provider Action Required:

1. Providers should thoroughly review Topics 40-45 of the Guidelines Pertaining to MACSIS under HIPAA prior to submitting test claim files.

    Topic 41(B) "Becoming a Business Associate/Trading Partner" in the Guidelines Pertaining to MACSIS under HIPAA relates specifically to MACSIS EDI testing policy. These guidelines will outline under what circumstances providers are required to submit test files, any pre-testing requirements, and what types of claim scenarios must be included in each test file.

2. The provider should discuss with their local Board how they expect to receive and/or be notified of test files submissions. This procedure will vary by Board depending on the file transfer arrangements they have made for their providers.

3. When ready to submit a test file, the provider should ensure that the test file is appropriately named as follows:

    For 837P v5010 files containing NPI: Txxxxxx#.julyy (ex., T0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

4. Upon submission of the test file, the provider should notify their Board that the test file is available per Board procedure.

Provider Procedure after Approval:

Once approved, providers may submit production 837P claim files starting December 12th, 2011, using the following naming convention:

> For 837P v5010 files containing NPI: Wxxxxxx#.julyy (ex., W0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.