

## 45. Topic: Claim Corrections in MACSIS

### **Purpose:**

To establish guidelines and specific procedures for when and how Boards may make claim corrections within MACSIS for erroneously billed services. All corrections must be made in accordance with the “Procedure for Claim Corrections within MACSIS”.

### **Policies:**

Only the following claim errors may be corrected in MACSIS:

- Finalized MH Medicaid and non-Medicaid claims
- Un-finalized MH Medicaid and non-Medicaid claims
- Finalized AOD Medicaid and non-Medicaid claims
- Un-finalized AOD Medicaid and non-Medicaid claims
- The wrong number of units were billed (i.e., straggler claim, incorrect units)
- The billed amount was incorrect
- Incorrect procedure code
- Incorrect modifier
- Incorrect third party amounts
- Wrong date of service
- Incorrect UCI
- Date of service on claim is over 365 days old when received in MACSIS
- OHIO claims
- Mismatch claims
- Claims that have been reported on the OHEXT Error Report
- Client has retroactive Medicaid eligibility
- Denied claims with missing information

**Note: “Denying” a claim for payment within MACSIS because it had been billed twice is not the same as “denying” a client treatment. The term “denial” in this document refers to the denial of payment, not the denial of treatment.**

1. This guideline is not to be used to reverse claims paid before a resolution to a residency dispute. This is because the Provider is not responsible for creating a residency dispute and therefore their funds should not be retracted accordingly. As noted in the “ODADAS - ODMH Guidelines Pertaining to the Implementation of MACSIS”,

Topic 8, section 16. Boards are to resolve monies owed due to residency dispute resolutions outside of MACSIS.

2. All claims adjusted/reversed/denied/etc. **MUST** have a reason code.
3. This Guideline is **NOT** to be used to adjust Medicaid rates. Medicaid rate changes are assigned an effective date based on the day they are input into Diamond by ODMH/ODADAS. Therefore, neither Boards nor Providers are to use the claims correction procedure to retroactively update Medicaid rate(s). In instances where Boards maintain separate rates for non-Medicaid, the claims correction procedure may be used to correct non-Medicaid claims due to an incorrect or retroactive rate change.
4. To ensure consistency across provider and board areas, both ODMH and ODADAS will allow correcting of Medicaid claims and non-Medicaid claims regardless of claim status.
5. All claims (whether AOD or MH) will be corrected following the “Procedure for Claim Corrections within MACSIS” (<http://mentalhealth.ohio.gov/assets/macsis/claims/hipaa-claim-correction-procedure.pdf>).
  - Boards may require claims that were originally denied in Diamond (missing/invalid modifier/diagnosis code) due to provider error to be resubmitted electronically.
  - Boards cannot require Providers to resubmit claims electronically if the claims were originally denied in Diamond due to Board error, unless mutually agreed to.
6. **DO NOT** reverse Medicaid claims that have not come back from the Ohio Department of Job and Family Services (ODJFS).

If ODJFS rejects the claim and a Board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the Provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to, and returned by ODJFS.
7. Boards **MUST** pay claims when they have been finalized and documented on the 835(s) (even if corrections are going to be made). The erroneous claims must then be “worked” following the “Procedure for Claim Corrections within MACSIS”.
8. Currently ODJFS’ adjudication deadline is 365 days from the date of service. If the date of service on the Medicaid claim is 366 days or older when it is received in MACSIS (based on the received date in

Diamond), the Board may deny the claim or may allow the claim to be submitted to ODJFS for adjudication.

9. Boards and Providers are responsible for identifying claims billed in error to ODJFS in a timely manner.
10. Boards and Providers must use the **Claims Correction Form** (<http://mentalhealth.ohio.gov/assets/macsis/claims/hipaa-claim-correction-form.pdf>) to identify erroneously billed claims. See <http://mentalhealth.ohio.gov/assets/macsis/claims/hipaa-claim-correction-form-instructions.pdf> for detailed instructions on how to complete the form.
  - Exception: For large batches of erroneous claims, boards and providers may mutually agree to another method to identify/report errors. The key is it must be a mutual agreement; otherwise, Boards and Providers must accept the standard **Claims Correction Form**. Boards and Providers **MUST** maintain a copy of this form (or mutually agreed upon report) to serve as written documentation that a service was or was not erroneously billed.
11. Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond.
12. Providers are permitted 30 days from the date of notification of the potential error to respond to the Board regarding the claim.
  - If no response is received from the Provider within 30 days, Boards may reverse a finalized claim or deny an un-finalized claim.
13. Boards are required to process corrections with little delay after receipt of a **Claims Correction Form** or a Provider response to a **Claims Correction Form**.
14. The actual, year-end Medicaid cost reconciliation will be handled according to ODADAS' or ODMH's Medicaid Reconciliation Guidelines.
15. Boards **MUST** "work" the OHEXT Error Report and correct Member eligibility spans to resolve claims that are being paid as Medicaid but are not being extracted and sent to ODJFS.
16. Boards **MUST** "work" the OHIO claims, the Mismatch claims, and the Retroactive Medicaid claims in a timely manner.

**\*The MACSIS Claim Correction Policy is adopted as phase I of ODADAS' re-engineering of Medicaid reconciliation. Phase I represents movement toward alignment of current Medicaid reconciliation processes with MACSIS technology.**