SHARES SYSTEM

PROVIDER USER GUIDE

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Overview

The Hamilton County Mental Health and Recovery Services Board (HCMHRSB), The Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Cuyahoga County; and The Alcohol, Drug and Mental Health Board of Franklin County (ADAMH) have jointly formed a **Council of Government** (COG) entity known as the **Three C Recovery and Health Care Network (Three C)**. The COG is responsible for the planning and development of the tri-county Board health care management information system known as the Shared Health and Recovery Enterprise System (**SHARES**).

SHARES is the health care management information system that will support management of client enrollment, benefit management, provider contracting, payment processes, and utilization and outcomes management. The system includes Incedo Web (for Board processing), Incedo Provider Connect (the Provider portal/IPC), and various administrative tools and applications including Phaseware (Helpdesk) and FIAT (the fiscal interface).

Incedo Provider Connect

Agency staff should use Internet Explorer 11 to access the Incedo Provider Connect (IPC) website and login page.

When entering the web address for IPC (https://ohshareipc.infomc.biz/ipc/), the user will be taken to a login page like the one below.

Login:

While the login page is the same for all users, agency staff will have varying security access settings based on the job functions of the staff person. Security categories include: Claims, Clinical, Enrollment, Limited Access, and Member Search. Staff will be placed in one or multiple security categories based on job responsibilities/need for access.

The **User Name** for these accounts will be ipc followed by Agency ID and some variation of the user's name (e.g. ipc1560rkopache), and a unique password.

The IPC Home Page will include agency specific information in a green box on the left, the navigation modules in the four boxes in the middle, and module specific links in the blue box on the right (see screen shot below).

The items in the blue box change according to the module that is selected. For example, if the Membership module is selected, the links in the blue box will be Search, Eligibility, Summary, Forms, Add (member), but if the File Transfer module is selected the links will be File Upload, and File Download.

The buttons and drop-down menu options on the blue navigation bar in the upper right hand corner will vary based on user security access settings.

To return to the home page after navigating to one of the modules, click on the small blue button in the upper left on the yellow bar (indicated by the purple arrow).
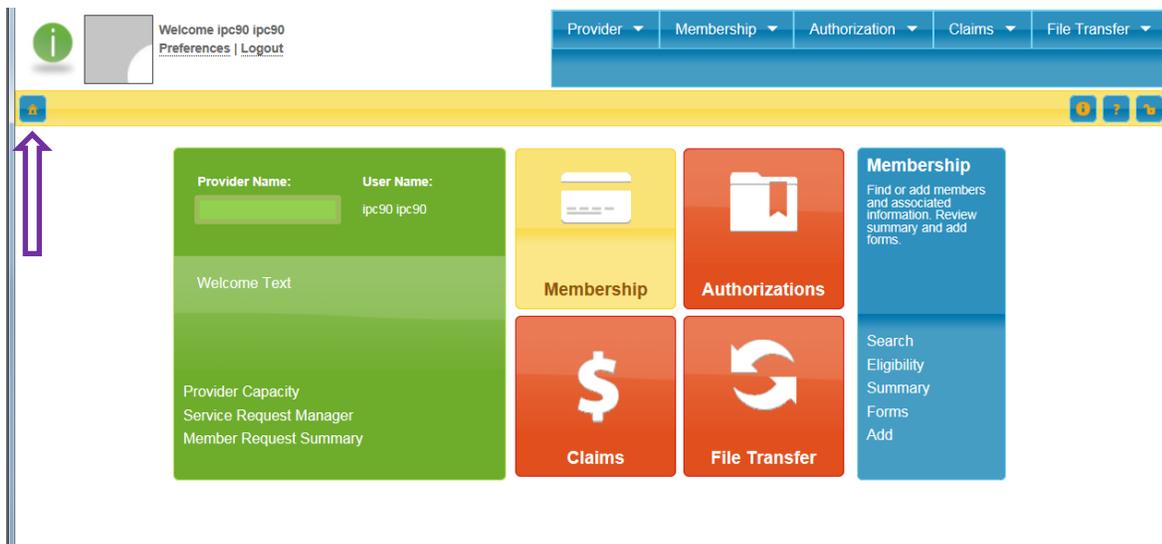
Processing Clients New to Agency in IPC

There are three steps in SHARES for processing clients who are new to your agency:

1. Conduct search to determine if the client is already a member of SHARES
2. Verify/update member information in SHARES
3. If not a member of SHARES, complete the Add Member application and SHARES Eligibility and Enrollment form

Detailed instructions for each of these three steps are provided below.

Step One: Conduct Member Search

Before adding/enrolling a client in SHARES, agency staff should search for the member to determine whether they are already a member in SHARES. From the IPC home page, user can access the Search page using either of the following methods:

a) Click on the "Membership" tab in the upper right, and select "Search", or

b) Click on the "Membership" box in the middle of the page, and select "Search" from the menu in the bottom portion of the blue box on the right.
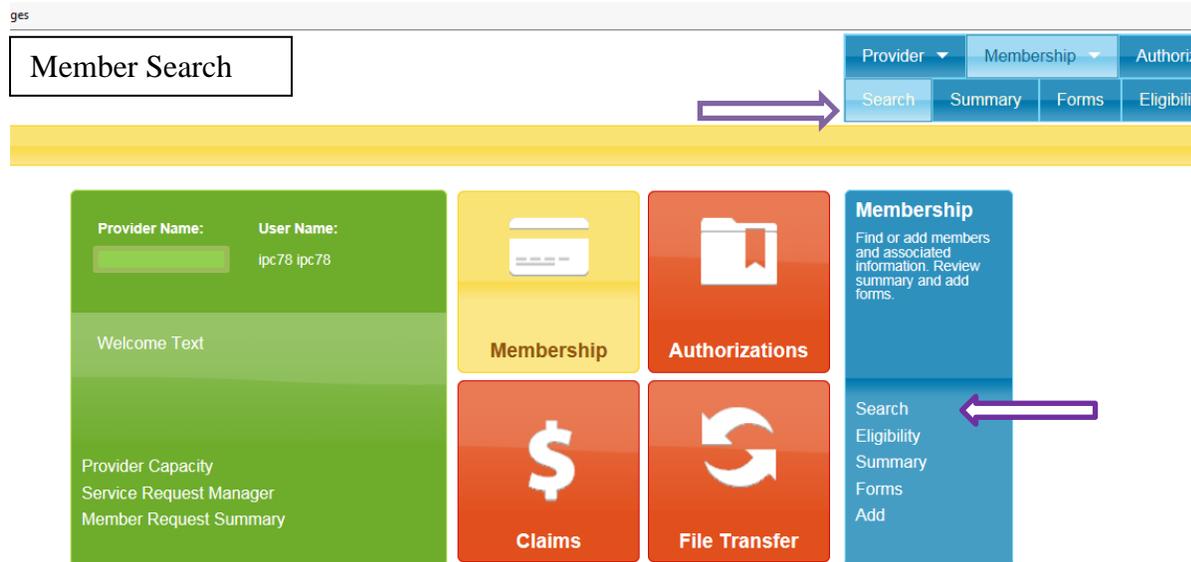
The screen shot below shows the member search page. Choose one of the required data combinations below to conduct a member search:

- Patient ID
- SSN (this was recently added as a search option)
- Last name, Date of Birth, and Gender
- Last name, SSN, Gender

Because member date of birth, SSN, and/or lname in SHARES sometimes don't match the information that an agency has for the member, provider's should attempt a member search using multiple search options.

For example, numbers used for SSN and date of birth get transposed at times, so 12/21/63 could have been created as 12/12/63.

If member is in SHARES, proceed to Step Two. If the member is not in SHARES, skip to Step Three.

Step Two: Verify/Update SHARES Member Information

1. **Open member summary page:** If the client is already in SHARES, their name will appear as a search result. Click on the name to open the member "Summary" page.

2. **View member Summary to verify information:**

A. If information in the summary is correct, proceed to *verifying that the client is eligible for services in Hamilton County (#3 below).*

B. If demographic information (e.g. gender, ethnicity, race) is incorrect, submit the SHARES Eligibility and Enrollment Update Form completing only the fields in the form for which client information has changed.

The Eligibility and Enrollment Update form is accessed by going to the "Member" module or navigation bar, selecting "Forms," selecting "Other" from the list of form folders, then selecting the SHARES Eligibility and Enrollment Update Form, and then selecting "add form." Complete only the fields in the form for which client information has changed.

C. **If the member's *name, date of birth, social security number, address, or service intake date* is incorrect**, the agency must submit the HCMHRSB Eligibility Verification Documentation Form (Attachment A) and attach the form and verification documentation on the Member Summary page. The Member Summary Page is accessed by selecting "Summary" under the "Membership" tab. Attach documents by clicking on "Add Attachment" on the "Summary" page.

After completing the Eligibility Verification Documentation form and attaching the documentation, send an email to Board staff (rocheller@hcmhrsb.org or monicar@hcmhrsb.org) notifiying them that the member's file has been updated and needs to be reviewed for approval.
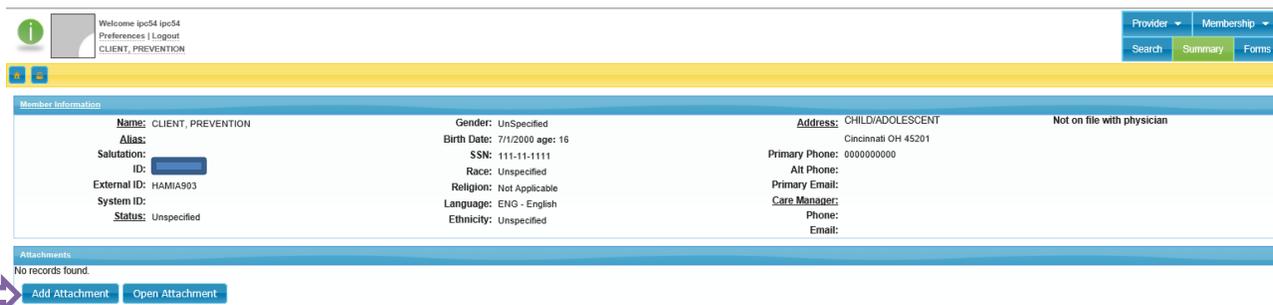
3. **Verify client eligibility for services:**

A. A member may be in SHARES but, for a variety of reasons, not currently eligible for services in Hamilton County (e.g. incomplete application, transfer from a different county). To verify client eligibility for services, check the "Status" on the member Summary page and

insurance on the "Eligibility" page (select Membership then Eligibility tab on navigation bar).

If the "Status" message on the Summary page is "Member Denied," the member application wasn't approved either because the member doesn't meet eligibility requirements or the agency submitting the application failed to provide all required information on the Eligibility and Enrollment form. Click on the underlined word "Status" to see notes related to the member denial (see notes in second screen shot below).

B. If the Status on the member Summary page does not say "Member Denied," go to the Eligibility page by selecting the "Membership" then "Eligibility" tabs on the navigation bar

and review the insurer, dates of the insurance span, and the designated plan as shown below.

If the dates of the insurance span on the Eligibility page do not cover the full range of dates that your agency has been serving the client, and/or the member does not have a current Hamilton County insurance span, agency must complete the SHARES Eligibility Verification Documentation Form, attach it as well as required documentation on the Member Summary page, and send notification email to HCMHRSB staff (rocheller@hcmhrsb.org or monicar@hcmhrsb.org).

Insurers

ID ⬍	Alert	Insurer	COB	Rank	Policy Number	Date From	Date To
378273		Cuyahoga County Board		Unspecified	▬▬▬	3/25/2013	5/5/2014
335800		Franklin County Board		Unspecified	▬▬▬	5/14/2014	12/31/2017

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If the member Eligibility insurance span(s) is for Cuyahoga or Franklin County, it means that this member was either enrolled by a provider in that county or the member was part of that county's member upload (enrolled in MACSIS by that county).

Because this member doesn't have a Hamilton County insurance span, claims submitted by Hamilton providers will deny with the reason of "Service not in Provider's Profile (i.e. rate schedule) until documentation is completed to successfully transfer this member to Hamilton County.

Insurer	COB	Rank	Policy Number	Date From	Date To	Status	Plan
Hamilton County Board		Unspecified	▬▬▬	6/28/2017	6/28/2017	Active	Hamilton Standard

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Because the member's "Date From" and "Date To" for insurance coverage span is the same day, older claims will be denied with the reason of "No Insurance." Claims submitted in the future will not make it to adjudication as the member will be tagged as an Exception on the ECP report.

Step Three: Add Member to SHARES

1. From the Provider Connect home page, add client using either of the following two methods:

   a. Click on the "Membership" tab in the upper right, and select "Add Member", or

   b. Click on the "Membership" box in the middle of the page, and select "Add" from the menu in the bottom portion of the blue box on the right.
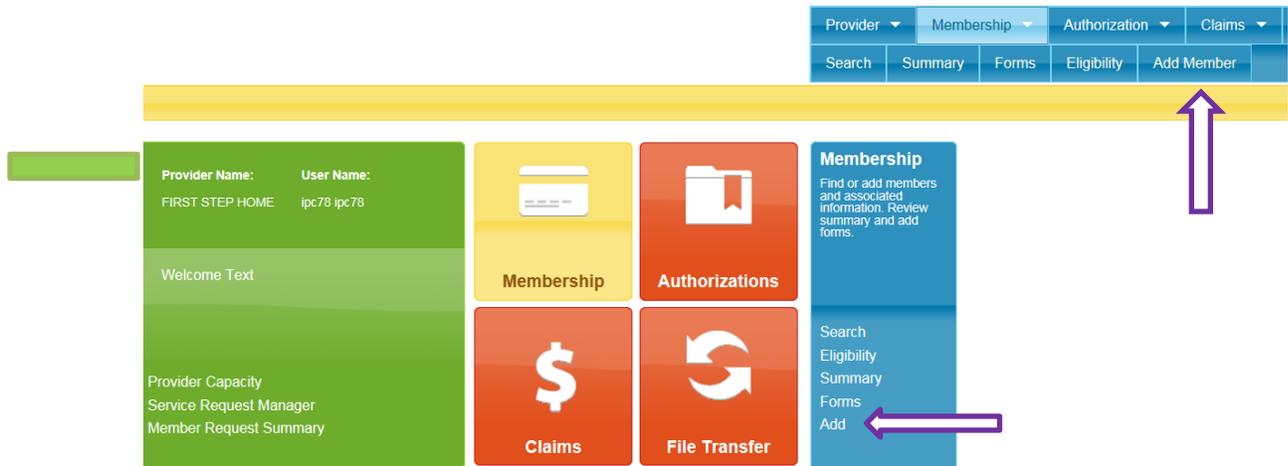
2. Complete the "Add Member" application. Fields highlighted in red font are required. If required fields are left blank, it will not be possible to save the record (add member).

   Note: While Race, and Ethnicity are not indicated as required fields in the SHARES system, they are required by the HCMHRSB. Failure to provide this information will delay application approval and may result in denial of member enrollment. While not required, it is recommended that member Social Security number (SSN) be provided as SSN is used to conduct a member search.

Note: The option "unspecified" should only be used when the information is not known for the client being enrolled. "Declined" should only be used when the client chooses not to share the information.

The underlined blue font text on the Add Member page are links to boxes for providing additional information (e.g. martital status, educations, income, etc.); click on the link to open the text box for that subject. The screen shot below displays the opened boxes.

Add Personal Info   *Add Educational Info*   *Add Special Needs & Accessibility*

Personal

Marital Status:	Veteran Status:	Driver's License No:	Date Issued:	Expiration Date:
--- Select One ---	Unspecified		__/__/____	__/__/____

Education

Grade Level:	Institution Name:
--- Select One ---	

Special Needs & Accessibility

Financial/Ability to Pay: Due Date:
--- Select One ---   ☐ Pregnant?   __/__/____

☐ Handicapped Access ☐ Visually Impaired Assistance ☐ Hearing Impaired Assistance

To select Hamilton County as the insurer, click on the "Select Insurer" button.

Insurance Information

Date From:*	Date To:	Status:
10/06/2015	__/__/____	--- Select One ---

Insurer:*
[   ] Select Insurer

Plan:	Group:

Business Unit:

Leaving the fields in the Insurer Lookup box blank (left screen shot below), click on the "Search" button in the bottom right of the box, and then in the box that opens click on "Hamilton County Board." This will populate the "Insurer" box with "Hamilton County Board."
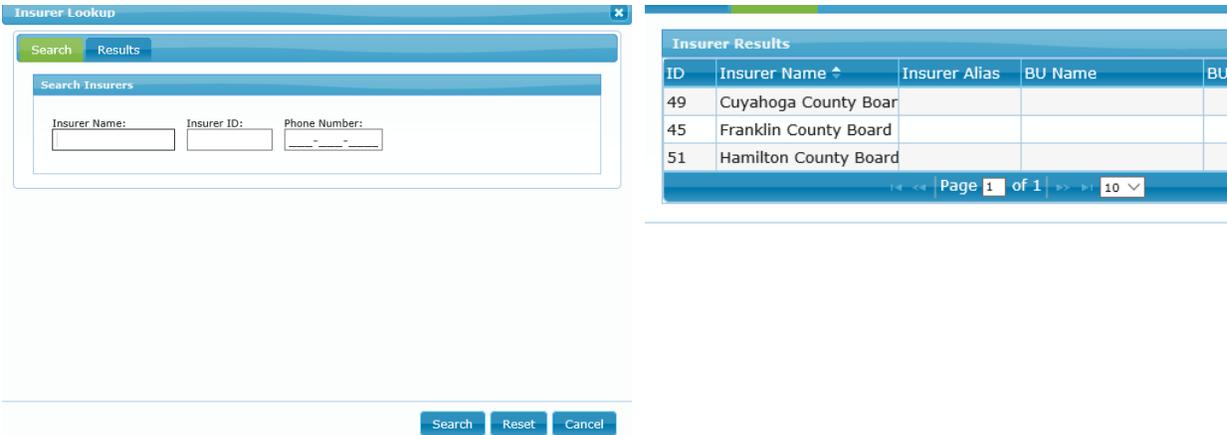
3. Click on the "Save" button in the upper left corner.

4. The "Policy Number" is auto generated. This is the SHARES Client ID.
   Note: Having a SHARES ID does not assure that the client is eligible for services in Hamilton County. The client must be approved and have a current Hamilton County insurance span.

5. Complete Member Eligibility and Enrollment Request Form

After saving the "Add Member" record the "Member Enrollment" form will open in a new window. Complete the form being certain to provide all of the required information listed on the next page and in Attachment B, and then click on "Save." **Never use the "Save as Draft" button on the Eligibility and Enrollment form.**

If additional information needs to be added for the member enrollment application after the enrollment form has been saved, open the member file (using search feature), click on the "Membership" and "Forms" tab in the navigation bar, and then click on the SHARES Eligibility and Enrollment form in the list. Once the form opens, click on the "Edit" button in the upper left corner, add/change information, and the Save the file. *If you update an Eligibility and Enrollment form after the MHRSB has reviewed the member application, notify Board staff that the form has been updated.*

Note: The Eligibility and Enrollment form cannot be updated after a member has been approved.

After saving the initial Eligibility and Enrollment form, a new window will pop up asking if you would like to add another member or go to the "Member Request Summary" page. If you have another member to add, choose "Add Another Member" and repeat the steps in this section. Otherwise, select "Member Request Summary Page" to verify member information and obtain the auto-generated client ID#.

Below is a screen shot of the Member Request Summary page that opens after initially saving the Eligibility and Enrollment form. The Client SHARES ID # is on the far left of the section highlighted in yellow. This ID is utilized to access a member's file and add/modify forms and information.

To view the member's application information, click on their name. Note that the member status at this point is "Member Unprocessed. This is because the HCMHRSB has yet to review the application.

Hamilton County Required Fields in the SHARES Eligibility and Enrollment Request Form:

The following fields must be completed when adding an Eligibility and Enrollment Request form for a Hamilton County client. Failure to provide all required information will result in the member (client) application being pended or denied rather than approved thus preventing the processing of claims for that member.

The items marked with an asterisk must be updated when changes occur or annually by using the SHARES Eligibility and Enrollment Update Form.

A. Provider Screening Date

B. Source of Income *

C. Monthly Modified Adjusted Gross Income (MAGI) Amount *

D. Family/Household Size (# People Dependent on the Monthly Income *

E. Subsidy Scale Percentage *

F. Other Payor/Other Carrier Type (Check all that apply) *

G. Residency Eligibility and Verification: *

1. Is client living at Legal/Primary Residence entered in iPC?

2. Provider reviewed contractually-required residency documentation?

3. Provider attached contractually-required residency documentation to this Enrollment?

   NOTE: Number two (2) **or** number three (3) must have a "yes" response. When the response to #3 is "no," the HCMHRSB may request additional documentation.

H. Clinical – Member Mental Health and Substance Use Diagnosis (Use ICD-10 Diagnosis Codes/Names

   NOTE: Must provide at least one diagnosis

I. Provider attests that all federal, state, and contractual requirement, including but not limited to the following, have been met.

   1. Consent for treatment
   2. Authorizations for release of information
   3. Notices of privacy practices

The SHARES Eligibility and Enrollment Request Form can only be used when enrolling a client (adding member) in SHARES. All updates must be made using the Eligibility Verification Documentation Form (application data) or the Eligibility and Enrollment Update Form (Enrollment Request Form data).

To use the Update form, open member file, click on Membership and Forms, click on the "Other" Folder at the bottom of the page, select the Eligibility and Enrollment Update Form, click on "Add Form", complete only the fields that have changed, and Save the document.

Member Application Review Process

The member application review process occurs as follows:

1. Agency adds member application and completes the Eligibility and Enrollment form (as described previously on pages 8-12).

2. HCMHRSB staff reviews the application and Eligibility and Enrollment form and makes one of three determinations: approve, pend, or deny.

3. Agency goes to the Member Request Summary page to obtain the HCMHRSB determination on the member application, review HCMHRSB notes, and provide additional information as needed.

4. HCMHRSB reviews the modified application and again decides on the status. This process will repeat itself if the client remains in "Pending" status.

Provider Member Request Summary list for all enrolled clients:

1. From the Provider Connect home page, go to the Member Request Summary page using either of the following two methods:

    a. Click on the "Member Request Summary" link at the bottom of the left cube on the home page, or

    b. Click on the "Provider" tab on the blue navigation bar in the upper right of the page and select "Member Request Summary."
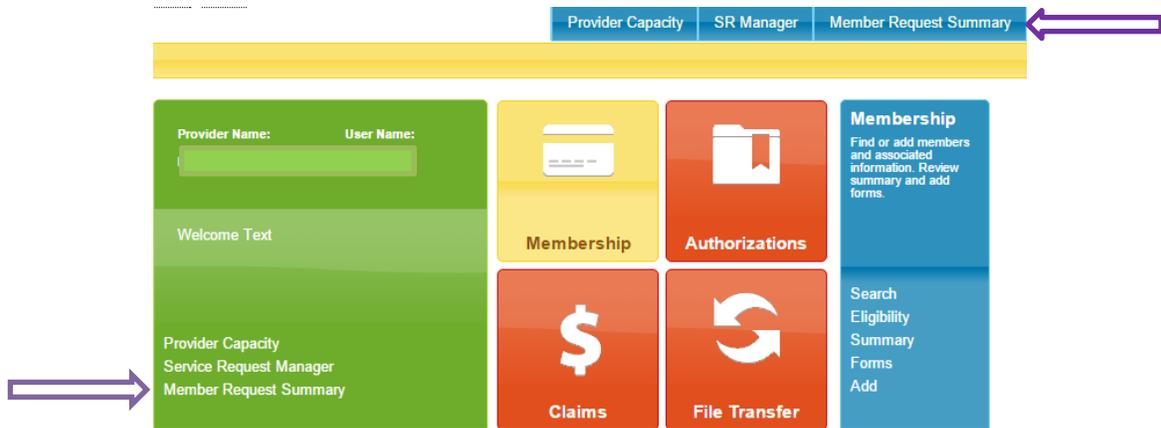
2. For each applicant in the list, note the "Status" column and comments in the Notes box. If a member's status is "approved", verify the insurance start date on the Member Eligibility page. If the status is "denied," it means that the HCMHRSB has determined that the client is not eligible for HCMHRSB funded services. If the member's status is "pending," it means that additional information is needed from the agency (e.g. not all HCMHRSB required fields on the application and/or Eligibility and Enrollment form were completed).

In the example below, the status for Estes Park is "Member Pending" and the note states "Enrollment form is incomplete....items E – Subsidy Scale Percentage, H – Clinical Diagnosis, and I – Consent, Authorization, and Privacy Notification on the Eligibility and Enrollment Checklist are not completed on the enrollment form. Revise and resubmit." (Checklist items are on page 12 and included in Attachment C).

To revise the Eligibility and Enrollment Request form, click on the "Edit" button in the upper left corner of the page, click on the "SHARES Eligibility and Enrollment Request" hyperlink, make changes/additions, Save the form, and email notification to HCMHRSB staff (rocheller@hcmhrsb.org or monicar@hcmhrsb.org).

Note: The Eligibility and Enrollment form cannot be updated after a member has been approved.

3. HCMHRSB reviews the modified application and again decides on the status. This process will repeat itself if the client is in "Pending" status. **An incomplete Eligibility and Enrollment form may result in significant delay in member application approval. If an application remains incomplete longer than 30 days, the member application will be denied.**

Note: The only members that you will find in the Member Request Summary (MRS) are those enrolled by your agency. The MRS should only be used to enroll and track enrollment application process/status. If a member is found in SHARES via a member search but is not in the MRS, it is either because a) the member was being served in our system prior to SHARES (i.e. they were a part of the MACSIS member upload) or b) they were enrolled by a different agency.

Frequently Encountered Enrollment Issues

1. Provider assumes that application is approved and doesn't check the application status.

2. Incomplete member application/enrollment form.

3. Member is in SHARES but not eligible for services in Hamilton County either because:
   a. Member is denied

   b. Member transferred from Franklin or Cuyahoga County, but Insurer has not been updated to a Hamilton Plan

   These circumstances will result in an Exception on the ECP and claims will not process.

   NOTE: The ECP process was modified in July to identify all non-approved members as an Exception. Claims submitted for these members will not go through adjudication.

   The HCMHRSB in in the process of having all claims that were previously approved for non-approved member re-adjudicated to a Denied status.

4. Member information in provider's data system doesn't match member data in SHARES.
   a. Different name spelling, date of birth, and/or social security number in your agency records than what is in SHARES will likely result in the member being designated an Exception on the ECP report.

      To update member data in SHARES, the provider must submit the Eligibility Verification Documentation form and attach member verification documentation.

5. Multiple enrollments for same member.
   a. Accounts will be merged thus potentially leaving agency with the wrong SHARES member ID for data submission

   b. May cause claim to be flagged as an Exception on the ECP report

   c. May result in overlapping insurance spans/plans

   Note: Providers should conduct member search prior to enrolling to avoid duplication.

6. Inaccurate member information provided on member application and enrollment request form.
   a. Provider can correct information on the Enrollment Request Form simply by editing the form.

   b. To correct information on the member application, provider must submit the Eligibility Verification Documentation form, attach member verification

documentation, and email notification of application update to HCMHRSB staff (rocheller@hcmhrsb.org or monicar@hcmhrsb.org).

7. Residency Verification form that list "homeless" as the address.
    a. If an agency indicates that a member is homeless, a Hamilton County Homeless Certification must be attached on the Membership/Summary page.

    b. Failure to submit acceptable forms of verification (Attachment A)
    Acceptable residency verification:

    - Driver License
    - State ID Card
    - Homeless Certification VESTA card (dates cover requested dates of residency – no time limit)
    - Lease agreement
    - Utility bill with the current address
    - Power of attorney papers
    - Guardianship Papers
    - Adoption or custody papers
    - Statement from Client (Signed and Witnessed) Indicating Residency – I.e. JFS Form
    - Mailing address – documents HC address
    - Voting card
    - Car registration
    - Location of family (next of kin provide support)
    - Signed Residency form (with current date)
    - General conduct (Person actions demonstrate MH/AOD services needed with no history homeless certification or outreach connection but clearly can be identify as a Hamilton County resident based on criminal history from the Clerk of Courts website).

    Acceptable supporting documentation for enrollment updates and demographic changes:

    - Intake/Admission Form (for verification of member eligibility/insurance start date)
    - MACSIS member screen shot – **only** acceptable for 2015 October, November, and December intake dates
    - Driver License
    - State ID Card
    - Marriage License
    - Power of attorney papers
    - Guardianship Papers
    - SS Card
    - Homeless Certification VESTA card (dates cover requested dates of residency – no time limit)
    - Lease agreement
    - Utility bill with current address
    - Adoption or custody papers
    - Statement from Client (Signed and Witnessed) Indicating Residency – I.e. JFS Form
    - Mailing address - documents HC address
    - Voting card
    - Car registration
    - Service Authorization/Referral (for Plan change - Authorization should include dates of service)

Adding and Utilizing Ohio Scales Outcomes Instruments and Reports in IPC

The five Outcomes Instruments included in SHARES are adult mental health, youth mental health (parent, youth, and worker versions), and the Brief Addiction Monitor for adult substance abuse. For each survey instrument (form), there is a corresponding real-time, client level report that can be generated.

Steps to Add (complete) an Outcomes Survey:

1. If the member file for whom an Outcome is to be added is not already open, the user can open the member file from the home page by selecting "member" and "search."
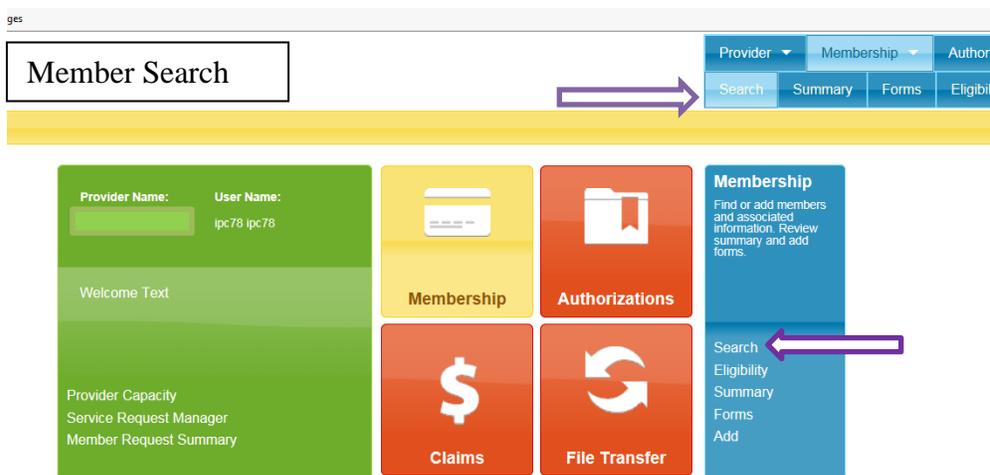
2. Enter the Client ID# in the field labeled "ID" on the member search page and click on the top left "Search" button.
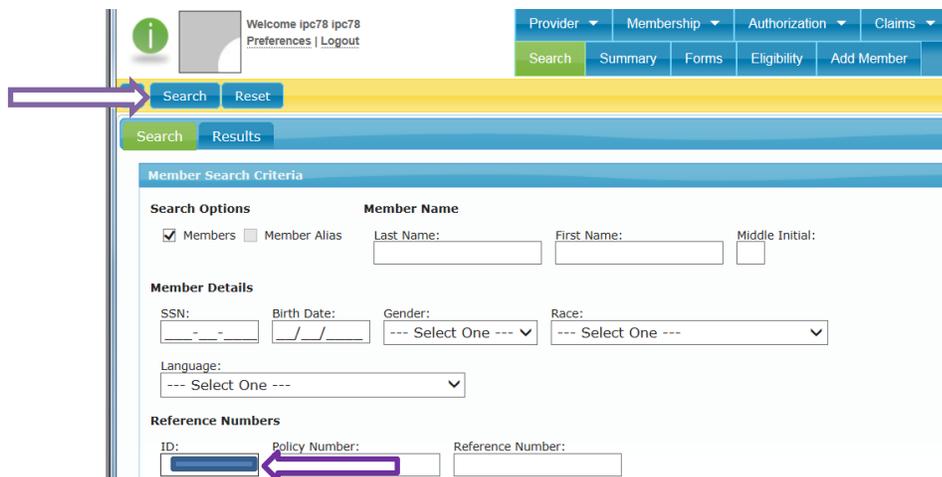
3. When the member name appears, click on it to open the member file.
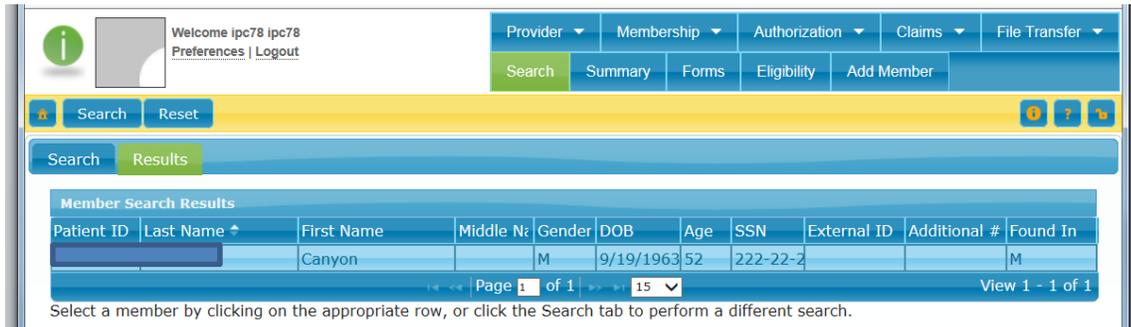
4. Using the tabs in the upper right corner of the page, select "membership" and "forms." This will provide a list of forms previously completed (top portion of page) as well as a list of forms that can be completed (folders on bottom of page).

To complete a new survey, select the "Outcomes" folder, the desired Outcomes survey, and then "Add Form" (see screen shot below).
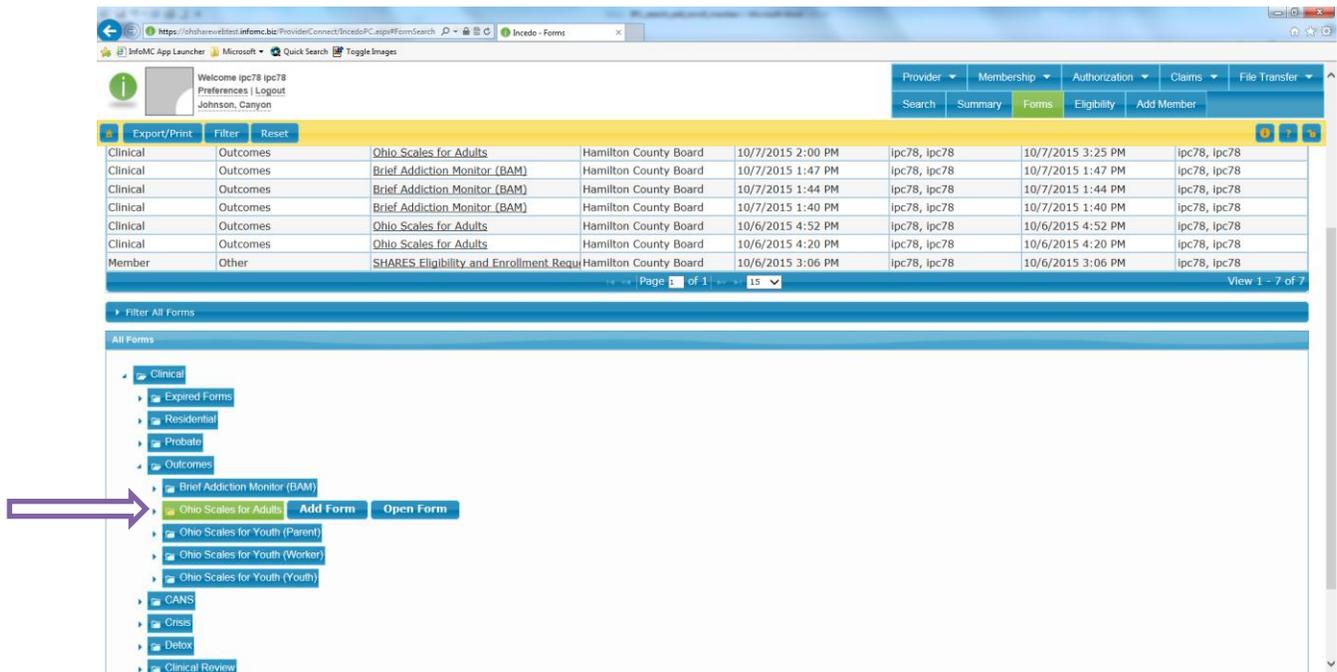
5. The survey form will open in a new window, complete the survey and then click on "Save."
   Note: The Agency ID field is the SHARES ID for each agency.

6. After saving the form, the report generator will automatically open. The report generator page includes a drop-down menu that will list all previous outcomes surveys of the same type administered by your agency.

   If the just completed survey is the initial administration, the drop down will only include the option of "no history" which can be selected to generate a report for that administration. If a prior administration of the survey exists for the member, the drop-down menu will allow the clinician to select the desired T1 administration to be compared with the just saved T2 survey. If there are multiple previous administrations, the clinician will be able to select the particular survey that they want to use as the T1 administration.

Batch Outcome Submission Process

All Outcome batch submissions will be uploaded by agency staff through the SHARES Incedo Provider Connect (iPC) File Transfer Menu**.**

File compression is not supported by the SHARES system, and in order to transmit successfully, the file extension must be .csv. Either upper or lower-case file extensions will be processed.

To upload a batch Outcome file follow the steps outlined below:

Note: While these steps outline the process for the Ohio Scales for Adults instrument, the same steps apply for all instruments, with the exception of selecting a different instrument.

1. From the Provider Connect home screen, select "File Transfer" and then "Upload" using either the modules in the middle of the page or the navigation menu in the upper right corner.
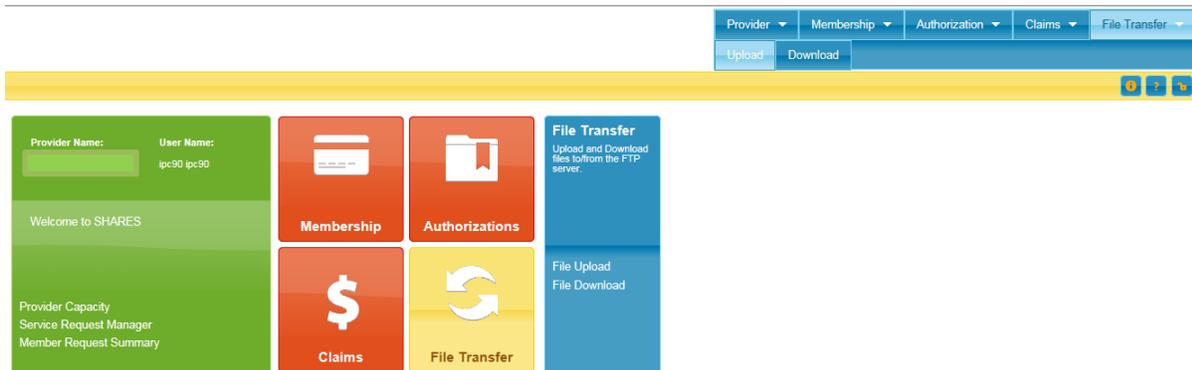
2. When the new page opens, complete the date, select "MH Adult Outcomes Form" from the "File Type" drop down menu, and enter file name. Then click on the "Upload" button (upper left).

   Note: The naming convention for files to be submitted is as follows:
   a. HAMI_AID_AdultOutcomes_yyyymmdd
   b. HAMI_AID_YouthParent_yyyymmdd
   c. HAMI_AID_YouthWorker_yyyymmdd
   d. HAMI_AID_YouthYouth_yyyymmdd
   e. HAMI_AID_BAM_yyyymmdd

3. Click on the "Browse" button to select the desired Ohio Scales for Adults outcome file from your computer for upload, choose "MH Adult Outcomes Form" from drop down menu, add notes to the "Submitter Notes" box as desired, and click on the "Upload" button in the bottom right of the box.

4. After the Batch file has been uploaded, the Upload Status page will open. If this page does not open, click the browser Refresh button. Note: the Result of "Successful" only means that the file was successfully uploaded.

Accessing Existing Forms and Reports in IPC – Filtering

A list of existing forms for all members or agency clients enrolled in SHARES is accessed by logging in but having no member file open and clicking on the Membership and then Forms tab.

A list of existing forms for a member is accessed by opening the member file (via member search), and clicking on "Membership" and "Forms" tab.   If no forms (surveys) appear, it may be because the default filter only searches for the previous two weeks. To access older files, click on the link titled "Filter forms for [client name]," modify the search criteria, then click on the blue "Filter" button.
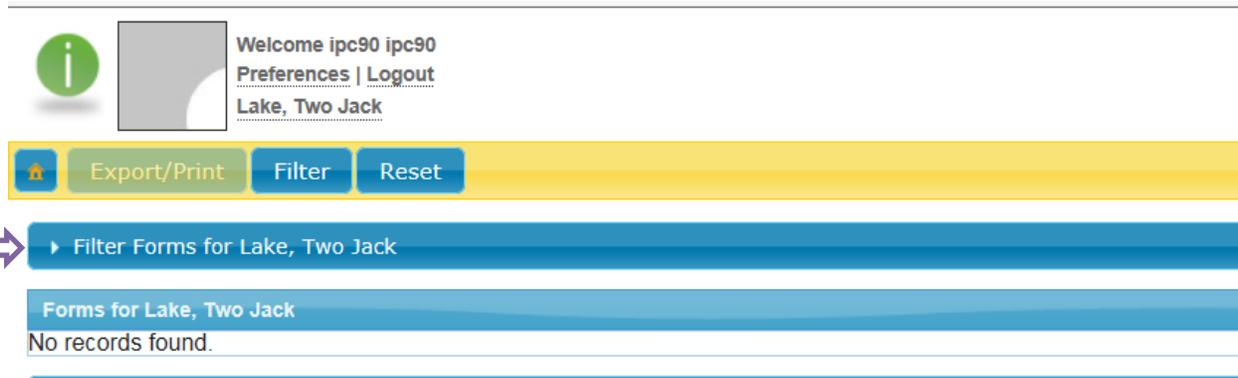
In this example, the date was changed to 10/20/2014 and then the "Filter" (top, next to Reset) button was clicked.
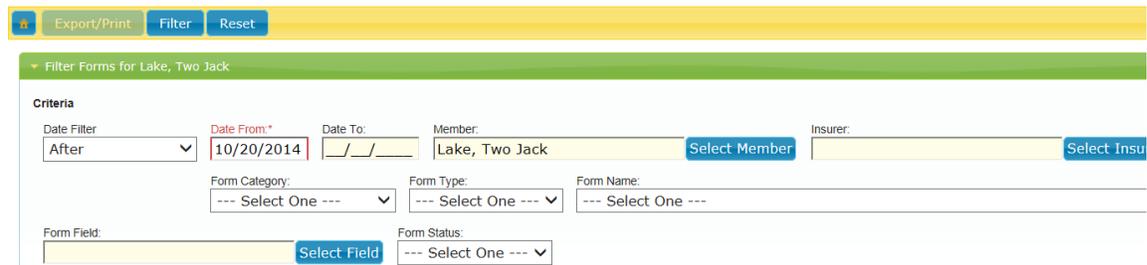
The Filtering process produced three outcome reports. If there were other forms (e.g. Enrollment), they would also appear in the list. To view the form and/or run a report, click on the form name in the list as it serves as a hyperlink.
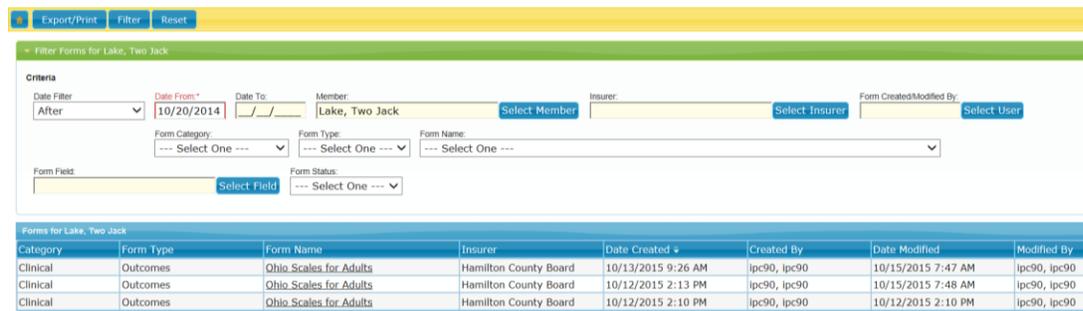
Batch Claims Submission Process

SHARES 837 Guidelines

All 837 Claims batch submissions will be uploaded by agency staff through the IPC File Transfer Menu.

File compression is not supported by the SHARES system, and in order to transmit successfully, the file extension must be .txt or .x12. Either upper or lower-case file extensions will be processed.

SHARES Interchange Requirements: The following values are required as noted in the ISA/GS segments and Loops below.

ISA 05 =	ZZ
ISA 06 =	Agency/Sender Tax ID or NPI
ISA 07 =	ZZ
ISA 08 =	SHARES837
GS 02 =	Agency/Sender Tax ID or NPI
GS 03 =	SHARES837
1000A NM1 09 =	Sender Tax ID or NPI
1000B NM1 09 =	SHARES837
2010BB NM1 03 =	SHARES
2010BB NM1 09 =	SHARES

Transaction Segment Delimiters and Terminators

Required SHARES delimiters and terminators are listed in the table below.   Claims that use other values will be rejected by the SHARES system.

Segment Delimiter	'*' Asterick
Composite Element Delimiter	':' Colon
Segment Terminator	'~' Tilde

Claim Matching

The SHARES client ID (CID) is now required for all 837 transactions within the SHARES claims processing system.   The system matches clients by the SHARES ID along with several matching iterations that include the client name, date of birth and SSN.   Providers are matched first by the National Provider Identifier (NPI).   If there is no match on the NPI the system will match by the provider's Taxpayer Identification Number (TIN).   If either the NPI or TIN are not matched the SHARES claims system has the ability to match on the first 15 characters of the

provider's address.   All unmatched claims will appear on the Electronic Claims Processing Report (ECP) Inventory Report distributed to agency iPC download directories after a claims submission.

Service Line Unit Conversions

The SHARES system is unable to process decimals. With various services, whole units will now need to be divided by 4.   As an example, a previous MACSIS single 60-minute unit of service will need to be billed as 4 15-minute units. For instance, an H0031 assessment of 1 unit = 60 minutes should be billed as 4 x 15-minute units within SHARES. ***Please refer to the handout SHARES Procedure Code Conversions from MACSIS or Board Specific Levels of Care for further information.***

To upload an 837 Batch file, follow the steps outlined below.

1. From the Provider Connect home screen, select "File Transfer" and then "Upload" using either the modules in the middle of the page or the navigation menu in the upper right corner.
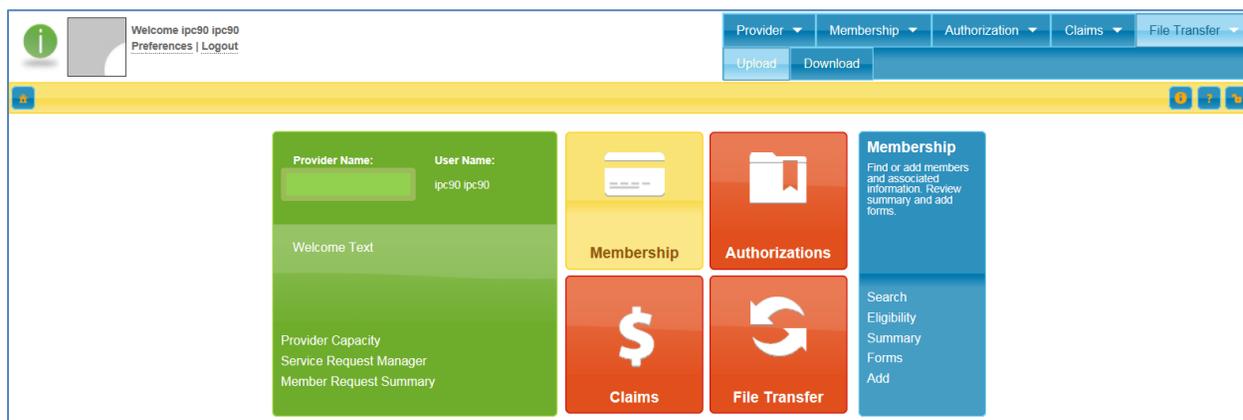
When the new page opens, complete the date, select "837 Claim" from the "File Type" drop down menu, and enter the file name.

File Names

The following file naming convention is required when submitting files.
<Board Acronym><Provider ID><Daily Increment><Date>

- Board Acronym – HAMI
- SHARES Provider ID – DDDD
- Daily Increment – Starts at 01 and increments by 1 for each file sent daily
- Date – YYYYMMDD

Example: HAMI15870120151209.txt

File extensions should be one of the following to transmit successfully: .txt, .x12.   File compression is not supported by the SHARES system and only ASCII text will be processed.

After entering/selecting the information, click on the "Upload" button in the upper left.
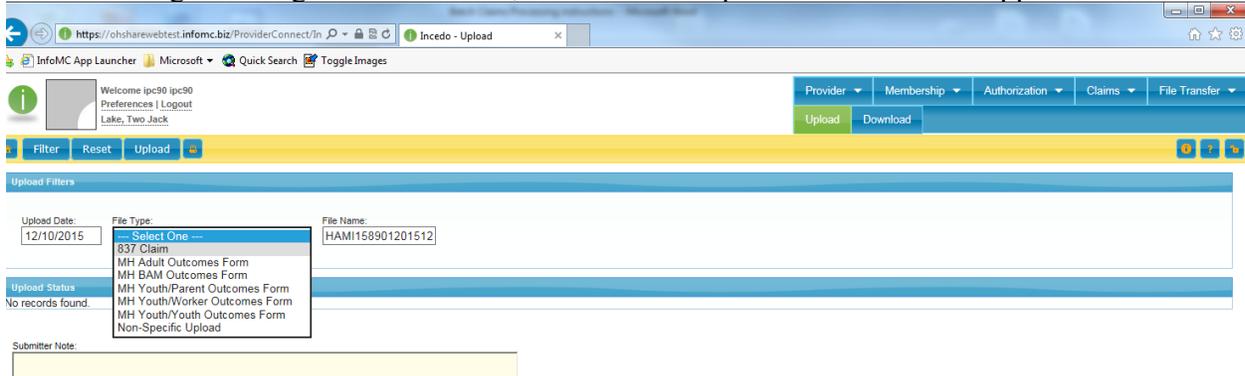
2. Click on the "Browse" button to select the desired 837 file from your computer for upload, choose "837 Claim" from the "File Type" drop down menu, add notes to the "Submitter Notes" box as desired, and click on the "Upload" button in the bottom right of the box.
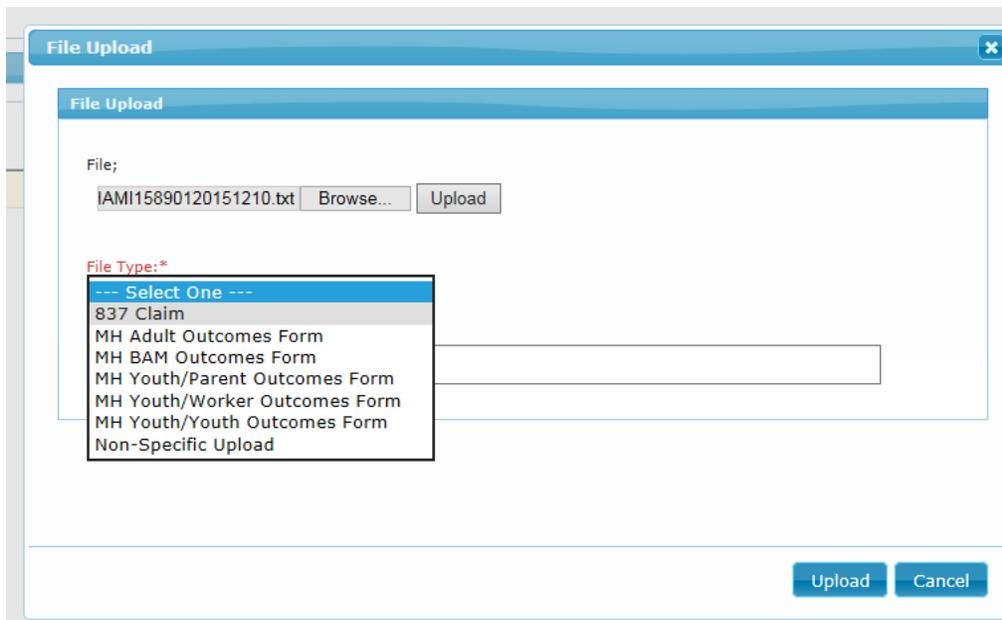
3. The uploaded file will appear in the Upload Status section (bottom) of the page. You may have to refresh the page for the file to appear. The Result of "Successful" only means that the file was successfully uploaded.
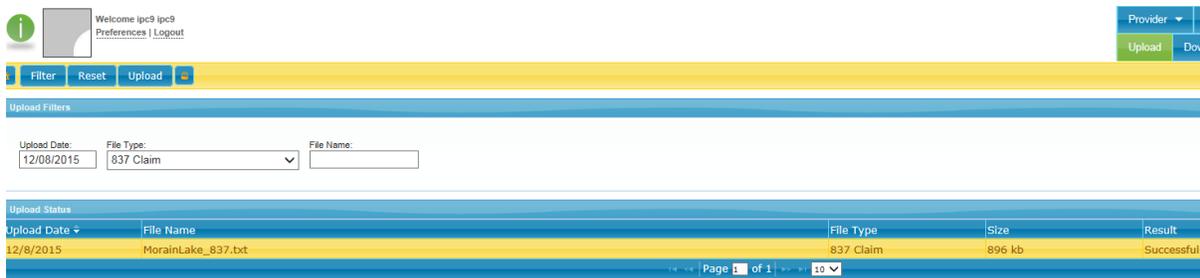
Functional Acknowledgment – 999 Transactions

Each successful upload of an 837 meeting 5010 standards will generate a 999-transaction file available for download by the submitting agency.   The 999 file will follow ANSI standards.   If the 837 batch is rejected due to compliance reasons the 999 Functional Acknowledgements will be not be generated.

It is the submitting agency's responsibility to research and correct any compliance issues prior to resubmittal.   If the 999 does not appear within the agency iPC download directory within an hour the file has typically been rejected.   At this point an agency should refer to EDI error checking software such as Liaison EDI Notepad or similar software to troubleshoot the error. If further assistance is needed after the local EDI error check, agencies may submit a Self-Service Center ticket to receive assistance from HCMHRSB or the software vendor.

To download a 999 Transaction, follow the steps below.   From the Provider Connect home screen select "File Transfer" and then select "Download".

To view the 999 for an accepted claim, double click on the file link.   If a 999 for a submitted file does not appear on the list, it was rejected and will need to be fixed and resubmitted.
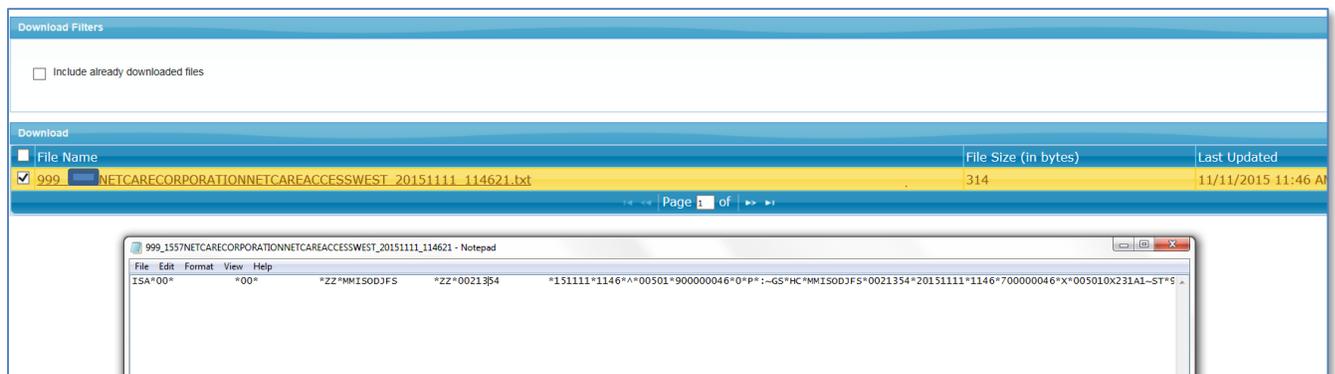
A popup will appear giving the user the option to "Open" or "Save", "Save as", or "Save and open" the 999.

Claims Status: After the 999 is generated, the claims will appear in the Claims section of IPC with a status of "Received".

Tracing 999s To Inbound Files

The inbound 837 filename will not be included in the resulting 999 filenames or within its segments.   However, the 999 Loop 2000 AK202 Transaction Set Control Number can be traced to the 837's Transaction Set Header ST02 (Transaction Set Control Number).   See example below.
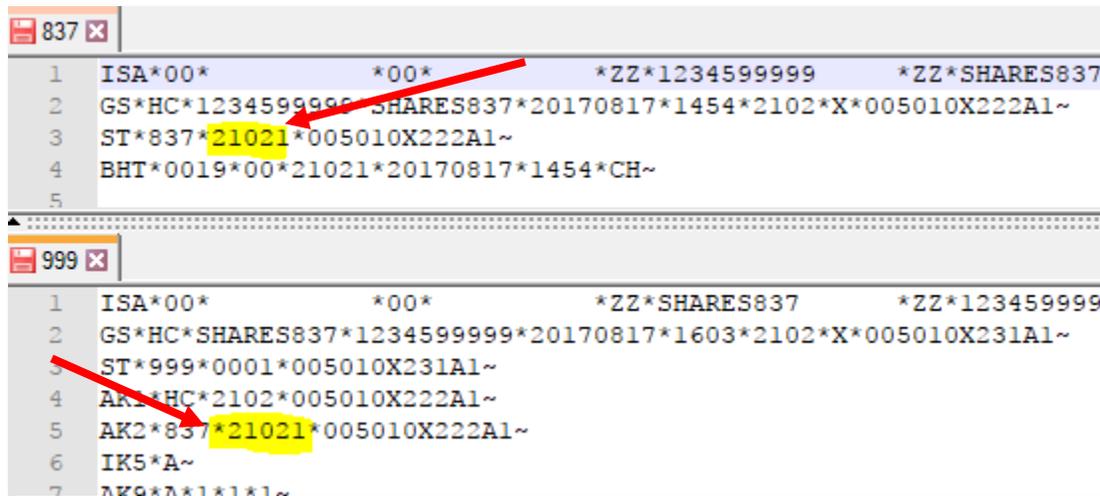
Common File Rejection Reasons:

- 1SA06 Interchange Sender ID – *Agency sending less than 15 characters*

- GS08 Functional Group Header Industry Control Code *--Missing "A1" appendix*

- Loop 2010BA DMG02 Subscriber Demographics *--Client Birthdate Missing*

- Loop 2400 Service Line *--Maximum loop requirement exceeded.   SHARES only allows 50 service lines per claim*

- Loop 2000A --Agency sending Line Adjudication Information segment (SVD) without correlating Date of Adjudication (DTP) segment

Manual Claims Submission Process

1. <u>Conduct search to open member file:</u>

Open a member file by selecting "Membership" and then "Search" using the module in the middle of the page or the navigation bar in the upper right corner.
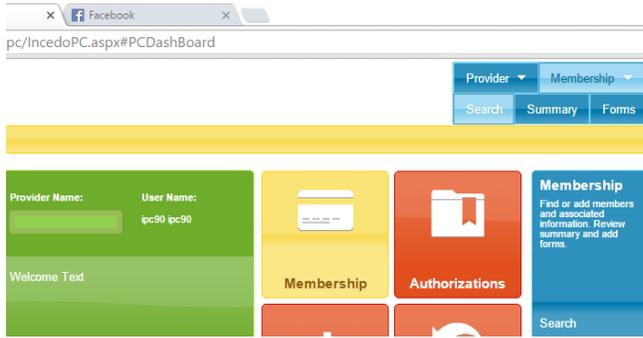
In the Search page, type the client SHARES ID# in the "ID" field and click on the blue Search button in the upper left of box. This will open the Member Summary page. If a member is not found, verify the ID# and that they have been added as a member to SHARES.
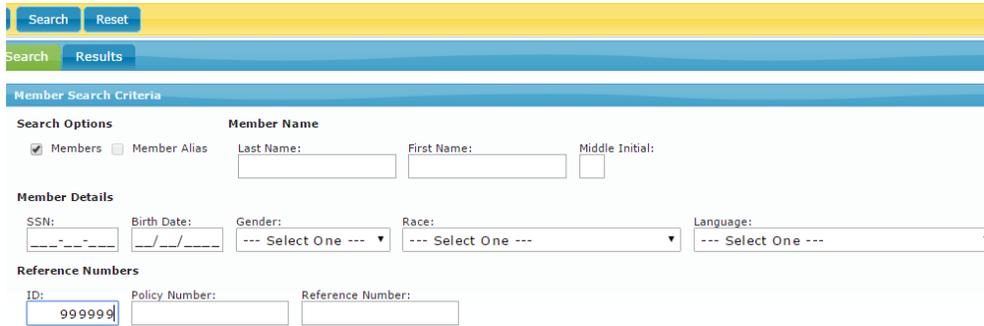
2. <u>Select "Claims" and "Add Claim":</u>
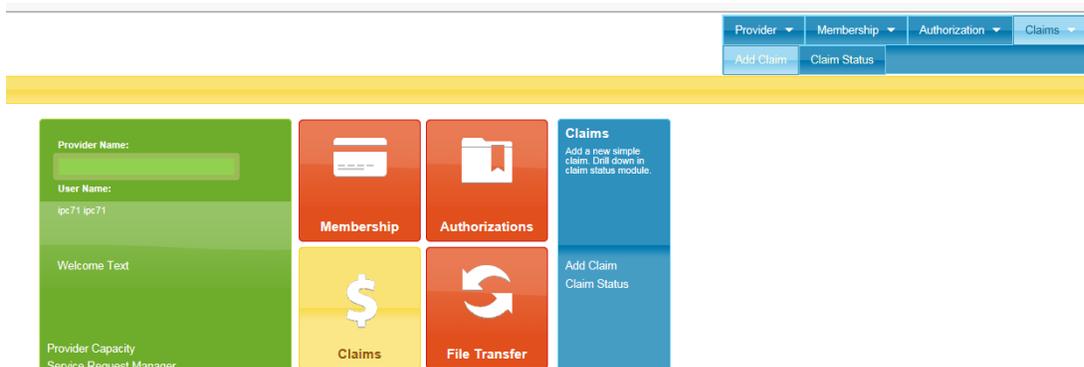
3. Add claim:

Simple Claim submission is a two-step process in which the provider first adds and saves each service and then saves the full claim submission. Up to six services can be added within one claim submission.

To add a claim, the following information is required and is described in detail on the following pages.

- A. Billing Provider (does not appear for all agencies)
- B. Provider to be paid
- C. Service date of claim
- D. Insurer
- E. Service date(s) – From and To
- F. Claimed amount
- G. Units (number of)
- H. Diagnosis
- I. Procedure code
- J. Modifiers
- K. Place of service code

A. ***Billing Provider:*** Select your agency from the drop down menu (field will not appear for all agencies).

B. ***Provider to be paid:*** Select your agency from the drop down menu.

C. ***Service date of claim:*** Enter the date of service for the claim being submitted. **Note:** If the date of service is not entered in this field, and the member's plan has changed sinse the date of service, an incorrect insurer/plan will appear in the Insurance section (D).

D. ***Insurer:*** Select the Hamilton County Board and appropriate plan from the drop down menu.

E. ***Service date (From & To):*** Enter the date of service for the claim being submitted.

F. ***Rate:*** Refer to your Agency rate schedule, *Attachment A, Allocation Summary* of your contract.

G. ***Number of Units:*** The unit definitions for many services in SHARES differs from the existing unit structure. See Attachment at the end of this User Guide.

H. *Diagnosis:*

1) Click on the "Select Diagnosis" button. In the "Diagnosis Lookup" window that opens (left image below), type the member ICD 10 diagnosis code in the "Code/Description" box and then click on the "Search" button.

2) In the "Diagnosis Results" box that opens next (right image below), verify the diagnosis that is listed and then click on it to populate the diagnosis box as demonstrated on the next page.
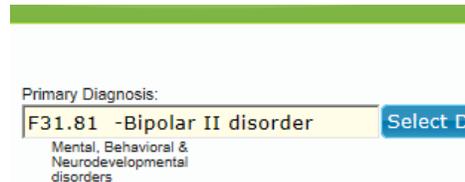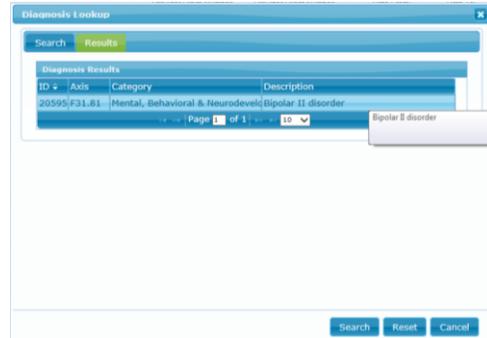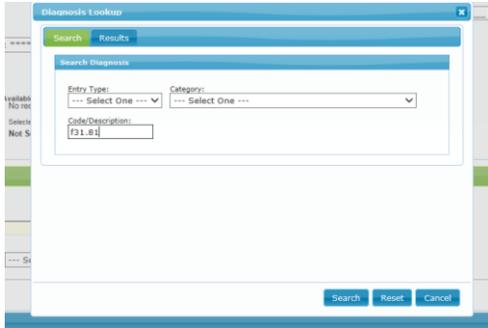
I. *Procedure code:*

1) Click on the "Select Code" button. In the "Code Lookup" box (left image below), type the procedure code in the "Code/Description" field and then click on the "Search" button.

2) In the "Code Results" box that opens next (right image below), verify the procedure code that is listed and then click on it to populate the "Code" box as demonstrated below.
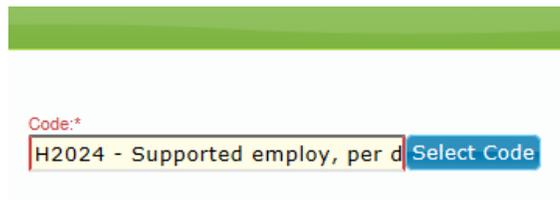
J. *Modifiers:* Use modifiers as assigned for the particular service being claimed.

K. *Place of Service:* Enter place of service code.

After completing all required fields, click on the "Save Service" button in the bottom right corner. Once saved, the claim(s) will appear on the "Services" list at the bottom of the page.

If you want to submit additional services for the member, click on the "Add" button and repeat process described above (#3 Add Claim). If you are done, click the Save button in the upper left corner. **You must click the Save button in the upper left corner before exiting the claim submission page.**

Note: If a mistake has been made in the previously added Simple Claim submission, the service can be edited until the claim is saved. Once saved, a service should not be edited until after the claim has been adjudicated and appears on an adjudication report. *Approved claims should not be edited.* If there is a need to adjust an approved claim (most likely due to inaccurate number of units or incorrect rate), providers must submit a void request for the claims. Once voided, the provider can re-submit the corrected claim.

Once submitted, claims (via 837 and Simple Claims) will appear on the Claim Status page with a "Received" status. During processing, this status can change to Accepted, Accepted with Errors, and In Adjudication.

CLAIMS PROCESSING

The following reports provide agencies with detailed information on claims processing:

1) **999 Functional Acknowledgment report** is generated and available to review by the provider in Incedo Provider Connect (IPC) in File Transfer/download.

   a. When an 837 batch is processed, and accepted by SHARES, the agency will receive a 999.

   b. 999 file will follow ANSI standards.

   c. If the 837 is not accepted in SHARES, it is the submitter's responsibility to research and correct any compliance issues prior to resubmittal.

2) **Exceptions (ECP) Report** is generated and available to review by the provider in IPC in File Transfer/download.

   a. Exceptions Report matches client identifying information on claim submission to members in SHARES.

   b. Both matched and unmatched members will appear on the report.

   c. Provider is responsible to search SHARES for member based on information in report and correct member's information as indicated in SHARES to resubmit claims.

3) **Adjudication Status Report** is generated after the processing of simple claims entered directly in IPC or the successful processing of an 837 file in SHARES. The report is generated and available to review by the provider in IPC File Transfer/download.

   a. **Adjudication Status Report** is generated from either a processed 837 file or simple claims submission and provides information on the submitted claims status.

   b. It is the submitter's responsibility to research and correct any compliance issues prior to resubmittal.

Exceptions (ECP) Report

Once claims are successfully submitted, and the provider receives the 999 report, the claims processing begins to take place. The first significant portion of this process is the claim/member matching. The results are distributed to providers in the ECP report, which can be found in the provider File/Download section of IPC. There is not a one-to-one relationship between claims submission and the ECP report. In other words, multiple batches of claims may appear on one ECP report.

Note: Claim submissions that are listed as an Exception on the ECP report will not adjudicate. The provider must review the ECP report, member information in SHARES, and claim information to determine the error. Once identified and fixed, the claim should be resubmitted.

BatchNur	Patient_ID	MemberName	MemberDOB	Claim_Nun	SS_NUMB	BillingProvider	ServiceDate	ProcCode	LOC_Desc	ClaimStatus	Reason	Charge	create_date
52416	0	Lake, Emerald	1/20/1950			Center	11/8/2016	H0020		Exception	Unable to match a member using DOB Last Name First Name SSN Policy Number	$16.87	5/5/2017
52416	0	Lake, Emerald	1/20/1950			Center	11/9/2016	H0020		Exception	Unable to match treatment provider site.	$16.87	5/5/2017
52416	0	Lake, Emerald	1/20/1950			Center	11/10/2016	H0020		Exception	No unique level of care is available for selected CPT code	$16.87	5/5/2017
52416	0	Lake, Emerald	1/20/1950			Center	11/12/2016	H0020		Exception	Member does not have a treatment for specified provider and level of care	$16.87	5/5/2017

BatchNur	Patient_ID	MemberName	MemberDOB	Claim_Nun	SS_NUMB	BillingProvider	ServiceDate	ProcCode
52416	0	Lake, Emerald	1/20/1950			Center	11/8/2016	H0020
52416	0	Lake, Emerald	1/20/1950			Center	11/9/2016	H0020
52416	0	Lake, Emerald	1/20/1950			Center	11/10/2016	H0020
52416	0	Lake, Emerald	1/20/1950			Center	11/12/2016	H0020

LOC_Desc	ClaimStatus	Reason	Charge	create_date
	Exception	Unable to match a member using DOB Last Name First Name SSN Policy Number	$16.87	5/5/2017
	Exception	Unable to match treatment provider site.	$16.87	5/5/2017
	Exception	No unique level of care is available for selected CPT code	$16.87	5/5/2017
	Exception	Member does not have a treatment for specified provider and level of care	$16.87	5/5/2017

Note: If you see a reason like "Member does not have a treatment for specified provider and level of care, No unique level of care is available for selected CPT code," look at the procedure code….most often, it is an invalid procedure code for your agency.

M3148   Exception   Member does not have a treatment for specified provider and level of care,
                 No unique level of care is available for selected CPT code

Adjudication Process

Claims that match in the Electronic Claims Processing (ECP) go through a multi-step process before and throughout adjudication:

1. Claims bump up against the Third Party Liability (TPL) matrix to determine if the claimed procedure code is for a Medicaid billable service.

   A. If it is not a Medicaid billable service, the claim proceeds to adjudication.

   B. If it is a Medicaid billable service, the SHARES System checks for an existing Medicaid Coordination of Benefits (COB) insurance span on the claimed date of service.

      A) If a COB is found, the claim is denied for "Medicaid Non-Covered Service." The agency is responsible for submitting the claim to MITS.

      B) If a COB is not found, the claim is given a status of "Pending Eligibility Verification," and the member is included in the Health Care Eligibility Benefit Inquiry 270 file that goes to the state (Medicaid Dept.) to determine whether the individual had Medicaid on the date of service.

2. All claims go through adjudication, with those that go up on the 270 listed as "Pending Eligibility Status" on the adjudication report.

3. The 271 Health Care Eligibility Benefit Inquiry response from the state and the SHARES system:

   A. SHARES creates a Medicaid COB for all Members who were found to have Medicaid in the 271 response.

   B. SHARES adjudicates claims for members who return on the 271:

      A) If no Medicaid is found, the claim is either approved/accepted for payment or denied for some reason other than Medicaid (e.g. No Insurance),

      B) If Medicaid is found, claim is denied for Medicaid Non-Covered Service. Agency is responsible for submitting the claim to MITS.

IPC Claim Status Page

You can access your agency's claims by selecting the Claims and then Claim Status tabs on the navigation bar. The top portion of the Claim Status page is for filtering. Claims can be filtered by service date(s), claim submission date, claim status, procedure code/service, modifiers, claim number, member and insurer.

The default filter is the "Claims Received After" field, which has a default date of one month prior to the current date. To remove data from this or any field, double click on the field to highlight the filter data, hit "Delete" on your keyboard, and then select the "Filter" button in the upper left hand corner.

The bottom portion of the claim status page is where the claims are listed. Claims may have one of four statuses: Accepted, Accepted with Errors, Received, and In Adjudication.

Accepted with Errors: This claim status means that there was a problem with the submission and that the claim will not adjudicate. The most common reason for this status is issues with member matching. When this status appears, check the ECP for Exception and then the claim for errors. Below is a screen shot of claim that has Accepted with Errors status.

To view claim detail: click on the plus (+) sign on the left. To edit a claim, click on the claim number. To see additional information for a given field, hover over the i icon. For example, when hovering over the i for the Total Non-Approved column, the denial reason is provided.

Note: The Treat Date column is not the date of service. To see the date of service, you must click on the plus (+), which opens the claim detail.

Adjudication Detail Report:

Claims that have gone through adjudication will appear on an Adjudication Detail Report accessed in the IPC Download folder. There is not a one-to-one relationship between claims submission and the Adjudication Detail Report. In other words, multiple batches of claims may appear on one adjudication report.

Adjudication Status Detail Report Field Key	
Provider ID	Agency SHARES ID number
Provider name	Agency name
Tax ID	Agency Tax ID number
NPI	Agency National Provider Identifier
SHARES patient ID	Client/member SHARES ID number
Last name	Client/member last name
Middle	Client/member middle name
First Name	Client/member first name
Date of birth	Client/member date of birth
SHARES span start date	Date insurance began for current client/member insurance span
SHARES span end date	Date insurance ends for current client/member insurance span
Board	Name of county Board that claim was submitted to
Benefit plan name	Name of benefit plan for client/member (Standard, FAIR, HOPE, Journey)
Level of care description	Description of service and procedure code -long
Type	Mental Health or AOD Service
Mode	Not currently used in Hamilton County
Intensity	Not currently used in Hamilton County
Procedure code	Service procedure code for billed claim
Procedure code description	Description of service - short
Modifier code 1	two-character code for 1st modifier
Modifier code 2	two-character code for 2nd modifier
Modifier code 3	two-character code for 3rd modifier
Modifier code 4	two-character code for 4th modifier
Place of service	Two-digit code identifying place of service
Principle diagnosis	Member diagnosis
Admitting diagnosis	Not used in Hamilton County
Other diagnosis 1	Additional diagnosis
Other diagnosis 2	Additional diagnosis
Claim batch date	Date claim was adjudicated
Claim batch number	Number assigned to adjudication batch
Claim master ID	Unique identifier assigned by vendor - provider will need for claim inquiry/reversal requests
Claim detail ID	Unique identifier assigned by vendor - provider will need for claim inquiry/reversal requests
Claim number	Unique identifier assigned by vendor - provider will need for claim inquiry/reversal requests
Line item control number	Sub number for claims with multiple service lines
Authorization number	Currently not being used in Hamilton County
Status ID	Numeric status of claim: 1 = approved, 2 = pended, 3 = denied
Adjudication status	Text status of claim: approved, pended, denied
Adjudicated amount	total claim amount for service
Adjudication reason	Description of reason for adjudication status
Date of service	Date on which service was provided (claim date)
Date received	Date simple claim/837 file was received into SHARES
Date entered	Date simple claim/837 file was entered into SHARES
Last processed on	Date simple claim/837 file was last touched in SHARES
Units	Number of units for claimed service/procedure code
Contract rate	Unit rate for claimed service/procedure code
Total claimed amount	Number of units multiplied by the unit rate for the service/procedure code
Payable amount	Amount approved for payment
Copay	Not currently used in Hamilton County
Withheld amount	Not currently used in Hamilton County
Deductible	Not currently used in Hamilton County
Other paid amount	Not currently used in Hamilton County
Coinsurance amount	Not currently used in Hamilton County
Post date	Date report was posted in IPC

How to Use the Report, What to Look For:

The adjudication report gives a point in time status of a claim. The status of the claim can change, and when it does, appear on a future report. Likewise, if a claim on the report had been previously submitted, the status of that claim on this report could be different than the status on the initial or previous reports. For these reasons, it is important to look at the full history of a claim across all adjudication reports that the claim was on.

Whether utilizing a database, spreadsheet, or some other data collection mechanism, agencies may want to have a master document that includes claims from all adjudication reports. This allows the ability to see the full history of a claim as well as issues that may need to be addressed.

The data can be sorted, filtered, or queried to:

1. Determine the status of claims/identify claims not approved for payment.

   In a file that includes all claims for the agency, sort the data using the following order.

a. SHARES Patient ID b. Date of service c. Procedure code d. Modifier 1 e. Modifier 2 f. Date entered (most recent first) or Last processed on.	

This clumps all submissions of a claimed service together with the most recent listed first. Claim status will be evident.

Claimnumber	Adjudicated	Adjudicationreason	Dateofservice	Datereceived
	69.5	Duplicate Claim	5/15/2017	8/10/2017
	57.61	Contract Amount	5/15/2017	6/27/2017
	11.89	Exceeded Amount	5/15/2017	6/27/2017
	57.61	Required modifier 2 is missing/invalid.	5/15/2017	6/5/2017
	57.61	Required modifier 2 is missing/invalid.	5/15/2017	6/8/2017

Another example:

AE	AJ	AK	AL	AM
Claimnumber	Adjudicat	Adjudicationreason	Dateofservice	Datereceived
	26.88	Contract Amount	1/2/2016	7/27/2016
	64.51	Exceeded Amount	1/2/2016	7/27/2016
	70.56	Duplicate Claim	1/2/2016	8/30/2016
	94.08	Duplicate Claim	1/2/2016	12/13/2016

2. Find members with problematic insurance coverage needing attention.

   Denial reason of No Insurance, Insurance Terminated, and Service Not in Provider's Profile are indicative of insurance coverage issues that need to be addressed before a claim for the member will be approved.

   In a file that includes all claims for the agency, sort the data using the following order.

   g. Adjudication reason
   h. Patient ID

1320					201701362918	2017(	Denie	178	No Insurance
1820					201701376601	2017(	Denie	98.4	No Insurance
1822					201701376613	2017(	Denie	98.4	No Insurance
0740					201701114113	2017(	Denie	67.9	Service not in Provider's Profile
9195	4/1/2015	12/31/2020	Hamilton	Fair	201701155671	2017(	Denie	34.5	Service not in Provider's Profile
6612					201701423486	2017(	Denie	46.6	Service not in Provider's Profile
5555					201700494867	2017(	Denie	96.9	Insurance Terminated
5555					201700494868	2017(	Denie	96.9	Insurance Terminated
5555					201700635511	2017(	Denie	96.9	Insurance Terminated

Another way to identify members with problematic insurance is to look at the Shares span start date and Shares span end date columns in the adjudication detail report. If there is no date, it typically means the member does not have insurance.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Provide	SHARESp	Sharesspan:	Sharesspaner	Board	Levelofcaredescription	Procedu	Mod	Mod	Modi	Modi	Plac	Princi
57620	9999					OP Mental Health CPST H0036HE-Comm	H0036	HE	99	MH	MH	99	F33.2
57621	9999					OP Mental Health CPST H0036HE-Comm	H0036	HE	99	MH	MH	99	F33.2
57747	9999					OP Mental Health Community Supports	Z1304	HE	99	MH	MH	99	F25.0
63145	9999					OP Alcohol & Drug Outpatient Treatme	H0005	HF	99	HR	IN	11	F11.1(

No Insurance:

There are two reasons for the claim denial of No Insurance:

1. Member is not approved (denied, pended, or unprocessed) **and** insurance span is closed.

   The Status on the member summary page (Membership and then Summary navigation tabs) shows that the member is denied, and the insurance span on the Eligibility page is closed.

Alias:		Birth Date:
Salutation:		SSN:
ID:		Race:
External ID:		Religion:
System ID:		Language:
Status:	Member Denied	Ethnicity:

   Relationships

Insurer	COB	Rank	Policy Number	Date From	Date To	Status	Plan
Hamilton County Board		Unspecified		7/25/2016	7/25/2016	Active	Hamilton Fair

   In July 2017, the Board requested a re-adjudication to address claims for members who had been in, or remain in, Denied/Pended/Unprocessed status. This resulted in changes to status for some claims previously approved for members with Denied/Pended/Unprocessed status:

   a. For members who remain in Denied/Pended/Unprocessed status, the re-adjudicated claims changed from Approved to Denied. For these claims to be approved, provider must provide the documentation required to verify member is eligible for services in Hamilton County.

   b. For members who were approved after the claim submission, the claim status did not change unless if the claim date of service is outside the date range of the insurance span.

2. Member is approved, but service date of claim does not fall within the member's insurance span.

   Example: Member Insurance Span (Eligibility Page) shows coverage dates of 7/13/17 through 12/31/2020. Because the Date of Service on the claim is 7/6/17, the claimed denied for No Insurance.

Edit	Save	Cancel	Delete	🔒						Add M

Alert	Insurer	COB	Rank	Policy Number	Date From	Date To	Status	Plan	Gr
	Hamilton County Board		Unspecified	▬▬▬	7/13/2017	12/31/2020	Active	Hamilton Fair	

|◀ ◀◀ Page 1 of 1 ▶▶ ▶| 10 ⌄

	A	B	C	D	K	L	M	N	O	P	Q	R	S
1	SHARESpa	Sharesspa	Sharesspa	Board	Adjudicati	Adjudicat	Adjudication ⊤	Dateofservic	Units	Contrac	Totalclaime	Payableamount	
104	999999				Denied	213.06	No Insurance	7/6/2017	0	0	213.06	0	

Service Not in Provider's Profile:

This denial reason occurs when the claimed service is not in the provider's agreement. Typically, this occurs when a claim is submitted for a member who has a Cuyahoga or Franklin County insurance span.

The example below shows a Franklin span for a member who had claims submitted by a Hamilton County provider. The denial reason was Service Not in Provider's Profile because the Hamilton County agency doesn't have a provider agreement with the Franklin Board.

dit	Save	Cancel	Delete	🔒						Add Mer

Alert	Insurer	COE	Rank	Polic	Date From	Date To	Status	Plan	Gro
	Franklin County Board		Unspecified	▬	3/1/2013	12/31/2017	Active	Franklin Standard	
	Hamilton County Board		Unspecified	▬	8/3/2005	2/28/2013	Active	Hamilton Standard	

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Insurance Terminated:

This denial reason will appear when the date of service falls after the date in the "Date To" (i.e. insurance span end date) field.

Claim Denial Reasons & Fixes

Adjudication Reason	Meaning	Adjudication Status	How to Fix if required
Contract Amount	Claim was approved	Approved	No further action required
Zero Amount Claimed	Payment Process External to SHARES	Accepted	No further action required
Pending Eligibility Verification	Claim status pended until 271 is returned and processed	Pended	No further action is required at this time. Check future adjudication report for claim status post 271 return.
Exceeded Amount	The contract rate was approved but claimed amount that exceeded the contract rate was denied.	Denied	Verify contract rate for service. If the correct amount was approved for payment, adjust future claims to reflect correct contract rate.
No Insurance	Member is denied pended or unprocessed or claim falls outside of insurance eligibility dates.	Denied	Refer to the "Verify client eligibility for services" section of User Guide (pages 6-8).
Medicaid Non-Covered Service	Medicaid Eligible during date of service	Denied	Bill MITS
Modifier 1 Invalid/ Missing	Modifier 1 is either missing or invalid	Denied	Add or correct Modifier 1 and resubmit claim
Modifier 2 Invalid/Missing	Modifier 2 is either missing or invalid	Denied	Add or correct Modifier 2 and resubmit claim
Modifiers 3 and 4 Invalid/Missing	Modifiers 3 & 4 are either missing or invalid combination	Denied	Add or correct Modifiers 3 & 4 and resubmit claim
Diagnosis Required on All Claims	Diagnosis is missing or invalid	Denied	Add or correct diagnosis and resubmit claim
Insurance Terminated	Insurance terminated as member was discovered to be ineligible for services.	Denied	Refer to the "Verify client eligibility for services" section of HCMHRSB SHARES User Guide (pages 6-8).
Invalid Diagnosis Effective Date	Not a billable or specific ICD-10-CM diagnosis code as there are codes	Denied	Look up the corresponding sub-code and resubmit claim using that code (e.g. F34.8

	below it that describe the diagnosis in greater detail		denied, resubmit using the appropriate correct code of F34.81 or F34.89).
Clinical Denial	If the confirmation status for a service unit is denied, the system denies the claim. Number of claimed units exceeds number of days in claimed service date range	Denied	If claim denies for this reason, and the number of claimed units is equal to the number of days in the date range, submit ticket to help desk.
Corrected Claim	Claim has been corrected after adjudication	Denied	Check future adjudication report for status of corrected claim
Duplicate Claim	Claim has already been submitted and approved for payment	Denied	No further action is required unless if the approved amount is inaccurate, in which case a void request must be submitted and the fixed claims re-submitted.
Invalid LOC/Modifier/Place of Service combination	Place of Service is either missing or invalid	Denied	Add or correct Place of Service
Unclear Claim	Voided Claim	Denied	Resubmit claim
Service Not Authorized	Claim date for service does not fall within the date range specified for the service in the provider's agreement or the submitted procedure codes does not match the stored level of care procedure code.	Denied	Verify claimed service code is a contract service of your agency. If procedure code and LOC do not match, submit ticket to help desk.

Service Not in Provider's Profile	Claimed service is not in the provider's agreement. Typically, this occurs when claim is submitted for a client who is not insured by Hamilton County.	Denied	Check to assure member's insurance is for Hamilton County
Invalid Units	The number of units submitted is not consistent with the dates of service that were submitted, or an incorrect unit measure was used.	Denied	Provide the correct unit amount and measure and resubmit
Bill Type Missing	If claim submitted does not contain a bill type, the system denies the claim for this reason.	Denied	At this time HCMHRSB contract providers should not see this denial reason. If claim denies for this reason, submit ticket to help desk.

Claim Void Process

When a claim is voided in SHARES, that claim is meant to nullify an original claim. Only approved claims are voided. The provider initiates the void request by following the Void Process identified in the SHARES User Guide.

A voided claim will appear on the adjudication report as a denied claim with the adjudication reason of "unclear claim".

Reasons to Void a Claim:

1) Provider identifies detail of the claim was submitted in error (i.e., # of units incorrect, 3rd & 4th modifier incorrect).

2) Provider identifies services were billed to the wrong member.

3) The claim was approved for payment by HCMHRSB, but later the provider received payment from other insurer for same service.

Void Request:

1. Providers will submit a 3C HelpDesk ticket with a classification category "Void Claims" under Claims/Enrollment.
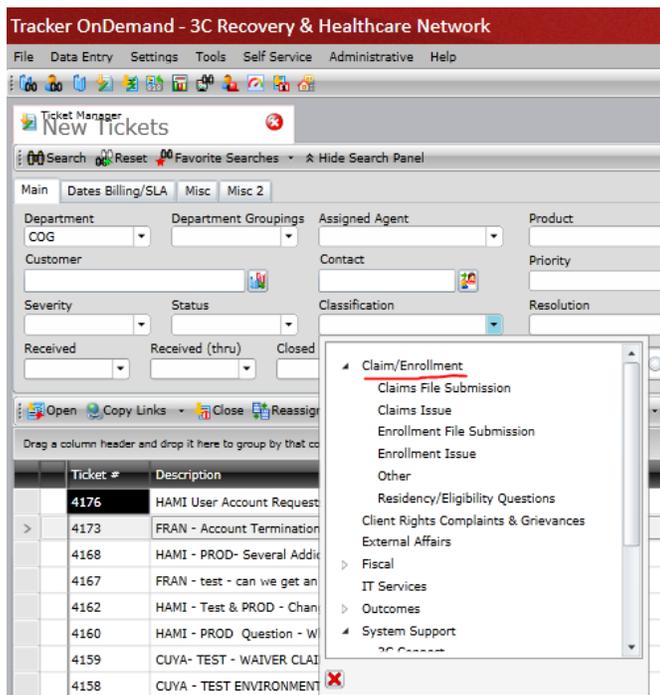
2. Provider will provide the following information –

 A) Ticket Description: **HAMI-iPC #### (Provider ID) - VOID Claims**
 Example iPC 9999 WYOMINGYOUTHSERVICES VOID Claims

 B) Add Journal Entry:

 Example: Please process the attached file – include file name
  Provider ID_Provider name_VOID_Submission Date(mmddyyyy)_Sequence Number
  Add Attachment - Include the file

  File naming convention –
  Provider ID_Provider name_VOID_Submission Date(mmddyyyy)_Sequence Number .

  Example 9999_WYOMINGYOUTHSERVICES_VOID_09302016_1

  Sequence number in case providers have more than one file with same date. **Providers should increment the sequence numbers if they are sending multiple files on the same day**. If files are not correctly named they could be overwritten and will not be placed in the ftp folder. Board Admin will be notified in this situation.

3. File will include the following columns from the adjudication report. Highlighted columns are not required and will not be included [**NO PHI**]

 Provider ID
 Provider name
 Tax ID
 NPI
 SHARES patient ID
 Last name
 Middle
 First Name
 Date of birth
 SHARES span start date
 SHARES span end date
 Board
 Benefit plan name
 Level of care description
 Type
 Mode
 Intensity
 Procedure code
 Procedure code description

Modifier code 1
Modifier code 2
Modifier code 3
Modifier code 4
Place of service
Principle diagnosis
Principle diagnosis description
Admitting diagnosis
Other diagnosis 1
Other diagnosis 2
Claim batch date
Claim batch number
Claim master ID
Claim detail ID
Claim number
Line item control number
Authorization number
Status ID
Adjudication status

Adjudicatedamount
Adjudicationreason
Date of service
Date received
Date entered
Last processed on
Units
Contract rate
Total claimed amount
Payable amount
Copay
Withheld amount
Deductible
Other paid amount
Coinsurance amount
Post date

HAMI Adjudication reports prior to 9/26/2016 will include the following fields:
Claim_num
Auth_numb
Adjud_date
Prov_id
Patient_id
Last_name
First_name
Procmodcode
Adjud_doll

4. Ticket will be assigned to COG

5. COG will send the ticket to BPO and place the file in the VOID folder on ftp. The journal entry will explain the process by vendor to complete the void. See ticket journal entry detail:
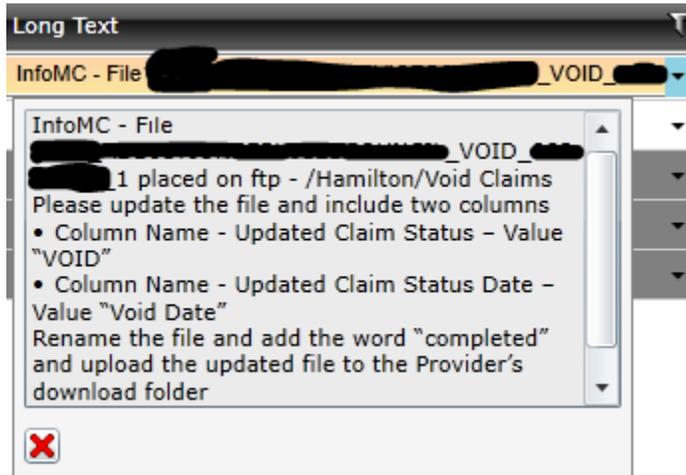
6. BPO will process the file.

7. After the process is complete, BPO will update the file and include two columns after Post Date to indicate the changes that were made
   - Column Name - Updated Claim Status – Value "VOID"
   - Column Name - Updated Claim Status Date – Value "Void Date"

8. BPO will rename the file and add the word "completed" and upload the updated file to the Provider's download folder

   (Provider ID_Provider name_VOID_Submission Date_Sequence Number_completed)

9. BPO Ticket Status will be updated to "Resolved."

10. COG will update 3C HelpDesk ticket and re-assign ticket to the Board Admin

ATTACHMENT A

Hamilton County Mental Health and Recovery Services Board
SHARES ELIGIBILITY VERIFICATION DOCUMENTATION FORM

The HCMHRSB Eligibility Verification Documentation Form should be used when an agency requests a change to the **name, date of birth, SSN, address, or service intake date** for a member previously enrolled in SHARES. Please check the appropriate box for only those items that need to be changed and provide the data currently in SHARES along with the desired change.

Once the form is complete, attach the form and verification documentation for all items marked with an "X", to the member in SHARES (Member/Summary page), and notify HCMHRSB staff (Rochelle Render, Monica Reed) by email of the desired request. (See User Guide pgs. 5 and 6). Acceptable supporting documentation see Attachment A.

Agency Provider ID: _____   Staff Name: _____

SHARES ID: _____   Date of Request: _____

Current Insurer: _____ Hamilton   _____ Franklin   _____ Cuyahoga

"X" Box to identify data to change		Data Currently in **SHARES**	Corrected Data
	First Name		
	Last Name		
	Date of Birth		
	Social Security		
	Address		
	Service Intake Date		
	Plan Change		

ATTACHMENT B

HAMILTON COUNTY MHRSB Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards

1. Residency determinations are to be based upon the following:
   i. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which read as follows:

   "Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residence means the county where the criminal charges were filed.

   ii. For alcohol/drug clients, the definition of residency established by OhioMHAS, which reads as follows:

   "Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

2. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, OhioMHAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" Board because of a client's placement in a special residential program or facility or because of other unusual circumstances.

3. The provisions of ORC Section 5122.01(S) and the OhioMHAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:
   . A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).

A. <u>Hamilton County Acceptable Supporting Documentation REQUIRED for Residency Verification</u>

- Driver License
- State ID Card
- Homeless Certification VESTA card (dates cover requested dates of residency – no time limit)
- Lease agreement
- Utility bill with the current address
- Power of attorney papers
- Guardianship Papers
- Adoption or custody papers
- Statement from Client (Signed and Witnessed) Indicating Residency – I.e. JFS Form
- Mailing address – documents HC address
- Voting card
- Car registration
- Location of family (family with history of residence in Hamilton County is providing support)
- Signed Residency form (with current date)
- General conduct (Person actions demonstrate MH/AOD services needed with no history homeless certification or outreach connection but clearly can be identify as a Hamilton County resident based on criminal history from the Clerk of Courts website).

B. <u>Hamilton County Acceptable Source of Income Verification (DETERMINE) by the provider per the MHRSB contract agreement with the providers</u>
It is the Provider's responsibility to obtain sufficient documentation to determine the client's income eligibility. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the income determination process.

C. <u>Hamilton County Acceptable supporting documentation REQUIRED for Enrollment updates & demographic changes</u>

- Intake/Admission Form (for verification of member eligibility/insurance start date)
- MACSIS member screen shot – **only** acceptable for 2015 October, November, and December intake dates
- Driver License
- State ID Card
- Marriage License
- Power of attorney papers
- Guardianship Papers
- SS Card
- Homeless Certification VESTA card (dates cover requested dates of residency – no time limit)
- Lease agreement
- Utility bill with current address
- Adoption or custody papers
- Statement from Client (Signed and Witnessed) Indicating Residency – I.e. JFS Form
- Mailing address - documents HC address
- Voting card
- Car registration
- Service Authorization/Referral (for Plan change - Authorization should include dates of service)

ATTACHMENT C

Checklist for Hamilton County Required Fields in the SHARES
Eligibility and Enrollment Request Form

The following fields must be completed when adding an Eligibility and Enrollment Request form for a Hamilton County client. Failure to provide all required information will result in the member (client) application being pended or denied rather than approved thus preventing the submission of claims for that member.

A. Provider Screening Date
B. Source of Income *
C. Monthly Modified Adjusted Gross Income (MAGI) Amount *
D. Family/Household Size (# People Dependent on the Monthly Income *
E. Subsidy Scale Percentage *
F. Other Payor/Other Carrier Type (Check all that apply) *

G. Residency Eligibility and Verification: *
    1. Is client living at Legal/Primary Residence entered in iPC?
    2. Provider reviewed contractually-required residency documentation?
    3. Provider attached contractually-required residency documentation to this Enrollment?
 	
    NOTE: Number two (2) **or** three (3) must have a "yes" response. When #3 is "no," the HCMHRSB may request additional documentation.

H. Clinical – Member Mental Health and Substance Use Diagnosis (Use ICD-10 Diagnosis Codes/Names   NOTE: Must provide at least one diagnosis

I. Provider attests that all federal, state, and contractual requirement, including but not limited to the following, have been met:
 	
    1. Consent for treatment
    2. Authorizations for release of information
    3. Notices of privacy practices

The items marked with an asterisk must be updated when changes occur or annually by using the SHARES Eligibility and Enrollment Update Form.

ATTACHMENT D
SHARES Procedure Code - MH Services

SERVICES	PROC CODES-SHARES	UNIT-SHARES
Assessment, Non-physician	H0031	15 minutes
Consultation - Prevention	Z5077	15 minutes
Co-Treatment	Z2002	15 minutes
Counseling, Group	H0004	15 minutes
Counseling, Individual	H0004	15 minutes
Court Testimony 1- FAIR	Z1650	15 minutes
Court Testimony 2- FAIR	Z1651	15 minutes
CPST, Group	H0036	15 minutes
CPST, Individual	H0036	15 minutes
Crisis Intervention	S9484	15 minutes
Forensic - Liaison	Z1652	15 minutes
Hotline-	H0030	15 minutes
Individualized Aid	Z1694	15 minutes
MH Education - Prevention	Z5084	15 minutes
Partial Hospitalization	S0201	15 minutes
Payee Service- Freestore	Z1679	Monthly
Pharmacologic Management	90863	15 minutes
Prevention - Prevention	Z5000	15 minutes
Psych. Interview w/ Physician	90792	15 minutes
Psychosocial Rehabilitation Support	Z1698	Episode
Scoring & Analysis - FAIR	Z2005	15 minutes
Temporary Housing	Z1204	15 minutes
AGENCY SPECIFIC PROCEDURE CODES		
Community Residence - CCHB - CMHH (w/h) Tier 1/ Level 1	Z0303	Daily
Community Residence - CCHB - CMHH (w/h) Tier 2/ Level 2	Z0304	Daily
Community Residence - CCHB - CMHH (w/h) Tier 3/Level 3	Z0305	Daily
Community Residence – GCBHS (Lrchwd/Madsn/Bellevue/Lester	Z0909	Daily
Community Residence- Tender Mercies Dana Property	Z0306	Daily
CPST Services/Vocational- GCBHS	Z1300	15 minutes
Crisis - Bed (w/h) - St. Joes	Z3011	Daily
Crisis - Bed (w/h) - CCHB	Z3010	Daily
Employment Services - GCBHS	Z1304	15 minutes
Employment Services- GCBHS HUBE Client Work Hours	Z1306	15 minutes
Employment Services – Group - IKRON	Z1718	15 minutes
Employment Services - Individual - IKRON	Z1719	15 minutes
Family Functional Therapy - Lighthouse IDD	Z1404	15 minutes
Housing Assist. - Housing -Subsidized Housing - Excel	Z1114	Daily
In-Home Behavioral Management Service- Camelot	Z1696	Daily
In-Home Behavioral Management Service- Pressley Ridge	Z1965	15 minutes
Mobile Crisis - Central Clinic A C	Z3021	15 minutes
Residential Care Facility - GCBHS Kemper	Z0225	Daily

Respite Care Facility - (w/h) - Talbert House Q/A Montgomery	Z0903	Daily
Respite Care Facility - (w/ll2 - Talbert House Q/A Hamilton	Z0902	Daily
Room & Board-Talbert House Res Care- Montgomery	Z0226	Daily
Room & Board - Talbert House Res Care Bridge	Z0227	Daily
Social/Rec, Grp. - Talbert House	Z1737	15 minutes
Social/Rec, Ind. -St. Joes	Z1669	15 minutes
Social/Rec, Ind. -Talbert House	Z1671	15 minutes
Therapeutic Foster Care- Pressley Ridge	Z0801	Daily

SHARES Procedure Code
AOD Services

SERVICES	PROC CODES- SHARES	Unit- SHARES
Alternatives	H0029	15 minutes
Assessment	H0001	15 minutes
Case Management	H0006	15 minutes
Community-Based Process	H0026	15 minutes
Consultation	Z1658	15 minutes
Crisis Intervention	H0007	15 minutes
Education	H0025	15 minutes
Environmental	H0027	15 minutes
Family Counseling	T1006	15 minutes
Group Counseling	HOOO5	15 minutes
Individual Counseling	H0004	15 minutes
Information Dissemination	H0024	15 minutes
Intensive Outpatient	H0015	15 minutes
Laboratory Urinalysis	H0003	15 minutes
Medical/Somatic	H0016	15 minutes
Methadone Administration	H0020	15 minutes
Outreach	H0023	15 minutes
Problem Identification & Referral	H0028	15 minutes
Referral & Information	Z1657	15 minutes
Room and Board	A0740	Daily
Sub-Acute Detoxification	H0012	Daily
Urine Dip Screen	Z2001	Screen
AGENCY SPECIFIC PROCEDURE CODES:		
AOD Not Otherwise Classified - Crossroads - OARS	Z2017	15 minutes
AOD Not Otherwise Classified - Court Clinic (TASC Bundled Service)	Z2021	15 minutes
AOD Not Otherwise Classified- Talbert House Pretreatment Groups	Z2014	15 minutes
AOD Not Otherwise Classified- Alcoholism Council (Interpret srvs.)	Z2016	15 minutes
Non-Medical Community Residential Treatment- CAT short term	Z0051	Daily
Non-Medical Community Residential Treatment- Prospect NAR R & B	Z0165	Daily
Non-Medical Community Residential Treatment- Talbert House NAR ADAPT	Z0167	Daily
Room & Board - Cornell	Z0056	Daily
Room&Board - Talbert House	Z0054	Daily
Room & Board - CAT NAR Residential short term	Z0164	Daily
Room & Board - Crossroads	Z0052	Daily
Room & Board - First Step Home	Z0053	Daily
Room & Board- Foundations	Z0057	Daily
Room & Board- Soujourner	Z0055	Daily
Recovery Housing - First Step Home & Talbert House	Z1OOO	Daily
Recovery Housing - Talbert House	Z1001	Daily
Naltrexone (depot from Vivitrol)	J2315	1 mg.
Prescription Drug Oral (Buprenophine/Naloxone)	J8499	1 mg.
Recovery Support Services	Z1350	15 minutes

SHARES 3rd and 4th Modifiers for Claim Submission			
Mental Health Codes for Modifiers:			
Codes for Modifier 1:	HE	=	mental health service
	HQ	=	group service
	GT	=	telephone contact
Codes for Modifier 2:	UK	=	face to face contact with significant other, client not present
	99	=	place holder
Codes for Modifier 3:	MH		
Codes for Modifier 4:	MH		
AOD Codes for Modifiers:			
Codes for Modifier 1:	HA	=	child/adolescent program
	HF	=	AOD service
Codes for Modifier 2:	HD	=	women's program
	H9	=	court ordered
	99	=	place holder
Codes for Modifiers 3 and 4:			
	Modifier 3	Modifier 4	Fund Name
	HB	HG	IDAT Surplus Funding
	HC	HC	JFS FAIR
	HC	HF	Indigent Drivers Alcohol Treatment (IDAT)
	HC	HN	HHIC Levy
	HC	HI	Family Services & Treatment Levy & CCA Grant
	HC	HI	HHIC Levy – Designated for Drug Court clients
	HC	HN	Prevention & Treatment Multiple Funding Source
	HC	HT	Community Coalition Pass Through Grant
	HC	HU	TASC Pass Through Grant

	HC	HV	Drug Court Pass Through Grant/Circle for Recovery
	HC	HW	Women's Set Aside Pass Through Grant
	HC	HZ	State DYS Aftercare
	HF	HI	State Gambling Pass Through Grant
	HF	HO	Problem Gambling – Prevention
	HF	HP	Problem Gambling – Treatment
	HC	HT	UMADAOP Operating Pass Through Grant
	HR	IN	Hamilton County Heroin Coalition
	CU	RE	21st Century CURES
	AT	PS	Addiction Treatment Program Services