This Bulletin is to inform providers that additional claims processing edits, reflecting data errors, will be enforced as of the claims processing date of **March 6, 2019** for 5010 Health Insurance Portability and Accountability Act (HIPAA) transactions and paper claims.

Because the edits reflect unacceptable data, they will result in the rejection of claims *before* the adjudication process. An acknowledgement called a 277CA will be applied and made available to the provider electronically in these cases. As a reminder, providers are responsible for ensuring that the data submitted is correct.

The Front-End Edits listed below will be in effect on the claims processing date of March 6, 2019. As a reminder, Front-End Edits can be found in the CBH 5010 Health Care Claim Acknowledgement Companion Guide.

MAXIMUM NUMBER OF UNITS BILLED

The maximum number of units that can be billed on a service line to CBH is 999 for a Professional claim. The maximum number of units that can be billed on a service line to CBH is 9,999 for a Institutional claim.

A billed **Professional claim service line exceeding 999 units** or a billed **Institutional claim service line exceeding 9,999 units** will reject at the 277CA with the following message:

> **Category Code A7= Acknowledgement/Rejected Invalid Information Claim Status Code 258= Days/Unit for Procedure/Revenue Code**

RENDERING PROVIDER ENTITY TYPE QUALIFIER

The data submitted within the Rendering Provider Name segment (Loop 2310B) must be correct. The Entity Type Qualifier submitted in the position NM102 of the 2310B loop can either be the number 1 (Person) or the number 2 for a (Non-Person Entity). If the Entity Type Qualifier is 1, then you must send the NM103 (The Person Last Name) and NM104 (The Person First Name). If the Entity Type Qualifier is 2, then you must send NM103 (Organization Name).

A claim submitted with the incorrect Entity Type Qualifier and naming format will reject at the 277CA with the following message:

- If Entity Type Qualifier is 1 (Person) and:

  - If NM103 (The Person Last Name) is missing:
    Category Code A6 = Acknowledgement/Rejected for Missing Information
    Claim Status Code 504 = Entity's Last Name

     o   If NM104 (The Person First Name) is missing:
        Category Code A6 = Acknowledgement/Rejected for Missing Information
        Claim Status Code 505 = Entity's First Name

- If Entity Type Qualifier is 2 (Non-Person Entity) and:

     o   If NM103 (Organization Name) is missing:
        Category Code A6 = Acknowledgement/Rejected for Missing Information
        Claim Status Code 504 = Entity's Last Name

ADMISSION DATE, ADMISSION HOUR, DISCHARGE DATE, AND DISCHARGE HOUR

CBH-contracted services submitted on the 837I or UB04 are:
- Inpatient Psychiatric (100-1 thru 100-35)
- Inpatient Psychiatric Extended Acute (140-1 thru 140-22)
- Inpatient Drug and Alcohol (150-1 thru 150-8)
- Residential Treatment Facility Accredited (500-1 thru 500-24)

All 8371/UB04 services require the following information to be sent:
- The Admission Date with the Admission Hour
- **If the member is discharged** on the end date of service, the Discharge Date with the Discharge Hour.

A claim submitted without the required Admission Date with the Admission Hour and when applicable, Discharge Date with the Discharge Hour, will reject at the 277CA with the following message:

    Category Code A6= Acknowledgement/Rejected for Missing Information
    Claim Status Code 189= Facility Admission Date
    Claim Status Code 230= Hospital Admission Hour
    Claim Status Code 190= Facility Discharge Date
    Claim Status Code 233= Hospital Discharge Hour

ADMISSION HOUR MUST BE LESS THAN THE DISCHARGE HOUR

On a single day of service, the Admission Hour must be less (earlier) than the Discharge Hour. A claim submitted with the Discharge Hour before the Admission Hour will reject at the 277CA with the following message:

    Category Code A7= Acknowledgement/Rejected Invalid Information
    Claim Status Code 230 = Hospital Admission Hour

Questions regarding this Bulletin can be directed to your assigned Claims Analyst.