Community Behavioral Health

Standard Companion Guide Transaction Information

Health Care Claim Acknowledgment (277)

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.2

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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

CBH will publish the Communications/Connectivity component in a separate document.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X214	Health Care Acknowledgment (277)

3 Getting Started

3.1 Submitting Claims to CBH

Provider shall bill CBH for Covered Services rendered to Enrollees, in the manner specified in this section.

Provider shall submit "Clean Claims" no more than 90 days following the date of service for Covered Services. In the event Provider is pursuing Coordination of Benefits, provider must obtain a final determination from the primary payor dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payor.

"Unclean Rejected Claims" must be resubmitted as clean claims within the time requirements stated herein.

CBH reserves the right to make no payments for claims received beyond the time requirements stated herein.

3.2 Requirements for Provider Signature

The provider rendering the service must sign all invoices for claims, whether they are submitted manually or electronically. The signature certifies that the service has been rendered according to Medical Assistance (MA) regulations.

All claims received that do not meet the provider signature requirements will not be processed. These claims will be returned to the provider for correction.

3.2.1 Method of signing electronic claims

3.2.1.1 Electronic Claims

- An electronic certification is incorporated into the submission process. During the electronic submission process in Step 2, you will certify the information is accurate by agreeing to the following statement:

  I certify that the information in the file is accurate and complete, as submitted. I understand that payment and satisfaction of these claims will be from Federal and State funds and that I may be prosecuted for false claims, statements or documents, or concealment of material facts.

This represents your organization's attestation that you have on file the following for all claims submitted:

- An actual handwritten authorization signature of the provider is on file. The provider's initials or printed name are not acceptable signatures.
- If the MA-307 form is required, an actual handwritten authorization signature of the provider directly on the MA-307 Invoice Transmittal Form, a form used to certify that treatment services have been delivered by the provider.

3.3 Receiving Health Care Claim Acknowledgments (277)

Health Care Claim transactions are created on a daily basis to correspond with CBH's daily EDI processing schedules. The 277 will be available at the same time as the TA1 (Interchange Acknowledgments) and 999 (Implementation Acknowledgments). The Health Care Claim Acknowledgment transaction files become available for retrieval after the EDI processing has been completed for the file received date (day prior).

The CBH 277 includes EDI front end edit rejections and load into adjudication rejections. See the Figure 1 below:

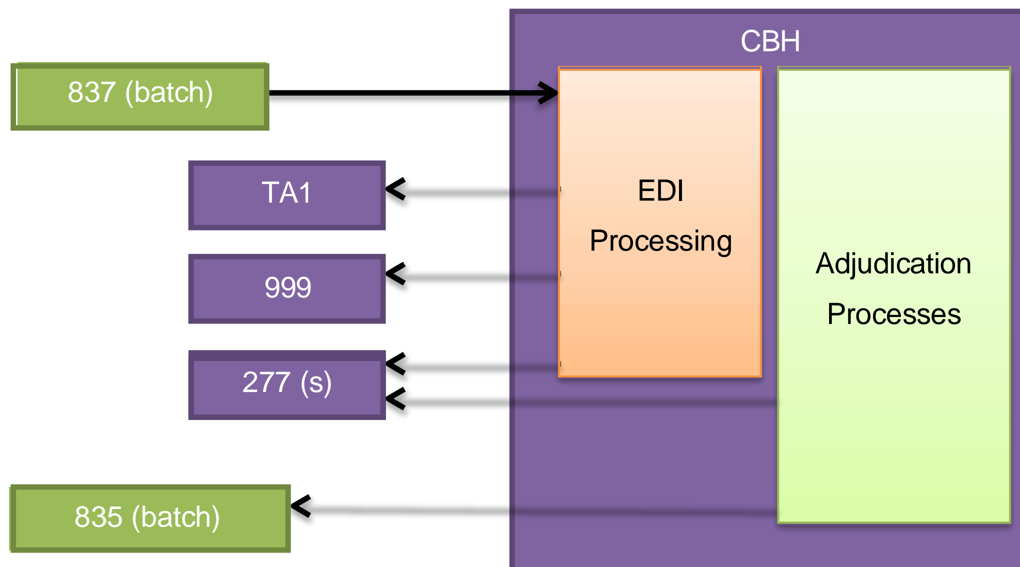

Figure 1

CBH 277 Limitations:

- The CBH 277 is created for rejected claims only.
- The CBH 277 supports claim rejections, and does not support service line rejections. If you receive a 277 for a claim, the entire claim has been rejected, inclusive of all service lines.
- The CBH 277 responds to one and only one claim at a time. CBH does not support the batch 277.

4 Contact Information

4.1 Claims Department (EDI) and Technical Assistance

Contact information for CBH Claims Department:

Email: cbhclaim.support@phila.gov

Or

Telephone: (215) 413 7125

Or

Address:
Claims Department
801 Market Street,
7th Floor,
Philadelphia, PA 19107

When contacting the Claims Department, please have your Parent ID available. These numbers facilitate the handling of your questions.

Claims department personnel are available for questions from 9:00 a.m. to 3:00p.m. Eastern Time, Monday through Friday.

4.2 Applicable websites / e-mail

https://www.cbhphilly.org
http://www.dhs.pa.gov
http://www.x12.org/

5 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

005010X214E2 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
210AA	NM1	Information Source Name		
	NM109	Information Source Identifier	232766661	CBH Tax ID
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the trading partner number for the entity which submitted the original 837 transaction,
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge the receipt of the claim by the payer. It does not mean all of the claims have been accepted for Processing. CBH will not report rejected claims at this level.
	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level
	STC01-2	Health Care Claim Status Code	20	Default value for this status level
	STC03	Action Code	WQ	This element will always be set to WQ to represent the transaction level acceptance. Claims specific rejection and acceptance will be reported in 2200D
	STC04	Total Submitted Charges		Will be the value of the claims dollars (CLM02) of the 837 being acknowledged.
2200C		Provider of Service information Trace Identifier		The loop 2200C will not be used . Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Claim rejection status will always be reported at this level, not at the line level. The errors will always be claim level rejections.
	STC01-1	Health Care Claim Status Category Codes	A7	CBH support the use of this code. ‘Invalid Information’

005010X214E2 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC01-1	Health Care Claim Status Category Codes	A3	CBH supports the use of this code. 'Other.'
	STC01-1	Health Care Claim Status Category Codes	A6	CBH supports the use of this code. 'Missing Information.'
2200D	STC01-2	Health Care Claim Status Code	27	Code Description: Policy cancelled.* **(New: Effective <date>)*
2200D	STC01-2	Health Care Claim Status Code	29	Code Description: Subscriber and policy number/contract number mismatched.* **(New: Effective <date>)*
2200D	STC01-2	Health Care Claim Status Code	33	Code Description: Subscriber and subscriber id not found.* **(New: Effective <date>)*
2200B	STC01-2	Health Claim Status Code	128	Code Description: Entity's tax id. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '40' (Receiver) in STC01-3*
2200C	STC01-2	Health Care Claim Status Code	132	Code Description: Entity's Medicaid provider id. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '85' (Billing Provider) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	132	Code Description: Entity's Medicaid provider id. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '82' (Rendering Provider) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	153	Code Description: Entity's id number. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send 'HK' (Subscriber) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	153	Code Description: Entity's id number. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send 'PR' (Payer) in STC01-3*

005010X214E2 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2200D	STC01-2	Health Care Claim Status Code	156	Code Description: Patient relationship to subscriber. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send 'QC' (Patient) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	158	Code Description: Entity's date of birth. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send 'HK' (Subscriber) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	171	Code Description: Other insurance coverage information (health, liability, auto, etc.).
2200D	STC01-2	Health Care Claim Status Code	187	Code Description: Date(s) of service.
2300	STC01-2	Health Care Claim Status Code	188	Code Description: Statement from-through dates. ***Institutional Only***
2200D	STC01-2	Health Care Claim Status Code	189	Code Description: Facility admission date.
2200D	STC01-2	Health Care Claim Status Code	190	Code Description: Facility discharge date.
2200D	STC01-2	Health Care Claim Status Code	197	Code Description: Effective coverage date(s).* **(New: Effective <date>)*
2200D	STC01-2	Health Care Claim Status Code	249	Code Description: Place of service.
2200D	STC01-2	Health Care Claim Status Code	252	Code Description: Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number. Note: *This code requires the use of an Entity Code.* Entity Code: *CBH will send 'HK' (Subscriber) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	254	Code Description: Primary diagnosis code. This change effective 11/1/2011: Principal diagnosis code.
2200D	STC01-2	Health Care Claim Status Code	255	Code Description: Diagnosis code.
2200D	STC01-2	Health Care Claim Status Code	454	Code Description: Procedure code for services rendered.
2200D	STC01-2	Health Care Claim Status Code	456	Code Description: Covered Day(s). ***Institutional Only***

005010X214E2 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2200D	STC01-2	Health Care Claim Status Code	457	Code Description: Non-Covered Day(s). ***Institutional Only***
2200D	STC01-2	Health Care Claim Status Code	458	Code Description: Coinsurance Day(s). ***Institutional Only***
2200D	STC01-2	Health Care Claim Status Code	459	Code Description: Lifetime Reserve Day(s). ***Institutional Only***
2200C	STC01-2	Health Care Claim Status Code	500	Code Description: Entity's Postal/Zip Code. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '85' (Billing Provider) in STC01-3*
2200C	STC01-2	Health Care Claim Status Code	500	Code Description: Entity's Postal/Zip Code. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '87' (Pay-to Provider) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	500	Code Description: Entity's Postal/Zip Code. Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send 'HK' (Subscriber) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	510	Code Description: Future date. Note: *At least one other status code is required to identify the data element error.*
2200D	STC01-2	Health Care Claim Status Code	535	Code Description: Claim Frequency Code
2200D	STC01-2	Health Care Claim Status Code	535	Code Description: Claim Frequency Code Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '233' (Hospital Discharge Hour) in STC10-2*
2200D	STC01-2	Health Care Claim Status Code	562	Code Description: Entity's National Provider Identifier (NPI). Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '82' (Rendering Provider) in STC01-3*
2200D	STC01-2	Health Care Claim Status Code	562	Code Description: Entity's National Provider Identifier (NPI). Note: *This code requires use of an Entity Code.*

005010X214E2 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
				Entity Code: *CBH will send '71' (Attending Physician) in STC01-3* ***Institutional Only***
2200D	STC01-2	Health Care Claim Status Code	562	Code Description: Entity's National Provider Identifier (NPI). Note: *This code requires use of an Entity Code.* Entity Code: *CBH will send '85' (Billing Provider) in STC01-3*

6 TI Additional Information

6.1 Business Scenarios

CBH reserves this section and will add business scenarios as needed during the revision of this Companion Guide to support other business functions such as Third Party Liability.

6.2 Payer Specific Business Rules and Limitations

6.2.1 Third Party Liability (TPL) Billing:

CBH supports the electronic submission of TPL billing. Third Party Liability (TPL) refers to specific entities, such as Medicare, Blue Cross and parties other than CBH that may be liable for all or part of a client's health care expenses. When third party resources are available to cover behavioral services provided to Medicaid recipients, CBH is the "payor of last resort."

For all services requiring prior authorization, the provider should obtain an authorization number from a CBH Care Manager prior to submitting a claim. This applies regardless of whether CBH is the primary payor or any other insurance carrier. Please also note that providers should obtain authorization numbers at the time clients are admitted to a facility.

Once it is determined that a client has other insurance, the bill should be sent first to the primary insurance carrier(s) for payment consideration. CBH will consider for payment all balances for behavioral health services that are unpaid by the other insurance carriers.

Before CBH can consider a TPL claim for payment, the provider must submit the 837 with the information contained from the Explanation of Benefits (EOB), or the denial letter(s) sent to the provider by any and all other carriers. This

information must be submitted in the transaction set as documented in the implementation guide.

The claim must be fully considered and resolved with the primary carrier before it is billed to CBH. If the services are rejected by the primary carrier due to missing, incomplete, or incorrect information, the service must be re-billed to the primary carrier before CBH will consider payment. The EOB or the denial letter(s) must be the final determination.

It is important that the provider's bill matches the EOB information. This applies to the billed amount, beginning and ending dates of service, approved amount, deductible, the co-insurance amount, and other insurance paid amount.

6.2.2 Billing for Consecutive Days – "Span Billing"

When billing for per diem services that were provided on consecutive days, the provider does not need to enter each individual date of service on the claim form, but may "span bill" the entire period of service. "Span billing" means that the provider notes on the claim the dates that treatment began and ended and the number of units of service provided.

Both the "service begin" date and the "service end" date must be within the authorized period.

6.2.3 Billing for Non-Consecutive Days

When billing for non-consecutive days within a particular period, the provider must note each date of service separately.

Do not span bill for non-consecutive days of service or non-per diem services. Such claims will be rejected.

6.2.4 Post-Payment Recoveries

According to the City of Philadelphia's contract with the Pennsylvania Department of Human Services (DHS-PA), Community Behavioral Health (CBH) is required to take all reasonable measures to ensure CBH is the payor of last resort when other third-party resources are available to cover the cost of medical services. The new post-payment recovery process will begin Thursday, November 19, 2020.

Please note that the post-payment recovery process has changed. Previously, CBH notified the providers when third-party resources were identified for claims paid inappropriately as CBH primary. Providers would review and resubmit the claims after coordinating benefits with the primary carrier, prior to CBH recovering the claims. Moving forward, CBH will recover payments immediately upon identification of third-party coverage. Providers will be responsible for resubmitting claims for review and reprocessing.

When CBH becomes aware of payments made on behalf of a CBH member who has valid third-party resources, post-payment recoveries will be pursued. If

a provider is identified as having received an inappropriate payment, a post-payment recovery letter will be sent to the provider listing all the impacted claims that were retracted by CBH. Providers who receive such letters are required to bill the primary carrier(s) and resubmit the claim, along with a copy of the recovery letter and the final determination, for CBH review and processing. If the claim is being submitted electronically, the provider should include 'recovery' in the file name and notify CBH that the claims are being submitted. Electronic files need to be submitted as late submission. The provider has 90 days from the date of the post-payment recovery letter to resubmit the claims and EOB and/or final determination letter with the appropriate Claim Adjustment Group Code (CARC) and Remittance Advice Rejection Code (RARC) to CBH for re-processing consideration. The DHS-PA will pursue all cases that CBH is unable to recover.

6.2.5 Member Co-Payment Prohibition

Federal law prohibits treatment providers from requesting co-payments from MA recipients in the Commonwealth of Pennsylvania. Billing CBH members for co-payments for services is also in violation of the CBH Provider Agreement.

6.2.6 Where to Email / Mail Claims

All manual claims must be emailed per below:

- In-network Providers:
    - Paper Claims must be emailed to claims.INprovider@phila.gov

- Out-of-network Providers:
    - Paper Claims must be emailed to CBHclaimsOON@phila.gov

For providers who are unable to email, manual claims must be sent via U.S. Postal System or delivery service to:

CBH Claims Department,
801 Market Street, 7th Floor,
Philadelphia, PA 19107

Hand-delivered mail **will not** be accepted.

6.2.7 Claims Processing Cycle

- Adjudication process:

  CBH will adjudicate 100% of clean claims within 45 days and adjudicate 100% of all claims within 90 days. Adjudicate means to pay or reject a claim.

- Payment of claims:

  Payments will be made via EFT. For Providers who are unable to accept EFT payments, payment will be mailed in the form of a check to the address designated by the provider in the provider information form.

  Any changes in address must be reported in writing under the signature of the Chief Executive Officer or Chief Financial Officer to CBH's Provider Relations Representative.

6.3 Other Resources

The CBH Companion Guide has also been created to be used in conjunction with the **latest** Pennsylvania PROMISe™ Companion Guides. These companion guide can be downloaded from:

https://www.dhs.pa.gov/docs/For-Providers/Pages/PROMISe-Companion-Guides.aspx

In the event that no instructions are present for a segment, element or code, please follow the instructions in the Pennsylvania Specific Medical Assistance HIPAA Billing Guide where applicable.

In some instances, the needs of CBH differ from those of the State. While the State Descriptions are listed for reference purposes, the CBH Instructions must be followed when they differ from the State Description instructions.

For any other additional information you can read the CBH Provider Manual. The manual describes the procedures developed by the Community Behavioral Health (CBH) under the HealthChoices initiatives to assure that all recipients of mental health and substance abuse services receive the most appropriate treatment in the least restrictive environment possible.

https://cbhphilly.org/cbh-providers/oversight-and-monitoring/cbh-provider-manual/

7 Glossary

7.1 Definitions

7.1.1 Clean Claim:

A clean claim shall mean a claim that can be processed without requiring additional information from the provider of the service or from a third party. A clean claim does not include: claims pended or rejected because they require additional information either from a provider or from internal sources (i.e., claims pended for a determination of third-party liability, etc.); a claim under review for medical necessity; or a claim submitted by a provider reported as being under investigation by a governmental agency, the City of Philadelphia or CBH for fraud or abuse. However, if under investigation by the City or CBH, the Department of Public Welfare (DPW) must have prior notice of the investigation.

7.1.2 Unclean Rejected Claim:

An unclean rejected claim shall mean a claim that is returned to the provider or third party for additional information.

7.1.3 Clean Rejected Claim:

A clean rejected claim shall mean a claim that is returned to the provider or third party due to ineligible recipient or service.

8 TI Change Summary

Version	Date	Section(s) changed	Change Summary
1.0	2/21/2013	None	N/A
1.1	10/22/2013	5.0	Updated Instruction Table
1.2	05/31/2022	All sections	Various updates to align with CBH's current policies and procedures.