Community Behavioral Health

Standard Companion Guide Transaction Information

Health Care Claim Payment/Advice (835)

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

Companion Guide Version Number: 1.1

October 5, 2022

This document has been formally submitted to the Data Interchange Standards Association, ASC X12's secretariat, according to the policies found here: http://store.x12.org/store/ip-use. The document has been conditionally approved to reproduce or cite ASC X12 materials and is pending a complete review. Following that complete review the document may change.

This page left intentionally blank.

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.

Table of Contents

1 TI Introduction 7

1.1 Background 7
1.1.1 Overview of HIPAA Legislation 7
1.1.2 Compliance according to HIPAA 7
1.1.3 Compliance according to ASC X12 8
1.2 Intended Use 8

2 Included ASC X12 Implementation Guides 8

3 Getting Started 9

3.1 Submitting Claims to CBH 9
3.2 Requirements for Provider Signature 9
3.2.1 Method of signing electronic claims 9
3.2.1.1 Electronic Claims 9
3.3 Receiving Claim Payment/Advice 10

4 Contact Information 11

4.1 Claims Department and Technical Assistance 11
4.2 Applicable websites / e-mail 11

5 Instruction Tables 12

6 TI Additional Information 13

6.1 Business Scenarios 13
6.2 Payer Specific Business Rules and Limitations 13
6.2.1 Third Party Liability (TPL) Billing: 13
6.2.2 Billing for Consecutive Days – “Span Billing” 14
6.2.3 Billing for Non-Consecutive Days 14
6.2.4 Post-Payment Recoveries 15
6.2.5 Member Co-Payment Prohibition 16
6.2.6 Where to Email / Mail Claims 16
All manual claims must be emailed per below: 16
6.2.6.1 In-network Providers: 16
6.2.6.2 Out-of-network Providers: 16
6.2.7 Claims Processing Cycle 16
6.2.7.1 Adjudication process: 16

6.2.7.2 Payment of claims: 16
6.3 Other Resources 17
7 Glossary 18
7.1 Definitions 18
7.1.1 Clean Claim: 18
7.1.2 Unclean Rejected Claim: 18
7.1.3 Clean Rejected Claim: 18
8 TI Change Summary 19

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
005010X221A1	Health Care Claim Payment/Advice (835)

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 Claim Payment/Advice

Payment Health Care Claim Payment/Advice (835) transactions are created on a weekly basis to correspond with CBH's weekly payment cycles. The 835 Health Care Claim Payment/Advice (835) will be available at the same time as the current payment detail and rejection reports. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete. If a Health Care Claim Payment/Advice (835) transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact Claims Analyst for assistance.

Limitations:

- Paper claims may not provide all data utilized in the Health Care Claim Payment/Advice (835). Therefore, some data segments and elements may be populated with "default data" or not available as a result of the claim submission mode.
- Administrative checks are issued from a manual process and are not part of the weekly or daily payment cycles; therefore, they will not be included in the Health Care Claim Payment/Advice (835) transaction. A letter or some form of documentation usually accompanies the check. An Administrative check does not routinely contain an Explanation of Benefits notice.
- The following information will be populated with data from internal databases:
  - Payer name and address
  - Payee name and address

4 Contact Information

4.1 Claims Department 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.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I	CBH remittance detail is sent separately from the payment.
	CUR	CUR -Currency Information		CBH does not use this segment.
1000A	N1	Payer Identification		
	N102	Payer Name	Community Behavioral Health	
	N104	Payer Identifier	232766661	CBH Tax ID
1000A	PER	Payer Business Contact Information		EDI Operations (215) 413 7125
1000A	PER	Payer Technical Contact Information		EDI Operations (215) 413 7125
1000A	PER	Payer WEB Site		http://www.dbhids.org/community-behavioral-health/
1000B	REF	Additional Payee Identification		
	REF01	Additional Payee Identification Qualifier	TJ	The Provider’s Tax Identification number will be sent when the Provider’s NPI is sent in the 1000B Payee Identification N104
1000B	RDM	Remittance Delivery Method		CBH will not send this segment
2100	CLP	Claim Payment Information		
	CP01	Patient Control Number		CBH will send the value from the CLM01 if the claim was submitted as an 837. Otherwise it will be a “0”.
	CLP02	Claims Status Code		CBH will send ‘1’ for paid as primary, ‘4’ for denied and ‘2’ for all TPL claims
	CLP07	Payer Claim Control Number		This will be the internal ID assigned to the claim by CBH and is the value to be used

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
				for all correspondence, appeals, corrections or voids of the claims.
	PLB	Provider Adjustment		CBH will utilize the PLB segment for the following business purposes: Acceleration of Benefits IRS Levy Overpayment Recovery Periodic Interim Payment

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:

6.2.6.1 In-network Providers:

Paper Claims must be emailed to claims.INprovider@phila.gov

6.2.6.2 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

6.2.7.1 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.

6.2.7.2 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 Guide - **837 Institutional**. This 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	3/6/2012	None	N/A
1.1	05/31/2022	All sections	Various updates to align with CBH's current policies and procedures.