

CBH SCREENING PROGRAM
HL7 Submission Guide

V1.3 | Updated February 13, 2026

**Community
Behavioral
Health**

TABLE OF CONTENTS

- 1. Introduction..... 4
 - 1.1. Purpose of This Document..... 4
 - 1.2. Target Audience..... 4
 - 1.3. Importance of Standardized Data Submission..... 5
 - 1.4. Overview of HEDIS Measures Covered..... 5
- 2. Change Log..... 6
- 3. Definitions and Acronyms 6
- 4. Understanding HL7..... 7
 - 4.1. What is HL7? 7
 - 4.2. HL7 Version 2.x Basics 8
 - 4.3. Common HL7 Message Types for Clinical Data..... 9
- 5. HEDIS Measures: Definitions and Data Requirements..... 9
 - 5.1. Social Needs Screening and Intervention (SNS-E) 10
 - 5.2. Depression Screening and Follow-up (DSF-E) 11
 - 5.3. Depression Remission or Response (DRR-E) 12
 - 5.4. Postnatal Depression Screening and Follow-up (PDS-E)..... 13
- 6. HL7 Message Structure for HEDIS Measure Data Submission 14
 - 6.1. Recommended HL7 Message Type: ORU^R01 (Unsolicited Observation Message) 14
 - 6.2. Key Segments for HEDIS Data Submission..... 14
 - 6.3. Encoding LOINC, SNOMED CT, and CPT Codes within the OBR and OBX Segments..... 19
- 7. Connectivity and Transmission Options 20
 - 7.1. SFTP Submission..... 20
 - 7.2. Response File..... 21
 - 7.3. Contact Information 21
 - 7.4. Transaction-Specific Information 21
 - 7.5. Submitting HL7 Files..... 21
- 8. HL7 Batch File Segments 22
 - 8.1. Purpose and Benefits of Batch Segments 22
 - 8.2. Segment Details 23
- 9. Detailed HL7 Implementation Examples..... 26
 - 9.1. Example 1: SNS-E – Positive Social Needs Screening with Referral 26
 - 9.2. Example 2: DSF-E – Depression Screening (PHQ-9) with Follow-Up Plan 30

9.3. Example 3: DRR-E – Depression Remission Assessment	32
9.4. Example 4: PDS-E – Perinatal Depression Screening	34
10. Data Standards	36
10.1. Coding Standards	36
11. Support and Troubleshooting	37
11.1. Common Issues and Troubleshooting	37
11.2. Frequently Asked Questions	37
Appendix A: Social Needs Screening and Intervention (SNS-E) Information	46
Appendix B: Depression Screening/ Remission (DSF-E/DRR-E) Information	48
Appendix C: Postpartum Depression Screening and Follow-up (PDS-E) Information	50
Appendix D: Relevant HL7 Data Types and Table Values (Examples)	52
Appendix E: References and Further Reading	54
Attachment A: IPSWITCH Request Form	55
Attachment B: Code Definitions	57
Attachment C: SNOMED Codes for SNS-E Interventions	58

1. INTRODUCTION

As outlined in [CBH Provider Bulletin 25-26](#), CBH is going to begin collecting data on screening tools as part of the [PA DHS OMHSAS](#) Performance Improvement Project requirements. This document is a comprehensive guide for healthcare providers and organizations involved in the standardized electronic clinical data exchange using the Health Level Seven (HL7) messaging standard. Its primary aim is to outline the methodology for transmitting clinical information, observations, and procedures to support various quality reporting initiatives. By adhering to the guidelines herein, organizations can ensure that critical clinical data, often involving standardized terminologies such as SNOMED CT (Systematized Nomenclature of Medicine - Clinical Terms), LOINC (Logical Observation Identifiers Names and Codes), and CPT (Current Procedural Terminology), is accurately captured and transmitted in an HL7 v2.x format. This standardized approach is crucial for enabling efficient data processing, ensuring compliance with reporting requirements, and ultimately improving patient care outcomes.

1.1. Purpose of This Document

The primary purpose of this guide is to standardize the process for healthcare providers and organizations to collect and submit clinical data electronically using the HL7 messaging standard. While applicable to a broad range of clinical data submissions, it focuses explicitly on the transmission of data related to:

- ➔ Social Needs Screening and Intervention (SNS-E)
- ➔ Depression Screening and Follow-up (DSF-E)
- ➔ Depression Remission or Response (DRR-E)
- ➔ Postpartum Depression Screening and Follow-up (PDS-E)

This document provides guidelines for HL7 message structure, data elements, and coding standards like SNOMED CT, LOINC, and CPT. It aims to facilitate accurate, efficient, and compliant data exchange, supporting quality improvement initiatives and patient care enhancement.

1.2. Target Audience

This guide is intended for:

- ➔ **Healthcare Providers:** Physicians, nurses, social workers, and other clinical staff who conduct screenings and interventions related to social needs and depression
- ➔ **EHR/EMR System Administrators:** Individuals responsible for configuring and managing Electronic Health Record (EHR) or Electronic Medical Record (EMR) systems to ensure proper data capture and HL7 export capabilities
- ➔ **IT/Technical Staff:** Developers and IT professionals responsible for implementing and maintaining HL7 interfaces
- ➔ **Data Managers:** Personnel involved in the collection, validation, and submission of healthcare data for quality reporting

- ➔ **Client Organization Staff:** The team responsible for receiving, processing, and forwarding the HL7 data for [HEDIS](#) (Healthcare Effectiveness Data and Information Set) measure compliance

1.3. Importance of Standardized Data Submission

Standardized data submission via HL7 offers several significant benefits:

- ➔ **Interoperability:** Facilitates seamless exchange of health information between disparate systems, reducing manual data entry and errors
- ➔ **Accuracy and Completeness:** Ensures that all required data elements for HEDIS measures are consistently captured and transmitted
- ➔ **Efficiency:** Automates data flow, saving time and resources for both providers and the receiving organization
- ➔ **HEDIS Compliance:** Enables accurate calculation and reporting of HEDIS measures, which are vital for quality improvement initiatives and regulatory compliance
- ➔ **Improved Patient Outcomes:** Reliable data supports better understanding of population health trends and informs targeted interventions

1.4. Overview of HEDIS Measures Covered

This document addresses explicitly the HL7 data submission requirements for the following HEDIS measures:

- ➔ **[Social Needs Screening and Intervention \(SNS-E\)](#)** focuses on identifying and addressing patients' social needs (e.g., food insecurity, housing instability, transportation barriers). It measures screening for food, housing, and transportation needs using tools like PRAPARE, with interventions within 30 days for positive screens. See [Appendix A](#) for more information.
- ➔ **[Depression Screening and Follow-up \(DSF-E\)](#)** measures the percentage of members aged 12 and older who were screened for depression and, if screened positive, received a follow-up plan. It tracks members aged 12 and older screened for depression (e.g., PHQ-9) with follow-up within 30 days. See [Appendix B](#) for more information.
- ➔ **[Depression Remission or Response \(DRR-E\)](#)** assesses the percentage of members with a diagnosis of depression who achieved remission or response to treatment. This measure requires an initial depression diagnosis and subsequent assessments. It assesses remission or response within 4-8 months for members aged 12 and older with positive depression screens. See [Appendix B](#) for more information.
- ➔ **[Postpartum Depression Screening and Follow-up \(PDS-E\)](#)** measures the percentage of pregnant and postpartum members who were screened for depression and, if screened positive, received a follow-up plan. This measure is specific to the perinatal period (pregnancy through 12 months postpartum). It evaluates depression screening during pregnancy/postpartum with follow-up for positive screens. Accurate data submission for these measures is critical for assessing the quality of care provided and identifying areas for improvement in addressing both health-related social needs (HRSN) and mental health needs. See [Appendix C](#) for more information.

2. CHANGE LOG

This section details the revisions made to this document. Providers will be notified of revisions via their Community Behavioral Health (CBH) representative.

Version	Date	Description
1.3	February 13, 2026	Significant changes throughout
1.2	October 15, 2025	Sections 5.1.1, 6.2.2 (PID.3), and Attachment B (Social Needs Screening Tools LOINC)
1.1	September 2, 2025	Additions to Attachment B: Code Definitions
1.0	August 1, 2025	Initial release

3. DEFINITIONS AND ACRONYMS

Term	Acronym	Definition
Acknowledgment File	ACK	An output report acknowledging what was sent and processed
Batch Header Segment	BHS	Groups messages in a batch
Batch Trailer Segment	BTS	Closes a batch
Current Procedural Terminology	CPT	A medical code set maintained by the American Medical Association (AMA) that describes medical, surgical, and diagnostic services. CPT is used for procedures
Electronic Clinical Data Systems	ECDS	HEDIS reporting
Electronic Health Record	EHR	A digital version of a patient’s paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.
Electronic Medical Record	EMR	A digital version of the paper charts in the clinician’s office. An EMR contains the medical and treatment history of patients in one practice.
File Header Segment	FHS	Starts an HL7 file
File Trailer Segment	FTS	Closes an HL7 file
Healthcare Effectiveness Data and Information Set	HEDIS	A widely used set of performance measures in the managed care industry, developed and maintained by NCQA
Health Level Seven	HL7	A set of international interoperability standards for transfer of clinical and administrative data between healthcare information systems

Term	Acronym	Definition
Health-Related Social Needs	HRSN	Non-medical factors affecting health, like socioeconomic status and geographic location
Logical Observation Identifiers Names and Codes	LOINC	A universal standard for identifying medical laboratory observations and other clinical observations
Message Header Segment	MSH	Starts a patient message
Minimal Lower Layer Protocol	MLLP	A standard protocol used for sending HL7 messages over a TCP/IP network
National Committee for Quality Assurance	NCQA	A private, non-profit organization dedicated to improving health care quality
National Provider Identifier	NPI	A unique identification number for covered health care providers
Observation Request Segment	OBR	For screening details
Observation/Result Segment	OBX	For screening results
Protected Health Information	PHI	Any health information about an individual that is created, received, or transmitted by a covered entity
Patient Identification Segment	PID	The PID segment is used by all applications as the primary means of communicating patient identification information.
Response	RES	HL7 response to each individual message processed.
Secure File Transfer Protocol	SFTP	A network protocol that provides file access, file transfer, and file management over any reliable data stream
Systematized Nomenclature of Medicine – Clinical Terms	SNOMED CT	The most comprehensive, multilingual clinical health care terminology in the world
Transport Layer Security	TLS	A cryptographic protocol that provides secure communication over a computer network
Virtual Private Network	VPN	A technology that creates a safe and encrypted connection over a less secure network, such as the internet

4. UNDERSTANDING HL7

4.1. What is HL7?

HL7 is a set of international standards for transferring clinical and administrative data between healthcare information systems. The “Level Seven” refers to the highest level of the Open Systems Interconnection (OSI) model, the application layer responsible for direct communication between applications. HL7 standards define the format and content of healthcare data messages, enabling different healthcare applications (e.g., EHRs, lab systems, billing systems) to communicate and exchange information seamlessly. This interoperability is fundamental to modern healthcare, allowing for a more integrated and efficient healthcare ecosystem.

4.2. HL7 Version 2.x Basics

HL7 Version 2.x is a widely adopted messaging standard characterized by its pipe-delimited format. Messages are composed of segments, fields, components, and subcomponents, each carrying specific pieces of information.

4.2.1. Segments

A segment is a logical grouping of data fields. Each segment begins with a three-character segment ID (e.g., MSH for Message Header, PID for Patient Identification, OBX for Observation Result). A carriage return terminates segments.

Example:

```
PID|1||1234567890^^^PA^MAID||DOE^JOHN^A||19700101|M||123 MAIN  
ST^^ANYTOWN^MN^55123^USA|| (555) 123-4567||M|
```

4.2.2. Fields

Fields are the basic units of information within a segment, separated by the field delimiter (typically a pipe |). Each field has a defined data type and meaning.

Example (from PID segment):

- ➔ PID.1: Set ID - PID (e.g., 1)
- ➔ PID.3: Patient Identifier List (e.g., 1234567890^^^PA^MAID)
- ➔ PID.5: Patient Name (e.g., DOE^JOHN^A)

4.2.3. Components and Subcomponents

Some fields are complex and contain multiple pieces of information called components. Components are separated by the component delimiter (typically a caret ^). Subcomponents, if present, are separated by the subcomponent delimiter (typically an ampersand &).

Example (from PID.5 Patient Name):

```
DOE^JOHN^A
```

- ➔ DOE: Family Name (component 1)
- ➔ JOHN: Given Name (component 2)
- ➔ A: Middle Initial or Name (component 3)

4.2.4. Data Types

HL7 defines various data types for fields, such as:

- ➔ ST (String Data): Free text

- ➔ NM (Numeric): Numbers
- ➔ TS (Time Stamp): Date and time information (e.g., YYYYMMDDHHMMSS)
- ➔ CE (Coded Element): A coded value, often used for diagnoses, procedures, or observations, typically including code, text, and coding system (e.g., CODE^TEXT^CODING_SYSTEM), crucial for SNOMED CT and CPT
- ➔ XPN (Extended Person Name): Used for names with multiple components
- ➔ XAD (Extended Address): Used for addresses with multiple components
- ➔ XTN (Extended Telecommunication Number): Used for phone numbers

4.2.5. Repetitions

Some fields or segments can repeat within a message. Repetitions are separated by the repetition delimiter (typically a tilde ~). For example, a patient might have multiple identifiers or multiple observations.

Example (multiple identifiers in PID.3):

```
PID|||1234567890^^^PA^MAID~12345678^^^EHR^EHRInternalID
```

4.3. Common HL7 Message Types for Clinical Data

While many HL7 message types exist, the ORU^R01 (Unsolicited Observation Message) is the most suitable and commonly used for transmitting clinical observation results, including screening outcomes and associated codes, which are precisely needed for HEDIS measure data submission.

- ➔ **ORU^R01 (Unsolicited Observation Message)** is used to send observations (results) from a producing system (e.g., a lab system, an EHR) to a consuming system (e.g., a clinical data repository, a quality reporting system). This message type contains segments like OBR (Observation Request) and OBX (Observation Result) to convey detailed clinical findings.
- ➔ **ADT (Admission, Discharge, Transfer) Messages** are used for patient demographic and encounter information (e.g., ADT^A01 for admit, ADT^A03 for discharge). While not the primary message for results, patient demographics from ADT messages are often linked to ORU messages.
- ➔ **ORM (Order) Messages** are used for ordering procedures or observations (e.g., ORM^O01). This document will focus on the ORU^R01 message type as the primary vehicle for transmitting the required HEDIS measure data.

5. HEDIS MEASURES: DEFINITIONS AND DATA REQUIREMENTS

This section overviews the specific HEDIS measures, their definitions, and the key data elements required for accurate reporting, including SNOMED CT and CPT codes.

Important Note on Codes: This document will provide examples of where SNOMED CT and CPT codes should be placed within the HL7 message structure. Providers and clients must use the most current and appropriate SNOMED CT, LOINC, and CPT codes defined by the [National Committee for Quality Assurance \(NCQA\)](#) and other authoritative sources for HEDIS reporting. The examples below use generic placeholders (e.g., [SNOMED_CODE_FOR_SCREENING]) that must be replaced with the actual, specific codes.

5.1. Social Needs Screening and Intervention (SNS-E)

5.1.1. Measure Description

The SNS-E measure assesses the percentage of members screened for social needs (e.g., food insecurity, housing instability, transportation barriers, interpersonal safety, utility needs) and, if identified with an unmet social need, received an intervention or referral. As outlined in the CBH HL7 Measure Data Submission FAQ, Section 4.3, providers are expected to submit responses to **all** required questions (See below) from the social needs screening tool. However, referrals/interventions for positive screening results are only required for:

- ➔ Food Insecurity
- ➔ Homelessness Insecurity
- ➔ Housing Instability
- ➔ Inadequate Housing
- ➔ Transportation

Providers have the option to submit results from one of the following screening tools (see [Attachment B](#) for links and LOINC codes):

Social Needs Screening Tool	Required Questions for Submission
Accountable Health Communities Health-Related Social Needs (AHC HRSN) Screening Tool	1-10
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	1-17
Health Leads Screening Panel	1-10
WellRx Questionnaire	1-11
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	1-15

5.1.2. Required Data Elements

- ➔ Patient Demographics: Age, gender, date of birth
- ➔ Date of Screening: When the social needs screening was performed

- ➔ Screening Tool Used: Identification of the specific validated social needs screening tool (e.g., PRAPARE, Accountable Health Communities Health-Related Social Needs Screening Tool)
- ➔ Screening Results: Documentation of social needs response to question
- ➔ Intervention/Referral: If an unmet need was identified, documentation of an intervention (e.g., direct assistance, education) or a referral to a community resource
- ➔ Date of Intervention/Referral: When the intervention or referral occurred

5.1.3. LOINC and SNOMED CT Codes for SNS-E

- ➔ LOINC Codes (for Screening details, Identified Needs or referrals):
 - » Codes representing the administration of a social needs screening tool (e.g., 96777-8, 93025-5)
 - » Codes representing the individual questions within the screening tool (e.g., 71802-3, 96778-6)
 - » Codes representing specific identified social needs (e.g., LA31993-1, LA28580-1).
- ➔ SNOMED CT Codes (for Services and Referrals):
 - » Codes representing the intervention or referral service (e.g., 441041000124100 - [Counseling about nutrition (regime/therapy)], 471051000124104 - [Referral to Homelessness Prevention Program]).

5.2. Depression Screening and Follow-up (DSF-E)

5.2.1. Measure Description

The DSF-E measure assesses the percentage of members aged 12 and older screened for depression using a validated screening tool and, if screened positive, received a follow-up plan. CBH has selected the PHQ-9 or the PHQ9-M to be utilized by the provider network for depression screenings. A completed Edinburgh Postnatal Depression Scale (EPDS) will also count for this measure for those who are postpartum. Additionally, a PHQ-2 may be utilized and submitted for individuals who did not have a score of 3 or higher. Members who score 3 or higher on a PHQ-2 must be screened with a PHQ-9 or PHQ-9M.

5.2.2. Required Data Elements

- ➔ Patient Demographics: Age, gender, date of birth
- ➔ Date of Screening: When the depression screening was performed
- ➔ Screening Tool Used: Identification of the specific validated depression screening tool (e.g., PHQ-9 or EPDS)
- ➔ Screening Score/Result: The numerical score from the screening tool and/or the qualitative result (e.g., “positive screen for depression,” “negative screen for depression”)
- ➔ Follow-up Plan: If screened positive, documentation of a follow-up plan (e.g., referral for mental health services, medication management, psychotherapy)

- ➔ Date of Follow-up Plan: When the follow-up plan was documented

5.2.3. SNOMED CT and CPT Codes for DSF-E

- ➔ SNOMED CT Codes (for Screening and Results):
 - » Codes for the administration of the depression screening tool (e.g., [SNOMED_CODE_FOR_PHQ9_SCREENING]).
 - » Codes indicating the screening result (e.g., [SNOMED_CODE_FOR_POSITIVE_DEPRESSION_SCREEN], [SNOMED_CODE_FOR_NEGATIVE_DEPRESSION_SCREEN]).
 - » Codes for specific depression diagnoses, if applicable.
- ➔ CPT Codes (for Services and Follow-up):
 - » Codes for the screening service (e.g., 90837 for treatment service, or other applicable codes).
 - » Codes for follow-up services (e.g., [CPT_CODE_FOR_PSYCHOTHERAPY], [CPT_CODE_FOR_MEDICATION_MANAGEMENT], [CPT_CODE_FOR_REFERRAL_TO_MENTAL_HEALTH]).

5.3. Depression Remission or Response (DRR-E)

5.3.1. Measure Description

The DRR-E measure assesses the percentage of members 18 years and older with a diagnosis of depression who achieved remission or response to treatment within a specified timeframe. This measure requires an initial depression diagnosis and subsequent assessments. CBH has selected the PHQ-9 for the provider network to utilize for this measure.

5.3.2. Required Data Elements

- ➔ Patient Demographics: Age, gender, date of birth
- ➔ Initial Depression Diagnosis: Date and type of initial depression diagnosis
- ➔ Initial Depression Severity Score: Baseline score from a validated depression assessment tool (e.g., PHQ-9) at the time of diagnosis or treatment initiation
- ➔ Follow-up Assessment Dates: Dates of subsequent depression assessments
- ➔ Follow-up Assessment Scores: Scores from subsequent validated depression assessment tools
- ➔ Remission/Response Status: Documentation of whether remission or response criteria were met based on score changes

5.3.3. LOINC and CPT Codes for DRR-E

- ➔ LOINC and CPT Codes (for Diagnosis and Assessment):

- » Codes for specific depression diagnoses (e.g., [CPT_CODE_FOR_MAJOR_DEPRESSIVE_DISORDER])
 - » Codes for the administration of depression assessment tools (e.g., [LOINC_CODE_FOR_PHQ9_ASSESSMENT])
 - » Codes indicating remission or response status (e.g., [LOINC_CODE_FOR_DEPRESSION_REMISSION], [LOINC_CODE_FOR_DEPRESSION_RESPONSE])
- ➔ CPT Codes (for Services):
- » Codes for office visits, psychotherapy, medication management, or other services related to depression treatment and assessment

5.4. Postnatal Depression Screening and Follow-up (PDS-E)

5.4.1. Measure Description

The PDS-E measure assesses the percentage of pregnant and postpartum members who were screened for depression using a validated screening tool and, if screened positive, received a follow-up plan. This measure is specific to the perinatal period (pregnancy through 12 months postpartum). CBH has selected the Edinburgh Postnatal Depression Scale (EPDS) for this measure.

5.4.2. Required Data Elements

- ➔ Patient Demographics: Age, gender, date of birth, pregnancy status, delivery date
- ➔ Date of Screening: When the postnatal depression screening was performed
- ➔ Screening Tool Used: Identification of the specific validated postnatal depression screening tool (e.g., EPDS - Edinburgh Postnatal Depression Scale)
- ➔ Screening Score/Result: The numerical score from the screening tool and/or the qualitative result (e.g., “positive screen for perinatal depression”)
- ➔ Follow-up Plan: If screened positive, documentation of a follow-up plan specific to perinatal depression (e.g., referral for mental health services, medication management, psychotherapy, support groups)
- ➔ Date of Follow-up Plan: When the follow-up plan was documented

5.4.3. LOINC and CPT Codes for PDS-E

- ➔ LOINC Codes (for Screening and Results):
 - » Codes for the administration of the perinatal depression screening tool (e.g., [LOINC_CODE_FOR_EPDS_SCREENING])
 - » Codes indicating the screening result (e.g., [LOINC_CODE_FOR_POSITIVE_POSTNATAL_DEPRESSION_SCREEN])
 - » Codes for specific perinatal depression diagnoses, if applicable

- ➔ CPT Codes (for Services and Follow-up):
 - » Codes for the screening service
 - » Codes for follow-up services specific to perinatal mental health (e.g., [CPT_CODE_FOR_PERINATAL_COUNSELING], [CPT_CODE_FOR_REFERRAL_TO_PERINATAL_MENTAL_HEALTH])

6. HL7 MESSAGE STRUCTURE FOR HEDIS MEASURE DATA SUBMISSION

This section details the recommended HL7 message structure for submitting data for the HEDIS social needs and depression measures. We will focus on the ORU^R01 message type and the key segments that convey the necessary information, including SNOMED CT and CPT codes.

6.1. Recommended HL7 Message Type: ORU^R01 (Unsolicited Observation Message)

The ORU^R01 message is ideal for transmitting observation results, encompassing the outcomes of screenings, assessments, and the documentation of interventions or referrals. It allows for detailed reporting of clinical findings.

A typical ORU^R01 message structure for this purpose will include the following segments, in order:

- ➔ MSH: Message Header
- ➔ PID: Patient Identification
- ➔ [PD1]: Patient Demographic (for additional patient info)
- ➔ [PV1]: Patient Visit (encounter details)
- ➔ [PV2]: Patient Visit - Additional Information
- ➔ ORC: Common Order if linked to an order)
- ➔ OBR: Observation Request (One per observation battery/group)
- ➔ OBX: Observation Result (One or more per OBR, for individual observations)
- ➔ [NTE]: Notes and Comments (for additional narrative)
- ➔ [DG1]: Diagnosis (One or more per encounter, for related diagnoses)
- ➔ [PR1]: Procedures (for related procedures)

6.2. Key Segments for HEDIS Data Submission

Let's break down the essential segments and their relevant fields for HEDIS measure data submission.

6.2.1. MSH (Message Header)

The MSH segment defines the message’s origin, destination, type, and control information.

Field	Description	Example Value	Notes	Required/Optional
MSH.1	Field Separator	`	`	Required
MSH.2	Encoding Characters	^~\&	Standard HL7 delimiters	Required
MSH.3	Sending Application	EHR_SYSTEM_NAME	Name of the sending system (e.g., "Epic", "Cerner")	Required
MSH.4	Sending Facility	PROVIDER_FACILITY_ID	Identifier for the sending facility	Required
MSH.5	Receiving Application	CLIENT_APPLICATION_NAME	Name of the receiving system (e.g., "HEDIS_Processor")	Required
MSH.6	Receiving Facility	CLIENT_FACILITY_ID	Identifier for the client’s facility	Required
MSH.7	Date/Time Of Message	YYYYMMDDHHMMSS	Message creation timestamp	Required
MSH.9	Message Type	ORU^R01	Unsolicited Observation Message	Required
MSH.10	Message Control ID	UNIQUE_MESSAGE_ID	Unique identifier for this message	Required
MSH.11	Processing ID	P	P for Production, T for Training, D for Debugging	Required
MSH.12	Version ID	2.5.1	HL7 version (e.g., 2.5.1)	Required

6.2.2. PID (Patient Identification)

The PID segment contains demographic information about the patient.

Field	Description	Example Value	Notes	Required/Optional
PID.1	Set ID - PID	1	Sequence number	Required
PID.2	Patient ID	EXTERNAL_ID	External patient identifier (optional)	Optional
PID.3.4	Assigning Authority	1233456789^^PA^MAID	Use (PA) for Pennsylvania	Required
PID.3.5	Patient Identifier List	1234567890^^PA^MAID	patient’s Medical Assistance Identification number use (MAID) as the identifier type	Required
PID.5	Patient Name	DOE^JOHN^A	Last Name^First Name^Middle Initial	Required
PID.7	Date/Time of Birth	YYYYMMDD	patient’s date of birth	Required

Field	Description	Example Value	Notes	Required/Optional
PID.8	Administrative Sex	M or F or U	M (Male), F (Female), U (Unknown)	Required
PID.11	Patient Address	123 MAIN ST^^ANYTOWN^MN^55123^USA	Patient's current address	Required
PID.13	Phone Number - Home	(555)123-4567	Patient's home phone number	Required
PID.16	Marital Status	M or S or D	Marital status (e.g., M for Married)	Optional
PID.19	SSN Patient	XXX-XX-XXXX	Patient's Social Security Number (if available and permissible)	Required

6.2.3. PV1 (Patient Visit)

The PV1 segment contains patient visit information, including encounter details. This is crucial for linking observations to specific encounters.

Field	Description	Example Value	Notes	Required/Optional
PV1.1	Set ID - PV1	1	Sequence number	Required
PV1.2	Patient Class	O or I	O for Outpatient, I for Inpatient	Required
PV1.3	Assigned Patient Location	CLINIC_A^ROOM_101	Location of the patient during the encounter	Optional
PV1.7	Attending Doctor	SMITH^JANE^DR	Name of the attending physician	Optional
PV1.10	Hospital Service	MED or PSY	Service area (e.g., MED for Medical, PSY for Psychiatry)	Optional
PV1.18	Patient Type	REG	Patient type (e.g., REG for Regular)	Optional
PV1.19	Visit Number	VISIT_ID_123	CLM*1234567 Unique identifier for the patient's visit/encounter. Crucial for linking observations to an encounter. Submit CLM01 segment Loop 2300 for Professional and Institutional Claims	Required
PV1.44	Admit Date/Time	YYYYMMDDHHMMSS	Date and time of the patient's admission or start of encounter.	Required
PV1.45	Discharge Date/Time	YYYYMMDDHHMMSS	Date and time of discharge or end of encounter.	Required

6.2.4. OBR (Observation Request)

The OBR segment describes an order for a battery of observations or a single observation. For HEDIS measures, each screening or assessment (e.g., a PHQ-9 screening, a social needs screening) would typically correspond to one OBR segment, followed by one or more OBX segments for the individual results.

Field	Description	Example Value	Notes	Required/Optional
OBR.1	Set ID - OBR	1	Sequence number	Required
OBR.2	Placer Order Number	ORDER_ID_456	Unique identifier for the order	Optional
OBR.3	Filler Order Number	FILLER_ORDER_ID_789	Unique identifier assigned by the performing system	Optional
OBR.4	Universal Service Identifier	[CODE]^SCREENING_TYPE^L	Identifies the type of observation or battery. Use LOINC or a local code	Required
OBR.7	Observation Date/Time	YYYYMMDDHHMMSS	Identifies the year, date, and time. (E.g., 20250527113700)	Required
OBR.16	Ordering Provider	Provider NPI	Provider NPI	Required
OBR.25	Result Status	F (Final)	Results list available in Appendix D	Optional

6.2.5. OBX (Observation Result)

The OBX segment carries the actual observation result for a single observation. This is where the specific outcomes of screenings, assessments, and details of interventions are reported.

Field	Description	Optionality/Comments	Required/Optional
OBX.1	Set ID	Sequential number (e.g., 1).	Required
OBX.2	Value Type	CE (Coded Entry) or TX (Text). NM (Numeric) can be used for scores.	Required
OBX.3	Observation Identifier	SNOMED CT or LOINC (e.g., 88122-7^Food insecurity^LN).	Required
OBX.5	Observation Value	Result (e.g., Y for positive, numerical score, or coded value).	Required
OBX.11	Result Status	F (Final).	Required
OBX.14	Date/Time of Observation	YYYYMMDDHHMMSS (e.g., 20240520101500). When the observation was made.	Required
OBX.15	Producer's ID	CBH 6-Digit CHILD ID	Required
OBX.16	Responsible Observer	Provider NPI (e.g., 7583493848^Randolph^James^^Jr^Dr.^MD^^^^^^NPI).	Required

6.2.6. NTE (Notes and Comments)

The NTE segment allows for additional narrative comments related to a preceding segment, such as an OBX or OBR.

Field	Description	Optionality/Comments	Required/Optional
NTE.1	Set ID - NTE	Sequential number.	Optional
NTE.3	Comment	Notes on OBX results (e.g., Referred to community food bank).	Optional

6.2.7. DG1 (Diagnosis)

The DG1 segment contains patient diagnosis information. This segment is useful for measures like DRR-E, where an initial depression diagnosis is required.

Field	Description	Optionality/Comments	Required/Optional
DG1.1	Set ID - DG1	Sequential number (e.g., 1).	Required
DG1.2	Diagnosis Coding Method	I9 for ICD-9-CM, I10 for ICD-10-CM.	Optional (for backwards capability)
DG1.3	Diagnosis Code	The diagnosis code and description (e.g., F32.9^Major depressive disorder, single episode, unspecified^I10).	Required
DG1.5	Diagnosing Date/Time	YYYYMMDDHHMMSS. Date and time of the diagnosis.	Required

6.2.8. PR1 (Procedures)

The PR1 segment contains information about procedures performed on the patient. While often captured in OBR/OBX for HEDIS, this segment can provide additional detail for complex procedures or interventions.

Field	Description	Optionality/Comments	Required/Optional
PR1.1	Set ID - PR1	Sequential number (e.g., 1).	Required
PR1.2	Procedure Code Type	C4 for CPT, I9 for ICD-9-CM procedure, I10 for ICD-10-PCS.	Optional (for backwards capability)
PR1.3	Procedure Code	The procedure code and description (e.g., 90832^Psychotherapy, 30 min^C4).	Required
PR1.5	Procedure Date/Time	YYYYMMDDHHMMSS. Date and time the procedure was performed.	Required

6.3. Encoding LOINC, SNOMED CT, and CPT Codes within the OBR and OBX Segments

Accurate encoding of SNOMED CT and CPT codes is paramount for HEDIS reporting. These codes are primarily conveyed within the OBX (Observation Result) and OBR (Observation Request) segments using the CE (Coded Element) data type. The CE data type typically follows the format CODE^TEXT^CODING_SYSTEM. In some cases, only the code is needed (as defined by the segment field structure).

6.3.1. OBR Segment for identification of the specific HEDIS measurement tool

The OBR segment contains information about the service performed on the patient. In this context, it will identify (among other details about the service) which HEDIS measurement tool was used (e.g. Depression, social needs). This information is detailed in the OBR.4 field.

- ➔ **OBR.4 (Universal Service Identifier):** This field contains a LOINC code which identifies the specific HEDIS reporting tools used during the service.

- » Example for depression screening:

```
OBR||44261-6^ PHQ-9 Total Score^LN|...
```

- » Example for social needs screening:

```
OBR||93025-5^ Prepare^LN|...
```

6.3.2. OBX Segment for Screening Results or Interventions/Referrals

The OBX segment reflects the result of the patient service (as identified in the OBR segment). The results can be communicated using a LOINC code or SNOMED CT Code depending on the service type. Namely, one of the following:

- ➔ Reporting the total score of a depression screening,
- ➔ Specific observation within a particular social needs screening tool
- ➔ Intervention/Referral in response to a positive social needs screening outcome

The OBX.3 and OBX.5 fields within the OBX segment will be used to relay this information.

- ➔ **OBX.3 (Observation Identifier):** The value (numeric or coded entry) of this field will vary depending upon the screening tool identified in OBR.4.

- » Example observation identifier for a PHQ-9 depression screening:

```
OBX|1|NM|44261-6^ PHQ-9 Total Score^LN||18|...
```

- » Example observation identifier for a specific observation within an ARC HRSN screening tool:

```
OBX|1|CE|71802-3^What is your living situation?^LN||LA31995-6|...
```

- ➔ **OBX.5 (Observation Value):** This field contains the screening’s result (answer to a question or ultimate outcome). When the result itself is a coded value (e.g., a positive screening result, a specific type of social need identified, or a remission status), a SNOMED CT code is used here.

- » Example observation value for a depression screening tool:

```
OBX|1|NM|44261-6^ PHQ-9 Total Score^LN||18|...
```

For numerical scores (from a depression screening), OBX.2 indicates ‘NM’ (Numeric), and OBX.5 contains the score (e.g., 18).

- » Example LOINC observation value for a specific observation within an ARC HRSN screening tool:

```
OBX|1|CE|71802-3 ^What is your living situation?^LN||LA31995-6|...
```

- » Example for a referral/intervention:

```
OBX|1|CE|71802-3 ^What is your living situation?^LN||471041000124101|...
```

7. CONNECTIVITY AND TRANSMISSION OPTIONS

This section outlines the available methods for connecting with CBH and securely transmitting HL7 files, along with details on file formats and naming conventions.

7.1. SFTP Submission

Beginning September 2, 2025, CBH will begin collecting screening results from providers via HL7 Version 2.5.1 ORU^R01 message version, in accordance with the [HL7 Implementation Guide](#) for batch processing and via claims data. Providers will submit HL7 files via IPSWITCH and submission of files should be uploaded to the HL7 subfolder. The naming convention must be used in order for the file to be processed correctly.

For secure file transfer, please use the following SFTP details.

- ➔ In order to access IPSWITCH, providers must complete a form to securely exchange files with CBH and gain access to the HL7 file folders (See [Attachment A](#)). The completed form must be sent to the CBH.FileTransfer@phila.gov and CBH will update your permissions and share credentials.
- ➔ File Format: HL7 ORU^R01 files (.hl7), zipped with AES-256 encryption
- ➔ Naming Convention:
 - “par_XXXX_YYYYMMDD.HL7”

XXXX refers to your respective 4-digit parent ID number. The date should be the date the file is uploaded into IPSWITCH.

7.2. Response File

Acknowledgement and Response files will be produced by CBH as follows. These files can be found in the provider IPSWITCH HL7 outbound file.

- ➔ **Acknowledgement File:** After testing, CBH will produce an acknowledgement file with the naming convention of PAR_XXXX_YYYYMMDD.HL7_report within 1 business day following the receipt of PAR_XXXX_YYYYMMDD.HL7file.
- ➔ **Response File:** After testing, within 1 business day of the ingestion of PAR_XXXX_YYYYMMDD.HL7 file, CBH will produce response files with the naming convention: PAR_XXXX_YYYYMMDD.HL7_response.

7.3. Contact Information

For any questions or support, please follow-up with your CBH provider representative.

7.4. Transaction-Specific Information

7.4.1. HL7 Version Standard

Please use HL7 Version 2.5.1 ORU^R01 messages per the HL7 Implementation Guide for Observation Reporting.

7.4.2. HL7 Protocol Standards

- ➔ Transport: SFTP (preferred)
- ➔ Security: AES-256 encryption for files, TLS 1.2+ for HTTPS
- ➔ Delimiters: | (field), ^ (component), & (subcomponent), \ (escape)

7.5. Submitting HL7 Files

Follow these steps for submitting your HL7 files:

1. Generate the ORU^R01 message within your EHR or other platform.
2. Validate the message using HL7 tools (e.g., HAPI HL7v2, HL7 Inspector).
3. Compress the file into a zip archive and upload it to the SFTP server.
4. You will receive a confirmation and any error reports as outlined in 7.2 above.

7.5.1. File Format

- ➔ **File Format:** Files must be plain text (ASCII or UTF-8) using HL7 delimiters:
 - » |: Field separator (e.g., separates PID-1 from PID-3)
 - » ^: Component separator (e.g., separates last name from first name in PID-5)
 - » &: Subcomponent separator (e.g., used in coded elements)
 - » \: Escape character for special characters
 - » *Example:* PID|1||1148649301^^^PA^MAID||Smith^John^

8. HL7 BATCH FILE SEGMENTS

HL7 Version 2.5.1 ORU^R01 messages are used to submit clinical data in batches. The following explains the purpose and details of these batch file segments, which benefit measures such as SNS-E, DSF-E, DRR-E, and PDS-E.

8.1. Purpose and Benefits of Batch Segments

- ➔ **FHS (File Header Segment):** Starts the HL7 file, identifying the provider (e.g., NPI) and file metadata (e.g., creation date, file name)
 - » **Benefits:** Ensures the receiving system can verify the file's origin and integrity, which is critical for tracking submissions from multiple providers in HEDIS reporting
- ➔ **BHS (Batch Header Segment):** Groups multiple patient messages (MSH segments) within a file, allowing submission of data for multiple patients or measures (e.g., SNS-E, DSF-E)
 - » **Benefits:** Simplifies processing large datasets, reduces file management overhead, and supports state-wide platform submissions
- ➔ **BTS (Batch Trailer Segment):** Closes a batch, specifying the number of messages included
 - » **Benefits:** Allows the receiving system to confirm all messages were received, preventing data loss
- ➔ **FTS (File Trailer Segment):** Closes the file, specifying the number of batches
 - » **Benefits:** Confirms file completeness, ensuring no batches are missing

8.1.1. Why Use These Segments?

While optional in HL7 Version 2.5.1, FHS, BHS, BTS, and FTS are recommended for HEDIS submissions to handle high-volume data from multiple providers or the state-wide platform. They ensure accurate processing, error detection, and traceability, especially for complex submissions involving SNS-E, DSF-E, DRR-E, and PDS-E measures. Omitting them may lead to errors in multi-patient submissions.

8.2. Segment Details

This section provides detailed information on the key fields within each HL7 segment relevant to HEDIS data submission.

8.2.1. FHS - File Header Segment

Field	Description	Optionality/Comments
FHS-4	Sending Facility	Required: Provider NPI or assigned ID (e.g., 1234567890^ProviderName^L).
FHS-9	File Name/ID	Required: Matches file name (e.g., 1234567890_20250527_SNSE_001).

8.2.2. BHS - Batch Header Segment

Field	Description	Optionality/Comments
BHS-4	Sending Facility	Required: Same as FHS-4.

8.2.3. MSH - Message Header Segment

Field	Description	Optionality/Comments
MSH-4	Sending Facility	Required: Provider NPI or assigned ID.
MSH-9	Message Type	Required: ORU^R01.
MSH-11	Processing ID	Required: P (Production) or T (Test).
MSH-12	Version ID	Required: 2.5.1.

8.2.4. PID - Patient Identification Segment

The PID segment contains demographic information about the patient.

Field	Description	Optionality/Comments
PID.1	Set ID - PID	Required: 1.
PID.2	Patient ID	Optional: External patient identifier
PID.3	Patient Identifier	Required: Member ID (PA MA ID).
PID.5	Patient Name	Required: Last^First^Middle.
PID.7	Date of Birth	Required: YYYYMMDD (e.g., 19850515).
PID.8	Sex	Required: F, M, or U.

Field	Description	Optionality/Comments
PID.11	Address	Required: Mailing address (type M, e.g., 123 Main St^^Anytown^TX^78701^M).

8.2.5. OBR - Observation Request Segment

The OBR segment describes an order for a battery of observations or a single observation. For HEDIS measures, each screening or assessment (e.g., a PHQ-9 screening, a social needs screening) would typically correspond to one OBR segment, followed by one or more OBX segments for the individual results.

Field	Description	Optionality/Comments
OBR.1	Set ID - OBR	Required: Sequential number (e.g., 1).
OBR.4	Universal Service Identifier	Required. Identifies the type of observation or battery. Use LOINC or a local code.
OBR.7	Observation Date/Time	Required: YYYYMMDDHHMMSS (e.g., 20250527).
OBR.16	Ordering Provider	Required: Provider NPI.
OBR.25	Result Status	Optional: F (Final).

8.2.6. OBX - Observation/Result Segment

The OBX segment carries the actual observation result for a single observation. This is where the specific outcomes of screenings, assessments, and details of interventions are reported.

Field	Description	Optionality/Comments
OBX.1	Set ID	Required: Sequential number (e.g., 1).
OBX.2	Value Type	Required: CE (Coded Entry) or TX (Text). NM (Numeric) can be used for scores.
OBX.3	Observation Identifier	Required: SNOMED CT or LOINC (e.g., 423100009^Food insecurity^SCT).
OBX.5	Observation Value	Required: Result (e.g., Y for positive, numerical score, or coded value).
OBX.11	Result Status	Required: F (Final).
OBX.14	Date/Time of Observation	Required: YYYYMMDDHHMMSS (e.g., 20240520101500). When the observation was made.
OBX.15	Producer's ID	Required: Performing organization or provider. CBH 6-Digit CHILD ID
OBX.16	Responsible Observer	Required: Provider NPI (e.g., 7583493848^Randolph^James^^Dr.^MD^^^^^^NPI).

8.2.7. NTE - Notes and Comments Segment

The NTE segment allows for additional narrative comments related to a preceding segment, such as an OBX or OBR.

Field	Description	Optionality/Comments
NTE.1	Set ID - NTE	Optional: Sequential number.
NTE.3	Comment	Optional: Notes on OBX results (e.g., Referred to community food bank).

8.2.8. BTS - Batch Trailer Segment

The BTS segment closes a batch, specifying the number of messages included.

Field	Description	Optionality/Comments
BTS-1	Batch Message Count	Required: Number of MSH segments.

8.2.9. FTS - File Trailer Segment

The FTS segment closes the file, specifying the number of batches.

Field	Description	Optionality/Comments
FTS-1	File Batch Count	Required: Number of batches (BHS segments).

8.2.10. Example: Multi-Patient Submission for SNS-E and DSF-E

This example shows a batch file with two patients: one with a food insecurity screening (SNS-E) and one with a depression screening (DSF-E). FHS and FTS bookend the file, while BHS and BTS group the messages.

```
FHS|^~\&|1234567890^ProviderName^L|||20250527||1234567890_20250527_SNSE_001
BHS|^~\&|1234567890^ProviderName^L|||20250527
MSH|^~\&|1234567890^ProviderName^L|||20250527||ORU^R01|ORU_R01|P|2.5.1
PID|1||1148649301^^^^MB||Smith^John^||19850515|M|||123 Main
St^^Austin^TX^78701^M
OBR|1|||96777-
8^AHC^LN|||20250527100000||||||7583493848^Randolph^James^^^^^^^^^NP
I||||||F|
OBX|1|CE|88123-5^4. Within the past 12 months, the food you bought just
didn't last and you didn't have money to get more.^LN||
464031000124101|||||F|||20250527100000|7583493848|Randolph^James
NTE|||Referred to community food bank
```

```

MSH|^~\&|1234567890^ProviderName^L|||20250527||ORU^R01|ORU_R01|P|2.5.1
PID|1||1148649302^^^PA^MAID||Doe^Jane^||19900620|F|||456 Oak
St^^Austin^TX^78701^M
OBR|1|||44261-6^(PHQ-9) total
score^LN|||20250527100000|||||||7583493848^Randolph^James^^^^^^^^^^^NP
I|
OBX|1|NM||44261-6^PHQ-9 total
score^LN||18|||||F|||20240522104500|par_xxxx^ProviderName
|7583493848^Randolph^James^^^^^^^^^^^NPI
NTE|||Referred to mental health services
BTS|2
FTS|1

```

Explanation:

- ➔ **FHS:** Identifies the file with provider NPI and file name (matches naming convention)
- ➔ **BHS:** Starts a batch for multiple patient records
- ➔ **First MSH Group:** Reports a food insecurity screening (SNS-E) for John Smith, with a positive result and referral
- ➔ **Second MSH Group:** Reports a depression screening (DSF-E) for Jane Doe, with a positive PHQ-9 result and referral
- ➔ **BTS:** Confirms two messages (MSH segments) in the batch
- ➔ **FTS:** Confirms one batch in the file

9. DETAILED HL7 IMPLEMENTATION EXAMPLES

This section provides concrete HL7 message examples for each HEDIS measure, demonstrating how the required data elements, including SNOMED CT and CPT codes, are placed within the ORU^R01 message structure.

Note: These examples use placeholder codes (e.g., [SNOMED_CODE], [CPT_CODE]). In a real-world implementation, these must be replaced with the exact, current, and HEDIS-compliant codes. Dates and times are in YYYYMMDDHHMMSS format.

9.1. Example 1: SNS-E – Positive Social Needs Screening with Referral

9.1.1. Scenario

A patient, Jane Doe, born on 1985-03-15, underwent a social needs screening on 2024-05-20. The screening identified food insecurity, and on the same day, a referral to a local food bank was made.

9.1.2. HL7 Message Example

```

MSH|^~\&|EHR_SYSTEM|PROVIDER_FACILITY|HEDIS_PROCESSOR|CLIENT_FACILITY|2
0240520103000||ORU^R01|MSG12345|P|2.5.1
PID|1||PATIENTID123^^^PA^MAID||DOE^JANE^A||19850315|F|||123 MAIN
ST^^ANYTOWN^MN^55123^USA|| (555)123-4567||S
PV1|1|O|||||123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI|||||||Claim
Number|||||||20240520100000
OBR|1|||96777-8^Accountable health communities (AHC) health-related
social needs screening (HRSN)
tool^LN|||20240520101500|||||||123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI
|
OBX|1|CE|71802-3^1. What is your living situation today?^LN||LA31993-
1|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^
Dr.^MD^^^^^^NPI|
OBX|2|CE|96778-6^2. Think about the place you live. Do you have
problems with any of the following?^LN||LA9-3|||||F|||20240520101500|
par_xxxx^FACILITYNAME|123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI|
OBX|3|CE|88122-7^3. Within the past 12 months, you worried that your
food would run out before you got money to buy more?^LN||LA28397-0
|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^D
r.^MD^^^^^^NPI|
OBX|4|CE|88123-5^4. Within the past 12 months, the food you bought just
didn't last and you didn't have money to get more.^LN||LA28397-0
|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^D
r.^MD^^^^^^NPI|
OBX|5|CE|93030-5^5. In the past 12 months, has lack of reliable
transportation kept you from medical appointments, meetings, work or
from getting things needed for daily living?^LN||LA32-
8|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^
Dr.^MD^^^^^^NPI|
OBX|6|CE|96779-4^6. In the past 12 months has the electric, gas, oil,
or water company threatened to shut off services in your home?
^LN||LA32-
8|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^
Dr.^MD^^^^^^NPI|
OBX|7|CE|95618-5^7. How often does anyone, including family and
friends, physically hurt you?^LN||LA6270-
8|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^
Dr.^MD^^^^^^NPI|
OBX|8|CE|95617-7^8. How often does anyone, including family and
friends, insult or talk down to you?^LN||LA6270-8
|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^D
r.^MD^^^^^^NPI|
OBX|9|CE|95616-9^9. How often does anyone, including family and
friends, threaten you with harm?^LN||LA6270-8|||||F|||20240520101500|
par_xxxx^FACILITYNAME|123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI|

```

```
OBX|10|CE|95615-1^10. How often does anyone, including family and
friends, scream or curse at you?^LN||LA6270-
8|||||F|||20240520101500|par_xxxx^ProviderName|123456789^SMITH^JOHN^^^
Dr.^MD^^^^^^NPI|
OBX|11|CE|88122-7^3. Within the past 12 months, you worried that your
food would run out before you got money to buy
more?^LN||464141000124105|||||F|||20240520101500|par_xxxx^ProviderName
|123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI|
NTE|1||Patient screened positive for food insecurity. Referral to food
bank provided.
DG1|1||Z71.82^Counseling on health without a specified
diagnosis^I10||20240520101500
PR1|1||90791^Psychiatric Diagnostic Evaluation without medical
services^C4||20240520102000
```

9.1.3. Explanation of Key Fields

- ➔ **MSH** (Message Header): Standard segment identifying the message's origin, destination, and type.
 - » MSH.4 (Sending Facility): EHR_SYSTEM
 - » MSH.9 (Message Type): ORU^R01 (Observation Result - Unsolicited, a common type for lab results and clinical observations)
 - » MSH.10 (Message Control ID): MSG12345 (Unique message identifier)
 - » MSH.12 (Version ID): 2.5.1 (HL7 version number)
- ➔ **PID** (Patient Identification): Provides the patient's demographic information
 - » PID.3 (Patient Identifier List): PATIENTID123 (The unique member ID)
 - » PID.5 (Patient Name): DOE^JANE^A
 - » PID.7 (Date of Birth): 19850315
 - » PID.8 (Administrative Sex): F (Female)
- ➔ **PV1** (Patient Visit): Details the patient's encounter or visit.
 - » PV1.2 (Patient Class): O (Outpatient)
 - » PV1.7 (Attending Doctor): DR_SMITH^JOHN^MD
 - » PV1.19 (Visit Number): VISIT_SNS_20240520 (Unique encounter identifier)
 - » PV1.44 (Admit Date/Time): 20240520100000 (The start date/time of the visit)
- ➔ **OBR** (Observation Request): Acts as a header for a group of observations. It identifies the overall assessment or service that was performed.

- » OBR.4 (Universal Service Identifier): 96777-8^SAccountable health communities (AHC) health-related social needs screening (HRSN) tool^LN. This LOINC code specifies that the observation group is related to a general SDOH assessment.
- » OBR.7 (Observation Date/Time): 20240520101500 (The date/time the assessment was completed)OBR.16 (Ordering Provider):
123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI
- » OBX (1-10)| (Screening Details): These segments provide detailed information (questions and answers) regarding the screening
- » OBX.2 (Value Type): CE (Coded Element), indicating the value is a code
- » OBX.3 (Observation Identifier): This is the LOINC code for the specific question asked.
- » OBX.5 (Observation Value): This is the LOINC code for the answer to the question asked.
- » OBX.14 (Date/Time of Observation): 20240520101500 (The date/time the observation was recorded).
- » OBX.15 (Producer's ID): par_xxxx^ProviderName. The provider who submitted the request
- » OBX.16 (Responsible Observer): 123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI. The provider who provided the referral.
- » OBX(11)| (Screening Outcome): This segment reports the direct result of the food insecurity screening, which is crucial for HEDIS measure calculation.
- » OBX.2 (Value Type): CE (Coded Element), indicating the value is a code
- » OBX.3 (Observation Identifier): 88122-7^Food Security Screening (AHC HRSN)^LN. This is the LOINC code for the specific screening tool that was used.
- » OBX.5 (Observation Value): LA28397-0^Food insecurity identified^LN. This is the LOINC answer code that confirms a positive finding for food insecurity.
- » OBX.14 (Date/Time of Observation): 20240520101500 (The date/time the score was recorded).
- » OBX.15 (Producer's ID): par_xxxx^ProviderName. The provider who submitted the outcome.
- » OBX.16 (Responsible Observer): 123456789^SMITH^JOHN^^^Dr.^MD^^^^^^NPI. The provider who provided the referral.
- » PR1 (Procedures): This segment is used to report a procedure or service performed, which in this case is the intervention.
- » PR1.3 (Procedure Code): 90791^Psychiatric Diagnostic Evaluation without medical services^C4. This is the CPT code for the intervention that counts towards the HEDIS numerator.

- » PR1.5 (Procedure Date/Time): 20240520102000 (The date/time the intervention was performed)
- ➔ NTE (Notes and Comments): Provides additional, human-readable context for the observations or procedures
 - » NTE.3: “Patient screened positive for food insecurity. Referral to food bank provided.” (A textual description of the clinical activity)

9.2. Example 2: DSF-E – Depression Screening (PHQ-9) with Follow-Up Plan

9.2.1. Scenario

A patient, John Smith, aged 35, underwent a PHQ-9 depression screening on 2024-05-22 during an outpatient visit. The score was 18, indicating moderately severe depression. A follow-up plan for referral to mental health services was documented on the same day.

9.2.2. HL7 Message Example

```
MSH|^~\&|EHR_SYSTEM|PROVIDER_FACILITY|HEDIS_PROCESSOR|CLIENT_FACILITY|2
0240522103000||ORU^R01|MSG67890|P|2.5.1
PID|1||PATIENTID456^^^EHR^MRN||SMITH^JOHN^A||19890522|M||456 OAK
ST^^ANYTOWN^MN^55123^USA||(555)987-6543||S
PV1|1|O||||DR_LEE^SUSAN^MD|||||||claim
number|||||||20240522101000|
OBR|1||44261-6^PHQ-9 total
score^LN||20240522101500|||||DR_LEE^SUSAN^MD||||F||
OBX|1|NM|44261-6^PHQ-9 total
score^LN||18||||F||20240522102000|||DR_LEE^SUSAN^MD|
DG1|1||F32.1^Major depressive disorder, single episode,
moderate^I10||||A||
NTE|1||Patient screened positive for depression with a PHQ-9 score of
18. A referral to mental health services was provided|
```

9.2.3. Explanation of Key Fields

- ➔ MSH (Message Header): Standard segment identifying the message’s origin, destination, and type.
 - » MSH.4 (Sending Facility): EHR_SYSTEM
 - » MSH.9 (Message Type): ORU^R01 (Observation Result - Unsolicited)
 - » MSH.10 (Message Control ID): MSG67890 (Unique message identifier)
 - » MSH.12 (Version ID): 2.5.1 (HL7 version number)
- ➔ PID (Patient Identification): Provides the patient’s demographic information.
 - » PID.3 (Patient Identifier List): PATIENTID456 (The unique member ID).

- » PID.5 (Patient Name): SMITH^JOHN^A.
- » PID.7 (Date of Birth): 19890522.
- » PID.8 (Administrative Sex): M (Male).
- ➔ **PV1** (Patient Visit): Details the patient’s encounter or visit.
 - » PV1.2 (Patient Class): O (Outpatient).
 - » PV1.7 (Attending Doctor): 123456789^LEE^SUSAN^^^Dr.^MD^^^^^^NPI.
 - » PV1.19 (Visit Number): VISIT_DSJF_20240522 (Unique encounter identifier).
 - » PV1.44 (Admit Date/Time): 20240522100000 (The start date/time of the visit).
- ➔ **OBR** (Observation Request): Acts as a header for a group of observations. It identifies the overall assessment performed.
 - » OBR.4 (Universal Service Identifier): 44261-6^PHQ-9 total score^LN. This LOINC code specifies that the observation group is related to the PHQ-9 assessment.
 - » OBR.7 (Observation Date/Time): 20240522101500 (The date/time the assessment was started).
 - » OBR.16 (Ordering Provider): 123456789^LEE^SUSAN^^^Dr.^MD^^^^^^NPI.
- ➔ **OBX** (Screening Outcome): This segment reports the direct numeric score from the PHQ-9, which is a key component for HEDIS measure calculation.
 - » OBX.2 (Value Type): NM (Numeric), indicating the value is a number.
 - » OBX.3 (Observation Identifier): 44261-6^PHQ-9 total score^LN. This is the LOINC code for the total score of the PHQ-9.
 - » OBX.5 (Observation Value): 18 (The patient’s numeric score).
 - » OBX.14 (Date/Time of Observation): 20240522102000 (The date/time the score was recorded).
 - » OBX.15 (Producer’s ID): par_xxxx^ProviderName. The provider who submitted the request.
 - » OBX.16 (Responsible Observer): 123456789^LEE^SUSAN^^^Dr.^Md^^^^^^NPI. The provider who conducted the measurement.
- ➔ **NTE** (Notes and Comments): Provides additional, human-readable context for the observations or procedures.
 - » NTE.3: “Patient screened positive for depression with a PHQ-9 score of 18. A referral to mental health services was provided.” (A textual description of the clinical activity)
- ➔ **DG1** (Diagnosis): This segment is used to report a diagnosis or, in this case, a finding that counts as a behavioral health encounter.

- » DG1.3 (Diagnosis Code): F32.2^Major depressive disorder, single episode, severe without psychotic features^I10. This ICD-10-CM code is part of the “Behavioral Health Encounter Value Set” and documents the counseling/follow-up action.
- » DG1.5 (Diagnosis Date Time): 20240522102000

9.3. Example 3: DRR-E – Depression Remission Assessment

9.3.1. Scenario

A patient, Sarah Davis, diagnosed with Major Depressive Disorder on 2023-11-01, had an initial PHQ-9 score of 20. On 2024-05-25, a follow-up PHQ-9 assessment was performed, yielding a score of 4, indicating remission.

9.3.2. HL7 Message Example

```
MSH|^~\&|EHR_SYSTEM|PROVIDER_FACILITY|HEDIS_PROCESSOR|CLIENT_FACILITY|2
0240525110000||ORU^R01|MSG98765|P|2.5.1
PID|1||PATIENTID789^^^EHR^MRN||DAVIS^SARAH^L||19851015|F|||789 MAPLE
AVE^^ANYTOWN^MN^55123^USA|| (555) 555-1212||S
PV1|1|O|||||DR_JONES^MARY^MD|||||||claim
number|||||||||||||||||||||20240525103000|
OBR|1||44250-7^PHQ-9
panel^LN|||20240525104500|||||||DR_JONES^MARY^MD||||F|||
OBX|1|NM|44261-6^PHQ-9 total
score^LN||20||||F|||20231101120000|||DR_JONES^MARY^MD|
OBX|2|NM|44261-6^PHQ-9 total
score^LN||4||||F|||20240525105000|||DR_JONES^MARY^MD|
NTE|1||Follow-up PHQ-9 score of 4 indicates remission of depression
symptoms.|
DG1|1||F33.42^ Major depressive disorder, recurrent, in full remission
(no significant symptoms for at least two months)
^I10||||A|||20240527|
```

9.3.3. Explanation of Key Fields

- ➔ **MSH** (Message Header): Standard header identifying the message’s origin, destination, and type
 - » MSH.4 (Sending Facility): EHR_SYSTEM
 - » MSH.9 (Message Type): ORU^R01 (Observation Result - Unsolicited)
 - » MSH.10 (Message Control ID): MSG98765 (Unique message identifier)
 - » MSH.12 (Version ID): 2.5.1 (HL7 version number)
- ➔ **PID** (Patient Identification): Provides the patient’s demographic information
 - » PID.3 (Patient Identifier List): PATIENTID789 (The unique member ID)
 - » PID.5 (Patient Name): DAVIS^SARAH^L

- » PID.7 (Date of Birth): 19851015
- » PID.8 (Administrative Sex): F (Female)
- ➔ **PV1** (Patient Visit): Details the patient's encounter or visit
 - » PV1.2 (Patient Class): O (Outpatient)
 - » PV1.7 (Attending Doctor): 123456789^JONES^MARY^^^Dr.^MD^^^^^NPI
 - » PV1.19 (Visit Number): VISIT_DSF_20240525 (Unique encounter identifier)
 - » PV1.44 (Admit Date/Time): 20240525103000 (The start date/time of the visit)
- ➔ **OBR** (Observation Request): Acts as a header for a group of observations; identifies the overall assessment performed
 - » OBR.4 (Universal Service Identifier): 44261-6^PHQ-9 panel^LN (This LOINC code specifies that the observation group is related to the PHQ-9 assessment.)
 - » OBR.7 (Observation Date/Time): 20240525104500 (The date/time the assessment was started)
 - » OBR.16 (Ordering Provider): 123456789^JONES^MARY^^^Dr.^MD^^^^^NPI.
- ➔ **OBX** (Screening Outcome): This segment reports the direct numeric score from the follow-up PHQ-9, which is a key component for HEDIS measure calculation.
 - » OBX.2 (Value Type): NM (Numeric), indicating the value is a number
 - » OBX.3 (Observation Identifier): 44261-6^PHQ-9 total score^LN (This is the LOINC code for the total score of the PHQ-9.)
 - » OBX.5 (Observation Value): 4 (The patient's numeric score) A score of <5 indicates remission, satisfying the numerator criteria.
 - » OBX.14 (Date/Time of Observation): 20240525105000 (The date/time the score was recorded)
 - » OBX.15 (Producer's ID): par_xxxx^ProviderName.
 - » OBX.16 (Responsible Observer): 123456789^JONES^MARY^^^Dr.^MD^^^^^NPI.
- ➔ **NTE** (Notes and Comments): Provides additional, human-readable context for the observations or procedures
 - » NTE.3: "Follow-up PHQ-9 score of 4 indicates remission of depression symptoms." (A textual description of the clinical activity)
- ➔ **DG1** (Diagnosis): Reports the patient's primary diagnosis; demonstrates the existence of the major depressive disorder
 - » DG1.3 (Diagnosis Code): F32.2^Major depressive disorder, single episode, severe without psychotic features^I10. This is the ICD-10-CM code for the diagnosis.

» DG1.5 (Diagnosis Date/Time): 20231101101500 (The date the diagnosis was made)

9.4. Example 4: PDS-E – Perinatal Depression Screening

9.4.1. Scenario

A pregnant patient, Maria Garcia, 28 years old, had an EPDS screening on 2024-05-27. Her score was 14, indicating a positive screen for perinatal depression. A referral for perinatal mental health counseling was made on the same day.

9.4.2. HL7 Message Example

```
MSH|^~\&|EHR_SYSTEM|PROVIDER_FACILITY|HEDIS_PROCESSOR|CLIENT_FACILITY|2
0240527103000||ORU^R01|MSG54321|P|2.5.1
PID|1||PATIENTID999^^^PA^MAID||GARCIA^MARIA^E||19960305|F|||123 ELM
ST^^ANYTOWN^MN^55123^USA|| (555) 333-4444||S
PV1|1|O|||||123456789^PATEL^ANNA^^^Dr.^MD^^^NPI|||||||||claim
number|||||||||20240527100000
OBR|1|||99046-5^Edinburgh Postnatal Depression Scale (EPDS) total
score^LN|||20240527101500|||||123456789^PATEL^ANNA^^^Dr.^MD^^^NPI|
OBX|1|NM|99046-5^Edinburgh Postnatal Depression Scale (EPDS) total
score^LN||14|||||F|||20240527102000|par_xxxx^ProviderName|123456789^PA
TEL^ANNA^^^Dr.^MD^^^NPI|
NTE|1||Patient screened positive for perinatal depression with an EPDS
score of 14. A referral for mental health counseling was documented.
DG1|1||Z33.1^Pregnant state, incidental^I10||20240527101500|||A|||
DG1|2||F32.2^Major depressive disorder, single episode, severe without
psychotic features^I10||20240527101500|||A|||
PR1|1||90791^Psychiatric Diagnostic Evaluation without medical
services^C4||20240527101500
```

9.4.3. Explanation of Key Fields

- ➔ **MSH** (Message Header): Standard segment identifying the message's origin, destination, and type
 - » MSH.4 (Sending Facility): EHR_SYSTEM
 - » MSH.9 (Message Type): ORU^R01 (Observation Result - Unsolicited)
 - » MSH.10 (Message Control ID): MSG54321 (A unique message identifier)
- ➔ **PID** (Patient Identification): Provides the patient's demographic information
 - » PID.3 (Patient Identifier List): PATIENTID999 (The unique member ID)
 - » PID.5 (Patient Name): GARCIA^MARIA^E
 - » PID.7 (Date of Birth): 19960305
 - » PID.8 (Administrative Sex): F (Female)
- ➔ **PV1** (Patient Visit): Details the patient's encounter or visit

- » PV1.2 (Patient Class): O (Outpatient)
- » PV1.7 (Attending Doctor): 123456789^PATEL^ANNA^^^Dr.^MD^^^NPI
- » PV1.19 (Visit Number): VISIT_PDS_20240527 (A unique encounter identifier)
- ➔ **DG1** (Diagnosis) | 1: Reports the patient’s pregnancy status, which is a key part of the PDS-E measure’s denominator
 - » DG1.2 (Diagnosis Coding Method): I10
 - » DG1.3 (Diagnosis Code): Z33.1^Pregnant state, incidental^I10. This ICD-10-CM code establishes the patient’s pregnancy status.
 - » DG1.5 (Diagnosis Date/Time): 20240527 (The date the pregnancy was confirmed or documented in the chart)
- ➔ **OBR** (Observation Request): Acts as a header for a group of observations; identifies the overall assessment performed
 - » OBR.4 (Universal Service Identifier): 99046-5^EPDS total score^LN. This LOINC code specifies that the observation group is related to the EPDS assessment.
 - » OBR.7 (Observation Date/Time): 20240527101500 (The date/time the assessment was started)
 - » OBR.16 (Ordering Provider): 123456789^PATEL^ANNA^^^Dr.^MD^^^NPI.
- ➔ **OBX** (Screening Outcome): This segment reports the direct numeric score from the EPDS. A score of 14 is a positive finding, satisfying the screening criteria.
 - » OBX.2 (Value Type): NM (Numeric), indicating the value is a number
 - » OBX.3 (Observation Identifier): 99046-5^ EPDS total score^LN. This is the LOINC code for the total score of the EPDS.
 - » OBX.5 (Observation Value): 14 (The patient’s numeric score, which is a positive screen)
 - » OBX.14 (Date/Time of Observation): 20240527102000 (The date/time the score was recorded)
 - » OBX.15 (Producer’s ID): par_XXXX^ProviderName.
 - » OBX.16 (Responsible Observer): 123456789^PATEL^ANNA^^^Dr.^MD^^^NPI.
- ➔ **NTE** (Notes and Comments): Provides additional, human-readable context for the observations or procedures
 - » NTE.3: “Patient screened positive for perinatal depression with an EPDS score of 14. A referral for mental health counseling was documented.” (A textual description of the clinical activity)
- ➔ **DG1** (Diagnosis) | 1: Reports the patient’s pregnancy status, which is a key part of the PDS-E measure’s denominator

- » DG1.3 (Diagnosis Code): Z33.1^Pregnant state, incidental^I10. This ICD-10-CM code establishes the patient’s pregnancy status.
- » DG1.5 (Diagnosis Date/Time): 20240527 (The date the pregnancy was confirmed or documented in the chart)
- ➔ **DG1** (Diagnosis) | 2: This second diagnosis segment documents the counseling provided, which satisfies the follow-up portion of the measure.
 - » DG1.3 (Diagnosis Code): F32.2^Major depressive disorder, single episode, severe without psychotic features^I10. This ICD-10-CM code is part of the “Behavioral Health Encounter Value Set” and documents the counseling/follow-up action.
 - » DG1.5 (Diagnosis Date/Time): 20240527101500 (The date the pregnancy was confirmed or documented in the chart)
- ➔ **PR1** (Procedures): This segment is used to report a procedure or service performed, which in this case is the intervention.
 - » PR1.3 (Procedure Code): 90791^Psychiatric Diagnostic Evaluation without medical services^C4. This is the CPT code for the intervention that counts towards the HEDIS numerator.
 - » PR1.5 (Procedure Date/Time): 20240527101500 (The date/time the intervention was performed)

10. DATA STANDARDS

This section details the recommended data elements and coding standards for HEDIS measure submissions, ensuring consistency and accuracy in reporting.

10.1. Coding Standards

Adherence to the following coding standards is essential for accurate HEDIS reporting:

- ➔ LOINC: Screenings (e.g., 96777-8 for food insecurity, 44261-1 for PHQ-9)
- ➔ SNOMED CT: interventions (e.g., 663211000124100 referral to peer support specialist (Procedure))
- ➔ *Source:* [NCQA HEDIS Value Set Directory](#).

See [Attachment B](#) and [Attachment C](#) for 2025 HEDIS Value Set Directories specific to CBH-required screenings.

11. SUPPORT AND TROUBLESHOOTING

This section provides guidance on common issues and answers frequently asked questions to assist providers in successfully submitting HL7 data.

11.1. Common Issues and Troubleshooting

Common Issue	Troubleshooting
Invalid Codes	Verify against NCQA Value Set Directory.
Missing Segments	Ensure FHS, BHS, MSH, PID, OBR, OBX are included.
SFTP Errors	Confirm credentials and file naming.
Validation Failures	Use HAPI HL7v2 or HL7 Inspector.
Delimiter Errors	Ensure , ^, &, \ are used correctly.
Incorrect Data Types	Sending a string where a numeric value is expected, or vice-versa
Outdated Codes	Using old or incorrect SNOMED CT or CPT codes. Regularly update code sets and communicate changes
Date/Time Format Issues	HL7 timestamps (TS) require YYYYMMDD[HHMM[SS[.SSSS]]] format. Inconsistent formats are a common source of errors.
Character Encoding	Ensure consistent character encoding (e.g., UTF-8) across systems to avoid garbled text.
Missing Patient Context	Ensure PID and PV1 segments are complete and accurately reflect the patient and encounter associated with the observations.
Ambiguous Observation Identifiers (OBX.3)	Use specific LOINC or SNOMED CT codes for observation identifiers to clearly define what is being measured. Avoid generic local codes if a standard exists.
Misuse of OBX.5 (Observation Value)	Ensure the value type (OBX.2) matches the content of OBX.5. If OBX.5 is a coded element, it should follow the CODE^TEXT^CODING_SYSTEM format.

11.2. Frequently Asked Questions

The following FAQs were pulled from the HL7 Provider Training and follow-up emails and originally posted on August 29, 2025:

1. Why use FHS/BHS/BTS/FTS?

They organize and validate batch submissions, ensuring no data is lost in multi-patient or multi-measure files.

2. Can I use alternative header segments?

FHS and BHS are standard for HL7 Version 2.5.1 batch processing. Alternatives (e.g., FHIR, CDA) are incompatible without significant system changes—contact support for guidance.

3. What if my EHR uses an older HL7 version?

Versions 2.2-2.4 may be accepted; contact support.

4. How do I get access to HL7 files?

<mailto:CBH.FileTransfer@phila.gov>: Complete the IPSWITCH HL7 request form in Attachment A and submit request to CBH.FileTransfer@phila.gov.

5. What file format is required?

Plain text with HL7 delimiters (|, ^, &, \), zipped with AES-256 encryption.

11.2.1. Provider Participation

1. Can a provider “opt out” if implementation is prohibitively expensive (to get their electronic health record (EHR) to accommodate the need for vendor development) or if the provider does not have an EHR?

Providers are not able to opt out. Providers should submit their compliance plan, including a timeline, to CBH.PIP@phila.gov.

2. Is CBH offering a financial incentive to ensure the current EHR has the required screenings and HL7 capabilities? Can we bill to administer the screening tools and data input into the EHR?

At this time, CBH is not offering any financial incentives for this requirement, and billing for administration and data input is not allowed. Completion of the screening is not a standalone billing service. As the tools are meant to be hardcoded into the electronic health record and mapped on the backend to the appropriate codes, providers should work with vendors and internally to develop workflows to complete the tools with members as part of the clinical appointment.

3. ICWC already submits HEDIS and SDOH data to the state. Will they be expected to comply with this duplicative reporting requirement? Just FYI, OMHSAS told ICWCs and CCBHCs at a provider meeting that SNOMED/LOINC/HL7 wouldn't be implemented sooner than 2026.

The state processes for ICWCs, CCBHCs, and the PIP have different requirements. CBH does not receive the data submitted to the state by ICWCs. This data will need to be reported to CBH via the requirements outlined in the HL7 Submission Guide.

11.2.2. HL7 Data Submission Requirements

1. For some agencies, staffing challenges are real. Was this taken into consideration for this requirement? If so, what are the measures by CBH and the State to address current staffing issues that may prevent agencies from completing this requirement?

While we understand some agencies continue to have staffing challenges, completing screening tools is a standard part of behavioral health treatment delivery and should be completed as part of the treatment session.

2. **Has there been an effort by CBH to connect with providers of all types, service levels, etc., to find out what EHRs and systems are used throughout the network to assess this from a technical and billing perspective, and how certain LOCs are already reporting on these metrics? Many are not set up with LOINC codes, SNOMED, or, at the least, ways to automatically pull correct ones into visit types, F codes, CPT, or E&M codes (for those to which that's relevant). What was that assessment process like, beyond the survey sent out via Provider News Blasts?**

As outlined in CBH Bulletins 25-17 and 25-26, the HEDIS measures are required by OMHSAS for the statewide PIP. CBH has been sharing information about the PIP with stakeholder groups such as the Provider Advisory Committee (PAC) and executive directors, and at individual provider meetings. Published on April 28, 2025, CBH Bulletin 25-17 offered opportunities to complete a root cause analysis around barriers related to the screening tools and a provider readiness survey around HL7 requirements and capabilities. Survey results from the provider readiness survey indicated that some providers already utilize the LOINC and SNOMED codes and share this information with other payors. CBH has compared the survey results to all EHR types. A majority of providers indicated they would be able to comply within a few months.

3. **For providers operating in multiple counties, have the BH-MCOs made any efforts to align their approach to meeting the PIP requirements?**

CBH has been working with other BH-MCOs in the state to share information and work to align the approach when possible.

4. **If you are looking for readiness, then why the expectation of dates for completing this?**

CBH is required to submit the PIP proposal on September 30, 2025. It is also required to include baseline data for the previously discussed HEDIS measures, which is why the start date is set for September 2, 2025. Some providers completed the readiness survey, indicating they already have the capacity and/or have already submitted this information for other payors. If you don't have the capacity, see the comment below around provider participation expectations.

5. **Why would clinical spaces that do not offer case management services be responsible for interventions for SNS-E?**

Addressing health-related social needs is a priority of *Healthy People 2030* and of the OMHSAS PIP. As stated in CBH Bulletin 18-15, Social Determinants of Health (SDOH) contribute to overall outcomes of care at a disproportionate rate, and the process for assessing z-codes for SDOH has been a requirement since 2018. Completing the screening tools for the SNS-E measure ensures that members' needs are captured and addressed. Addressing these needs can improve the member's experience, reduce healthcare costs, and help the member achieve better overall health. Providers will be responsible for sharing referral resources related to food, housing, and

transportation. This will be documented in the clinical record. The referrals will be mapped to the corresponding SNOMED codes and submitted via the instructions in the HL7 Submission Guide.

6. Will this requirement be the subject of future audits? If so, what would be the penalty for not reporting this data on time?

At this time, we do not plan to conduct formal audits. However, CBH staff will reach out to providers who have not submitted the data and have not submitted their timeline and plan for compliance. As previously shared, the start date begins on September 2, 2025. For those who have barriers, please submit a plan for compliance to CBH.PIP@phila.gov.

7. If a CBH member completes a screening with their medical provider and I can pull those results, will I be required to complete a new screening and submit the results?

If a member has a screening completed within the past calendar year as part of a shared record system, the screening results should be documented in the chart. If the provider is able to submit the results and required information in the HL7 format, CBH will accept the screening results. Providers should make a clinical judgment as to whether or not the situation has changed for the member, and a new screening should be completed.

8. How often do you expect the HL7 files to be uploaded? Weekly, monthly?

The frequency of HL7 files can be uploaded at the provider's convenience (e.g., daily, weekly, monthly). All information must be submitted within 90 days of the service date.

11.2.3. Electronic Health Record Systems

1. Is CBH requiring an update to your EHR system?

To meet the requirements of the HL7 Submission Guide and CBH Bulletin 25-26, providers will need to ensure that electronic health record systems contain the required screening tools and can produce an HL7 Version 2.5.1 ORU^R01 message version, in accordance with the HL7 Implementation Guide. Vendor assistance may be necessary to understand what is currently available and/or what changes/updates will be needed for your EHR system.

11.2.4. Technical Operations

1. You mention zipping the file and renaming it to an HL7 file. Is that naming the text file inside to HL7 or the zip file itself?

A compressed file in zip format (i.e., zip file) must have an extension of “.zip”. The uncompressed file (i.e., HL7 file) must have an extension “.HL7”. The names of the compressed file and the uncompressed file should be the same as identified by the guide (e.g., par_xxxx_mmddyyyy)

2. Will a companion guide be released for the HL7?

The HL7 Submission guide was shared on 8/1 and is currently available on the CBH website under the Provider Bulletin section.

3. What happens when the decision points are not ‘positive’, as in the flow diagram?

In the example of the SNS screening tools (AHC_HRSN and PRAPARE), an intervention would not be indicated if the individual does not screen positive for a social need. In this instance, CBH expects you to only send the appropriate LOINC code response to the question. All responses should be submitted using the SNS screening tools, even the questions that do not have a “referral intervention SNOMED code.”

4. Does Find Help automatically map for referral interventions?

Our current understanding is that Find Help does not map the SNOMED codes for referral interventions.

5. If we only use the Converter currently, will we have to get set up and learn Ipswitch?

Currently, we are only supporting receiving HL7 files via Ipswitch.

6. Is there a “backup” way to submit, and how will CBH assist providers in this situation? Is it possible for CBH to put the screenings on their portal so we can complete them with families and have them auto-submit to CBH?

CBH is evaluating whether this is possible. However, at this time, there is not a “backup” way to submit this information. Providers should submit their plan for compliance, including a timeline, to CBH.PIP@phila.gov.

7. How do we request tech assistance? Can CBH help providers connect with others who use the same EHR?

Please review the bulletins, HL7 Submission Guide, and this FAQ. If providers have additional questions not addressed, they can email CBH.PIP@phila.gov. We will hold group sessions with providers utilizing the same EHR as needed.

8. How do you submit the date of the referral on this at the same time as submitting the SDOH information and claim data all at the same time?

The referral information exists in the OBX segment of the HL7 document. The date and time of the referral will be listed in the OBX.14 field.

9. Why are you stressing LOINC codes when an LLM can easily run and extract? There are no LOINC ways in systems that do not accommodate. I need authorization for LLM extraction direct into HEDIS HL7. LOINC is an outdated hard code. LLM will get ready immediately and validate data H7.

LOINC codes are required for the HEDIS measures. There are currently no other options.

10. Is patient data going to be deidentified? Or are we submitting patient PHI and clinical data to the state? If we share specific patient data and private health information that will be

shared outside of CBH, are we expecting patients to consent to signing a specific release for their information to sit in a database? What if a patient does not consent?

Individual patient PHI and clinical data are not being submitted to the state. Patient data will be submitted to CBH as HIPAA allows and utilized to create aggregate HEDIS rates. Aggregate HEDIS rates will be submitted to the state. Patients will not need to consent to share this data.

- 11. I anticipate many of my patients will express concern about their protected mental health information being collected by the city or state, due to fear of termination of treatment (related to gender identity and sexuality) or fear of forced hospitalization. What if patients refuse to complete screening tools?**

The patient has the right to refuse. Completion of the screening tools is not required to receive treatment.

- 12. Can a sample submission file with test patient date be provided?**

Example files can be found throughout the HL7 Submission Guide.

- 13. How will the follow-up be submitted to CBH?**

Follow-up encounters or medication management for depression and postpartum depression screenings will be identified through claims visits. Best practices for follow-up can be found in the depression screening and postpartum depression guides.

Follow-up referrals/interventions for positive social needs screening are submitted via the SNOMED codes outlined in Attachment C of the HL7 Submission Guide. The guide outlines the process for submitting these codes.

11.2.5. Screening Tools

- 1. Do we need to use the mentioned screeners, or can we use other alternative screeners that may measure the same construct?**

The HEDIS measures require the use of certain screeners, so the required screener must be utilized. If a different screener is accepted by HEDIS but not in the bulletin, please contact CBH.PIP@phila.gov for further discussion.

- 2. Our EHR uses a screener that gives PHQ-2 first and then expands to PHQ-9 only if the PHQ-2 is positive. Would all the negative PHQ-2s not count as depression screening for the DSF-E measure since only PHQ-9 was listed for it on a previous slide? We are using the PHQ-A for ages 12-17, which is more appropriate for this age range. Is that allowed, or must it be the PHQ-9 even if it's less appropriate?**

Providers may use a PHQ-2 for the DSF-E screening and LOINC code 56758-7 with a total score. However, positive screenings must use a PHQ-9 in addition. Providers may opt to use a PHQ-9M for adolescents ages 12-17 and LOINC code 89204-2 with the total score. The PHQ-9 or PHQ-9M are the only allowable tools by the DRR-E HEDIS measure.

- 3. Any action from the state or CBH for people with depression challenges? Is this just a reporting requirement? If so, with what end?**

Data collected in this reporting requirement will be utilized to develop system, provider, and member-specific interventions to address depression and other measure requirements. Improving the health of Philadelphians is the priority.

- 4. Is this applicable to members who use Modivcare transportation and also meet other requirements?**

Yes! Even if a member does not have apparent SDOH needs, the purpose is to assess individuals at least annually, as their situations may change.

- 5. When can we expect CBH to release a list of referral options we can provide clients for food, housing, transportation needs, etc., that those of us who are not case management can provide?**

DBHIDS has an [extensive webpage with SDOH resource packets](#).

- 6. Are the screeners intended to be used as measurement tools of clinician effectiveness and/or qualification for treatment? Will CBH/OMHSAS indicate/dictate treatment/intervention based on clients' assessment scores?**

Not at this time.

11.2.5.1. Clinical Workflow Questions

- 7. Will CBH provide providers with clinical training? When are measures expected to be administered? How frequently? With which services/CPT codes? Will there be a clinical meeting to review the clinical process of care and required follow-up? How would depression screening apply to youth who are non-speaking, non-reading, and not yet able to comprehend the questions being asked (We provide ABA to autistic youth)?**

The use of screening tools for depression, postpartum depression, and suicide screening must be clinically relevant. CBH will be publishing program guides for depression (ages 12 and over) and postpartum depression screenings, which address resources for training and provide guidance on frequency and modality of screenings.

The HEDIS measures do not require that the screenings be completed during specific health encounters. Follow-up care will be submitted via claims, and a list of CPT codes that meet follow-up care will be attached to the depression and postpartum depression screening guides. Additional information around suicide screening will be forthcoming in clinical practice guidelines.

- 8. We currently use the MFQ. Will this fit? Several of our units currently utilize the BASIS-24 as an Evidence-Based Assessment EBA. This tool provides additional insights and subscores beyond what the PHQ-9 offers. Could you please confirm whether the BASIS-24 will be accepted in lieu of the PHQ-9?**

Currently, the MFQ and BASIS-24 tools for the DSF-E HEDIS measure are not allowed.

11.2.5.2. Health-Related Social Needs (HRSN) Workflow Questions

- 9. Why are we switching to a new HRSN? We were using the Arizona before, and it's working fine.**

Currently, Arizona is not an allowed tool for the SNS-E HEDIS measure.

- 10. We treat youth in placement and often don't have contact with their parents or guardians. How are we supposed to use the social determinants tool?**

The tools should be completed as part of your treatment sessions.

- 11. Does the HRSN need to be the longer version (26 questions) or can we use the shorter version (10 questions)?**

The PRAPARE or AHC HRSN should be completed annually and is required for all CBH members. For youth under 18, the AHRC HRSN can be used for children under 18 by a parent or caregiver, and we are not collecting the supplemental questions. The 10 questions are sufficient and are outlined in Attachment B of the HL7 submission guide. HealthCenters has modified the PRAPARE tool to engage family members. See the [PRAPARE Frequently Asked Questions page](#) and [Compass Community Health's implementation explainer](#) to learn more about how to modify the PRAPARE tool for youth.

Utilize the resources in Bulletin 25-26 to train staff on administering the HRSN screening tool.

- 12. Additionally, our facility has integrated the HealthLeads HRSN screening tool into our EMR. Can you confirm if this tool meets the requirements outlined in the bulletin?**

The HealthLeads HRSN tool is acceptable for the SNS-E HEDIS measure. Appropriate LOINC codes will be added to the HL7 Submission Guide.

11.2.6. Suicide Screenings and Submission of M Codes

- 1. Would we be expected to submit multiple codes within the same encounter (e.g., screening for suicide AND individual reports SI)?**

Yes. It is possible to submit more than one code at a time. For example, code M1352 for suicidal ideation may be submitted at the same time as M1350 for completion of a suicide safety plan within 24 hours of the index clinical encounter.

- 2. In light of the HL7 submission requirement and since there is overlap between G and M code reporting and some HL7 data reporting, should we move forward with submitting G and M codes? While we have built a process to report the codes, we would like clear guidance so we don't take time away from service provision to build and implement a system that will soon be replaced.**

Yes, they are two separate processes and are required for different purposes. The G Code submission is required for the Core Data Set. Providers should continue to submit the G codes in their claims submissions with encounter data. The HL7 data requires the “total score” for the depression screening, which cannot be obtained via G codes. The M codes do not overlap with HL7. All M codes should be submitted with the claims submission and are not to be submitted via HL7.

3. If we have to use the C-SSRS, which one should we use? The screener, recent since last visit, or full version?

The Suicide Safety Plan Codes (M Codes M1350-56) will be used to run MIPS #504 measure (Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk) as part of the OMHSAS-required PIP.

MIPS specifications indicate that the C-SSRS “Screen Version” can be used to screen for suicidal ideation and/or behavior symptoms. C-SSRS “Lifetime/Recent” can be used to assess for risk level. MIPS also allows for the use of other standardized assessment tools to assess suicidal ideation/behavior/risk level (e.g., PHQ-9 item 9, SAFE-T Protocol), as well as clinician clinical judgement.

CBH is open to providers choosing the version most clinically appropriate for the population served. Various versions of the C-SSRS are available for different levels of care or different care transitions. Providers can also use other structured, evidence-based tools such as the ASQ.

APPENDIX A: SOCIAL NEEDS SCREENING AND INTERVENTION (SNS-E) INFORMATION

Background

Social Needs Screening and Intervention (SNS-E) is a Digital Quality **HEDIS® measure**. This measure includes six individual rates and identifies the percentage of members who were screened for various social needs at least annually and received a corresponding intervention if they screened positive for the following:

- ➔ *Food Screening.* The percentage of patients who were screened for food insecurity
- ➔ *Food Intervention.* The percentage of patients who received a corresponding intervention within one month of screening positive for food insecurity
- ➔ *Housing Screening.* The percentage of patients who were screened for housing instability, homelessness, or housing inadequacy
- ➔ *Housing Intervention.* The percentage of patients who received a corresponding intervention within one month of screening positive for housing instability, homelessness, or housing inadequacy
- ➔ *Transportation Screening.* The percentage of patients who were screened for transportation insecurity
- ➔ *Transportation Intervention.* The percentage of patients who received a corresponding intervention within one month of screening positive for transportation insecurity

Purpose

Addressing health-related social needs (HSRN, previously referred to as social determinants of health, or SDOH) is a priority of **Healthy People 2030** and of the **OMHSAS** Performance Improvement Project (PIP). As stated in **CBH Provider Bulletin 18-15**, SDOH contribute to overall outcomes of care at a disproportionate rate, and the process for assessing z-codes for SDOH has been a requirement since 2018. CBH is required to implement the statewide *OMHSAS PIP to Improve Suicide Prevention and Community Resilience*. Completing the screening tools for the SNS-E measure ensures that patients' needs are captured, addressed, and meet the requirements for the OMHSAS PIP as outlined in CBH Provider Bulletins **25-17** and **25-26**. Addressing these needs can improve patients' experience, reduce their healthcare costs, and help them achieve better overall health.

Documenting Social Need Screening and Intervention

Social needs screening should occur with all patients and/or their families/caregivers at least once annually. Currently, CBH allows providers to utilize one of the following screening tools for SNS-E data submission via the HL7 messaging format found in this guide:

- ➔ **Accountable Health Communities Health-Related Social Needs (AHC HRSN)**
- ➔ **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**

- ➔ [Health Leads](#)
- ➔ [WellRx](#)
- ➔ [American Academy of Family Physicians \(AAFP\) Social Needs Screening Tool](#)

The responses for each question on the social needs screening are documented in the clinical record and coded using LOINC codes. All question responses on the screening tool should be submitted to CBH. See [Attachment B](#) in this guide for the appropriate LOINC code.

If a member has a positive response for any of the questions, providers should share a referral resource with the member. For positive responses related to food, transportation, and housing, providers should submit the corresponding SNOMED code as outlined in [Attachment C](#) in this guide.

Best Practices

- ➔ Social needs screening tools can be adapted for caregivers or younger individuals. See the [HL7 FAQ](#) for more guidance.
- ➔ For referrals, providers may develop their own resource guide for community-based organizations (CBOs) or other helpful resources local to the area, develop formal memorandums of understanding (MOU) or agreements with CBOs, and update agency resource guide regularly to ensure referral sources are up to date.
- ➔ Ensure patient consent has been obtained and documented when communicating on behalf of the patient with an outside organization.
- ➔ When possible, use a warm hand-off method to connect the patient to the referral resource.

APPENDIX B: DEPRESSION SCREENING/REMISSION (DSF-E/DRR-E) INFORMATION

Background

CBH will be utilizing two [HEDIS® measures](#) to ensure adequate depression screening and follow-up for adolescents and adults. These measures are calculated annually and include five rates, as follows:

- ➔ **Depression Screening and Follow-up for Adolescents and Adults (DSF-E)**
 - » *Depression Screening:* The percentage of patients who were screened for clinical depression
 - » *Follow-up on Positive Screen:* The percentage of patients who received follow-up care within 30 days of a positive depression screen finding
- ➔ **Depression Remission or Response for Adolescents and Adults (DRR-E)**
 - » *Follow-up PHQ-9:* The percentage of members who have a follow-up PHQ-9 score documented within 120-240 days (4-8 months) after the initial elevated PHQ-9 score (Score greater than 9)
 - » *Depression Remission:* The percentage of members who achieved remission within 120-240 days after the initial elevated score (Score less than 5)
 - » *Depression Response:* The percentage of members who showed response within 120-240 days (4-8 months) after the initial elevated PHQ-9 score (Score at least 50% lower than the initial PHQ-9 total score)

Purpose

CBH has implemented a depression screening program as part of the *OMHSAS PIP to Improve Suicide Prevention and Community Resilience*. Establishing a formal process of early identification and referral to treatment is essential to promoting optimal health for members included in the HealthChoices Medicaid program.

Conducting Depression Screening and Follow-up

Depression screening and follow-up should occur with all patients 12 and older as outlined in the CBH’s Depression Screening Program Guide (find the most recent version on the [CBH Quality Management PIP web page](#)). Currently, CBH allows providers to utilize the following screening tools for DSF-E and DRR-E data submission via the HL7 messaging format found in [Attachment B](#) of this guide.

Screening Tool	Notes	LOINC Code
PHQ-2	May be submitted for those who do not have a positive depression screening. Used for DSF-E only.	55758-7
PHQ-9	Use for DSF-E and DRR-E.	44261-6

Screening Tool	Notes	LOINC Code
PHQ-9M	Modified for Teens. Use for DSF-E and DRR-E.	89204-2

All screening results should be reviewed by the clinician and discussed with the member. Positive responses (score greater than 9) require follow-up within 30 days. Additionally, positive answers (score of 1-3) to item 9 may indicate suicidal thoughts and should trigger additional assessment (per provider protocols) and requires the completion of the [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#). The Depression Screening Program Guide outlines appropriate follow-up activities, which may include:

- ➔ Outpatient, telephonic, e-visit follow-up with a diagnosis of depression or other health condition
- ➔ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
- ➔ A behavioral health encounter, including assessment, therapy, collaborative care, or medication management
- ➔ A dispensed antidepressant medication

Appendix C of the Depression Screening Program Guide outlines the CPT codes allowed as a follow-up service. Members who screened positive should receive a follow up PHQ-9 or PHQ-9M within 4-8 months and should be submitted via the HL7 messaging format.

Best Practices

- ➔ Implement a standardized process for depression screening of all patients 12 and older during intake and annually.
- ➔ Ensure completion of a comprehensive evaluation, with the consideration of pharmacotherapy for depression management for positive depression screenings.
- ➔ Consider suicide risk assessment when appropriate.
- ➔ Develop a person-centered treatment plan and monitor ongoing treatment response.
- ➔ Schedule follow-up appointments with the patient before they leave the office and coordinate rescheduling for no-shows and cancellations.

APPENDIX C: POSTPARTUM DEPRESSION SCREENING AND FOLLOW-UP (PDS-E) INFORMATION

Background

The **Postpartum Depression Screening and Follow-up (PDS-E)** Digital Quality **HEDIS® measure** ensures that patients are screened for clinical depression during the postpartum period and receive follow-up care as needed. This measure is calculated annually and includes two rates, as follows:

- ➔ *Depression Screening:* The percentage of deliveries in which patients were screened for clinical depression during the postpartum period (7-84 days following delivery)
- ➔ *Follow-up on Positive Screen:* The percentage of deliveries in which patients receive a follow-up care visit within 30 days of a positive depression screen finding

Purpose

CBH is implementing a postpartum depression screening program as part of the *OMHSAS PIP to Improve Suicide Prevention and Community Resilience*. Establishing a formal process of early identification and referral to treatment is essential to promoting optimal health for members included in the HealthChoices Medicaid program.

Conducting Depression Screening and Follow-Up

Depression screening and follow-up should occur with all patients in the 7-84 days following delivery as outlined in the CBH Postpartum Depression Screening Program Guide (find the most recent version on the [CBH Quality Management PIP web page](#)). Currently, CBH allows providers to utilize one of the following screening tools for PDS-E data submission via the HL7 messaging format found in [Attachment B](#) of this guide:

Screening Tool	LOINC Code
Edinburgh Postpartum Depression Scale (EPDS)	71354-5
PHQ-9	44261-6

All screening results should be reviewed by the clinician and discussed with the member. Positive responses (scores equal to or greater than 10) require follow-up within 30 days. Positive answers to item 10 on the EPDS or item 9 on the PHQ-9 may indicate suicidal thoughts and should trigger additional assessment and completion of the [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#). Follow-up activities may include:

- ➔ An outpatient, telephonic, e-visit follow-up with a diagnosis of depression or other health condition

- ➔ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
- ➔ A behavioral health encounter, including assessment, therapy, collaborative care, or medication management
- ➔ A dispensed antidepressant medication

Appendix C of Postpartum Depression Screening Program Guide outlines the CPT codes allowed as a follow-up service.

Best Practices

- ➔ Implement a standardized process for postpartum depression screening of all patients who are in the postpartum period.
- ➔ Ensure completion of a comprehensive evaluation, with the consideration of pharmacotherapy for depression management for positive depression screenings.
- ➔ Consider suicide risk assessment, when appropriate.
- ➔ Develop a person-centered treatment plan and monitor ongoing treatment response.
- ➔ Schedule follow-up appointments with the patient before they leave the office and coordinate rescheduling for no-shows and cancellations.
- ➔ Coordinate with the OB-GYN, ensuring the patient has consented to care coordination.

APPENDIX D: RELEVANT HL7 DATA TYPES AND TABLE VALUES (EXAMPLES)

This appendix provides a brief overview of common HL7 data types and example table values that are frequently used in the context of clinical observations and patient demographics.

Common HL7 Data Types:

Data Type	Description	Example
ST	String Data	Patient expressed concerns.
NM	Numeric	15
TS	Time Stamp	20240527103000 (YYYYMMDDHHMMSS)
CE	Coded Element (Code, Text, Coding System)	LA28397-0^Food insecurity (finding)^SNM
ID	Coded Value for HL7 Defined Tables	F (for Final Result Status)
IS	Coded Value for User Defined Tables	MRN (for Identifier Type Code)
XPN	Extended Person Name (Last^First^Middle)	DOE^JANE^A
XAD	Extended Address (Street^City^State^Zip^Country)	123 MAIN ST^^ANYTOWN^MN^55123^USA
XTN	Extended Telecommunication Number (Phone Number)	555-123-4567

Example Table Values (for HL7-defined fields):

- ➔ MSH.11 – Processing ID (ID):
 - » P: Production
 - » T: Training
 - » D: Debugging
- ➔ MSH.12 – Version ID (ID):
 - » 2.5.1 (or other agreed-upon HL7 version)
- ➔ PID.8 – Administrative Sex (ID):
 - » M: Male
 - » F: Female
 - » U: Unknown

- » O: Other
- » A: Ambiguous
- » N: Not Applicable
- ➔ PV1.2 – Patient Class (ID):
 - » I: Inpatient
 - » O: Outpatient
 - » E: Emergency
 - » R: Recurring
- ➔ OBR.25 / OBX.11 – Result Status (ID):
 - » A: Some, but not all, results available
 - » F: Final results
 - » I: No results available; procedure incomplete
 - » R: Results stored, not yet verified
 - » P: Preliminary results
 - » C: Corrected results
 - » X: Cancelled results
 - » D: Deleted results

APPENDIX E: REFERENCES AND FURTHER READING

- ➔ [HL7 International](#): Official website for HL7 standards and documentation
 - » [HL7 v2.x Messaging Standard Documentation](#): For detailed segment and field definitions, refer to the specific version of the HL7 v2.x standard being implemented.
- ➔ [NCQA](#): Official source for HEDIS measure specifications
- ➔ [PA Navigate](#)
- ➔ [DBHIDS Social Determinants of Health \(SDOH\) Resources](#)
- ➔ [SNOMED International](#): Official website for SNOMED CT
- ➔ [American Medical Association \(AMA\)](#): Source for CPT codes
- ➔ [LOINC \(Logical Observation Identifiers Names and Codes\)](#): Official website for LOINC
- ➔ [CBH Clinical Practice Guidelines](#): Treatment of Adults with Major Depressive Disorder
- ➔ [CBH Provider Bulletin 25-17](#), released on April 28, 2025
- ➔ [CBH Provider Bulletin 25-26](#), released on August 1, 2025
- ➔ [CBH Member Resources Screening Program web page](#)
 - » CBH Screening Program Guides (most current versions on web page):
 - Depression Screening Program
 - Postpartum Depression Screening Program
 - SUD Screening Program for Individuals with Depression
 - » CBH HL7 HEDIS Measure Data Submission Training FAQ (now incorporated into the HL7 Guide, [Section 11.2.](#))

ATTACHMENT A: IPSWITCH REQUEST FORM

Dear Provider:

Thank you for choosing to securely exchange files with Community Behavioral Health. When filled out, this document allows you to formally request access to our secure file transfer server.

Our server currently supports two primary secure protocols: HTTPS and FTP over SSH. Additionally, we can accommodate FTP over SSL – please contact us if this is your preferred method. While your files are resident on our server, we use 256-bit, FIPS 140-2 validated AES encryption to protect your files from unauthorized use, theft, hacking and/or viewing. Additionally, depending on the client you choose, you may be able to take advantage of the file integrity and transfer resume features which are native to our multi-protocol file transfer server.

Please fill out the sections below with as much information as you can provide.

Identification

Contact Name		Organization Name	
CBH Parent ID		Provider #(s) <i>(n/a for Provider Claims)</i>	
Provider Location		Contact Job Title	
Contact Phone		Contact Email	

Purpose of Connection

Access to submit the following <i>(please select):</i>	<input type="checkbox"/> HL7 Files
Optional:	
Restrict Access to IP(s)/Host(s):	
Primary Organizational Contact <i>(if other):</i>	

Preferred Protocol and Client

You have your choice of protocols when using our server. You may opt to use more than one protocol and/or client with the same set of credentials, as all protocols access the same virtual filesystem on our secure server.

Please tell us which protocols and/or clients you plan to use with our service.

Preferred Protocol(s):	<input type="checkbox"/> HTTPS <input type="checkbox"/> FTP over SSH <input type="checkbox"/> Don't Know				
Preferred Secure Transfer Client(s):					
Name:		Version:		OS:	
Name:		Version:		OS:	
Name:		Version:		OS:	
<input type="checkbox"/> Don't Know					

Secure Transfer Confidentiality Agreement

I attest that I am authorized to set up secure transmissions on behalf on my organization. I promise to keep any credentials (including username and password) provided to me by Community Behavioral Health secret and well-protected. I understand that shared accounts are not allowed on this server. I further accept that transmissions made using these credentials will be treated in every way as being performed by me and/or my organization.

Authorized Signature: _____ **Date:** _____

Print Name and Title: _____

For additional information, please contact CBH.FileTransfer@phila.gov.

ATTACHMENT B: CODE DEFINITIONS

The tables below provide a crosswalk of each LOINC code that is required for the performance measure and a brief description of the code. SNOMED CT codes for SNS-E interventions are found in [Attachment C](#).

LOINC Codes

Performance Measure	LOINC Code	Description
DSF-E DRR-E PDS-E	44261-6	Code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
DSF-E	55758-7	Code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
DSF-E DRR-E	89204-2	Code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
PDS-E	99046-5	Code "Edinburgh Postnatal Depression Scale [EPDS]": '99046-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'

Social Needs Screening Tools LOINC

Providers should utilize the following links to find the most up-to-date LOINC codes associated with each screening tool. LOINC codes are available for three levels:

1. Completion of Screening Tool
2. Completion of Question
3. Question Responses

Providers are responsible for submitting all three levels of LOINC codes in the HL7 messaging format.

LOINC Code	Screening Tool
96777-8	Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool (AHC HRSN)
93025-5	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
99549-8	Health Leads Screening Panel
93667-4	WellRx Questionnaire
99593-6	American Academy of Family Physicians (AAFP) Social Needs Screening Tools

ATTACHMENT C: SNOMED CODES FOR SNS-E INTERVENTIONS

➔ [SNOMED Codes for SNS-E Interventions](#) *(downloadable xlsx spreadsheet)*