PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | JUNE 29, 2018 | UPDATE 18-444 | 13 PAGES

Medical Paper Claims Submission Rejections and Resolutions

The preferred and most efficient way for fast turnaround and claims accuracy is to submit medical claims electronically to Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company (Health Net). However, when additional documentation or attachments are required, paper claims will be accepted. The following information applies to medical paper claims and does not apply to pharmacy paper claims. All paper claims sent to the Health Net Claims Department must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. The following information will assist providers in submitting clean paper claims. The following topics are outlined and addressed in this provider update:

- Acceptable forms
- Claims rejection reasons and their resolutions
- Mandatory line items for claims submission
- Paper claims submission address change (reminder)
  - Using correct Health Net entity name
- Appendix A – CMS-1500 (02/12) form billing instructions
- Appendix B – CMS-1450 (UB-04) billing instructions

ACCEPTABLE FORMS

As a reminder Health Net is required to comply with requirements for providing complete claims information to regulatory agencies. Accordingly, claims must reflect complete and accurate data in all the required fields on the Centers for Medicare & Medicaid Services (CMS)-1500 or UB-04 original Flint OCR Red, J6983 ink claim forms in order to be accepted as complete or clean claims. Nonstandard forms include any that have been downloaded from the Internet or photocopied, which do not have the same measurements, margins, and colors as commercially available printed forms. Nonstandard forms will be rejected upon initial receive as non-clean claims. Providers must adhere to the claims submission requirements below to ensure that submitted claims have all the required information, which results in timely claims processing.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
  - Kern
  - Los Angeles
    - Molina
  - Riverside
  - Sacramento
  - San Bernardino
  - San Diego
  - San Joaquin
  - Stanislaus
  - Tulare

PROVIDER SERVICES
provider_services@healthnet.com

EnhancedCare PPO (IFP)
1-844-463-8188
provider.healthnetcalifornia.com
EnhancedCare PPO (SBG)
1-844-463-8188
provider.healthnet.com
Health Net Employer Group HMO, POS, HSP, PPO, & EPO
1-800-641-7761
provider.healthnet.com
IFP – Community Care HMO, PPO, PureCare HSP, PureCare One EPO
1-888-926-2164
provider.healthnetcalifornia.com
Medicare (individual)
1-800-929-9224
provider.healthnetcalifornia.com
Medicare (employer group)
1-800-929-9224
provider.healthnet.com
Medi-Cal – 1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com
fax 1-800-937-6086

Acceptable	Not acceptable/will be rejected
Professional Claims	
CMS-1500 (02/12) form Completed in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual Version 5.0 7/17 at www.nucc.org	Any other form will be rejected with a letter sent to the provider indicating the reason for rejection
Institutional Claims	
UB-04 form. The form must be completed in accordance with the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2018 at www.nubc.org	Any other form will be rejected with a letter sent to the provider indicating the reason for rejection
All Claims	
1. Flint optical character recognition (OCR) Red, J6983 (or exact match) ink form 2. Required original red form with the backer instructions 3. Typed in black ink 4. 10 or 12 point 5. Times New Roman font	Any of the following formats **will be rejected**. 1. Submitted on black and white or forms other than CMS-1500 (02/12) and UB-04 2. Handwritten 3. Highlighted, italics, bold text, or staples for multiple page submissions 4. Copies of the form

Health Net does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

CLAIMS REJECTION REASONS AND RESOLUTIONS

The following are some claims rejection reasons, challenges and possible resolutions.

Reject code	Reject reason	Requirements	CMS-1500 or UB-04
01	Member's DOB is missing or invalid	Enter the patient's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10
02	Incomplete or invalid member information	Enter the patient's Health Net member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the patient's current ID card to determine ID numbers	CMS-1500 box 1a UB-04 box 60
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 ("9" for ICD-9 or "0" for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: • Y – Diagnosis was present at time of inpatient admission. • N – Diagnosis was not present at time of inpatient admission. • Leave blank if cannot be determined	UB-04 box 66-70 UB-04 box 71

Reject code	Reject reason	Requirements	CMS-1500 or UB-04
75	The claim(s) submitted has missing, illegible or invalid value for anesthesia minutes	When box 24 is completed, then box 24G must be completed as well	CMS-1500 box 24D and 24G
76	Original claim number and frequency code required	Resubmission code is required for all corrected claims. If resubmission code is 6, 7, or 8 (field 22 on the CMS-1500 and field 4 on the UB-04), the original claim number is required (field 22 on CMS-1500 and field 64 on UB-04)	CMS-1500 box 22 UB-04 box 4 and 64
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit – Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)	UB-04 box 4
87	One or more of the REV codes submitted is invalid or missing	Include complete 3–4 character revenue code. Drop leading 0 if sending only 3 characters	UB-04 box 42
92	Missing or invalid NPI	Enter provider's 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any of these elements are missing, the claim will reject	CMS-1500 box 24D UB-04 box 43
A7	Invalid/missing ambulance point of pick-up ZIP code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pick (POP) ZIP in box 23 in addition to the addresses in 24 shaded area or box 32
A9	Provider name and address required at all levels	Include complete billing provider address including city, state and ZIP code	CMS-1500 box 33 UB-04 box 1
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank (for description see Reject code 17)	UB-04 box 67–67Q and 72A–72C

Reject Code	Reject Reason	Requirements	CMS-1500 or UB-04
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11D must be marked as *yes*. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d
AV	Patient's Reason For Visit should not be used when claim does not involve outpatient visits	Include patient reason for visit on all outpatient claims	UB-04 box 70a, b, c
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for description see Reject code 17)	CMS-1500 box 21 UB-04 box 66
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A

MANDATORY ITEMS FOR CLAIMS SUBMISSION

The attached Appendix A – CMS-1500 Billing Instructions on page 6 and Appendix B – UB-04 Billing Instructions on page 10 provide the mandatory items for both claim forms. For complete claims submission instructions, providers can refer to the Health Net provider operations manual > *Claims and Provider Reimbursement* > *Billing Submission* > *Claims Submission Requirements*.

PAPER CLAIMS SUBMISSION ADDRESS CHANGE

As a reminder, effective January 1, 2018, the addresses to submit paper claims were changed. All paper claims must be submitted to the addresses below with the exact entity names as provided.

Using correct Health Net entity name

If claims are submitted to the previous Lexington, KY address using inappropriate entity names other than what is provided below, the United States Postal Service (USPS) will return the claim back to the sender.

Additionally, USPS has been forwarding claims received at the Lexington, KY address to the correct address. Starting December 31, 2018, USPS will discontinue automatic forwarding of claims. Claims received at the previous Lexington, KY address starting December 31, 2018, will be returned to the sender via the USPS.

Providers must submit claims to the correct address using the appropriate entity names as identified below.

Line of business	Paper claims address
MEDICARE ADVANTAGE	**Health Net of California, Inc.** Medicare Claims PO Box 9030 Farmington, MO 63640-9030
MEDI-CAL	**Health Net Community Solutions, Inc.** Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020
HMO/POS/HSP, PPO, & EPO	**Health Net of California, Inc. (and/or)** **Health Net Life Insurance Company** Commercial Claims PO Box 9040 Farmington, MO 63640-9040

MEDICARE ADVANTAGE PHARMACY PAPER CLAIMS

Medicare Advantage (MA) pharmacy paper claims may be submitted to:

Health Net of California, Inc.
Attention: Pharmacy Claims
P.O. Box 419069
Rancho Cordova, CA 95741-9069

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at provider_services@healthnet.com within 60 days, by telephone or through the Health Net provider website as listed in the right-hand column of page one.

APPENDIX A – CMS-1500 BILLING INSTRUCTIONS

Field number	Field description	Required, conditional or not required
1	Insurance program identification	Required
1A	Insured identification (ID) number	Required
2	Patient's name (last name, first name, middle initial)	Required
3	Patient's birth date and sex	Required
4	Insured's name	Conditional – Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Conditional
6	Patient's relationship to insured	Conditional – Always mark to indicate self if the same
7	Insured's address (number, street, city, state, ZIP code) Telephone number (include area code)	Conditional
8	Reserved for NUCC	Not required
9	Other insured's name (last name, first name, middle initial)	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9A	Other insured's policy or group number	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan
9B	Reserved for NUCC	Not required
9C	Reserved for NUCC	Not required
9D	Insurance plan name or program name	Conditional REQUIRED if field 9 is completed
10 A, B, C	Is patient's condition related to	Required
10D	Claims codes (designated by NUCC)	Conditional
11	Insured policy or FECA number	Conditional REQUIRED when other insurance is available
11A	Insured date of birth and sex	Conditional

Field number	Field description	Required, conditional or not required
11B	Other claims ID (designated by NUCC)	Conditional
11C	Insurance plan name or program number	Conditional
11D	Is there another health benefit plan?	Required
12	Patient's or authorized person's signature	Conditional – Enter "Signature on File," "SOF," or the actual legal signature
13	Insured's or authorized person's signature	Not required
14	Date of current: Illness (first symptom) or injury (accident) or pregnancy (LMP)	Conditional
15	If patient has same or similar illness, give first date	Conditional
16	Dates patient unable to work in current occupation	Conditional
17	Name of referring physician or other source	Conditional – Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17A	ID number of referring physician	Conditional REQUIRED if field 17 is completed
17B	NPI of referring physician	Conditional REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services	Conditional
19	Reserved for local use – new form: Additional claim information	Conditional
20	Outside lab/charges	Conditional
21	Diagnosis or nature of illness or injury (related items A–L to item 24E by line). New form allows up to 12 diagnoses and ICD indicator	Required – Include the ICD indicator
22	Resubmission code/original REF	Conditional – For resubmissions or adjustments, enter the original claim number of the original claim

Field number	Field description	Required, conditional or not required
23	Prior authorization number or Clinical Laboratory Improvement Amendments (CLIA) number	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services
24 A–G SHADED	Supplemental information	Conditional – The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate
24A UNSHADED	Dates of service	Required
24B UNSHADED	Place of service	Required
24C UNSHADED	EMG	Not required
24D UNSHADED	Procedures, services or supplies CPT/HCPCS modifier	Required – Ensure NDC or UPIN is included if applicable
24 E UNSHADED	Diagnosis code	Required
24 F UNSHADED	Charges	Required
24 G UNSHADED	Days or units	Required
24 H SHADED	EPSDT (family planning)	Conditional – Leave blank or enter “Y” if the services were performed as a result of an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) referral
24 H UNSHADED	EPSDT (family planning)	Conditional – Enter the appropriate qualifier for EPSDT visit
24 I SHADED	ID qualifier	Required
24 J SHADED	Non-NPI provider ID#	Required
24 J UNSHADED	NPI provider ID	Required
25	Federal tax ID number and SSN/EIN	Required
26	Patient’s account NO	Conditional – Enter the provider’s billing account number

Field number	Field description	Required, conditional or not required
27	Accept assignment?	Conditional – Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment
28	Total charge	Required
29	Amount paid	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing
30	Balance due	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)
31	Signature of physician or supplier including degrees or credentials	Required
32	Service facility location information	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
32A	NPI – Services rendered	Conditional Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33
32B	Other provider ID	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
33	Billing provider INFO & PH#	Required
33A	Group billing NPI	Required
33B	Group billing other ID	Required

APPENDIX B – UB-04 BILLING INSTRUCTIONS

Field number	Field description	Required, conditional or not required
1	Unlabeled field	Required
2	Unlabeled field	Not required
3A	Patient control no	Not required
3B	Medical record number	Required
4	Type of bill	Required
5	Fed tax no	Required
6	Statement covers period from/through	Required
7	Unlabeled field	Not required
8A	Patient name	Not required
8B	Patient address	Required
9	Patient address	Required – Except line 9e county code
10	Birthdate	Required – Ensure DOB of patient is entered and not the insured)
11	Sex	Required
12	Admission date	Required
13	Admission hour	Required
14	Admission type	Required
15	Admission source	Required
16	Discharge hour	Conditional – Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge
17	Patient status	Required
18-28	Condition codes	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing
29	Accident state	Not required

Field number	Field description	Required, conditional or not required
30	Unlabeled field	Not required
31-34 A–B	Occurrence code and occurrence date	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing
35-36 A–B	Occurrence SPAN code and occurrence date	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing
37	Unlabeled field	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	Not required
39-41 A–D	Value codes and amounts	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing
42 LINES 1–22	REV CD	Required
42 LINE 23	Page ____of ____, Creation Date, Totals (for both columns)	Required
43 LINES 1–22	Description	Required
43 LINE 23	PAGE ___ OF ___	Conditional – Enter the number of pages. (Limited to 4 pages per claim)
44 LINES 1–22	HCPCS/rates	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed
45 LINES 1–22	Service date	Conditional REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 LINE 23	Creation date	Required
46 LINES 1–22	Service units	Required

Field number	Field description	Required, conditional or not required
47 LINES 1–22	Total charges	Required
47 LINE 23	Totals	Required
48 LINES 1–22	Noncovered charges	Conditional – Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts
48 LINE 23	Totals	Conditional – Enter the total noncovered charges for all service lines
49	Unlabeled field	Not required
50 A–C	Payer	Required
51 A–C	Health plan identification number	Not required
52 A–C	REL information	Required
53	ASG. BEN.	Required
54	Prior payments	Conditional – Enter the amount received from the primary payer on the appropriate line when Health Net is listed as secondary or tertiary
55	EST amount due	Not required
56	National Provider Identifier or provider ID	Required
57	Other provider ID	Required
58	Insured's name	Required
59	Patient relationship	Not required
60	Insured unique ID	Required
61	Group name	Not required
62	Insurance group no.	Not required
63	Treatment authorization code	Conditional – Enter the prior authorization or referral when services require precertification
64	Document control number	Conditional – Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Payer from field 50
65	Employer name	Not required

Field number	Field description	Required, conditional or not required
66	DX version qualifier	Required
67	Principal diagnosis code	Required
67 A–Q	Other diagnosis code	Conditional – Enter additional diagnosis or conditions that coexist at the time of admission
68	Present on admission indicator	Required
69	Admitting diagnosis code	Required
70	Patient reason code	Required
71	PPS/DRG code	Not required
72 A, B, C	External cause code	Not required
73	Unlabeled field	Not required
74	Principal procedure code/date	Conditional – Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 A–E	Other procedure code date	Conditional REQUIRED on inpatient claims when a procedure is performed during the date span of the bill
75	Unlabeled field	Not required
76	Attending physician	Required
77	Operating physician	Conditional REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care
78 & 79	Other physician	Conditional
80	Remarks	Not required
81	CC	Required
82	Attending physician	Required