PROVIDER*Update*

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Avoid Behavioral Health Claim Payment Delays & Denials

Essential tips to streamline submissions and simplify payments

Avoiding delays and denials in behavioral health claims starts with ensuring accurate submissions and leveraging tools that simplify the process. Errors in claims submissions can lead to frustrating delays, impacting timely reimbursements. To help you streamline the process, we've put together a list of best practices to reduce errors and ensure hassle-free claims processing. This list includes information on:

- Single practitioner submissions
- Guidelines for accurate claims submission
- Telehealth billing requirements
- Electronic Funds Transfer (EFT) account registration
- Important reminder on balance billing Medi-Cal members

Single practitioner submissions

When submitting claims using the CMS 1500 form, only include information for one practitioner per claim submission. Submitting details for multiple practitioners on a single form will result in claims delays and/or denials.

Guidelines for accurate claims submission

For guidelines on filing behavioral health claims using CMS 1500 or UB 04 forms, refer to the table on page 2.

THIS UPDATE APPLIES TO:

- Behavioral Health Providers

LINES OF BUSINESS:

- IFP
  - Ambetter HMO
  - Ambetter PPO
- Employer Group
  - HMO/POS
  - PPO
- Wellcare By Health Net
  - Medicare Advantage (HMO)
  - Medicare Advantage (PPO)
- Medi-Cal
  - Amador
  - Calaveras
  - Inyo
  - Los Angeles
  - Mono
  - Sacramento
  - San Joaquin
  - Stanislaus
  - Tulare
  - Tuolumne

PROVIDER SERVICES

provider_services@healthnet.com

Ambetter from Health Net IFP
Ambetter HMO – 888-926-2164

Ambetter from Health Net IFP
Ambetter PPO – 844-463-8188

Health Net Employer Group
HMO, POS & PPO – 800-641-7761

Medicare (individual & employer group) (Wellcare By Health Net) – 800-929-9224

Medicare Supplement – 800-641-7761

Medi-Cal (including CS and ECM providers) – 800-675-6110

Behavioral Health providers – 844-966-0298

PROVIDER PORTAL

provider.healthnetcalifornia.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)	Electronic Claims
Billing provider name, address and NPI	Enter the name, address, and 10-character NPI ID and taxonomy of the billing entity	Box 33	Box 1	Loop NM109 with XX qualifier
Subscriber (name, address, DOB, sex, and member ID required)	Enter the subscriber's Health Plan ID exactly as it appears on the member's current ID card.	Subscriber box 1a, 4, 7, 11	Box 58 and 60	2000B and 2010BA
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	Enter the member's Health Plan ID exactly as it appears on the member's current ID card.	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11	2000C and 2010CA
Attending provider with NPI	Enter the 10-character NPI ID and taxonomy for the attending practitioner.	N/A	Box 76	Loop 2300 NM1with DN qualifier
Rendering provider	Enter the 10-character NPI ID and taxonomy for the individual practitioner who rendered the service (this can be blank if a sole proprietor and that NPI is entered as the Billing Provider).	NPI in Box 24J Bill based on specialty specific modifiers. If paraprofessional modifiers are being billed, then the paraprofessional NPI is required in box 24J.	Box 56	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)
Service facility information	Enter the name, address, and 10-character NPI ID and taxonomy where the patient service was delivered (this can be blank only if provider is a sole proprietor).	Box 32	Box 1	Loop 2310C or 2310E NM1 with 77 qualifiers (if differs from billing provider)
Signature of physician or supplier including degrees or credentials	Enter the printed/typed name and signature of provider of service, including degree/credentials.	Box 31 Include the supervising physician's information if the rendering practitioner requires supervision, such as paraprofessionals.	Box 80. Remarks Field/Signature	Loop 2300 with Yes/No condition or response code

Telehealth billing requirements

When billing for a covered telehealth service, you must use the appropriate American Medical Association (AMA) CPT and HCPCS codes that are most descriptive for the service delivered. Refer to the table below for telehealth claims billing requirements based on the members line of business.

Medi-Cal members	Commercial members (HMO, POS, PPO)	Medicare members

Bill for telehealth services in accordance with the DHCS Provider Manual Telehealth requirements	• Use the normal place of service code (11, 23, etc.) – excluding FQHC/RHCs.
	  ○ Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Pricing using the Medicare physician fee schedule will result in payment parity in either situation for commercial claims.
	• Use appropriate modifiers – excluding FQHC/RHCs.
	  ○ Modifier 95; or
	  ○ Modifier GQ.
		• Bill in accordance with CMS requirements.
		• Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Any related pricing using the Medicare physician fee schedule will apply the applicable Medicare rate for the place of service code used (facility rate for place of service "02" and non-facility rate for place of service "10") in accordance with CMS guidelines

Electronic Funds Transfer (EFT) account registration

Register for EFT to avoid paper checks

If you do not have an EFT account, register today to receive your checks via EFT. Follow the information in the table below to register for an EFT account.

Behavioral health providers who had an EFT account prior to the MHN transition to Health Net

As a result of the behavioral health services administration transition from MHN to Health Net of California, Inc. (Health Net*), you are required to register for a new EFT account with Health Net and/or Payspan® to receive payments via EFT. Otherwise, you will continue to receive paper checks. Refer to the table below on how to register for an EFT account.

EFT account registration instructions are based on the applicable line of business

Individual & Family Plans (Ambetter HMO/PPO) and Individual Medicare Advantage	**Employer Group (HMO/POS/PPO) and Medi-Cal**
Payspan	**Health Net**
To enroll, you will need a unique registration code that can be requested by any of the following methods: • Online registration with Payspan or bit.ly/PaySpanReqCode. • Via email: ProviderSupport@Payspanhealth.com. • Contact Payspan Provider Services at 877-331-7154, option 1.	You have two options to register: • Register online: Go to bit.ly/EFTRegistration. • Download the form using this QR code.

Registration codes requested online or via email will be emailed from Payspan along with detailed registration instructions.	If you need help with registration, contact Health Net's Electronic Data Interchange (EDI) specialists at: **Email**: EDIBA@centene.com or **Phone:** 800-225-2573, extension 6075525

Important reminder on balance billing Medi-Cal members

Participating physicians and other providers may not bill or attempt to obtain reimbursement from a Medi-Cal member, or any person acting on behalf of a member, for any service covered under the Medi-Cal program.

Medi-Cal members are not liable for any amount unless a Medi-Cal share-of-cost must be met. Physicians and other providers should bill fee-for-service (FFS) Medi-Cal for services provided to a Medi-Cal member whose managed care coverage has been placed on hold.

Examples of prohibited balance billing include, but are not limited to:

- Billing members fees and surcharges for covered services, such as copayments, deductibles or coinsurance responsibilities.
- Requiring members to pay for a covered service that was denied or rejected by Health Net or the participating physician group (PPG) for valid/appropriate reasons.
- Charging Dual Special Needs Plan (D-SNP) members coinsurance, copayments, deductibles, financial penalties, or any other amount.
- Requiring members to pay the difference between the discounted and negotiated fees and the physicians' and other providers' usual and customary fees.

Penalties for non-compliance, if applicable, are outlined under the terms of your *Provider Participation Agreement* (*PPA)*. Those who exhibit a pattern and practice of balance billing members will be subject to disciplinary action.

Additional information

- For more information about claim submission, refer to the Behavioral Health Provider Operations Manual in the Provider Library at **providerlibrary.healthnetcalifornia.com.** On the left-hand column, select the applicable line of business, then Behavioral Health Provider Operations Manual or use the QR code to the right.
- To access resources and information about the behavioral health transition from MHN to Health Net visit the Administration of Behavioral Health Services Transition from MHN to Health Net at bit.ly/BHTransitionFAQs.
- For all other general inquiries or questions regarding the information in this update, contact Behavioral Health Customer Service at 844-966-0298.

[1]In accordance with Federal and State of CA law as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997 at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm and California Welfare and Institutions Code section 14019.4 9 at https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14019-4.html **respectively balance billing covered Medi-Cal enrollees is strictly prohibited**.