PROVIDERUpdate

Health Net®

NEWS & ANNOUNCEMENTS | JULY 27, 2018 | UPDATE 18-037HNOR | 14 PAGES

Paper Claims Submission Rejections and Resolutions

The preferred and most efficient way for fast turnaround and claims accuracy is to submit claims to Health Net of Oregon, Inc., and Health Net Life Insurance Company (Health Net) electronically. However, when attachments or additional documentation is required, paper claims will be accepted. 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. These form types will be rejected upfront as non-clean claims. Providers must adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

THIS UPDATE APPLIES TO:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Oregon
- Washington

LINES OF BUSINESS:

- EPO
- POS
- PPO
- CommunityCare
- Medicare Advantage (HMO/PPO)

PROVIDER SERVICES

www.healthnet.com

EPO, POS, PPO, & CommunityCare: 1-888-802-7001

Medicare Advantage: 1-888-445-8913

Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. and Centene Corporation. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. Confidentiality Note for Fax Transmission: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. OTH021491EH00 (0718)

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 ID for Commercial and Medicare. Social Security number (SSN) should not be used	CMS-1500 box 1a UB-04 box 60
06	Missing/invalid tax ID	Include complete 9-character tax identification (ID) number	CMS-1500 box 25 UB-04 box 5
17	Diagnosis indicator is missing. DRG code is not valid. POA indicator is not valid.	Ensure 9/0 is billed on the claims Ensure DRG code and POA indicators are valid when billed Include principal diagnosis codes matching the ICD indicator	UB-04 box 67 UB-04 box 69 UB-04 box 70 UB-04 box 71 UB-04 box 72
75	The claim(s) submitted is missing, illegible or invalid value for anesthesia minutes	If 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 CMS1500 and field 4 on the UB04), the original claim number is required (field 22 on CMS 1500 and Field 64 on UB04)	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	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 UPN qualifier, number, quantity, and type. 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	If box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a 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	UB-04 box 67 – 67Q and 72A – 72C
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 CMS1500 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, 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 inpatient claims	UB-04 box 70a, b, c
HP	ICD10 is mandated for this date of service	Submit the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms 5010 Guidelines requirement to bill this information	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 5 and Appendix B – UB-04 Billing Instructions on page 9 provide the mandatory items for both claim forms. For complete claims submission instructions, providers can refer to 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, automatic forwarding by USPS of claims will be discontinued. Claims received at the previous Lexington, KY address starting December 31, 2018, will be returned to the sender via USPS.

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

Line of business	Paper claims address
MEDICARE ADVANTAGE HMO & PPO	**Health Net of Oregon, Inc. (and/or)** **Health Net Life Insurance Company** Medicare Claims PO Box 9030 Farmington, MO 63640-9030
EPO, POS, PPO, & COMMUNITYCARE	**Health Net of Oregon, Inc.** Commercial Claims PO Box 9040 Farmington, MO 63640-9040

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center 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 of 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
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 number 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.
23	Prior authorization number or 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 For detailed instructions and qualifiers refer to Appendix IV of this guide
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 UPN are 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 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 SSN/EIN	Required
26	Patient's account NO	Conditional – Enter the provider's billing account number
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 – UB04 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 re-submissions 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	Rev CD	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	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	Service units	Required
47 LINES 1–22	Total charges	Required

Field number	Field description	Required, conditional or not required
47 LINE 23	Totals	Required
48 LINES 1–22	Non-covered charges	Conditional – Enter the non-covered 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 non-covered 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
66	DX version qualifier	Required
67	Principal diagnosis code	Required

Field number	Field description	Required, conditional or not 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

The following provider dispute request summary and form can be found at healthnet.com/provcom/pdf/54044.pdf.

Health Net HEALTH PLAN OF OREGON

Health Net LIFE INSURANCE COMPANY

PROVIDER DISPUTE REQUEST SUMMARY AND FORM

Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company, Inc. (Health Net) strives to informally resolve issues raised on initial contact whenever possible. If an issue involves a partial payment or payment denial and cannot be resolved by Health Net's Customer Contact Center associates, Health Net offers its providers a two-level internal dispute and appeal process.

Dispute Process

All supporting documentation submitted is reviewed along with the terms of the member's benefit plan and the Health Net *Provider Participation Agreement* (*PPA*) and its requirements. After reviewing all documentation, Health Net makes a determination regarding the provider's dispute request. If the provider is not satisfied with the review decision, he or she may request an appeal.

Step 1: Contact Health Net's Provider Services team at 1-888-445-8913 (Medicare) or 1-888-802-7001 (commercial) to review any denial or payment reductions. If a Provider Services associate is unable to resolve the issue to the provider's satisfaction, the provider will be advised of their right to dispute the decision.

Step 2: The provider may ask the Provider Services associate to forward his or her dispute, or he or she may prepare a written dispute and submit it to the appropriate address indicated in this document. Providers may also submit an unlimited number of verbal disputes over the phone with a Provider Services representative. Disputes may also be submitted via the Medicare provider portal, at provider.healthnetoregon.com, using the "messaging" feature. Complete and accurate preparation of the request facilitates a timely and thorough review.

Requests for review, whether written or verbal, must include:

- A completed Provider Dispute Request Form requesting review of the payment decision, along with additional information as appropriate, to support the description of the dispute.
- For reviews with a clinical component, such as denied hospital days or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.
- It is not necessary to include a copy of a claim previously processed, but include a copy of the remittance advice (RA) whenever possible.
- Per the Health Net PPA, disputes must be submitted within 365 days of the date the claim was denied or payment intended to satisfy the claim was made.

Step 3: Submit requests for disputes to the following addresses:

Medicare Provider Disputes
PO Box 9030
Farmington, MO 63640-9030

Commercial Provider Disputes
PO Box 9040
Farmington, MO 63640-9040

Step 4: If a determination is made to alter the initial decision and an additional payment is to be issued, providers are notified of the payment adjustment via the RA. If a decision is made to uphold the initial determination, providers are notified via a written response. Providers not satisfied with Health Net's decision may request an appeal. The provider appeal process is located in the operations manuals in the Provider Library.

Nonparticipating providers

For Medicare Advantage nonparticipating providers, when submitting an appeal on behalf of the member, the established Centers for Medicare & Medicaid Services (CMS) process must be followed and a completed Appointment of Representative (AOR) form must be included. When submitting a provider appeal, include a Confidential Communication Request (Waiver Liability) form, which is available in the Provider Library under Forms.

Please note: nonparticipating providers for commercial products have no appeal opportunities unless they are appealing on behalf of the member. If a nonparticipating provider is dissatisfied with a payment or nonpayment decision, only the member has the right to appeal by following Health Net's member grievance and appeal procedure.

PROVIDER DISPUTE REQUEST FORM

Date (mm/dd/yyyy):________________________

Requestor Information		
Provider name:		
Provider # or Tax ID:		
Contact name:	Signature:	
Telephone:	Fax:	
Address:		
City:	State:	ZIP Code:

Claim Information
Member name:
Member ID #:
Claim number(s):
Date(s) of service:
Billed amount:
Process date:

Action Requested (Please include a copy of the remittance advice, corrected claim(s) and chart notes if necessary).		
☐ Authorization #	☐ Billed/allowed amount (attach copy of manufacturer's invoice)*	
☐ COB	☐ Date of service	☐ Denied as duplicate
☐ Diagnosis code*	☐ Number of units	☐ Member responsibility*
☐ Place of service*	☐ Procedure code/modifier*	☐ Other
Narrative describing disputed payment:		

*May require information that substantiates the request; for example, statement from the physician, operative report, office notes, or supporting medical documentation.

FRM020720EW00 (6/18)

Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company are subsidiaries of Health Inc. and Centene Corporation. Health Net is a registered service mark of Health Net, Inc. All rights reserved.