Claims Processing

The details below help provide the claims information you need. But if you require more details about claims procedures, refer to the Claims section in your provider operations manual in the Provider Library at providerlibrary.healthnetcalifornia.com.

Filing limit

Providers must use correct coding to ensure prompt, accurate processing of claims. Physicians should use CMS-1500 forms and CPT or HCPCS coding, as indicated in the *Provider Participation Agreement (PPA)*. Hospitals use UB-04 (CMS-1450) forms and current UB coding, including CPT, DRG, HCPCS and ICD-10.

Submit claims timely as set forth in the *PPA*. Do not send claims to members unless the member has agreed, in writing, to take financial responsibility for a non-covered service.

EDI billing requirement

Electronic Data Interchange (EDI) gives you the tools you need to track electronic claims status, improve timely filing and access daily accept/reject reports. This also means easier receivables and account reconciliation. By using approved vendors and clearinghouses, HIPAA compliance is done for you, and you will have automatic access to highly secure and time-tested solutions.

The following transactions are available for providers through one of our approved clearinghouses:

- **837 electronic claim submissions.**
- **835 electronic remittance advice.**
- **EFT payments.**

We are CORE Phase III certified with our real-time claims status and member eligibility transactions, as well as compliant with federal operating rules.

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For successful EDI claim submission, you will need to use electronic reporting made available by your vendor and/or clearinghouse. Wellcare By Health Net (Health Net*) returns claims acknowledgements to the clearinghouse with notifications of acceptance or rejection of individual claims. Providers can review these reports to check the status of their submission.

Clearinghouses

Clearinghouse contact information for real-time transactions (eligibility and claims status):

Clearinghouse	Contact information	Health Net Payer ID
Ability (MDOnline)	888-499-5465 www.mdon-line.com	95567 Employer group Medicare Advantage (MA) HMO, HMO, PPO, EPO, Point of Service (POS), Medi-Cal, Cal MediConnect, Centene Corporation Employee Self-Insured PPO Plan.
Change Healthcare	866-817-3813 www.changehealthcare.com	HNNC
Availity	800-282-4548 www.Availity.com	68069 Individual MA HMO and MA PPO.

Paper claims

For paper claims, we accept the Centers for Medicare & Medicaid Services (CMS) most current:

- **CMS-1500 form –** complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, updated each July, and available through the National Uniform Claim Committee at www.nucc.org.
- **CMS-1450 (UB-04) form –** complete in accordance to UB-04 Data Specifications Manual, updated each July, and available through the American Hospital Association website at https://ebooks.aha.org/.

Other claim form types will be upfront rejected and returned to the provider. Providers should adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

We accept claim forms printed in Flint OCR Red, J6983 (or exact match) ink and do not supply printed claim forms. Providers should purchase these forms from a supplier of their choice. Member claims should be submitted to:

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

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Paper claims rejections 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. The 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
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.	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 three 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-up (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.	Complete provider billing address required, including city, state and ZIP code.	CMS-1500 box 33 UB-04 box 1
C8	Valid present on admission (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
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

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Reject code	Reject reason	Requirements	CMS-1500 or UB-04
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 inpatient 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

Resubmissions

When additional information regarding a claim is requested, you will have 60 calendar days from the date of the request to submit the requested information. The remittance advice (RA) and explanation of payments (EOP) must be submitted with the requested information.

If a claim is not submitted within 60 calendar days, or the requested information is not returned within 60 calendar days, the claim will be denied.

Clean claims

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The required elements to process the claims include, but aren't limited to, the member's name, ID number, participating physician group (PPG) and physician names, date of service (DOS), diagnosis code(s), and billed amount.

Emergency services, out-of-area urgently needed services and out-of-area renal dialysis do not require prior authorization to be considered a clean claim.

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