

Provider Notice



From: Magellan Healthcare

Subject: Update: Billing requirements for supervisory protocol claims

Attention: Update to claims submission formatting

Overview

On September 24, Magellan sent a communication to providers regarding billing requirements for services under supervisory protocol. There has been an update to the billing guidance in that communication regarding Box 33. Please submit claims using the accurate format below. This updated information will be reflected in the next version of the IBHP Provider Handbook Supplement. We apologize for any confusion this may have caused.

1. Claim submission format

When billing for services delivered by a supervised practitioner, the following fields are required:

- **Box 19:** Name of the supervised provider (paraprofessional): on the CMS1500
 - **In Availability**, this box is also titled, "Additional Claim Information"
- **24J:** Supervising provider's individual National Provider Identifier (NPI)
- **Box 31:** Supervisor's Signature and Date
- **Box 32:** The Billing Group or Organization Name and Address for the location where the services were rendered.
- **Box 32a:** The Billing Group or Organization NPI for the location where services were rendered, if different than 33a.
- **Box 33:** Billing Group or Organization Name and Billing Address which **MUST** be a physical location, not a P.O. Box.
- **Box 33a:** Billing Group or Organization's NPI

For Example:

Billing Group/Org, NPI, Address:

ABC Therapy

NPI: 123456789

123 Alphabet Street, Boise, ID 83701

Supervisor's Name, NPI,

Bert Richard

NPI: 234567891

Supervisee's Name, NPI, Rendering Address:

Ernie Smith
 NPI: 456789123

345 Main Street, Boise, ID 83701 (*this location has the same NPI as 123 Alphabet St)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QJAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17b NPI				19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Ernie Smith NPI 456789123 (Supervisor's Name and NPI if applicable)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ ICD Ind. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				23. PRIOR AUTHORIZATION NUMBER _____					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS P/INTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Rating Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1												NPI	234567891 (Sup NPI)
2												NPI	-----
3												NPI	-----
4												NPI	-----
5												NPI	-----
6												NPI	-----
25. FEDERAL TAX I.D. NUMBER			SSN EIN	26. PATIENT'S ACCOUNT NO			27. ACCEPT ASSIGNMENT? (for govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 0.00	29. AMOUNT PAID \$	30. Rsvd. for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Bert Richard (Supervisor's Name) SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION ABC Therapy (Billing Group/Org Name) 345 Main Street (Where services were rendered) Boise, ID 83701				33. BILLING PROVIDER INFO & PH# () ABC Therapy (Billing Group/Org Name) 123 Alphabet Street (Physical Billing Address) Boise, ID 83701 (Billing Group/Org NPI in Box a.)					
				a. *not required		b.		a. 123456789	b.				

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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Questions?

Please contact Magellan at IdahoProvider@MagellanHealth.com.