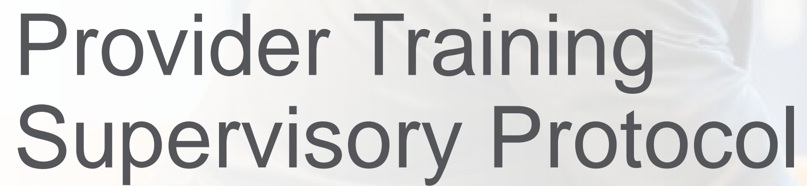

March 2019

Agenda topics

- Introduction
- Overview of Supervisory Protocol
- Eligible Provider Types
- Claims Submission
- Supervisory Protocol Addendum
- Requesting a Supervisory Protocol Addendum

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Introduction

Overview of the Supervisory Protocol

The **Supervisory Protocol Addendum** allows non-credentialed clinicians to render services while under the supervision of an independently licensed clinician.

- Clinicians rendering psychotherapy services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the clinician's training
- Supervision must:
  - Occur regularly on a one-to-one basis
  - Be documented
- Optum may periodically conduct chart audits to ensure compliance with Optum policies and procedures.

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Eligible Provider Types

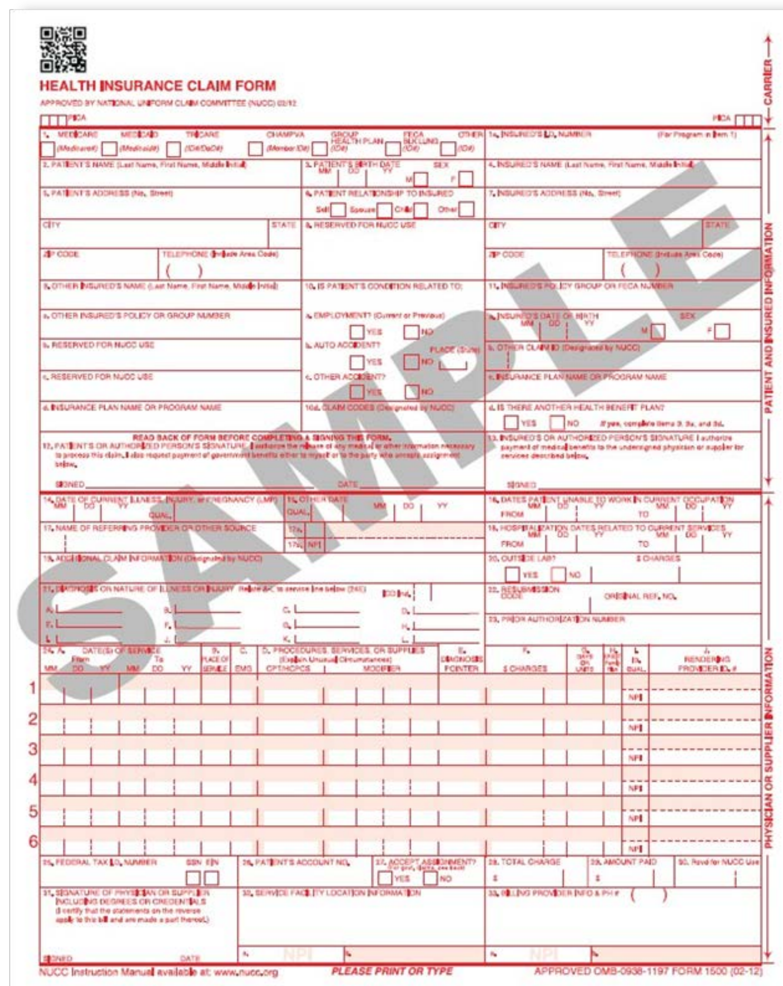
The Supervisory Protocol option is **available for groups only** – not for solo practitioners.

Eligible Supervising Providers: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MH/SUD Services are provided, who practices as an employee of a group and has been credentialed or formally rostered and approved by United Behavioral Health (UBH), in writing, as a MHSA Group Participating Supervising Provider.

NOTE: Optum requires all providers to be independently licensed unless the agency or group has executed a supervisory protocol addendum.

Claims

Claim form – CMS Form 1500 (v 02/12)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA | CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

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. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. 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 POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								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) YES NO

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

Claim form – CMS Form 1500 provider section, (continued)

- **Box 24J:** Independently licensed clinicians who render services enter their **NPI number** in the non-shaded portion
- **Box 24J:** For Non-independently licensed clinicians who render services, claims should be submitted with the Group Participating Supervising Provider's NPI number in Box 24J

	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 POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1															NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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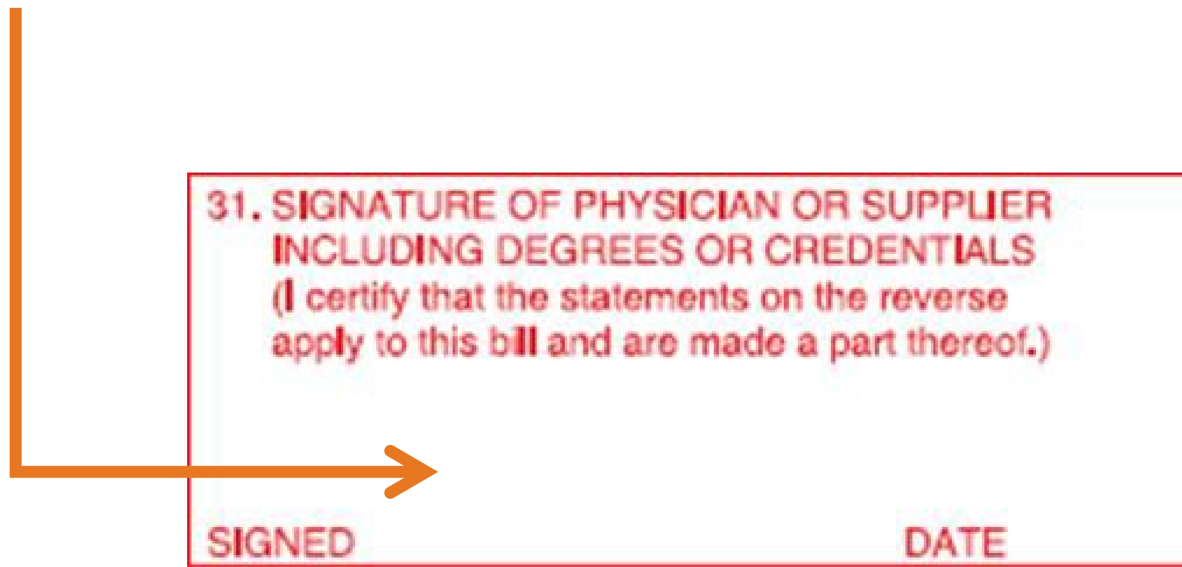
Claim form – CMS Form 1500 provider section, (continued)

- **Box 31:** Independently licensed clinicians who render services enter their name and licensure in Box 31
- **Box 31:** Non-independently licensed clinicians who render services enter the name of the agency in Box 31



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Claims form – CMS Form 1500 provider section, (continued)

For claims with non-independently licensed clinicians:

- **Box 33:** Agency name, address, and phone number
- **Box 33a:** Agency NPI number

33. BILLING PROVIDER INFO & PH # ( )

a. NPI | b.

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Supervisory Protocol Addendum

UNITED BEHAVIORAL HEALTH
AND
U.S. BEHAVIORAL HEALTH PLAN, CA
ADDENDUM TO THE
GROUP PARTICIPATION AGREEMENT

Provider Name (hereinafter, "Provider")	Provider TIN:	Medicare #	Medicaid #

This **ADDENDUM** summarizes the protocol for supervision of Non-credentialed Mental Health/Substance Use Disorder (MH/SUD) clinicians employed by Provider.

For purposes of this Addendum the follow definitions shall apply:

MHSA Non-Credentialed Group Participating Provider: An employee of a MH/SUD Group who provides mental health and/or substance use disorder services, but is not a Group-Based Supervising Provider. Employee of MH/SUD Group is not eligible for independent clinician or Group credentialing by UBH.

MHSA Group Participating Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MH/SUD Services are provided, who practices as an employee of a group and has been credentialed or formally rostered and approved by UBH/USBHPC, in writing, as a MHSA Group Participating Supervising Provider.

I. Supervision and treatment provided is consistent with the UBH/USBHPC Level of Care Guidelines and the UBH/ USBHPC Best Practice Guidelines. At all times, the Group Participating Supervising Provider requires the Non- credentialed Group Participating Provider to comply with the protocols and requirements of UBH/USBHPC and Payor and the requirements of all applicable regulatory authorities. Group Participating Supervising Providers and Non-credentialed Group Participating Providers conduct treatment and business practices in accordance with the Network Manual.

II. MHSA Participating Provider conducts verification of education for each Non-credentialed Group Participating Provider. A Non-credentialed Group Participating Provider's training and education includes but is not limited to:

A. Professional license eligibility
B. Minimum of master's degree for clinicians providing psychotherapy services (unless otherwise specified by *applicable* state law)
C. Work history – with explanation for any gaps of six months or longer
D. Specialized Training, where applicable

III. Non-credentialed Group Participating Providers practice within the scope of their training and abide by the ethical principles of their discipline's licensing Board, that of their Group Participating Supervising Provider, and the professional association with which they are affiliated.

SAMPLE

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Supervisory Protocol Addendum (continued)

IV. Supervision of Non-credentialed Group Participating Providers follows these guidelines:

A. A Group Participating Supervising Provider, who is in good standing in the UBH/USBHPC network, provides supervision of a Non- credentialed Group Participating Provider.

B. The Group Participating Supervising Provider must have regularly scheduled direct, one-one-one, physical supervision with the Non-credentialed Group Participating Provider to review treatment provided. Supervision must be documented and documentation must be kept on file.

V. Claims should be submitted with the Group Participating Supervising Provider as the rendering provider.

VI. UBH/USBHPC may periodically conduct chart audits to ensure compliance with UBH/USBHPC policies and procedures.

VII. Within 30 days of a request by UBH/USBHPC, or no more than semi-annually, MH/SUD Group provides, a written listing of all Non-credentialed Group Participating Providers employed by MH/SUD Group who provide treatment to UBH/USBHPC members.

The Addendum Effective Date is (to be completed by UBH only): ________________

UBH/U.S. Behavioral Health Plan, CA Address:	Provider Name:
______________________ Authorized Signature	______________________ Authorized Signature
______________________ Print Name	______________________ Print Name
______________________ Title	______________________ Title
______________________ Date	______________________ Date

SAMPLE

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Requesting a Supervisory Protocol Addendum

Requests for a Supervisory Protocol Addendum should be submitted via email to:

Email Address: provider.services@optum.com

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Thank you.

Contact information:

Alec Ward, Network Director

Gabriel Nathan, Senior Network Manager