Provider Bulletin

Revised: Winter 2025

Submitting Claims Reflecting Services Provided

To ensure accurate and timely claims processing, providers are reminded of the importance of submitting claims that accurately reflect the services rendered to patients. This bulletin outlines key guidelines for claims submission in accordance with payer requirements and industry standards.

Claims Submission Guidelines

1. **Accurate Service Documentation**
   - All claims must be supported by complete and accurate documentation in the patient's medical record.
   - The services billed must correspond to the care provided, as documented in the clinical notes.
2. **Correct Coding**
   - Use the most current ICD-10-CM, CPT, HCPCS, and other applicable coding standards.
   - Ensure procedure codes, diagnosis codes, and modifiers are appropriate and reflect the services delivered.
   - Avoid the use of default or "unspecified" codes unless they are the most accurate representation of the service provided.
3. **Date and Place of Service**
   - Include the correct date(s) of service and site of care/POS (e.g., office, telehealth).
4. **Provider Information**
   - Ensure the correct National Provider Identifier (NPI) and provider details are listed.
   - Claims should reflect the rendering provider who performed and/or supervised the service.
   - Bill exactly how you are registered with the State, this includes your practice's zip code and 4 digit zip code extension.
   - One claim per rendering provider.
   - Update your roster immediately with Therapy Network in order to avoid a delay.
   - **Attention Behavior Analysis Providers:** Your claim form must contain the Supervising Provider's name in addition to the Rendering Provider's information. Please use box 17 for the Supervision Provider; enter a qualifier to the left of the dotted vertical line (DQ = Supervision Provider) and enter the NPI in Box 17b, normally the member's primary care physician or diagnosing physician.

5. **Patient and Payer Information**
    - Verify patient demographic and insurance information before claim submission.
    - Include the correct member ID and any required authorization numbers.
6. **Timely Submission**
    - Submit claims within the timeframe specified by the payer to avoid denials due to timely filing limits.
    - Resubmissions or corrections should be clearly marked as such.
7. **Telehealth Services: (if applicable)**
    - Ensure telehealth services are appropriately coded with applicable modifiers (e.g., 95 or GT) and place-of-service codes (e.g., 02 for telehealth).

Claims Submission Process

- Claims can be submitted electronically through Direct Data Entry (DDE) through the HS1 Web Portal, or through the Clearinghouse, Smart Data Solutions, using:
    - Professional Payer ID: 65062
    - Institutional Payer ID: 12k89
- Paper claims submission may be mailed to:
  Therapy Network of Florida
  Claims Processing Center
  PO Box 240385
  Apple Valley, MN 55124
- Claim inquiries/Claims Status (877) 372-1273 *(please listen to the options)*

Reminder

Incomplete, inaccurate, or unsupported claims may result in payment delays or denials. Providers are responsible for adhering to billing guidelines as outlined by federal, state, and payer-specific requirements.

Thank you for your attention to this important aspect of claims processing.

References

Medicare Claims Processing Manual
Medicare Claims Processing Manual
Medicare NCC Medically Unlikely Edits| CMS
Medicare NCCI Policy Manual | CMS
MLN909160 – Complying with Medical Record Documentation Requirements