Training #3 Denial Clinic Activity Scenarios

Activity overview

In this 10-15-minute activity, each table group reviews a denied behavioral health claim and decides what went wrong, how to fix it, and how to prevent it.

Suggested flow

Break into small table groups, hand each group one short denied-claim case, and have every group answer the same four questions.

1. **Step 1:** Hand each table one case and the quick reference card.
2. **Step 2:** Group discussion.
    a. Groups answer four questions:
        i. Is this a rejection or a denial?
        ii. What caused it?
        iii. What's the fix: correct and resubmit, submit a corrected claim, or appeal?
        iv. What would have prevented it?
3. **Step 3:** Report out
    a. Each table gets about one minute: the case in one sentence, then its four answers. With more than four tables, give the same case to two tables and have only one of them report, with the other adding anything that was missed.
4. **Step 4:** Wrap up
    a. Name the prevention answers you heard as the takeaways.

Facilitator tip: If a group jumps straight to "appeal," ask them first whether the documentation actually supports the claim as billed. Several cases are designed so that appealing would be the wrong move.

Quick Reference Card

A rejection never entered the payer's system; a denial was processed and refused. That one difference decides how you fix it.

	Rejection	Denial
What happened	Claim failed front-end edits at the clearinghouse or payer and was never adjudicated	Claim was received, adjudicated, and not paid (in whole or in part)
Where you see it	Clearinghouse or payer acknowledgment report	Remittance advice (835/RA) with a denial reason code (CARC)
Typical causes	Invalid or unmatched member ID, wrong payer, missing NPI, formatting errors	Coding doesn't match documentation, service not covered, missing authorization, medical necessity not supported
In the payer's claim history?	No	Yes

The three fix paths:

Fix path	Use it when	Key point
Correct and resubmit	The claim was rejected	It's submitted as a new, original claim because the payer never processed the first one
Submit a corrected claim	The claim was denied (or paid wrong) because of an error on the claim, such as the wrong code, units, modifier, or place of service	Submitted as a replacement of the original claim, not a duplicate; only correct what the documentation supports
Appeal	The claim was billed and documented correctly and the payer's decision is wrong	An appeal can't fix documentation that doesn't support the service

Always check timely filing limits before deciding, since each fix path runs against a deadline.

Case A

Background: Longs Peak Behavioral Health is contracted with two RAEs. Most members belong to one, so billing staff sends behavioral health claims there by default. At check-in, front desk staff confirms Health First Colorado coverage is active but doesn't record which RAE the member is assigned to.

Claim detail	Value
Member	Alex, age 30
Dates of service	7 visits over 2 months (1 intake, 6 therapy sessions)
Codes billed	90791 (intake), 90834 (psychotherapy, 45 min)
Diagnosis	F43.23 (adjustment disorder with mixed anxiety and depressed mood)
Submitted to	The clinic's usual RAE

What came back: All seven claims appear on the clearinghouse acknowledgment report with the status "Denied: subscriber/member not found." Remittance advice will say subscriber/member not found; submit to correct payer. The billing specialist assumes it's a system glitch and resends all seven, unchanged, to the same RAE. They return the same message.

Front desk note excerpt:

> *3/4 Eligibility verified in provider portal. Health First Colorado active. Copay $0. Client scheduled weekly on Tuesdays at 2 pm.*

Your table's four questions:

1. Is this a rejection or a denial?
2. What caused it?
3. What's the fix: correct and resubmit, submit a corrected claim, or appeal?

4. What would have prevented it?

Case B

Background: A clinician at Red Rocks Behavioral Health has been seeing Jordan, age 16, for depression. Dr. Lee, a licensed psychologist, is the practice's designated Rendering Provider for pre-licensed clinicians. The RAE selects the claim for prepayment review and requests the record.

Claim detail	Value
Member	Jordan, age 16
Date of Service	August 2026
Code billed	90837 (psychotherapy, 60 min)
Modifier(s) on claim	None
Diagnosis	F32.1 (major depressive disorder, single episode, moderate)
Clinician who delivered the service	LPCC candidate (pre-licensed)
Rendering provider NPI on claim	The LPCC candidate's NPI
Treatment plan on file	Signed 7 months before this date of service; reviewed annually per agency policy, but the plan states "review in 90 days"

What came back: The remittance advice shows the claim denied with **CARC CO-150** (payer deems the information submitted does not support this level of service). The reviewer's letter also notes the treatment plan was past its stated review date.

Progress note excerpt:

> *Session started at 3:10 pm, ended at 3:55 pm. Met with client individually. Discussed coping skills and school stressors. Client engaged. Continue plan. Signed: [Clinician], LPCC candidate*

Your table's four questions:

1. Is this a rejection or a denial?
2. What caused it?
3. What's the fix: correct and resubmit, submit a corrected claim, or appeal?
4. What would have prevented it?

Case C

Background: A case manager at Plains Community Mental Health works with Devon, age 41, who has schizophrenia and unstable housing. The claim is selected for review.

Claim detail	Value
Member	Devon, age 41
Service billed	Case management, billed in 15-minute units
Units billed	5 units (75 minutes)
Diagnosis	F20.9 (schizophrenia, unspecified)
Note signed	5 weeks after the date of service

What came back: The remittance advice shows the claim denied with **CARC CO-150** (information submitted does not support this level of service). The reviewer notes that the documented activities don't support the units billed.

Case management note excerpt:

> *9:00 to 9:15 Called Eastside Housing Program x2, left voicemails re: housing application status. 9:30 to 10:00 Drove client to Grace Food Bank. 1:00 to 1:20 Phone call with client to review housing appointment on 10/20: documents needed, bus route, who to ask for. Client able to repeat back plan. Addresses Goal 2 (stable housing). 1:20 to 1:30: Completed documentation.*

Your table's four questions:

1. Is this a rejection or a denial?
2. What caused it?
3. What's the fix: correct and resubmit, submit a corrected claim, or appeal?
4. What would have prevented it?

Case D

Background: Taylor, age 28, is scheduled for a video therapy session from home with a therapist at Canyon Counseling. Five minutes in, the video keeps freezing, so the therapist calls Taylor and finishes the session by phone.

Claim detail	Value
Member	Taylor, age 28
Code billed	90834 (psychotherapy, 45 min)
Modifier	The clinic's standard video (audio-visual) telehealth modifier
Place of service	02 (telehealth provided other than in patient's home)
Diagnosis	F41.1 (generalized anxiety disorder)

What came back: The remittance advice shows the claim was denied because the place of service and modifier are inconsistent with the service as billed. On follow-up, the RAE also flags that the note doesn't accurately describe how the service was delivered.

Progress note excerpt:

> *Session conducted via secure video platform. Started at 10:00 am, ended at 10:47 am. Reviewed anxiety log; practiced diaphragmatic breathing and cognitive reframing of work-related worry. Client reports 2 panic episodes this week, down from 4. Continue plan.*

(The first sentence is auto-populated by the clinic's telehealth note template.)

Your table's four questions:

1. Is this a rejection or a denial?
2. What caused it?
3. What's the fix: correct and resubmit, submit a corrected claim, or appeal?

4. What would have prevented it?

Facilitator answer key

- Cases A, B, C, and D are denials
- None of them should be appealed

Case A: Right Member, Wrong RAE

1. **Rejection or denial?** It's a denial. The claims failed due to a front-end error ('member not found'). Because Health First operates 100% electronically, no paper remittance advice was received, meaning the RAE never actually adjudicated the claims."
2. **What caused it?** The claims went to the wrong payer. Most behavioral health services are paid through the member's assigned RAE, and Alex belongs to a different RAE than the clinic's default. Active eligibility and the responsible payer are two different checks, and the front desk only did the first. Resending unchanged claims was a second error: it repeated the same failure and used up time against timely filing.
3. **What's the fix?** Correct and resubmit. Confirm Alex's RAE assignment in the provider portal, then submit all seven as new claims to the correct RAE. Because the correct RAE never received the original claims, you can submit them as new rather than appealing or resubmitting. If the clinic isn't contracted with Alex's RAE, contact that RAE about a potential “single-case agreement” option before services continue.
4. **What would have prevented it?** Front-end eligibility verification: Front office staff should electronically verify the correct RAE for every patient or client through the state Medicaid provider portal prior to claim submission.

Case B: The 45-Minute Hour

1. **Rejection or denial?** Denial. It was adjudicated and appears on the remittance advice with CO-150.
2. **What caused it?** The documented time (3:10 to 3:55, or 45 minutes) doesn't meet the SBHS Billing Manual range for 90837 (53 to 74 minutes). The session supports 90834 (38 to 52 minutes). The claim also breaks HCPF's Health First Colorado Behavioral Health Rendering Provider Oversight (RPO) Policy: a pre-licensed clinician can't independently deliver Medicaid-reimbursable services, so the service must be billed under a Rendering Provider (a licensed, Medicaid-enrolled practitioner) who reviews the clinician's documentation and co-signs it as required by regulation, contract, or other policy guidance. Dr. Lee is the practice's Rendering Provider, but this record shows no evidence that Dr. Lee reviewed or co-signed the note, and the claim was billed under the candidate's NPI instead of Dr. Lee's. It is also missing modifier U9, which HCPF requires on every claim line for services delivered by a pre-licensed clinician or unlicensed professional for dates of service on or after July 1, 2026. Finally, the note is thin on medical necessity and doesn't tie interventions to plan goals.
3. **What's the fix?** Submit a corrected claim for 90834 with modifier U9, billed under Dr. Lee as the Rendering Provider, but only after confirming the rest of the record supports the service, including whether the missing Rendering Provider review and co-signature can be resolved under the practice's RPO policies. A co-signature added only after a denial is weak evidence, and correcting the code alone won't fix an oversight deficiency. An appeal is the wrong path: the payer was right that the documentation doesn't support 90837.

4. **What would have prevented it?** Record start and stop times on every time-based service, check the time against the code before billing (an EHR hard stop helps), write notes that connect the session to specific plan goals, and follow the practice's written RPO procedures: route pre-licensed clinicians' notes to the Rendering Provider for review and co-signature before the claim is released, bill under the Rendering Provider, and build a billing edit that adds U9 whenever the service provider is pre-licensed or unlicensed.

Discussion prompt: If this clinician routinely bills 90837, what happens if the RAE pulls a larger sample? A pattern of upcoding can turn one denial into an audit and recoupment.

Red herring: the treatment plan. Groups often list the overdue treatment plan as a denial reason. Ask them which rule it breaks. HCPF's Treatment Plan Standards say Medicaid sets no rules on when an assessment is done, how often it's repeated, or how often a plan is reviewed; RAEs audit whether plans are documented appropriately. So the 90-day review is the agency's own standard and an audit risk worth fixing, not the cause of this denial.

Case C: Counting the Minutes That Count

1. **Rejection or denial?** Denial (CO-150 on the remittance advice).
2. **What caused it?** The billed time includes activities that aren't billable case management time. HCPF's Time Documentation Standards count only direct time spent with the member in a billable activity and specifically exclude drive time with the member, so the 30 minutes of transportation doesn't count. Writing the note (10 minutes) is non-direct time, and the voicemails (15 minutes) involved no actual contact. Only the 20-minute call with Devon clearly qualifies, and that entry is well documented: it states the purpose, the member's response, and the linked goal.
3. **What's the fix?** Submit a corrected claim for 1 unit. Under HCPF's 15-minute unit rules, 1 unit covers at least 8 and fewer than 23 minutes, so the 20-minute call supports exactly 1 unit. Don't appeal: the payer correctly found the 5 units unsupported.
4. **What would have prevented it?** Train case managers on billable versus non-billable activities; have them document each activity with its own start and end time and purpose; apply the 15-minute unit table before billing; and sign notes within the agency's and RAE's required timeframe. A note signed five weeks later is weaker evidence even when the service was real.

Case D: The Video Visit That Was a Phone Call

1. **Rejection or denial?** Denial. The remittance advice adjudicated it and denied it.
2. **What caused it?** Three mismatches. The place of service should have been POS 10 (telehealth provided in the member's home), not POS 02. The modifier said video when most of the session was by phone; HCPF's Telehealth Policy requires modifier FQ in the first available position for audio-only services. The note, through an auto-populated template line, says video and leaves out Taylor's location, the switch to phone, and Taylor's consent. HCPF requires telehealth consent to be documented and allows phone-only delivery only when it's clinically appropriate, no other form of delivery is possible, and the record documents that.
3. **What's the fix?** Fix the record first, then the claim. The clinician adds a dated late-entry addendum explaining that video failed, why continuing by phone was clinically appropriate, Taylor's location, and Taylor's consent (never overwriting the original note).

Then, if the RAE authorizes 90834 by audio-only, submit a corrected claim with POS 10 and modifier FQ. If it doesn't, the service isn't billable. Appeal isn't appropriate because the claim billed was wrong.

4. **What would have prevented it?** Add a "modality change" field to the telehealth template, require clinicians to confirm (not just accept) auto-populated text, pull the modifier and place of service from the clinician's documentation instead of billing defaults, and document member location, consent at the start of every telehealth session, and that the provider is licensed in the state the patient is located in.

Discussion prompt: Who is responsible when a template generates a false statement in a signed note? The signing clinician is, for every word.

   a. Keep in mind documentation requirements for audio-visual don’t currently need the provider's location at the time of the video visit. But for audio-only, the documentation requires the provider's physical location as well as the patient's.