Training Series

Medicaid Participation & Organizational Readiness for Behavioral Health Providers

Training 3 Handout

Navigating Medicaid Behavioral Health Billing: Resolving Denials & Optimizing Reimbursement

Supporting Your Medicaid Journey

This handout includes supplemental links, reference materials, code lists, and checklists designed to reinforce the concepts presented in Training 3. It also expands on the billing and coding foundations covered briefly in today's session. Use it as a reference as you strengthen your organization's billing practices, prevent and resolve denials, and support successful Medicaid participation.

Links & Resources:

Colorado Behavioral Health Provider Solutions (CBHPS)

Health First Colorado (CO Medicaid Program)

Colorado Department of Healthcare Policy & Financing (HCPF)
HCPF Provider Trainings
HCPF Regional Provider Support

- Region 2 (Boulder, Broomfield, Clear Creek, Gilpin, **Larimer,** Morgan, & Weld)
    - **Gennesis Quinonez -** Region 2 HCPF Provider Support Field Representative

HCPF Provider Portal
HCPF Medicaid Sustainability Plan (CO Medicaid landscape information)
State Behavioral Health Services Billing Manuals (Capitated BH Benefit)
Behavioral Health Billing Services (Fee-for-Service)
HCPF Behavioral Health Policies, Standards & Billing References

- Rendering Provider Oversight Policy
    - Including updates on the NPI requirement for all pre-licensed clinicians and unlicensed professionals, starting January 1, 2027
    - RPO Policy Attestation Document
- Modifiers for Capitated BH Benefit
    - Including updates on the use of the U9 modifier, as of July 1, 2026
- National Correct Coding Initiative (NCCI) Edits
- CO Medically Unlikely Edits (MUEs) and Procedure-to-Procedure
- Time Documentation Standards/Rules

Accountable Care Collaborative & Regional Accountable Entity Map
Regional Organizations (RAE) Information
Additional RAE Information (from Rocky Mountain Health Plans)
Rocky Mountain Health Plans (RMHP)-Region 1

- RMHP BH Provider Contact Email: rmhpRAE_BH_PR@uhc.com
- 2026 Medicaid/CHP+ Provider BH Manual

Northeast Health Partners (NHP)-Region 2

- NHP BH Provider Contact Email: nhpRAE_BH_PR@uhc.com
- **Larimer County is in RAE Region 2**
- RAEs 1 & 2 Behavioral Health Updates Page (includes office hours & training registration links)

Colorado Community Health Alliance (CCHA)-Region 3

- Provider Assistance Request Form

Colorado Access (CO Access)-Region 4
Optum-Provider Express - used by RMHP & NHP

Billing & Coding Foundations:

Note: This section expands on the quick recap covered in today's session. Use it as a reference for newer staff or anyone who wants a refresher on the basics.

Billing vs. Coding

Billing and coding are two connected but different jobs:

- **Coding** — translating the clinical encounter into standardized codes (ICD-10, CPT, HCPCS) that document what was done and why.
- **Billing** — assembling those codes into a claim and managing it through submission, payment, and follow-up.
- Coding asks "what happened, and why?" Billing asks "how do we get paid for it, correctly?"
- The two are sequential, not interchangeable — accurate coding is what makes a claim billable in the first place.

Why Accurate Billing Matters

Accurate billing:

- Supports quality care and reflects services actually delivered
- Supports financial sustainability — reimbursement funds programs and positions
- Supports compliance and reduces audit risk
- Creates meaningful data for program and policy decisions
- Strengthens collaboration between clinical and billing staff

Billing is not separate from clinical care — it's how that care becomes sustainable.

The Core Code Sets

Codes are how the Golden Thread gets written down. A reviewer should be able to follow one clear thread from encounter to note to code to claim to payment.

- **ICD-10** — the diagnosis code: why the client needed the service
- **CPT** — what service was actually provided
- **HCPCS** — the Medicaid-specific services CPT doesn't cover
- **Modifiers** — the context that changes how a service is read
- **Units** — how much of that service is being billed

ICD-10 Diagnosis Codes

The International Classification of Diseases, 10th Revision (ICD-10) is the code set for diagnoses.

- The diagnosis code answers: **why** did the client need this service?
- It establishes **medical necessity** for everything billed.
- Required on every claim — without one, there's nothing to justify the service to the payer.

ICD-10 Code Tips:

- Capture every diagnosis addressed at the time of service
- Link each diagnosis to the specific service it justifies
- Code to the highest specificity the record supports
- The diagnosis must match the documentation that supports it

CPT Codes

Current Procedural Terminology (CPT) is the standard language for services.

- Five-digit numeric codes, maintained by the American Medical Association (AMA)
- Each code names **one specific service**, so payers never have to read a description
- Think of it as the barcode for a clinical encounter
- Behavioral health uses a small subset, mostly in the 908xx range

CPT Code Tips:

- The code **must match** what the documentation actually shows
- CPT answers "what did you do?" The diagnosis code answers "why?"

HCPCS Level II Codes

The Healthcare Common Procedure Coding System, Level II (HCPCS) picks up where CPT stops.

- Alphanumeric: **one letter followed by four digits**, like H0004
- Maintained by the Centers for Medicare & Medicaid Services (CMS), not the AMA
- Covers **Medicaid-specific services** that CPT has no code for

HCPCS Code Tips:

- In Colorado behavioral health, these are mostly "H-codes"
- Many are restricted to specific enrolled or credentialed provider types
- Medicaid usually wants the H-code; commercial payers and Medicare usually want the CPT equivalent

Modifiers

A modifier adds context to a code without changing what the code means.

- Two characters appended to a CPT or HCPCS code

- Tells the payer how, where, or by whom the service was delivered
- Can change whether a claim pays, how much it pays, or whether it's flagged
- Some are required, not optional — a missing modifier may be a denial

Appendix M of the SBHS Billing Manual lists modifiers for the RAE capitated benefit. See **Common Modifiers for Claims Submission** below.

Common ICD-10 Diagnosis Codes:

Note: This is not a comprehensive list; it includes commonly used behavioral health diagnosis codes. Always code to the highest specificity your documentation supports. For the full code set, refer to the ICD-10-CM manual or your EHR's code lookup tool.

Anxiety Disorders

- **F41.1:** Generalized Anxiety Disorder
- **F41.0:** Panic Disorder *(without agoraphobia)*
- **F41.9:** Anxiety Disorder, Unspecified
- **F40.10:** Social Phobia, Unspecified
- **F42.9:** Obsessive-Compulsive Disorder, Unspecified

Depressive Disorders

- **F32.9:** Major Depressive Disorder, Single Episode, Unspecified
- **F32.1:** Major Depressive Disorder, Single Episode, Moderate
- **F33.1:** Major Depressive Disorder, Recurrent, Moderate
- **F33.9:** Major Depressive Disorder, Recurrent, Unspecified
- **F34.1:** Persistent Depressive Disorder *(Dysthymia)*

Trauma- & Stressor-Related Disorders

- **F43.10:** Post-Traumatic Stress Disorder, Unspecified
- **F43.20:** Adjustment Disorder, Unspecified
- **F43.21:** Adjustment Disorder with Depressed Mood
- **F43.23:** Adjustment Disorder with Mixed Anxiety and Depressed Mood

Bipolar & Related Disorders

- **F31.9:** Bipolar Disorder, Unspecified
- **F31.81:** Bipolar II Disorder

ADHD & Neurodevelopmental Disorders

- **F90.9:** Attention-Deficit/Hyperactivity Disorder, Unspecified Type
- **F90.0:** ADHD, Predominantly Inattentive Type
- **F90.1:** ADHD, Predominantly Hyperactive/Impulsive Type
- **F84.0:** Autism Spectrum Disorder

Substance Use Disorders

- **F10.10:** Alcohol Use Disorder, Mild

- **F10.20:** Alcohol Use Disorder, Moderate or Severe
- **F11.10:** Opioid Use Disorder, Mild
- **F12.10:** Cannabis Use Disorder, Mild
- **F19.10:** Other Psychoactive Substance Use Disorder, Mild

Other Common Diagnoses

- **F60.3:** Borderline Personality Disorder
- **F20.9:** Schizophrenia, Unspecified
- **R45.851:** Suicidal Ideation
- **Z63.0:** Problems in Relationship with Spouse or Partner *(a Z-code; useful for relational/family issues that don't rise to a full diagnosis)*

Common CPT & HCPCS Behavioral Health Billing Codes:

Note: This is not a comprehensive list; it includes commonly used behavioral health codes. The codes your organization uses will vary by provider type and services offered. For additional codes, refer to the HCPF SBHS Billing Manuals linked above.

CPT Codes:

Diagnostic Evaluations

- **90791:** Psychiatric Diagnostic Evaluation *(without medical services; not separately timed)*
- **90792:** Psychiatric Diagnostic Evaluation with Medical Services *(includes medical assessment/prescribing; not separately timed)*

Individual Psychotherapy

- **90832:** Psychotherapy, 30 minutes *(exact time range: 16–37 minutes)*
- **90834:** Psychotherapy, 45 minutes *(exact time range: 38–52 minutes)*
    - This is often the baseline "standard hour" code preferred by many commercial panels.
- **90837:** Psychotherapy, 60 minutes *(exact time range: 53 minutes or more)*

Add-On Psychotherapy Codes (billed with an E/M code)

- **90833:** Psychotherapy, 30 minutes, add-on to E/M *(16–37 minutes)*
- **90836:** Psychotherapy, 45 minutes, add-on to E/M *(38–52 minutes)*
- **90838:** Psychotherapy, 60 minutes, add-on to E/M *(53+ minutes)*
- **+90785:** Interactive Complexity *(add-on; never billed alone)*

Crisis Psychotherapy

- **90839:** Psychotherapy for Crisis, first 60 minutes *(30–74 minutes)*
- **+90840:** Psychotherapy for Crisis, each additional 30 minutes *(add-on; billed with 90839)*

Family & Group Therapies

- **90847:** Family or Couples Psychotherapy, with patient present *(conjoint therapy)*
- **90846:** Family Psychotherapy, *without* patient present
- **90853:** Group Psychotherapy *(non-family group dynamics)*
- **90849:** Multiple-Family Group Psychotherapy

HCPSC and/or H-Codes:

- **H0001:** Alcohol and/or Drug Assessment *(1 unit per day, untimed evaluation)*
- **H0002:** Behavioral Health Screening *(Used to determine eligibility for admission to a treatment program)*
- **H0004:** Behavioral Health Counseling and Therapy, Individual *(Billed in 15-minute units; max 8 units/day)*
- **H0005:** Alcohol and/or Drug Services; Group Counseling *(Billed as a flat 1-hour unit session)*
- **S9454** Stress management classes, non-physician provider
- **H0006:** Alcohol and/or Drug Services; Case Management *(billed in 15-minute units)*
- **H0038:** Self-Help/Peer Support Services *(billed in 15-minute units; requires a certified Peer Support Specialist)*
- **H2011:** Crisis Intervention Service *(billed in 15-minute units)*
- **H2017:** Psychosocial Rehabilitation Services *(billed in 15-minute units)*

Common Modifiers for Claims Submission:

Note: This is not a comprehensive list; it includes modifiers commonly used on behavioral health claims. The modifiers required may vary based on the service provided, provider type, place of service, and payer requirements. For additional modifiers and specific billing requirements, refer to the HCPF BH Policies site linked above.

- **FQ-(Audio only):** Indicates a service was provided by telephone.
- **HO-(Ineligible Medicare Provider):** Indicates when an enrolled Medicaid provider is providing services to a Medicare member with Medicaid (Dual Eligible) and the provider is not eligible to enroll in Medicare
- **U9-(Rendering provider oversight)**: Indicates a service was delivered by a pre-licensed clinician or unlicensed professional, under oversight of the Rendering Provider
- **HQ:** Specifies group counseling or group therapy settings
- **HF:** Identifies substance use disorder (SUD) and addiction treatment programs or services.

The Claim: From Submission to Payment:

Note: This section expands on the claims content covered in today's session.

What Is a Claim?

A claim is the container your codes travel in.

- It tells the payer **who, what, why, when, and where**
- Most claims go out electronically as an 837 Professional (837P) claim

- The CMS-1500 is the paper version — **HCPF does not accept paper claims**

How a Claim Is Submitted

- **Electronic submission** — the 837P is the standard electronic format; it's what "going out electronically" means in practice.
- **Your EHR or practice management system** — builds the 837P from your documentation, codes, and charge entry, then transmits it.
- **A clearinghouse** — sits between your system and the payer; it scrubs the 837P for format and missing data, then routes it on.
- **The payer** — receives a clean, formatted claim and begins its own review of eligibility, coding, and medical necessity.

Clearing the clearinghouse is not payment — payers still review eligibility, coding, and medical necessity.

The Claims Lifecycle

Verify Eligibility → Document Service → Assign Codes → Submit Claim → Payment or Denial

The claims lifecycle is the operational path every service takes, from verifying eligibility to payment or denial.

Before You Bill

The first steps of the claims lifecycle — everything here happens before a claim exists:

- **Verify member Medicaid eligibility** — every member, every service date
- **Confirm the payer/RAE** still applies
- **Confirm prior authorization**, when the service requires it
- **Confirm filing deadlines** — 365 days from date of service
- Complete documentation, then coding and charge entry
- Run a pre-claim review before anything is submitted

Eligibility and RAE assignment can change month to month — verify, don't assume.

What Happens After Submission

Claim Submitted → Accepted or Rejected → Adjudication → Paid, Adjusted, or Denied

Claim acceptance is not the same as payment — an accepted claim still moves through adjudication before it's paid, adjusted, or denied.

Claim Statuses, Defined:

- **Accepted** — received and entering processing; no action needed yet
- **Rejected** — errors stopped it before processing; correct and resubmit
- **Adjudication** — the payer's review process that decides whether a claim is paid, adjusted, or denied
- **Paid** — approved, and payment has been issued
- **Adjusted** — a previously submitted claim was reprocessed or changed
- **Denied** — fully processed, but payment was not approved

Rejected and denied are the two that get confused — and they need completely different responses.

Common Billing Errors:

Error Category	Error	Impact/Risk
Missing Documentation	Missing treatment plans, progress notes, service time, Place of Service (POS), or evidence of medical necessity.	May result in claims denials
Inaccurate Time Documentation	Time-based CPT codes must be supported by documented time. Aggregating time across multiple visits, rounding up to meet a higher-level code, or failing to document start/stop times (or total face-to-face time).	May result in claims denials or audit findings
Cloned Documentation	Repeated or copied notes may suggest individualized services were not provided.	May trigger claims denials or audit findings
Missing Next Steps	Not documenting next steps (next appointment, next treatment plan, etc.)	Documentation may not support required medical necessity.
Vague Clinical Language	General statements in progress notes.	Do not adequately describe required skilled clinical services.

Denial Prevention Checklist:

Before submitting a claim:

- ☐ Eligibility verified
- ☐ Documentation complete
- ☐ Diagnosis supports service
- ☐ CPT/HCPCS selected
- ☐ Modifiers correct
- ☐ Authorization obtained
- ☐ Claim reviewed

Questions to Ask When Hiring a Biller or Billing Consultant:

Note: These questions apply whether you're hiring internal staff, engaging a billing company, or bringing on a consultant — not every question will apply to every model. See the Building Your Billing Support Team section of today's training for an overview of the options.

<u>Experience & Credentials</u>

- Do you (or your staff) hold a billing/coding certification (e.g., CPC, CPB, CPMA)? Which one, and is it current?

- How many years of experience do you have specifically with behavioral health billing, not just medical billing generally?
- How many years of experience do you have with Colorado Medicaid / Health First Colorado, RAE billing, and the SBHS Billing Manual specifically?
- Can you provide references from other behavioral health organizations you've worked with?

Behavioral Health & Medicaid-Specific Expertise

- Are you familiar with the RAE capitated benefit vs. Health First Colorado FFS, and how to determine which applies to a given claim?
- Do you stay current with HCPF policy updates and SBHS Billing Manual revisions? How?
- Are you experienced with the specific code sets we bill most (CPT 908xx, behavioral health HCPCS/H-codes)?
- Have you worked with our specific service types (individual therapy, group/family therapy, crisis services, SUD services, peer support, etc.)?
- Do you understand Colorado-specific NCCI edits (CO PTP/MUE) in addition to federal edits?

Process & Technology

- What EHR/practice management systems have you worked with? Do you work with ours, or is there a transition cost?
- What does your pre-claim review process look like? What do you check before a claim goes out?
- How do you handle eligibility and RAE verification — is it checked at every service date?
- What's your process for tracking and resolving rejections vs. denials?
- Do you track denial reasons over time to identify patterns, or just resolve each one individually?

Communication & Reporting

- How often will we receive reports on claims status, denials, and revenue?
- Who is our point of contact, and how quickly can we expect a response to a question?
- How do you communicate with our clinical staff when a note or documentation issue is causing denials?
- Will we have visibility into claims in real time, or only through periodic reports?

Accountability & Performance

- What's your average clean claim rate (percentage of claims paid on first submission)?
- What's your average time from submission to payment?
- How do you handle a claim that was denied due to your error vs. a documentation/coding error on our end?
- What happens if a pattern of denials suggests a training or workflow issue on our side — do you flag it, or just keep resubmitting?

Cost & Contract Structure

- Is pricing a flat fee, a percentage of collections, or per-claim? What does that translate to at our current volume?
- Are there setup fees, minimum contract terms, or termination clauses we should know about?
- Does the fee structure change if our claim volume grows or shrinks?
- Are appeals and corrected claims included, or billed separately?