Navigating Medicaid Behavioral Health Billing: Resolving Denials & Optimizing Reimbursement

PRESENTED BY THE STEADMAN GROUP

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LARIMER COUNTY BEHAVIORAL HEALTH SERVICES | STEADMAN GROUP | WESTERN SLOPE BILLING LLC

Welcome & Introductions

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BUILDING ON THE PREVIOUS TRAININGS

Each training builds toward sustainable Medicaid participation:

- Training 1 — Organizational Readiness
- Training 2 — Clinical Documentation & Workflow
- Training 3 — Navigating Behavioral Health Billing (today)

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LEARNING OBJECTIVES

By the end of this session, you will be able to:

- Connect clinical documentation to accurate coding and billing
- Apply key coding, modifier, and telehealth requirements to behavioral health claims
- Respond appropriately when a claim is rejected or denied
- Recognize common causes of denials and how to prevent them
- Identify strategies and resources that strengthen billing over time

Behavioral Health Billing Foundations: A Quick Recap

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BILLING AT A GLANCE

Coding translates the encounter into standardized codes (ICD-10, CPT, HCPCS) — what happened, and why.

Billing assembles those codes into a claim and manages it through submission, payment, and follow-up.

Clinical Team	Billing Team	Shared
• Provides the service • Completes the documentation • Establishes the diagnosis • Assigns codes and modifiers • Records time and interventions	• Verifies eligibility and payer • Submits and tracks claims • Posts payments, works denials	• Confirming medical necessity • Pre-claim review before submitting • Reviewing denial trends together • Keeping up with RAE and HCPF rules

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

WHO PAYS?

If…	Generally bill…
The behavioral health service is covered under the RAE capitated benefit	The member's assigned Regional Accountable Entity (RAE)
The service is designated by HCPF as Fee-for-Service	Health First Colorado Fee-for-Service (FFS)
The member is not enrolled in an RAE	Health First Colorado Fee-for-Service (FFS)
The member has commercial insurance and Health First Colorado	Bill the commercial payer first, then submit to the RAE or Health First Colorado as the secondary payer, when applicable. *Medicaid is a payer of last resort

KNOW THE RAES

Colorado's four Regional Accountable Entities:

- Region 1 — Rocky Mountain Health Plans (RMHP)
- Region 2 — Northeast Health Partners (NHP)
    - **Larimer County moved to Region 2 (NHP) on July 1, 2025**
- Region 3 — Colorado Community Health Alliance (CCHA)
- Region 4 — Colorado Access (CO Access)

Each RAE has its own portal, Payer ID, authorization process, and appeal deadlines.

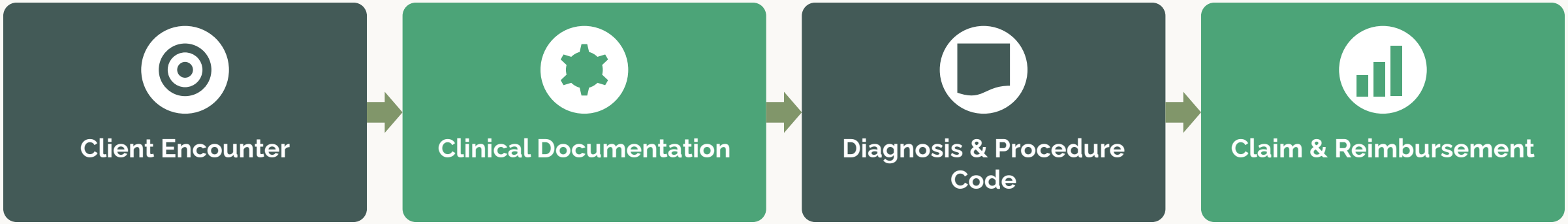
Behavioral Health Coding: Beyond the Basics

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THE GOLDEN THREAD



A reviewer should be able to follow one clear thread from encounter to note to code to claim to payment.

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CODE SETS: QUICK REFERENCE

Codes are how the Golden Thread gets written down:

Code Set	What It Answers	Format	Key Tips
ICD-10	Why did the client need this service? Establishes medical necessity.	Alphanumeric diagnosis code (e.g., F41.1)	Required on every claim. Code to the highest specificity the record supports and link each diagnosis to the service it justifies.
CPT	What service was provided?	Five-digit numeric code, maintained by the AMA. BH uses mostly 908xx.	The code must match what the documentation actually shows.
HCPCS Level II	Medicaid-specific services CPT has no code for.	One letter + four digits (e.g., H0004), maintained by CMS.	Mostly "H-codes" in CO BH; many are limited to specific provider types. Medicaid usually wants the H-code; commercial and Medicare usually want the CPT equivalent.
Units	How much of the service is being billed.	Time-based (e.g., 15-minute) or one per encounter.	Each code's unit is defined in the SBHS Billing Manual — covered in detail later.
Modifiers	How, where, or by whom the service was delivered.	Two characters appended to a CPT or HCPCS code.	Some are required — a missing modifier may be a denial. Appendix M of the SBHS Billing Manual lists RAE modifiers.

COMMON BH CPT CODES

Common (not all) codes many behavioral health providers use regularly, with what an auditor reads:

CPT Code	Description	Time Requirement	Key Documentation Requirements
90791	Diagnostic Evaluation	**60–90 min (not timed)**	Biopsychosocial assessment, MSE, diagnosis, initial treatment plan. Code time requirement is a minimum of 16 minutes, not to exceed 90 minutes.
90792	Diagnostic Eval. w/ Medical Services	**60–90 min (not timed)**	Above, plus medical evaluation, medication history, and medical decision-making
90832	Psychotherapy, standalone	**16–37 min**	Start/stop times, modality used (e.g., CBT, DBT), progress, symptom updates
90833	Psychotherapy add-on w/ E/M	**16–37 min**	Must pair with a primary E/M code; separate documentation and timing
90834	Psychotherapy, standalone	**38–52 min**	Start/stop times, clinical rationale, interventions, patient response
90836	Psychotherapy add-on w/ E/M	**38–52 min**	Must pair with a primary E/M code; time split from medical decision-making
90837	Psychotherapy, standalone	**53+ min**	Start/stop times, detailed interventions, response, rationale for duration
90838	Psychotherapy add-on w/ E/M	**53+ min**	Must pair with a primary E/M code; separate med management vs. therapy notes
90839	Crisis psychotherapy, first 60 min	**30–74 min**	High-acuity state, immediate safety plan, risk assessment, total duration
+90840	Crisis psychotherapy, add-on	**38+ min beyond 90839**	Billed alongside 90839; clear justification for extended crisis management

Code Tip: Add-on codes (+90785, +90833, +90836, +90838, +90840) never stand alone — they must attach to an eligible primary service.

CRISIS PSYCHOTHERAPY — 90839

90839 — first 60 minutes. Used when the patient is experiencing a **psychiatric crisis requiring urgent intervention**. Documentation should demonstrate:

NATURE OF THE CRISIS

What happened and why the patient required crisis intervention.

CLINICAL PRESENTATION

Symptoms, behaviors, risk factors, and/or functional impairment.

ASSESSMENT

Relevant mental status and clinical assessment.

RISK ASSESSMENT

When clinically applicable, document suicidal ideation, homicidal ideation, self-harm, safety concerns, or other relevant risks.

INTERVENTIONS

Specific crisis interventions provided by the clinician.

PATIENT RESPONSE

How the patient responded to the interventions.

MEDICAL NECESSITY

Why crisis psychotherapy was necessary rather than routine psychotherapy.

DISPOSITION / SAFETY PLAN

Follow-up, referrals, safety planning, higher level of care, emergency services, or other disposition when appropriate.

TIME

Documentation must support the time billed.

CRISIS PSYCHOTHERAPY — +90840

+90840 — each additional 30 minutes. An **add-on code** to 90839 when crisis psychotherapy extends beyond the initial service.

DOCUMENTATION SHOULD CLEARLY ESTABLISH

- The **start and stop times** of the encounter
- That **90839 was also appropriately reported**
- Continued need for crisis intervention
- Interventions provided during the additional time
- Patient response and ongoing clinical need

IMPORTANT AUDIT DISTINCTION

A difficult session does not automatically qualify as crisis psychotherapy.

The documentation should demonstrate that the patient was experiencing a **psychiatric crisis requiring immediate/urgent intervention** and that the provider was actively providing crisis psychotherapy.

Code Tip: +90840 never stands alone — it is billed only alongside 90839.

INTERACTIVE COMPLEXITY — +90785

What it is: +90785 is an add-on code used when the psychotherapy encounter requires additional communication procedures because of factors that significantly complicate the delivery of the service.

DOCUMENTATION REQUIREMENTS

- The primary psychotherapy/service code billed with +90785
- A specific description of what created the interactive complexity
- How that factor interfered with or complicated communication during the session
- The provider's interventions or communication techniques used to address the complexity
- Who was involved in the interaction, when applicable (e.g., child, caregiver, interpreter, third party)

SUPPORTING CIRCUMSTANCES

- Use of a translator/interpreter when communication is significantly complicated
- Third parties communicating clinically relevant information or participating in the session in a way that complicates the service
- Inability of the patient to communicate effectively, requiring additional communication procedures
- A child/adolescent whose behavior or communication requires significant involvement of a parent/guardian or other third party

***AUDIT CONCERN:* Simply documenting "interactive complexity present" or "parent participated" is generally not enough. The record should explain why the interaction was complex and how it affected the psychotherapy service.**

CPT CODES FOR FAMILY AND GROUP COUNSELING

CPT Code	Description	Typical Use / When to Bill	Documentation Requirements to Support Billing
90846 45–50 min	**Family Psychotherapy** *(without patient present)* Psychotherapy for the patient when the patient is not present with family members.	• Parent/caregiver sessions without the child present • Treatment planning, collateral information, parent guidance • Family functioning concerns	• Date, time, and total time of session • Participants: all individuals present and relationship to patient • Presenting problem / purpose of session • Interventions used (e.g., psychoeducation, support, parenting strategies) • Progress toward treatment goals • Plan for follow-up • Clinician signature and credentials
90847 45–50 min	**Family Psychotherapy** *(with patient present)* Psychotherapy for the patient when the patient is present with family members.	• Family therapy with child/adolescent and family members • Communication skills, conflict resolution, family dynamics	• All requirements listed above • The child's participation and response to interventions • Family interactions observed and addressed • Changes in symptoms or functioning
90849 60–90 min	**Multiple-Family Group Psychotherapy** Psychotherapy for multiple families (and their children) in a group setting.	• Parenting groups • Psychoeducation groups • Support groups for families with similar concerns	• All requirements listed above • All families and individuals present • Group topic / theme and interventions used • Participation of the patient and family • Progress toward group and individual goals
90853 45–90 min	**Group Psychotherapy** Psychotherapy for the patient in a group setting (not limited to families).	• Social skills groups • Coping skills groups • Anxiety, depression, trauma, or other support groups	• All requirements listed above • All group members present • Group topic / theme and interventions used • Patient's participation and response • Progress toward treatment goals

GENERAL DOCUMENTATION REQUIREMENTS

SESSION DETAILS

- ✓ Date of service and session start/end time
- ✓ Place of service (office, telehealth, etc.)
- ✓ Type of service provided and CPT code
- ✓ Names and roles of all participants
- ✓ Presenting problem / reason for session

CLINICAL CONTENT

- ✓ Mental status of the patient (as appropriate)
- ✓ Interventions / therapeutic techniques used
- ✓ Patient/family response to treatment
- ✓ Progress toward treatment goals
- ✓ Plan for continued treatment or next steps

***TIP:* Documentation should clearly support medical necessity, time spent, services provided, and progress toward goals.**

COMMON BH HCPCS CODES

The H-codes you'll see most often in Colorado:

HCPCS Code	Service	Billing Unit	Notes
H0001 / H0005	SUD assessment, and group counseling	Per encounter / session	
H0004	Behavioral health counseling and therapy	Per 15 minutes	**Most common H-code — ties to the units lesson**
H0006	SUD targeted case management	Per 15 minutes	
H2011	Crisis intervention	Per 15 minutes	
H0038	Peer support	Per 15 minutes	**Requires a certified Peer Support Specialist**
H2017	Psychosocial rehabilitation	Per 15 minutes	

HCPCS H0038 — SELF-HELP/PEER SERVICES

SERVICE

- Structured **individual or group recovery support** provided by eligible certified peer support professionals
- **1 unit = 15 minutes** of direct service
- **Daily limit: 12 units (3 hours)** when applicable

ELIGIBLE PROVIDERS

- **Comprehensive Safety Net Providers:** PT 78 / Specialty 887
- **SUD Clinics:** PT 64 / Specialty 371
- **Recovery Support Services Organizations:** PT 89 / Specialty 889

DOCUMENTATION & AUDIT REQUIREMENTS

- **Time:** Document exact start/end times and ensure units are supported.
- **Service Plan:** Connect services to measurable goals in the individualized service plan.
- **Service Detail:** Clearly document the peer/recovery support provided.
- **Setting:** Identify individual vs. group services.
- **Modifiers:** Use applicable modifiers (e.g., HQ) and telehealth indicators when required.

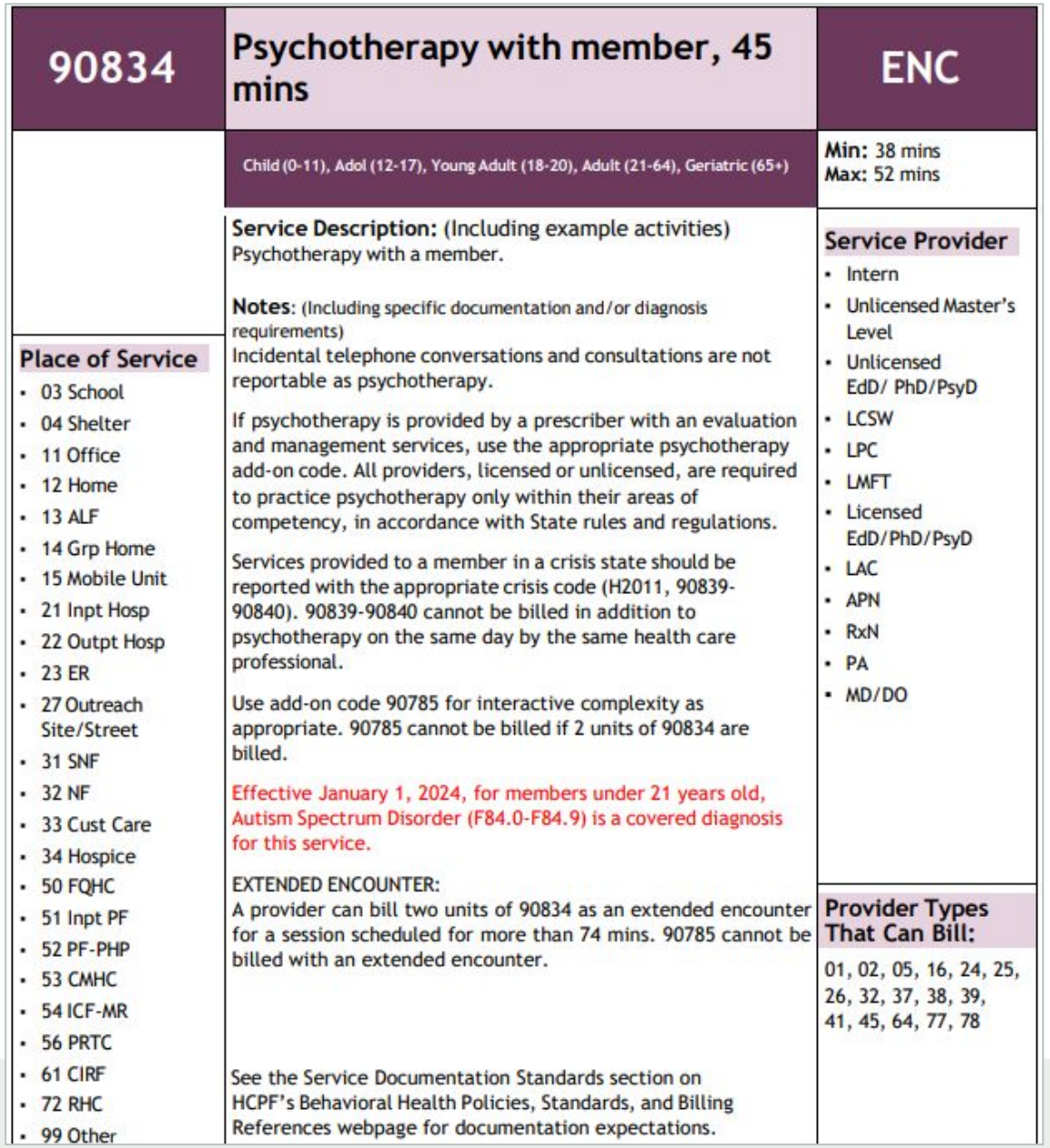
AUDIT FOCUS: ***Eligible provider + appropriate service + supported time/units + service plan connection + correct claim coding***

READING A BILLING MANUAL ENTRY

CPT and HCPCS Level II codes for Colorado behavioral health services are published in **HCPF's State Behavioral Health Billing Manuals** — one version for the RAE capitated benefit (SBHS Billing Manual), one for Health First Colorado FFS.

Entries in the capitation benefit billing manual use the same five-part format:

- **Code, description & unit** — what it's called and how it's counted
- **Time & age ranges** — minimum and maximum minutes, and who it applies to
- **Service description & notes** — what's included, plus documentation and diagnosis requirements
- **Place of service** — the approved settings for this service
- **Service provider & provider types** — who may deliver it, and who may bill it



90834	Psychotherapy with member, 45 mins	ENC
	Child (0-11), Adol (12-17), Young Adult (18-20), Adult (21-64), Geriatric (65+)	**Min:** 38 mins **Max:** 52 mins
Place of Service • 03 School • 04 Shelter • 11 Office • 12 Home • 13 ALF • 14 Grp Home • 15 Mobile Unit • 21 Inpt Hosp • 22 Outpt Hosp • 23 ER • 27 Outreach Site/Street • 31 SNF • 32 NF • 33 Cust Care • 34 Hospice • 50 FQHC • 51 Inpt PF • 52 PF-PHP • 53 CMHC • 54 ICF-MR • 56 PRTC • 61 CIRF • 72 RHC • 99 Other	**Service Description:** (Including example activities) Psychotherapy with a member. **Notes:** (Including specific documentation and/or diagnosis requirements) Incidental telephone conversations and consultations are not reportable as psychotherapy. If psychotherapy is provided by a prescriber with an evaluation and management services, use the appropriate psychotherapy add-on code. All providers, licensed or unlicensed, are required to practice psychotherapy only within their areas of competency, in accordance with State rules and regulations. Services provided to a member in a crisis state should be reported with the appropriate crisis code (H2011, 90839-90840). 90839-90840 cannot be billed in addition to psychotherapy on the same day by the same health care professional. Use add-on code 90785 for interactive complexity as appropriate. 90785 cannot be billed if 2 units of 90834 are billed. Effective January 1, 2024, for members under 21 years old, Autism Spectrum Disorder (F84.0-F84.9) is a covered diagnosis for this service. EXTENDED ENCOUNTER: A provider can bill two units of 90834 as an extended encounter for a session scheduled for more than 74 mins. 90785 cannot be billed with an extended encounter. See the Service Documentation Standards section on HCPF's Behavioral Health Policies, Standards, and Billing References webpage for documentation expectations.	**Service Provider** • Intern • Unlicensed Master's Level • Unlicensed EdD/ PhD/PsyD • LCSW • LPC • LMFT • Licensed EdD/PhD/PsyD • LAC • APN • RxN • PA • MD/DO **Provider Types That Can Bill:** 01, 02, 05, 16, 24, 25, 26, 32, 37, 38, 39, 41, 45, 64, 77, 78

Important! A concept that often causes expensive errors.

UNITS: TIME VS. OCCURRENCE

Every code in the SBHS Billing Manual (capitated benefit) has a defined Unit— the thing you're actually counting:

- **Time-based units (MIN, HOUR, DAY, MON)** — bill multiple units based on time spent, divided by the code's increment. H0004 is billed in 15-minute units, so a 45-minute session = 3 units.
- **Occurrence-based units (ENC)** — bill exactly one unit per encounter, no matter how long it ran. 90834 (45-min psychotherapy) is one unit — not multiplied by minutes.
- **Code selection and unit counting are different questions** — some codes need a minute range just to pick the code (30- vs. 45- vs. 60-min psychotherapy). 90834 does both: minutes pick the code, then it bills as one ENC unit. H0004 has no minute range for selection, but still bills in repeating time-based units.
- **Document face-to-face time only** — travel, scheduling, and after-visit paperwork don't count toward a timed service.

COMMON BH MODIFIERS

Two characters that add context without changing the code:

- **95** — telehealth with audio and video, paired with POS 02 or 10
- **93** — telehealth, audio only, also paired with POS 02 or 10
  - Tip: A telehealth modifier that doesn't match the place of service is a leading cause of denials for telehealth claims
- **U9** — pre-licensed clinician or unlicensed professional rendering clinician
- **HF** — service delivered through a substance use disorder program
- **77** — repeat procedure by another provider.
- **FQ** -Service furnished using audio-only communication technology

TELEHEALTH REQUIREMENTS

Bill telehealth with Place of Service 02 – "Telehealth Provided Other than in Member's Home" or 10 – "Telehealth Provided in Member's Home."

SERVICE DELIVERY

- All services must be synchronous.
- Health benefits provided through telehealth must meet the same standard of care as in-person care.
- Telehealth does not alter any provider's scope of practice, nor authorize services in a setting or manner not otherwise authorized by law.
- Telephone-only delivery is allowed only when clinically appropriate, no other form of delivery is possible, and this is documented in the clinical record.

MEMBERS & COVERAGE

- Members that are new to a provider must contact the provider to initiate services.
- Services for established members must be consistent with the member's treatment plan.
- Services not otherwise covered by the BHA or Health First Colorado are not covered when delivered via telehealth.
- Providers may only bill procedure codes they are contracted with an RAE/MCE to bill.

Audio-only (telephone): use modifier FQ in the first available position on the claim.

TELEHEALTH DOCUMENTATION & COMPLIANCE

What the record must show for every telehealth service:

MEMBER CONSENT

Providers must document the member's consent, **either verbal or written**, to receive telehealth services.

PRIVACY & RECORDS

Record-keeping and member privacy standards should comply with normal **BHA and Medicaid requirements, HIPAA, and 42 CFR Part 2**.

LOCATION & LICENSURE

Document the patient's location and state that the provider is licensed and certified in the state where the patient is located.

Ex: "At home in Colorado."

Ex: "I'm licensed and certified in the state of Colorado where the patient is located."

TELEHEALTH PLACE OF SERVICE CODES

Rendering providers bill the procedure code with POS 02 or 10 and the appropriate modifier (FQ, FR, 93, or 95) on the CMS-1500 paper claim form or as an 837P transaction.

PLACE OF SERVICE

- **POS 02 —** Telehealth provided other than in the patient's home
- **POS 10 —** Telehealth provided in the patient's home
- **Hospital —** When the patient is located in a hospital, use the place of service code for where the patient is located

TELEHEALTH MODIFIERS (ADD TO POS 02 & 10)

- **FQ —** Service furnished using audio-only communication technology
- **FR —** Supervising practitioner present through two-way audio/video communication technology
- **93 —** Synchronous telemedicine rendered via telephone or other real-time interactive audio-only system
- **95 —** Synchronous telemedicine rendered via a real-time interactive audio and video system

Source: CO RMHP Care Provider Manual

NCCI: PTP & MUE EDITS

National Correct Coding Initiative (NCCI) edits is a CMS program that promotes correct coding and prevents overpayment. This program screens claims before payment through two edit types:

PTP

Procedure-to-Procedure Edits

Code pairs that generally can't be billed together for the same client on the same date of service.

Example: 90791 with a psychotherapy code (90832), same date — won't pay.

MUE

Medically Unlikely Edits

The maximum number of units of one code that can be billed for one client, in one day.

A claim over the MUE cap for a code gets flagged before it's ever paid.

Example: H004+HF, 8 units per day, 15 min. unit

Colorado maintains its own CO PTP and CO MUE lists on top of the federal edits — and updates them regularly. Check HCPF's current lists before you bill, not after a denial.

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CODING PITFALLS TO WATCH FOR

Common patterns that often catch new billers:

- **Same-day conflicts** — some codes simply can't be billed together on one date. Example: don't report 90791/90792 the same day as psychotherapy codes 90832–90846.
- **Timing rules that cut both ways** — some codes are timed, some aren't, and it's easy to assume wrong. 90791/90792 aren't timed codes, though 45–60 minutes is typical; crisis time under 90839/90840 must be continuous and focused on one client.
- **Mixed E/M and therapy, same day** — keep the two distinct in the note. When E/M is billed alongside therapy, base the E/M on medical decision making, not time.
- **Documentation that doesn't isolate the billed time** — time-based codes need their own dedicated documentation. Psychotherapy time must be documented separately and dedicated only to therapy.

These are examples, not the full list — watch for codes that look interchangeable but aren't.

QUESTIONS?
&
5-MINUTE BREAK

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Building & Submitting the Claim

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THE CLAIM & HOW IT GETS SUBMITTED

A claim is the container your codes travel in — it tells the payer who, what, why, when, and where. Most go out electronically as an 837P (Professional); the CMS-1500 is the paper version. (HCPF does not accept paper claims)

1 · EHR / PM SYSTEM

Builds the 837P from your documentation, codes, and charge entry, then transmits it.

2 · CLEARINGHOUSE

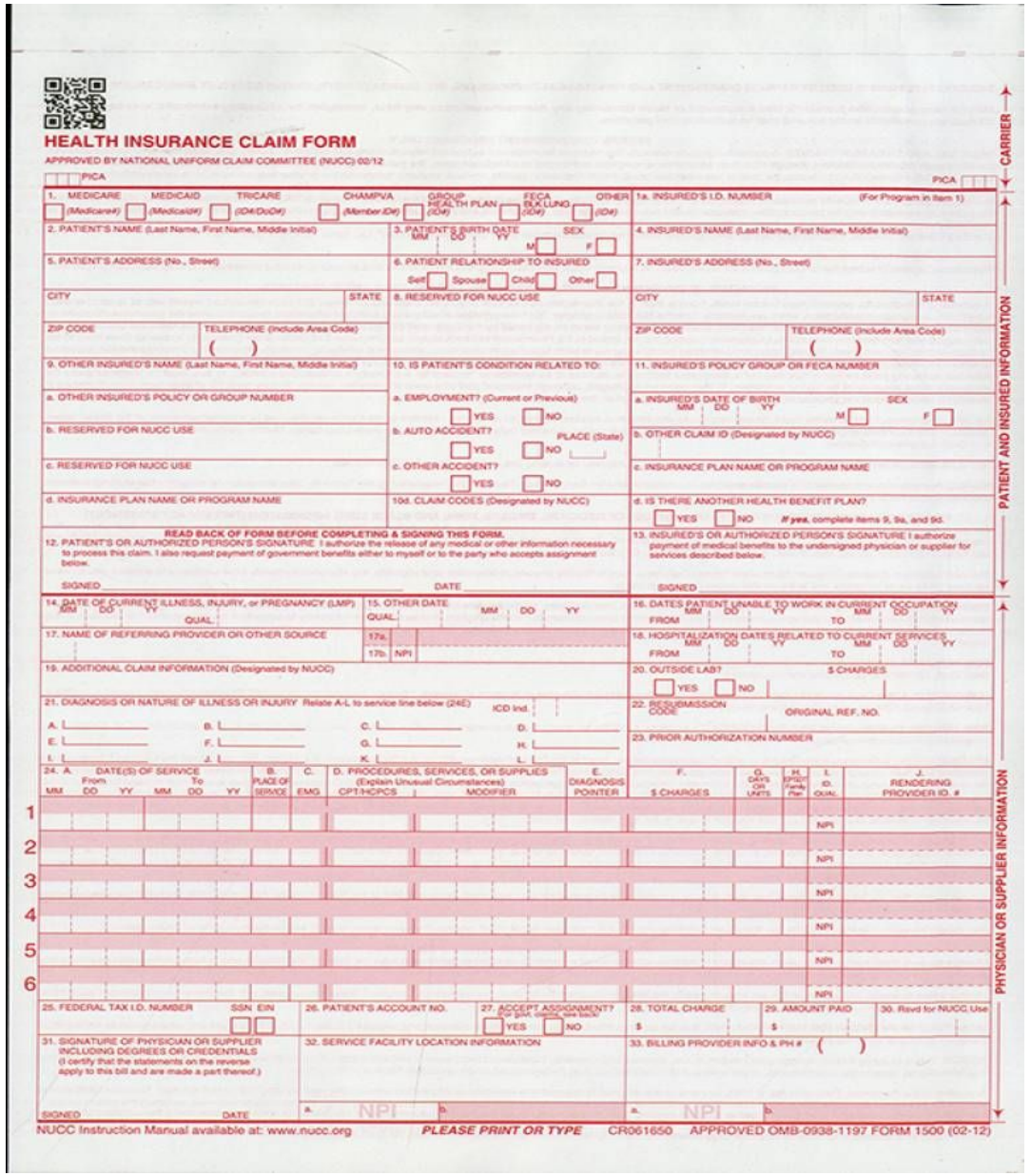
Sits between your system and the payer; scrubs the 837P for format and missing data, then routes it on.

3 · PAYER

Receives a clean, formatted claim and begins its own review — eligibility, coding, and medical necessity.

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

CMS-1500 FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

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)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

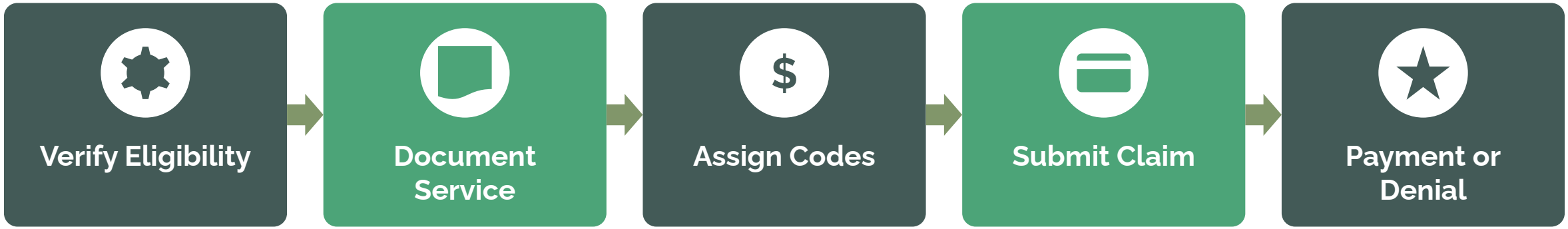
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061650 APPROVED OMB-0938-1197 FORM 1500 (02-12)

THE CLAIMS LIFECYCLE



Before you bill — the steps that happen 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

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

REQUIREMENTS OF A CLEAN CLAIM

Not just what's on the claim, but whether it's actually ready to go out clean:

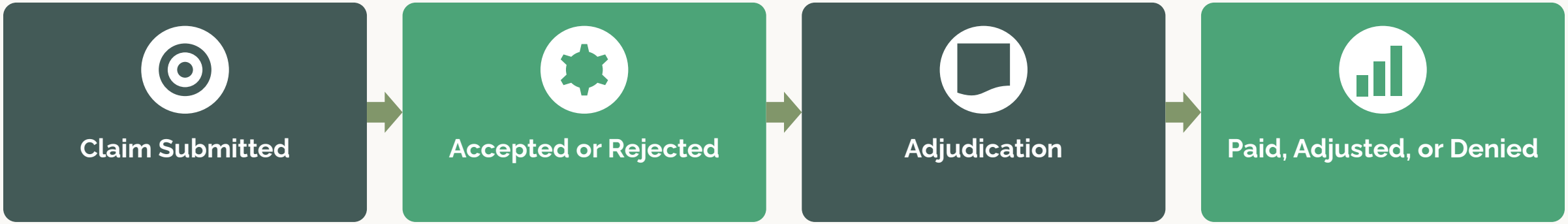
- ✓ **Complete member information**
- ✓ **Correct payer (RAE, Health First Colorado FFS, or primary insurer)**
- ✓ **Correct billing and rendering provider, with NPIs and taxonomy**
- ✓ **Accurate date and place of service**
- ✓ **Correct CPT/HCPCS codes**
- ✓ **Appropriate ICD-10 diagnosis codes**
- ✓ **Accurate units billed**
- ✓ **Required modifiers**
- ✓ **Required authorizations**
- ✓ **Complete supporting documentation**
- ✓ **Submitted within timely filing requirements**

Missing any one of these is enough to trigger a rejection or a denial.

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After You Submit

AFTER SUBMISSION: CLAIM STATUSES



Sent to the payer, usually routed through a clearinghouse.

Accepted — received and entering processing; no action needed yet.

Rejected — errors stopped it before processing; correct and resubmit.

The payer's review process that decides whether a claim is paid, adjusted, or denied.

Paid — approved; payment issued.

Adjusted — a previously submitted claim was reprocessed or changed.

Denied — fully processed, but payment not approved.

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Acceptance is not payment — and rejected vs. denied need completely different responses.

REJECTED VS. DENIED

Same outcome — no money — but two different problems:

REJECTED

Never entered processing — there's nothing to appeal.

- Almost always a data or formatting error
- Not a payer decision — just fix it and resubmit
- Still burns timely filing days — work these first

VS

DENIED

Processed and declined — a decision has been made.

- May be eligibility, coding, medical necessity, or authorization
- A decision exists, so there's something to correct or appeal
- Requires the right response: corrected claim or formal appeal

Getting this distinction wrong means appealing something you could have simply fixed.

UNDERSTANDING YOUR PAYMENT

A Remittance Advice (RA) is the payer's line-by-line explanation of what happened to your claim — this is where you find out which status you got:

- The RA shows how each claim line was paid, adjusted, or denied
- The ERA is the electronic version, delivered as an 835
- Work every adjustment and denial line — don't write them off
- FFS remittances come from the CO Provider Web Portal; RAE remittances from the RAE (often through their own portals)

Reason codes on the RA are what tell you why — look them up before you act.

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CORRECTING & RESUBMITTING

What to actually do, depending on what came back:

REJECTED

Fix the error and resubmit.

No appeal needed, no special coding — it's simply a new submission.

DENIED — FIXABLE

Send a corrected claim referencing the original.

Use resubmission code 7 (replace) or 8 (void) — Box 22 on a CMS-1500.

DENIED — YOU DISAGREE

Gather documentation and file a formal appeal.

Deadlines and process vary by RAE — check the provider manual.

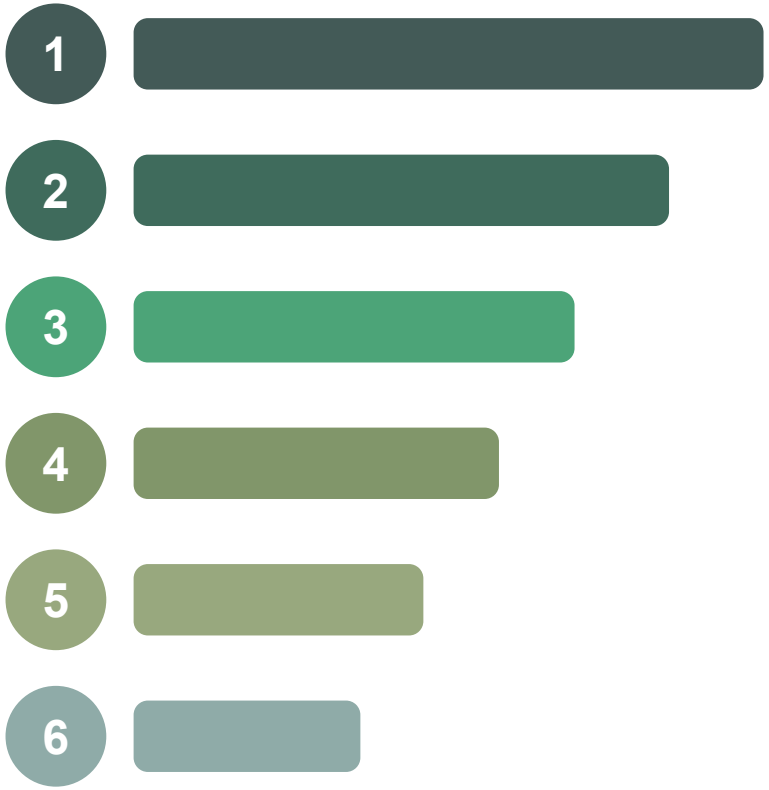
***IMPORTANT!:** Appeal and correction deadlines vary by RAE — check the provider manual before the clock runs out.*

Preventing Denials: Root Causes & Strategies

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COMMON BILLING CHALLENGES

Where claims often go wrong, in rough order of frequency:



1. **Eligibility not verified, or the claim went to the wrong payer**
2. **Missing or invalid NPI or taxonomy code**
3. **CPT and ICD-10 mismatch — the diagnosis doesn't support the service**
4. **Missing modifier, or a place of service that contradicts it**
5. **Documentation that doesn't support the time or service billed**
6. **Missing authorization, duplicate claims, and timely filing misses**

Almost every item on this list can be caught by a pre-claim review.

WHEN THE NOTE CAUSES THE DENIAL

Most coding denials trace back to documentation:

- Missing start and stop times, or time that doesn't support the code
- Rounding up, or combining time across multiple visits
- Cloned notes — group members or sessions that read identically
- No plan for next steps, so ongoing medical necessity isn't clear
- Vague language instead of the specific intervention and client response
- Claim submitted before the note is complete and signed

RENDERING PROVIDER OVERSIGHT (RPO)

Under HCPF's RPO Policy, pre-licensed clinicians and unlicensed professionals can deliver services but can't bill independently — NHP denies claims that don't follow the structure.

1 · RENDERING PROVIDER & U9

The Rule: Pre-licensed clinicians and unlicensed professionals cannot enroll in Medicaid or act as the Rendering Provider. Their services are billed under a Rendering Provider: a Colorado-licensed, Medicaid-enrolled clinician who oversees the member's course of treatment.

The Error: Listing the pre-licensed clinician's NPI as the rendering provider — NHP (and other RAEs) will deny it.

The Fix: List the Rendering Provider in the rendering field, and add **modifier U9** to every claim line for services delivered by pre-licensed or unlicensed staff (dates of service on or after July 1, 2026).

2 · RPO ATTESTATION

The Rule: Billing providers subject to the policy must submit the RPO Attestation **annually, by January 1**, to every RAE they contract with, including NHP, confirming they follow the policy.

The Error: If NHP doesn't have a current attestation on file, claims billed under that Rendering Provider for pre-licensed or unlicensed staff will be flagged and denied.

Sources: HCPF RPO Policy · Provider Express Unlicensed Provider Billing Policy

RPO: CREDENTIALING & DOCUMENTATION

Even if the paperwork is correct, the Rendering Provider may be the bottleneck.

3 · RENDERING PROVIDER CREDENTIALING

The Rule: The Rendering Provider must be fully credentialed and "in-network" with NHP (and other RAEs if applicable) specifically — not just broadly enrolled in Health First Colorado.

The Error: If the Rendering Provider is pending credentialing or their CAQH profile is out of date, NHP will reject their NPI, causing a cascading denial for the pre-licensed clinician's work.

4 · DOCUMENTATION FORMATTING

The Error: The electronic claim lists the Rendering Provider, but the clinical note in the EHR does not clearly show:

- The Rendering Provider's counter-signature
- Text explicitly detailing their oversight review
- The service provider's credentials (e.g., LPCC)

Result: the claim fails audit matching.

RESOLVING RPO DENIALS

Where to start when claims for pre-licensed or unlicensed staff are denied:

1 · CHECK THE REASON

Check the specific claim rejection reason (e.g., “Provider not covered,” “Missing Info,” or “CO-16”).

2 · CONTACT PROVIDER RELATIONS

Reach out to the Northeast Health Partners Provider Services line (and/or other RAE provider service lines) to verify they have your current **RPO Attestation** on file.

3 · AUDIT YOUR CLAIMS FEED

Ensure your EHR automatically drops the **Rendering Provider’s NPI** into the rendering field and adds **modifier U9** for every client seen by pre-licensed or unlicensed staff.

STRATEGIES FOR SUCCESS

What strong billing operations have in common:

Clean Documentation

Complete, specific, and signed before billing.

Pre-Claim Review

A dedicated review step with a named owner.

Clinical-Billing Communication

Standing communication between clinical and billing staff.

Full RA Review

Review every remittance advice line, not just the payments.

Denial Tracking

Track denial reasons over time to find the pattern.

Manual Refresh

Review the SBHS Billing Manual quarterly as it updates.
Review HCPF's BH Policies, Standards, & Billing References regularly

Small process improvements compound into significantly fewer denials over time.

BUILDING YOUR BILLING SUPPORT TEAM

Four models, no single right answer — size, volume, and internal capacity drive the choice:

INTERNAL STAFF	OUTSOURCED	CONSULTING	TRAINING
Internal billing staff	**Billing company**	**Billing consultant**	**Technical assistance & training**
Dedicated staff who own claims submission in-house, with direct clinical access.	An outsourced partner that manages billing on your behalf.	Expert guidance to strengthen your existing processes and staff.	Ongoing education to build skill within your current team.

Bringing It All Together

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KEY TAKEAWAYS

- Documentation quality drives everything downstream.
- Diagnosis, procedure code, and the note must tell one story.
- Know your payer before the service, not after the denial.
- Most denials are preventable with a pre-claim review step.
- A rejection is a fix; a denial is a decision — treat them differently.
- For pre-licensed and unlicensed staff, the claim, RPO attestation, credentialing, and note must all point to the same Rendering Provider.
- Successful billing is a clinical and billing partnership.
- Small process improvements and the right support structure compound into fewer denials over time.

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CONTINUING YOUR BILLING EDUCATION

Where to go when you need the current answer:

- **HCPF SBHS Billing Manual** — updated quarterly, review regularly
- **HCPF Behavioral Health Policies, Standards & Billing References** website — updated regularly, review often
- **Colorado Provider Web Portal** — eligibility, RAE, claim status & remittances (for FFS billing)
- **RAE's provider portals & support teams** — claim status, authorizations, and appeals
    - **RAE 1 & 2 Quarterly Office Hours** — interactive sessions with the latest BH updates, tools, and guidance (register here)
    - **RMHP (NHP) 2026 Medicaid/CHP+ BH Provider Manual** (linked on handout)
- **HCPF Provider Trainings** — enrollment, eligibility, billing, etc.

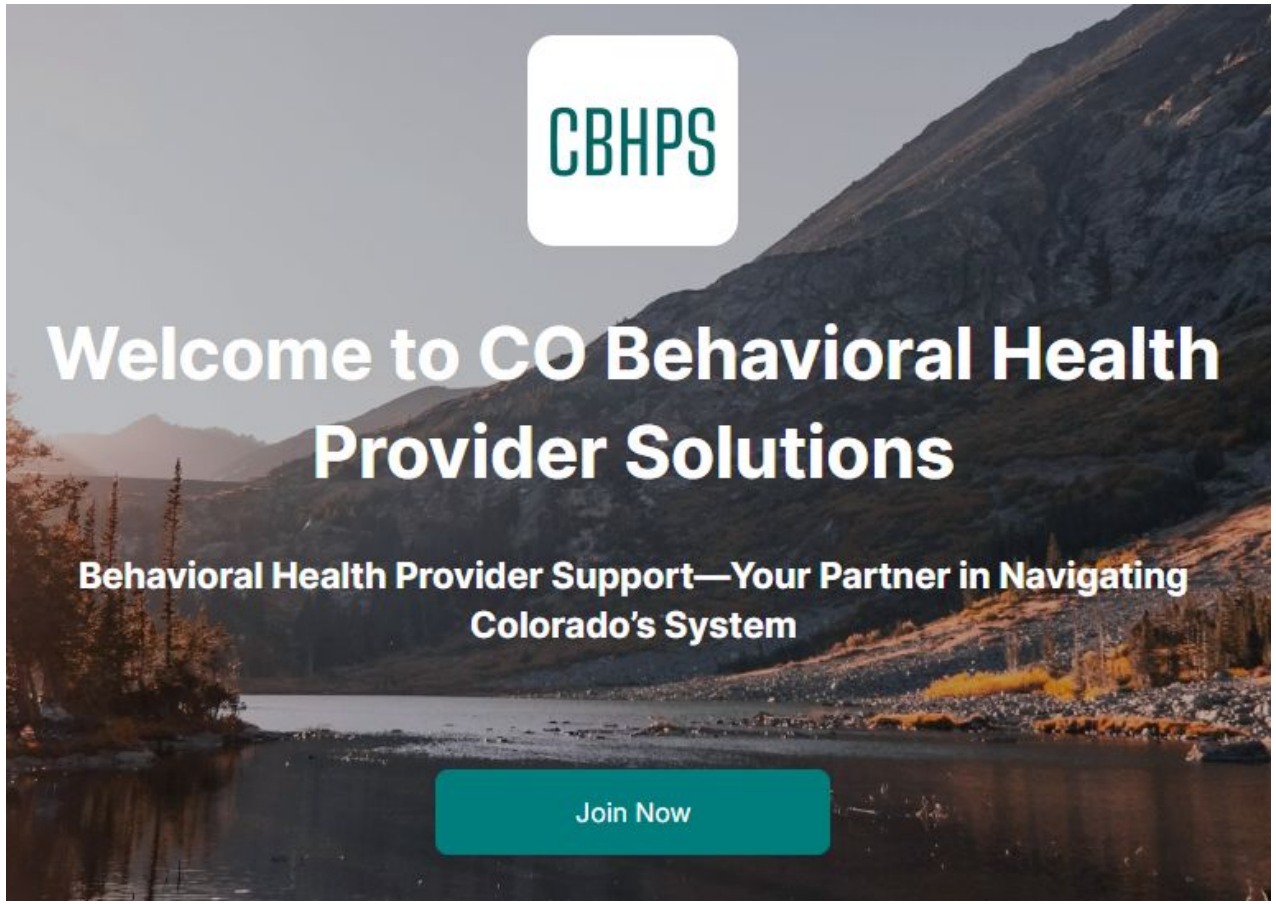
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Colorado Behavioral Health Provider Solutions (CBHPS)

Your Medicaid Technical Assistance Partner

No-Cost Support Includes:

- One-on-one, 30-minute consultation meetings
- Announcements, updates, events from the BHA, HCPF, Health First Colorado, RAEs, etc.
- Resources & Courses
  - Medicaid 101
  - Enrollment, credentialing & contracting
  - **BH Billing Foundations**
  - Value Based Payment Program
  - Quick Links
  - And more!
- Community connections



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Tabletop Activity:
DENIAL CLINIC

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Q&A WITH OUR BILLING & CODING SPECIALIST

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Thank you!

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