Extended Office Hours: HCPF BH Billing Codes – 2024/09/04 13:19 MDT – Transcript

Attendees

Allie Sawatzky, Allyson Gottsman, Alyssa Toohey, Amanda Maxwell, Amy Smith, Andrew Bienstock, Angie Schindler-Berg, April Haynes - HCPF, Barbra Corcoran, Breanne Croissant, Brian Gablehouse, Camron Morton, Casey Wolfington, cathy, Catie Shannon, CFH, Christy Graham, d=Debbie Campbell, Darcy Koehn, Diane Cardwell, e, Elise Peterson, Evelyn Wiant - HCPF, Hannah Herinckx, Honglan Lu, j. riley, Jayden Durbin, Jenny Webb, Jill Bumgardner, Jill Coughlan, John Laukkanen - HCPF, Kayla Ortiz, kellie Jackson, Kriste Hardt, Lauren Quintana, Marcia Newth, Maria Casaverde Marin, Marilyn Davis, Mary Kay Knode, Meg Taylor, Megan, Mindy Craig, Mitch ONeill, Nicole Gartner, Pamela Ballou-Nelson, Rachel Shuck - HCPF, read.ai meeting notes, renee martinez-epperson, Rosario Morales, Sarah Dayton, Sarah Haggard, Sarah Switala, Sherrie Bedonie, Tara Garvey, Taylor Miranda Thompson, Tiffany Dilsaver, Wendy Flottmeyer, Yolanda Trevino

Transcript

Rachel Shuck - HCPF: Book on it. And so, Some of you did provide pre-populated questions. And so what I'm thinking John is, I would like you to begin there. And then in the chat for everyone…

John Laukkanen - HCPF: Okay.

Rachel Shuck - HCPF: because there's quite a few people on the call for right now. If you can start chatting in additional questions, a lot of your questions, may already be answered by the time we get to yours and then we'll slowly work our way through those as our goes on. So John Amo pass. It already use her.

John Laukkanen - HCPF: I appreciate that. And can you bump up that list? I looked at it and I'm trying to find the list of the questions that came in which you shared with me. But can you either send me the link again in chat and I'll start there. but let me Just no,…

Rachel Shuck - HCPF: Yes, and I apologize. Should have already had that.

John Laukkanen - HCPF: that's great. No worries. Just tell me where it's coming and I'll pull it up and I'll find it. So, thanks everyone for obviously being here, and I'm happy to be here. I was a bit facetious that. I'm gonna make everything as clear as still water today but I want to make it as simple as possible. May not be clear but hopefully we can make it as simple as possible. Let me start with the six short-term behavioral benefit because that's the one that I got. A lot of those initial questions on and

Rachel Shuck - HCPF: John, they're in your chat. You're welcome.

John Laukkanen - HCPF: thank you so much, perfect. All And so, Let's start with those and then. Kind of talk more, broadly. so, first of all,

John Laukkanen - HCPF: And let me can someone explain to six requirements me. So that was a kind of a general question. So let me start with that late layout, that foundation policy, and then dig in more specifically to the questions. So, our six short term, April benefit, Allows primary Providers or spaces. Who have a behavioral health person on staff? To provide a behavioral health service using one of those six psychotherapy codes. And those six codes can be billed up to six times by the clinic. So the behavioral health provider is providing the service.

John Laukkanen - HCPF: Ideally or probably documenting that in your medical and then your clinic would bill for those services. In the same way you would bill for any medical Welchild, vaccine any other encounter that you have. And so it's using those six codes billing, it just to buff through fee for service gain, as our country processes those claims, and you can build for one member up to six sessions with that. Be able to provider but the clinic would bill There is no other real parameters to that benefits. It gets confusing because from behavioral health provider world and from behavioral provider perspective, we are bringing a lens that doesn't fit here and so let me tell you what doesn't apply. You don't need a treatment plan. This isn't an intake first, and then five sessions of therapy, all of that way. That

John Laukkanen - HCPF: Social workers and lpcs generally, practice doing therapy or doing kind of this type of work, we designed the benefit to be a medical context and to have a medical kind of culture to it. And so ideally, you've got a referral from a medical provider saying, Hey this kid's struggling in school, he's got stomach aches. It's not a medical reason, there's no constipation happening. I've ruled out all the medical causes here, probably some anxiety. Would you mind looking at him? Sure behavioral provider can go Through that conversation and a maybe 10 minutes. question and answer with Mom, you've done your assessment. you don't have to build a 90791. Just to be able to start billing a 9083234 etc. and the six visits, reset because it's an annual benefit, right? So you get six visits per year

John Laukkanen - HCPF: There's some reasons for that, and there's reasons for everyone to say That's ridiculous. We understand that but it was the best we could do in 2018, when that was stood up. So, yeah. And you don't have to use all six visits, you could use one or two visits you could follow up, you could give the kid the youth, the adults maybe a referral even to a longer term resource, maybe a higher intensity intervention. Maybe they need, weekly therapy somewhere else. Maybe there's significant trauma. That's not necessarily meant to be addressed in that in your clinic setting. You might be the only provider in your region. So, at some level, yeah, you could meet all the six benefits, not build by the baseball halls provider. Nope, they're provided by the behavioral provider build by the clinic.

John Laukkanen - HCPF: So if you try to bill it with the NPI of the provider, as the billing provider, it'll get denied when you build that fee for service. All right. So again, when it's coming to hit puff, it needs to be billed by the clinic, and then there's no problem that because they see and it's a provider type 16. However, the clinic is enrolled with Medicaid. They see that provider type come through with that 90791 and they accept it up to six times. And then after the six, if you want to provide ongoing therapy or clinical services, by that behavioral health clinician in the clinic, you can still do that, you would then just need to be the billing provider and that means to be billed to the ray. So any services outside of those six.

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John Laukkanen - HCPF: Aren't really considered under that benefit anymore, that doesn't mean you have to stop providing those services. And I've heard this before from other providers, especially you and rural clinics, right? we want this to happen. We want integrated care happening in rural spaces because you're

the only resource that's available out there. And so the six visits were allowed for low acuity brief intervention. Maybe early identification of significant issues, And so that's where that was intended to serve and function and that's why they allowed it to be built under the primary care provider.

John Laukkanen - HCPF: If you continue to provide those clinical services, as the behavioral provider and simply just have to have a contract with the ray and be billing, the ray under your MPI, as if you were an independent therapist in your own office, sitting, next door to the clinic, but it doesn't have to be that All right. So that's the high level of what that benefit is no treatment plans. You don't have to do an assessment or, what's considered a formal assessment before you start the therapy piece? You may only. so let me say the other question was our interventions don't ever meet the time here's The Medicaid's Billing Rules. State. If it is for a timed service, you have to have half plus one. so, for a 15 minute code, you have to have least

John Laukkanen - HCPF: Eight minutes with that member to be able to build a 15 minute service 90832, 30 minutes. You have to have 16 minutes with a member to be able to a 30 minute therapy session. So, in some ways instead of seeing 30 45, 60, You should be looking at the half plus one rule. All right. And that's spelled out in the billing manual. And in some of the initial pages there, it's not on the coding page itself because the code is 15 minutes. And when you start dealing with 15 minute increments, you can stack a minute codes and so that gets into the whole other side of things where, maybe for a 15 minute service. This isn't a part of the six, short term Marilyn benefit because those are time to codes but if you're somehow doing something else just to explain coding for you.

John Laukkanen - HCPF: We have an outreach code, 15 minutes. It's eight years or two three and some people do outreach, but they spent, 28 minutes with a member. that would be two units because it's up to 30, but the second one was half plus one. So, I'm a social worker, I say out There's three kinds of people in the world. There's people who are good at math and people who aren't

Rachel Shuck - HCPF: That's funny. I,

John Laukkanen - HCPF: I'll wait for the journal. so I don't do I frustrated with math, but you need math when you're starting to do billing and coding, all right. And so again that helps. So in the psychotherapy services that are 30, 45 minutes, etc, half plus one, be your rule and then you can do. And ideally you might be spending 16 minutes with a member, right? Or, if they have a come in for a short session, maybe you can spend 20 more minutes with the number. Go ahead and read.

Rachel Shuck - HCPF: So John there's a couple of questions. Do the six visits, reset And is it for calendar year?

John Laukkanen - HCPF: A reset July 1. It's the fiscal year. So it's the benefit year.

Rachel Shuck - HCPF: Okay.

John Laukkanen - HCPF: So when you think of for example your own health insurance your benefit coverage, whenever the benefit coverage starts, some of you may start calendar year in January, then you get a new deductible, right? You're deductible starts all over whenever you're benefit starts.

Rachel Shuck - HCPF: Yeah.

John Laukkanen - HCPF: That's the same way this works. So in Medicaid, the fiscal year is the coverage start time. So July 1, is when your coverages renew. If you think about it that way,

Rachel Shuck - HCPF: Thank you, Mitch and Kelly. We will come back to your questions here in a minute. I'm gonna let John go down the rest Of the populated.

John Laukkanen - HCPF: thank you.

John Laukkanen - HCPF: And then what are the appropriate codes for warm handoffs if it turns into an actual therapy session? Can we use a therapy code like 9032 before we build 90791? So let me answer the last half of that is absolutely you don't have to bill a 90791 and again that's taking us back to traditional therapy World Right where you have to do an evaluation. I'm gonna say this If you have looked at the clinical chart've seen Maybe this is the first time you've seen that member, Maybe there's the sixth time. You've seen that member, The medical provider has tried various interventions, and finally has ruled out. Nope, there's no medical cause to this issue and you've had a curbside consult. Maybe they've reviewed what's happened? And then you go into the room. Technically, you've done the evaluation. You may not even need to build a 90791. You can just start billing, 90832. Doctors told me this. I see X y and z you've tried. It hasn't successful. Let's try some of this. Or have you considered x y z? I mean, you're doing a clinical intervention. In that point, it might be more along the lines of a psycho education, right? It might be more of

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John Laukkanen - HCPF: Motivational interviewing you're trying to get them engaged in the idea that, hey, you might have depression. It's not really, some thyroid issue, right? It's a depression or something else. So, when you get into that room, in some ways, sometimes, you've already done the evaluation, you've already done this assessment. You've potentially already identified potentially the diagnosis, and so, yes, you can start by billing 90832 right away without a 90791 first. As far as the warm handoff, This is the one area that this entire 1302 project is actually trying to solve for there are some components integrated care that are just not billable curbside consults or warm handoffs is. I think that's where you're going. There's really not a billable.

John Laukkanen - HCPF: Code for that five minutes standing there at the counter in the hallway. Getting an update from the medical provider you giving a follow-up from the medical provider? Ideally what we're trying to accomplish in all of this work with 1302 is to find a way to account for those Non-billable services and make integrated care sustainable. So right now, there really isn't a code for that, but to the second half that question, you can build based on the intervention, you're providing. There's no standard or rigid there. Let me just go down these real quick.

John Laukkanen - HCPF: A visual billing tool for new Bhps would be helpful. I agree one that outlined psychotherapy codes and rules number of sessions etc. How charges are diverted to the ray when you do or do not need a mental health diagnosis, when you do or do not bill under a physical medical provider. So let me just say this and this might sound scary for some of you. We are looking to potentially do away with the six, short term behavioral benefit. It's been in place since July 1. 2018. It's been a benefit that we tried to stand up and establish and implement it came right after the In Sim initiative, that was a five-year effort to fund and promote and advance integrated care. And it really has been the only way that providers have been able to bill for these integrated care services. Again 1302

John Laukkanen - HCPF: Is intended to establish a true integrated care benefit model and reimbursement model. These six short term. Evil benefits were never intended to serve this role. That have psychotherapy codes not brief intervention codes, not the hay decodes. And so as we are moving toward July 1 2025, the

conversation has been, What do we need to stand up as a sustainable model for integrated care, understanding the dynamics and culture and the workflow of a primary care setting, And does that mean we really set these six short-term variables benefits? So I appreciate the idea of having a graphic and building out some of that I will say there's probably not capacity for that at this time as we are potentially looking to sunset that benefit, but that's helpful feedback for when we potentially stand up. What we are proposing as a new scope of benefit.

John Laukkanen - HCPF: Let me just look throat real quick. So how we'll be able to get reimbursed for all be able service? We were providing that do not meet the time limit. So I think I've dressed some of that. We know, Colorado access is utilizing separate code to care and so that's the point here. Again, we're trying to find codes that are more meaningful. This six, short term be able to benefit was never intended to be an integrated care solution. It just by default, because it was the only thing we had was the clear pathway for providers to use. And so, yes, we are hoping and intending to provide a much more intentional benefit for integrated care. that is, what is coming with the 1302 work. Is there an estimated time frame? We expect the process to be corrected. So, the short term benefit, our process paid correctly the first time. So thank you for rising this flag. Many of you might be aware, you were billing start a billing January one, there was a system.

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John Laukkanen - HCPF: Change hip hop system, change that impacted these codes from being processed correctly. And there were a lot of denials that came out about as a result of some of the changes that happened. So the system change request, all of the rules that need to go into place to correct that have been submitted and I am waiting to hear and I am happy to share with Rachel so she could share with all of you. I will tell you this, if you submit a claim to hit buff for these from be real benefits and get a denial,

John Laukkanen - HCPF: You don't have to panic, although I know there is panic because you need the money, but those claims you don't have to take additional action is, I guess, maybe the best way to say it. Those claims will be reprocessed. And so, even though there are denial right now in the system, they will be reprocessed. Once the rules have been fixed and then they will reprocess them back to January 1. So anything you submitted is reprocess If you need immediate support on that, please reach out. I'll give you the billing manual or the coding email, and if you send over, hey, we're sitting on $3,000 on, paid claims. Can you do something to help us out? send us that email. We'll see what we can do. Sometimes we can just get something force paid or advance paid. I can't promise you anything on that. But, I understand that's a burden for providers. Rachel.

Rachel Shuck - HCPF: John may I ask a question and Kellie asked a question.

John Laukkanen - HCPF: Yeah.

Rachel Shuck - HCPF: I think it allows to this as fellows billing and I apologize. I don't know what that means. but How do they know…

John Laukkanen - HCPF: So yeah.

Rachel Shuck - HCPF: if they're denial was about this change? In this, short-term behavioral health Is there a way that they would know that?

John Laukkanen - HCPF: Yeah.

Rachel Shuck - HCPF: Because this is something that has come up consistently on our quarterly reports that they're denials that they're getting a lot of denials for their six short term.

John Laukkanen - HCPF: So let me answer the first question first, so kellie, you'd asked about the BHC the behavioral health clinician or a fellow so yeah any intern fellow unlicensed, Masters degree. Clinician can provide a service that service though needs to be connected to a licensed clinician.

Rachel Shuck - HCPF: License.

John Laukkanen - HCPF: So the overseeing or supervising behavioral health clinician, Would. Be the one that has to, basically document the fellow can document it. The rendering provider would be considered the license clinician, but in that context Where you have rendering provider, NPI on a claim. The licensed clinician has to be that the billing provider still is the clinic. so again as if I can take one detour here on this, just so everyone hears this and knows this in Colorado, we operate under the authority of the Colorado, Mental Health Practice

John Laukkanen - HCPF: Medicaid, CMS allows Colorado to set the guidelines by which we allow certain providers to provide services to Medicaid members and that authority is our Mental Health Practice Act. This is laid out in our billing manual. If you want to understand it more or have a clear reference to it it is in our billing manual, in the first few introductory pages. But what that means is a license. Clinician can supervise unlicensed, hands-on providers, whether that's a peer a qbha, a Q map, I mean all the way up to a doctoral level on licensed provider. So a licensed clinician is the one who takes the responsibility for the care of the member and if they are working with and supervising and intern maths with level on license provider fellow etc or any of those terms that person can provide hands on care as long as that licensed clinician.

John Laukkanen - HCPF: is the one their NPI is on the claim in the rendering provider spot, So, there is no limitation for this and Medicaid or hiccup does not have a limitation. Even in the medical realm, all of you might be familiar with direct supervision versus indirect supervision. There's three categories of supervision or three levels of supervision when it comes to medical services. That is not the same for mental health services. So, theoretically again a licensed clinician needs to take the responsibility here, but if the license clinician it's on site. When you have a doctoral fellow actually providing hands-on care for in a pediatric, primary care setting we don't have any additional rules there other than what's laid out and mental Health, Practice

John Laukkanen - HCPF: And so please feel free, we know we have a workforce shortage, We know that we have challenges getting licensed staff but at the end of the day, if you have two or three sites or two, or three medical providers, and you're trying to have two or three behavioral health clinicians on site, they can be unlicensed staff. As long as there's at least one license staff who is overseeing and responsible for the care, that's being provided. All right, so that was my diversion. Yeah, Glenn.

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Rachel Shuck - HCPF: John and I I just wanted to say, so Sarah, you did make a good point about how the six visits are. that works out really well and then there's this huge leg with credentialing with the raise. And I think John it will talk a lot about the Acc3 and how this is going to change. We are not promoting any

one company, but I did provide you one. So, this is one that I'm aware of and you can find your own. We are allowing people to use ds. If you have extra funds in your budget to use a contractor to push your Ray contracting and credentialing. And there's a lot of our site to have already used this and it's cutting that time in by half because I know that credentialing is so hard.

John Laukkanen - HCPF: Here's the other piece that's important to know. So for the raise, when you're talking about an individual clinician, yes, they have 90 days to credential and contract with you. However, you can still build under your license clinician while you're in that process. So if you are a graduate or you have graduates or fellows, they've gotten their license for Dora and they still want to work and obviously start building for their own services as an independent clinician. If they had a relationship with a licensed

John Laukkanen - HCPF: Supervisor during that time, our policy allows you to continue to build even though you are licensed and you have your degree through door, you have your license. You can still bill under another licensed clinician. While that contracting and credentialing is happening. So again, I know that doesn't shorten anything but that is a resource for those who are trying to bring on interns and fellows and Masters level clinicians. And then you want them to stay and work with you and you want to be able to pay, claim services, that an option as All right. The last question that was submitted pre-- ahead of time. A lot of it was related to collaborative, care management. So we can speak to that. As far as we're having hard times setting prices for services, do you know where we can get this information to Bill accordingly? So,

John Laukkanen - HCPF: Technically. If you're billing fee your billing services, here we have the physicians fee schedule. So that's published every January and July that's on our website and Rachel. If you take no to some of these things, I'm happy to get you the links and then you can send them out to everyone. But just take note of what I'm referencing. And then I'll make sure we get a full list, but we have our physicians fee schedule.

Rachel Shuck - HCPF: Graham.

John Laukkanen - HCPF: And so anything, your billing to hit puff, it'll have a rate set, and you can put that rate in your EHR. So you make sure you're claiming and just for those of you may not be tracking the importance of that, Medicaid has a rule that pays the lesser of what is either submitted or that the determined rates. So if our fee schedule says, you get a hundred dollars but you only submit a claim for 80, they're only gonna pay 80. You should be getting $100 but based on what you submit the claim for they will pay you the lesser of the amount. So that's why it's important to have those. If you are trying to bill a service to the raise, the rates should be established in your rate contract. So you should be talking to the rays. To say, Hey we have all these codes in our contract that we are contracting with you to pay And when we submit a claim you will pay those services, they should have a rate.

John Laukkanen - HCPF: Or a fee schedule also. So those would be your two sources to get the rates Back to Rachel's question, I skipped over it. How do you know when you're denial for the six church and be able to benefit is because of this glitch, it'll be because it'll say not a covered service build array, you'll get a denial like that. Now, I would really encourage you please.

Rachel Shuck - HCPF: Okay.

John Laukkanen - HCPF: look, you may have a denial, not an appropriate, billing provider, not an enrolled, rendering provider, there's some of these other Denial reasons, and it may be that you tried to bill it under the not the clinic, you tried to bill it, some other way and there's another error there. You will be told that

that'll be its own denial reason. If you get a denial reason, must build a ray There's only one or two reasons that that's the case, it's because the glitch happened or you exceeded the six limit.

John Laukkanen - HCPF: But you should get a denial for that to say member exhausted benefit, It's an exhausted benefit. check your denial reason. If it's an exhausted benefit, that means you've already build six and you need to build seven to the ray, but if it…

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Rachel Shuck - HCPF: but,

John Laukkanen - HCPF: if it's just affirming into the array to bill then that's because of this glitch and everything else is correct.

Rachel Shuck - HCPF: so, It not a covered visit bill to Ray. I'm just going to say this out loud again because this was number one on our quarterly. So everyone to hear not a covered visit bill to Ray that's because of this glitch. So they should be rebuild, if you are in financial struggle because of that, I'm going to have you reach out to me. And we'll make sure that I'm making a list of things John's gonna get us that we'll get an email that you guys can email and say, this is a financial burden and…

John Laukkanen - HCPF: He?

Rachel Shuck - HCPF: we'll see if we can push that.

John Laukkanen - HCPF: So there was a fee schedule. I got it. So this was on the list of questions as well. And then Let me just say this about clavic collaborative, care management and then we can move on to live questions as well. So collaborative care management is a service and a closed set. That is not currently opened under Medicaid those codes.

John Laukkanen - HCPF: You could put them on a claim and maybe you could get reimbursed under private insurance, but you're not going to get paid through fee for service. You're not going to get paid through the raise, it's not a covered benefit. That is one of the services we are looking to add under the 1302 proposal. And so if you've been tracking that we ing your Rachel's, team is drafting a legislative report that needs to go to the legislature to say, Here's what we think is sustainable way to support integrated care. Some of the collaborative command codes, etc, are part of what that recommendation looks like. And so that's what we're looking at for this future state, ideally July, 125. Lots needs to happen for that to go live. That date that be the earliest it would go live, so you can build them now, or you might have a model now, which is why you can use your grant funding because you're not supplanting any Medicaid benefit by doing that but

John Laukkanen - HCPF: It just isn't available service at this time. So, ideally fingers crossed. And, the legislature agrees with us and everyone else agrees and we can make it all happen hopefully would be a part of our future world but it just doesn't exist now. So let me not necessarily go to detail about collaborative, care management if I can. So Rachel if you want to help me and others or…

Rachel Shuck - HCPF: yeah, I'm gonna go back to the top.

John Laukkanen - HCPF: if you want to raise your hand and just come online, go ahead. Yep.

Rachel Shuck - HCPF: Mitch O'Neill has the first question in Mitch. We may need you to unmute and clarify, But it says, When billing, the ray, where do they go to? They go directly to the rate that you are contracted with. And so, if you have an additional question to that, do you want to unmute and speak to us? Please.

John Laukkanen - HCPF: And while you're unmuting, I will say, yes, it is However, there are some rays that have what's called administrative service organizations, which you all probably know as carillon or used to be Beacon. Beacon is not array. They are a contracted administrative service organizations. So you have a lot of contact with Beacon / Carillon. And they're the ones who They're the ones who credential in contract you, and that would be for Race, Two, and four. The other raise do not have administrative service organizations, and then kind of run down the list Real quick. Correct, I believe Rocky Ccha Colorado Access Denver, health. Funny enough actually has Colorado access manage their benefits so you probably won't even interact with Denver Health necessarily a lot but Colorado access would so, yeah, if it's not the Ray themselves, it would be Beacon or Caroline for rate, two and four, who you would submit the claims to and you would get a

John Laukkanen - HCPF: Eob, or whatever From them from Caroline. But any clarification, you have Mitch. Or did we answer that question?

John Laukkanen - HCPF: If there's you,

Rachel Shuck - HCPF: Okay, I think we've gotten most of the rest down to Joe Bumgardner. I see it says, Should the six visits, be billed, under the PCP, then we try to …

Mitch ONeill: John.

Rachel Shuck - HCPF: Mitch I wait I see Just popped up. Are you there?

John Laukkanen - HCPF: Go ahead, yeah.

Mitch ONeill: About the Rays. how do you build them?

John Laukkanen - HCPF: So through their contracts with you, they should tell you who they're bill, or claim processing portal So it's just like, when you build Medicaid, there's a portal that you Submit your claims to ideal using electronic claims.

Mitch ONeill: A clearing house.

John Laukkanen - HCPF: I mean, some people can still be using paper claims but you're talking about electronic claims Mitch.

Mitch ONeill: Yes.

Rachel Shuck - HCPF: So, I am.

John Laukkanen - HCPF: so, each ray will have

Rachel Shuck - HCPF: So I don't know who Mitch is or what clinic, I think that.

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Mitch ONeill: I work for summit, primary care. And we are already credentialed With all the rays and everything but nobody's ever come back to me to tell me where to build it to.

John Laukkanen - HCPF:

Rachel Shuck - HCPF: And so you need to go back to the Ray directly and if you want to send me Rachel a direct email, I can work with you but that would go. If you're done with billing, pick up for the six, short term behavioral health, then you would be going directly back to your regional area into Tea and you can just call them and say, Hey, we're meeting some guidance so we can start billing us, but if you need further assistance with that, feel free to email me. And I'll see what I can do to provide you.

Rachel Shuck - HCPF: You're welcome. Okay, I'm going to go back down to Jill's. Do you see that one?

John Laukkanen - HCPF: billing onto the PCP, so I guess I will say this depends on how your clinic is set up.

John Laukkanen - HCPF: Generally, you are submitting claims under the clinic as a group enrollment, right? So, John Smith primary care is enrolled with kickoff as John Smith Primary Care. And then you have hysician your PCP affiliated with that. So that technically, how you even build a PCPs claims is the PCP is in the rendering provider slot and the clinic has its own NPI in the billing provider slot. So,

John Laukkanen - HCPF: Yeah, we can hear you Jill. You're trying to come off you.

John Laukkanen - HCPF: yeah, so this is where Again, your clinic is in the billing slot. the behavioral provider is in the rendering provider slot. So again, the claim is coming from the clinic and the clinic is the one who will get the money, but on the rendering providers spot, it's the behavioral health provider, not the pcmp because the pcmp cannot build those codes.

Jill Bumgardner: And so that's…

John Laukkanen - HCPF: So it's the behavioral clinicians.

Jill Bumgardner: what we did. But when we had her as that's not one, I'm just trying to figure So we've done it every way you can think of and they're still being denied so they will come back and say Bill the Ray and so we started doing our behavioral health specialist unlicensed under our licensed and then when we did that, they said it to go to the RE because his behavioral health, not medical even though the codes or

John Laukkanen - HCPF: talking about. This is the glitch that I'm talking about.

Jill Bumgardner: And the physical.

John Laukkanen - HCPF: Starting in January 1, the short-term Beirut benefit. Some rules broke in the interchange that pays those claims in the thief or service side. And again, if you have the billing provider, correct? And they're saying, Send it to the ray. I'm going to say, 95% positive is a part of this glitch that we are trying to fix. So

John Laukkanen - HCPF: Maybe if you want to send me or have you already sent me because your name looks familiar to me. I'm thinking I've seen emails with you on it. Okay.

John Laukkanen - HCPF: Yep, she works under me.

John Laukkanen - HCPF: and maybe you and I need to set up a call and with your team, whoever but again, here's the challenge, if one of those variables is off then I would say, All right, if you're trying to stability behavioral service with an unlicensed provider, We have to figure she may be looking at that as saying yeah that's the April's benefit you to build a ray. Not realizing. We'll know you're in a primary care setting So let's just try to set up a meeting and we can walk through this so that you're not getting the wild goose. Chase.

John Laukkanen - HCPF: Right.

Rachel Shuck - HCPF: 'Ll, do you have John's email?

John Laukkanen - HCPF: Sounds great, please.

Rachel Shuck - HCPF: Okay, I'll let you take care of that, so I'm gonna keep scrolling down Mitch if you see Meg, Taylor put a message in there for you to contact, if they can. First help you with your disconnect with your ray. And then, if you continue to need help that works great. And then somebody asked for my contact information, And so in an email, I added our hip puff integrated care email and mine feel free to email me directly, but we like to have the integrated care box added because I'm not always in office and my entire team gets that message so that we can respond very quickly to all of you. So if you'll just please make sure you do that.

00:35:00

Rachel Shuck - HCPF: so the next question, Christy Graham, John, if you see, it says you build a ray via the insurance company's pay ID, find array in Medicaid portal. I think that's more of a statement. Not a question. I apologize. All right, so if everybody wants to just keep scrolling through the questions. Thank you. Christy for your response to that.

Rachel Shuck - HCPF: and Mitch, you see my email address above, Amanda Maxwell, if you build as a facility institutional claims, you have to change your revenue code to 900.

John Laukkanen - HCPF: Wait, what kind of facility are you talking about Amanda?

Rachel Shuck - HCPF: Amanda feel free to.

John Laukkanen - HCPF: Health clinics.

John Laukkanen - HCPF: All right, let's talk about rural health clinics and…

Rachel Shuck - HCPF: End. Okay.

John Laukkanen - HCPF: fqhcs. So There's additional billing guidance for fqhcs and rural health clinics. That is different than just a standalone prime provider that is not classified as one of those two. So, That as more complexity here, both fqhc's and rural health clinics can build a six short-term baby, both benefit and yes, it should build to higpuff under your billing guidance. So I would just Want to be very specific. For

those two provider types. They bill under a revenue code as a header of a code and I'm using maybe not the right terminology here and then you put your underneath that revenue code, the specific.

John Laukkanen - HCPF: Psychotherapy code the service that was provided but that's unique billing to rural health clinics and fqhcs. So thank you and Rachel's providing those. Let me say for a minute. How these billing codes interact with each other, that might be helpful. If you are a rural health clinic or a fqhc, I would say Start with your specific billing code because that actually tells you the claim form, how information needs to go on a claim. And yes, you have specific reimbursement, methodology that applies to you, which is why then you have a revenue code, that's specific to a behavioral health encounter, or whatever that is, The.

John Laukkanen - HCPF: State Behavioral Services Really is a comprehensive billing manual that lists out each of the CPT codes. And it's intent really is to help you identify the scope of the service, the details of that service, who can provide that service, who can build that service etc. And so you'll find a lot of information in this state. The Sdhs that's State Behavioral Services That may not be in the other billing manuals and so that really is more of I think I would say a clinicians guide to yeah, this service description fits what we're doing again that goes well beyond just the short-term behave health benefits. There's 155 codes in there that are covered under the rays and that's really specifically when you're billing the raise what the scope of that billing manual is but for rural health clinics, Indian Health Services fqhc's. Thank you for the Indian as well. You have specific guidance for when you're billing

John Laukkanen - HCPF: fee for service or hiccups specifically and then it also informs you as to how you build a raise with some of that formatting or The approach that and I apologize, that's pretty stumbling over but these hang together that way. And so I would say, If you are a specific identity, use your specific audience billing guidance, document first, and then you can go to our state, behavioral billing manual for additional content. And again, that's outside of the state or the six short term being with benefit.

Rachel Shuck - HCPF: Okay.

John Laukkanen - HCPF: Yes You're welcome to schedule a meeting with me. Sorry, I'm just seeing it. I did put under there, the hick puff coding, email address. That goes to Sandy Grossman on my team and if you can just reference, hey, John said we can schedule a meeting, she'll just forward that over to me or we'll try to get a meeting on the books with you.

Rachel Shuck - HCPF: Thank you. The next question is Barbra. It says We currently build behavioral health, advocate services, under a license to be For example, if they are working with social determinants of health needs,

00:40:00

John Laukkanen - HCPF: can you clarify what a growth advocate is because we list out.

Rachel Shuck - HCPF: A career coordinator and advocate resource navigator, they have a variety of different names but the advocates who are providing the resources, reservable referrals, warm handoffs, etc. And…

John Laukkanen - HCPF:

Rachel Shuck - HCPF: if anybody else has a bigger definition, please join in.

Rachel Shuck - HCPF: You're welcome Barbra.

John Laukkanen - HCPF: Things.

Barbra Corcoran: That was what I was going to say.

Barbra Corcoran: Thanks, Rachel.

John Laukkanen - HCPF: so, in our billing manual, we list out the service providers as distinct from billing providers, we have both but when you under the list of service providers and…

Barbra Corcoran:

John Laukkanen - HCPF: then in the back we have an appendix because at some level, we have to

John Laukkanen - HCPF: identify that this is For lack of a better word Cential real. Role. Right It's an actual direct care, provider and so we list those out. So you may be hiring this person as a behavioral advocate. I guess my question then Does that person fit any of the criteria? We have listed there? Are they appear? Or We now have qbhas qualified behavioral, health assistance and there's a Statutory or legislative, or regulatory definition of what that is. So, I would say in general many of our direct care workers, their services can be billed under a licensed clinician. But I will tell you that title is not one that I know of as indicated in the coding manual.

John Laukkanen - HCPF: But we have a bachelor's level provider, And what is that? So there's a definition in there for someone who has a bachelor's degree in a human Behavioral field, I think or a different bachelor's degree with one year of service and a behavioral field, right? So again, maybe they fit under that So I would say Look at the appendix that lists out all the credentials or the scope of authority for each of these titles, if it fits and if you're hiring someone else that doesn't fit under that. I mean I think we're trying to figure every way possible to expand the workforce so let's have a conversation and it may be that maybe that we can't. If it's just somebody with a height mama with no years of experience and they're working as a navigator I don't know. What we would do with that. But yeah, let me know what you think based on the descriptions we have

John Laukkanen - HCPF: Listed in the manual.

John Laukkanen - HCPF: Correct. Yeah. Yeah.

Rachel Shuck - HCPF: Okay, next question, Cameron Morton and I apologize, I just keep rolling, so we don't run out of time. The six codes are only for hiccup via Medicaid and PCP only, I'll post visits will be billed, the array and build as the pH in PI. That is correct.

John Laukkanen - HCPF: So yeah. And maybe just to unpack that for those…

Rachel Shuck - HCPF:

John Laukkanen - HCPF: who didn't understand all those acronyms, hopefully you did. so yes the six codes. Build two, hick puff fee for service via Medicaid means 10 different things. Depending on what sense you put that in, so I always like to spell that out. So via puff fee for service and the PCP bills that. Yes. And anything after those six visits is build to the raise under the Behavioral Health Providers NPI because they are the primary and billable provider to the ray. Correct.

Rachel Shuck - HCPF: And I think this is a good place for us to state John and I recently very clearly clarified that there is no limit on the assessment. and John, I don't know if you feel confident in talking a little bit more about that, but we had several people say, How many assessments can we build per person and during covid that was listed. Is that correct?

John Laukkanen - HCPF: So there's a few things at play here. If you want to get in the weeds with me or the swamp, is the case may be. we're talking about 90791 or 90792, I'm presuming that's, what's considered like us an assessment code or a lot of times people call use that as an intake code.

John Laukkanen - HCPF: CMS provides some guidance, that X about reasonableness of. How often a code is billed or is billable, there are rules called mue's medically unlikely edits. So if, for example, a code is being billed, more frequently seems reasonable based on clinical, practice, they have those limits that they potentially would say, claims are beyond appropriate utilization. so when we think about 90791 and you're seeing a member, there's nothing that says you can't bill that twice. It may take you to sometimes even three If you have a family here or you've got other complex dynamics. It may take you two or three sessions to complete a quote intake or a biopsychosocial, And so each of those three encounters, you could, bill a 90791, because you are continuing a biopsychosocial.

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John Laukkanen - HCPF: That's different than saying, can't we did an assessment in January Now they're coming back and we just need to do Another assessment to see, is that still right? when you talk about that, CMS is guidance, That's says that it's roughly once every six months is a reasonable time to do a new intake or a new assessment. But again, Depending on what you're talking about when you're saying assessment, are you talking about just how often can I build 90791? Right? Or how often can I do a new assessment? That's a different question. And so there's different rules that apply for that. But yes, the initial answer. I gave Rachel, I think there's no limit. For how often you build that 90791, as you're trying to engage a family, create the biopsychosocial or do an intake. However, let me also say to you, that is not an expectation in a primary care setting. We understand that in many ways.

John Laukkanen - HCPF: You don't have an hour to do a full-on, biopsychosocial ing with stomach, ache members presenting with suicidal ideation. You might have 15 minutes. You might be able to look at a medical chart, see that this is been a recurring coming back headaches, or suicidal thoughts or screen positive on a suicidal screen, three, four times. You're gonna be addressing suicidal ideation, You're not going to be doing a full, cycle social there. And so yes, you could bill for three sessions 90791, but I would go back to clinically is Probably not appropriate in a primary care setting, where you might move on to crisis stabilization interventions and then referral for longer term support or again, depending on where you're at. You might start to lay out, a safety plan or some of those other things. So, again, in integrated care, I would really encourage you to kind of be shifting your mindset.

John Laukkanen - HCPF: not in that traditional therapeutic approach, but in this brief intervention, diagnostic clarification in partnership with the medical provider. some of those approaches that are really more expedited and are appropriate and efficient in that space.

John Laukkanen - HCPF: Any questions about that?

Rachel Shuck - HCPF: Then there's Renee's, last question. If you see that in regards to the sixth visits checking he crack,

John Laukkanen - HCPF: and if there's a Ray representative on the call, I'd happy to phone a friend here. I believe this is visible in The provider portal. But I'm not sure again, this is now outside of my space. Renee, please.

John Laukkanen - HCPF: Were you gonna help me answer, you have a different question.

John Laukkanen - HCPF: Okay, Wendy is saying it's visible in the Colorado portal.

Wendy Flottmeyer: Okay. renee,…

renee martinez-epperson: Etiquette portal.

John Laukkanen - HCPF:

Wendy Flottmeyer: It's an extra click, Renee, I don't have it up in front of me at the moment but there's an extra BH. Benefit kind of plus down there at the bottom and then it'll say one of six use.

renee martinez-epperson: Does it have to be built first in from anybody before it shows? Okay.

Wendy Flottmeyer: Yes.

John Laukkanen - HCPF: Yeah.

John Laukkanen - HCPF: No bill or claim has come through for it, correct?

John Laukkanen - HCPF: And Cameron you are correct. It is across all providers. So for example, where this might

John Laukkanen - HCPF: And obvious example to me is gynecology. So you might have a new mom coming in for a baby. You might have a positive depression screen. BH provider goes in bills, and 90832 as an intervention, but then she has a follow up with her OBGYN and that OBGYN does a depression screen sees, she's elevated and then does an intervention as well. So potentially you could have two providers using those six visits for that member. in that scenario, the exception is a lot of times Pcmps bill under the baby and the Obgyn would Bill and her mom. So you potentially wouldn't even see that. But if you are one of those sites that builds under Mom, because she's an established patient with you. Also your family practice and you go under baby and mom and your billing mom for that behavioral encounter then that's where you might see.

00:50:00

John Laukkanen - HCPF: Three visits already claim, but you only provided one. So yes, you are correct. Cameron to highlight that it is across all providers.

John Laukkanen - HCPF: And the other questions.

Rachel Shuck - HCPF: We sure blaze through, we've got about four minutes left. Is there any other questions? For John big one. Here we go. From Sarah John.

John Laukkanen - HCPF: All right, let me read that. Many clinics only become worse.

John Laukkanen - HCPF: Fair point Sarah,…

Rachel Shuck - HCPF:

John Laukkanen - HCPF: and this is where though, as we think about integrated care and behavioral health We are trying to. Expand behavioral health services in primary care settings. Obviously, for all the ideal and noble reasons, we all understand, right? It's best to approach this member in a context and setting where they have a trust relationship where we reduce stigma, all of these things, But It also means that for providers who are going to step into this place, you need to have full awareness of the kind of the universe.

John Laukkanen - HCPF: This is another reason though, why we are trying to change a lot of this. So, one of the proposals and again, this is a part of what we're doing with 1302 is to remove that six limit, visit that if a services provided in a primary care setting, it will just be paid for in a primary assistance care setting and you don't have to count numbers. You don't have to, do that math stuff that I don't like. So again, your point is well taken. And again this benefit was not really intended to be an integrated care benefit and it has a lot of, again,

John Laukkanen - HCPF: Challenges to it. And that's why I am hoping we will move through this to our new proposal. That is really intended to be an integrated care benefit and do away with that. That's six visit. But I will say that's not going to change. The fact that Colorado has a health managed care system and that the majority of our behavioral services are under the responsibility of our regional accountable entities and so as medical providers and as clinics, it's really critical. Because again, if you are members out, clearly, you can't manage all situations. You're not going to be dealing with psychosis. I hope you're not in your Severe suicidality, obviously you would do crisis management and then obviously b refer potentially the long term residential care, hospitalization etc, right? And so at some level, even though you're in the primary care space, you still have to be aware of all the other systems and even how we pay for those higher acuity services. And so, wherever we can work or Rachel and her

John Laukkanen - HCPF: Can work to make primary care providers aware of that larger ecosystem. we can give a training, let's do it because that will always remain and…

Rachel Shuck - HCPF: Yeah.

John Laukkanen - HCPF: how we interact and set up referral processes. and do all of that is still going to be a critical part of integrated care. When will the glitch be fixed? my goodness, I want it yesterday. as I mentioned before, you may have come on late and I love. How did you get just e as your name?

Rachel Shuck - HCPF: I wonder that too.

John Laukkanen - HCPF: That's amazing. Yeah, I'm thinking e Cummings, it's even a lowercase. He not capital e on ee comings. I always admired that often. Although documentation for what the fix needs to be is submitted, I am waiting to get ETA and I said, I will share with Rachel soon as I get that as to when it's gonna be fixed and when it does get fixed, in case, you didn't hear this, all of the claims that were denied will be reprocessed. So you'll be paid out. If you had a denied claim that falls under the right print, the parameters of this benefit

Rachel Shuck - HCPF: I'll try.

John Laukkanen - HCPF: Yeah, any training for behavioral health?

Rachel Shuck - HCPF: I know it and John. I will tell you. I'm also getting a slew of emails of people saying, We may need more assistance.

John Laukkanen - HCPF: Yeah, we could do it again next month or in two weeks or whatever. If you want me to come back and we can then dig in, I will say,…

Rachel Shuck - HCPF:

John Laukkanen - HCPF: I will say as a first answer to this question, the coding manual the first 30 pages, it lays out the Colorado State Behavioral Health system. if you're an insomniac and you need something to put you sleep, bring that to your best side or if you, have a long, waiting room appointment, it's coming up sitting at a train trying to get home for 45 minutes like I do every once in a while. Read those first 30 pages, it really lays out how the BHA fits with Colorado, our mental health, practice act, all those things that I was sharing with you, we try to put all that content in the coding manual so that you can understand the behavioral ecosystem. That's a start.

00:55:00

Rachel Shuck - HCPF: And so Amanda, we've not been able to get any BH claims paid by our array, please invite them to the next meeting to provide guidance

John Laukkanen - HCPF: so, let me say this, if you have not gotten paid by array, I would not wait…

Rachel Shuck - HCPF: Isn't that a whole other email?

John Laukkanen - HCPF: because we have a provider complaint form and if you've tried and they're not responsive, they're not responding in a timely way. Please fill out a provider complaint form, and it's in my signature line, Rachel on any of my emails. I just can't find it right now, but I'll give it to you and we can send it out as well, submit that form and that just allows hiccup to monitor that issue, and then we can reach out to the race. Hey, here's Thank you Evelyn, please appreciate it. So that you're not waiting weeks on end, that should not, Be appropriate for you to hear nothing or get no response. About this provider complaint form. Let us know, kind of the situation and your efforts to try to get that resolved. and we can step in Yep.

Rachel Shuck - HCPF: Yeah That's a problem. So we'll make sure Evelyn is going to work on getting the provider complaint for them. and we'll make sure we get that information out to everybody. thank you Evelyn. So we'll stay on here especially an extra moments. Everybody can click on that, thank you Evelyn. please feel that out, because I do know that Kristen and the rest of the team do take those complaints seriously and they do monitor them,

Rachel Shuck - HCPF: And I'm gonna have to defer to John to ask. Do we think that our race would attend a meeting like this? I don't need to be longer than an hour.

John Laukkanen - HCPF: I'm sure they could or would I think the issue is defining what a helpful scope would be. Because again, for example, if it's regarding

John Laukkanen - HCPF: if we want to start digging into practice modealities, that's not necessarily where they would lead it. Is it a covered benefit or not like that would fall to me or state staff to answer those questions for the most part. But if you have race specific questions and then I think the other pieces,

when we start about, we are in a pilot right now and so the raise have limited ability to navigate pilot type work versus the long term work existing covered benefits. So again, if we have a defined scope that it would be meaningful happy to have them, I think the other challenges to just be direct, we don't really want to bring the raise in just to start calling them out and Ccha won't do this and Rocky won't do that but Colorado access does this and that getting a kind of a sibling rivalry or whatever there that just Kellie doesn't help. In that sense.

Rachel Shuck - HCPF:

Rachel Shuck - HCPF: thank you Sherrie stated so What I'll do is I'll work with John possibly next month.

John Laukkanen - HCPF: Thank you, Sherrie.

Rachel Shuck - HCPF: That might be two. Just so we are sure, we have enough time. we'll work with our practice. Facilitators will work with John and schedule an additional time for this. but when in doubt,...

John Laukkanen - HCPF: E's use the emails.

Rachel Shuck - HCPF: guys, Yeah.

John Laukkanen - HCPF: Yeah, please use the emails in the middle, in between time if it's a billing or coding issue, if it's a ray concern you can use the complaint form. Use it often, again we really do want to understand where there are Delays barriers from a provider perspective. So that's what that form is then I'll see Rachel's emails. And go from there and...

Rachel Shuck - HCPF: and remember,

John Laukkanen - HCPF: then to those of you who ask for meeting just the coding email that I sent and we'll try to get a meeting set up.

Rachel Shuck - HCPF: and just remember guys that when you email that hip team, for whatever reason it, we try to be exceptionally responsive. We will also say, This is something we can't answer and that's when I send it to John, that is when I reach out and say I need additional help and then we link him in and we get it going. So sometimes it may take it a few more days but we will get your responses quickly as possible.

Rachel Shuck - HCPF: Thank you Evelyn for John's email address. Will remain on here for just another minute or two so we can close it out. And again we'll get this up and posted on our website but if there's something we weren't able to address today again send it out an email to us and we really appreciate all the interaction today. We hope it helped.

01:00:00

Rachel Shuck - HCPF: Thank you, everyone.

Rachel Shuck - HCPF: Thank you, John.

John Laukkanen - HCPF: Take care.

Barbra Corcoran: Thank you.

Rachel Shuck - HCPF: thank you Evelyn, I think you can Go ahead and close down the recording at this time.

Rachel Shuck - HCPF: Awesome. Have

Meeting ended after 01:00:32 👋