SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

March 2025

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Updates

Clarification from February's Newsletter

In the FAQ, it was noted that a session with the client to review items from the CalOMS or Health Questionnaire can be billable when the purpose is for gathering information pertinent to the ASAM assessment or for determining a diagnosis. This would be considered an assessment service, not care coordination. As a reminder,

continued on page 2…

WHAT'S NEW?

Timely Access

Towards the end of 2024, it was announced that the timely access requirements under the Federal Final Rule applies not just to the initial appointment, but to every appointment. The change does not apply to the residential or withdrawal management levels of care. Previously, for the Outpatient levels of care, this meant that an intake appointment was required to be offered to a client within ten (10) days of the client's request for services. Now, the same timeframe applies to all subsequent non-urgent appointments with a non-LPHA or non-medical LPHA. The timeframe is within fifteen (15) days for MD appointments. This does not mean that clients must be seen at this frequency. Clients may be seen at the frequency that is most clinically appropriate based on their treatment needs and generally accepted standards of care. To make sure that we comply with this requirement, we need to document for those clients who do not need to be seen at these

continued on page 2…

Training & Resources Access

DMC-ODS Payment Reform 2024 - CPT Guide (version 2):

DMC-ODS Payment Reform 2024 CPT Guide v2.pdf (ochealthinfo.com)

Updated SUD Documentation Manual

DMC-ODS_CalAIM_Doc_Manual.pdf

Updated MAT Documentation Manual

FINAL_CalAIM_MAT_Documentation_Manual_v3_11.6.24.pdf

NOTICE: In lieu of a standalone SUD Documentation Training, please refer to the most recent Documentation Manual, CPT Guide, and the monthly newsletters for the most recent changes! If you are unsure about the current guidance, please reach out to BHPSUDSupport@ochca.com

Updates (continued)

…continued from page 1

an assessment service is not separately billable at the residential and withdrawal management levels of care. Assessment is considered part of the daily bundle of services to be provided.

Multiple encounters of the same service type by the same provider for the same client on the same day

Such encounters must be submitted as one claim in the billing system. What does this mean for the documentation?

For County providers: one progress note is required to capture all encounters.

For Contracted providers: option to complete one progress note with all encounters OR complete a progress note for each separate encounter. Remember that the information entered in the billing system must match what is documented. If choosing to complete multiple progress notes, it may be necessary to develop an internal procedure to ensure that your program's billing specialist can easily know to combine the time for data entry into the billing system so information is consistent.

WHAT'S NEW? (continued)

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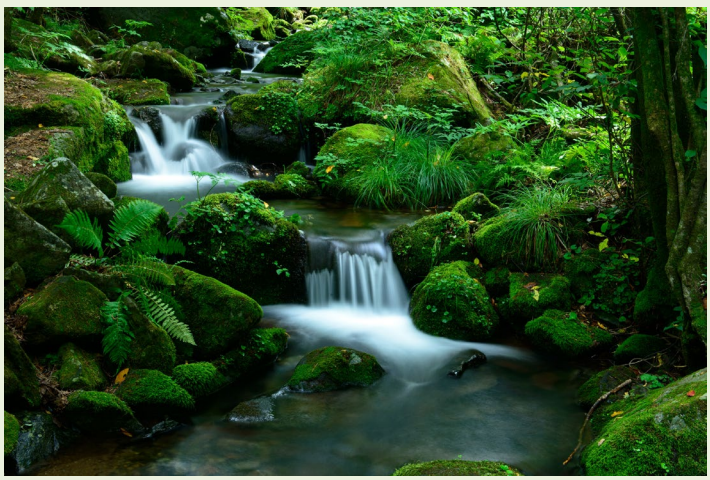
frequencies. A few examples of where this can be documented:

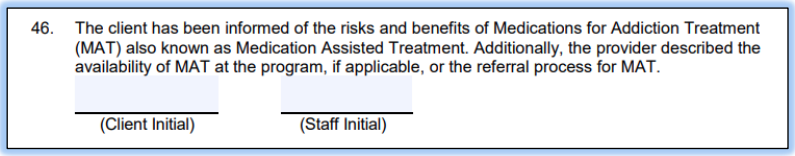
- Case formulation or narrative write-up by the LPHA where treatment recommendations are made;
- Treatment plan or problem list (e.g., if there is a section where the frequency of services to be provided can be indicated);
- Plan section of the progress notes (e.g., explaining the clinical appropriateness of the next scheduled appointment being 30 days from date of service).

For the NTPs, an appointment must be offered within three (3) days of request for the initial appointment.



Documentation FAQ

1. Is completing this section on the Health Questionnaire sufficient documentation of a MAT referral?



46. The client has been informed of the risks and benefits of Medications for Addiction Treatment (MAT) also known as Medication Assisted Treatment. Additionally, the provider described the availability of MAT at the program, if applicable, or the referral process for MAT.

(Client Initial) (Staff Initial)

No. This question only addresses whether the provider has educated the client on the risks and benefits of MAT and the referral process. There needs to be separate documentation about the evidence-based MAT assessment that is administered (in accordance with your program's Policies and Procedures) and what the outcome was (i.e., whether linkage to a MAT provider is warranted and how this will be done). It is also advised to file the actual assessment documents used to corroborate the documentation.

2. Can the LPHA at Residential programs bill for developing the case formulation or narrative write-up?

No. The LPHA's conceptualization of the required narrative to document the client's appropriateness for the level of care placement determination is considered an assessment activity. Therefore, at the residential levels of care, it is considered part of the daily bundle of services. There is no separate billing permitted on top of the treatment day.

3. Is letter writing a billable activity?

Most letter writing is non-billable. Typically, letters in the SUD treatment programs are provided to outside agencies/entities as documentation of the client's status (e.g., date of admission, types of services being offered, number or frequency of services, and attendance), which does not require a clinical provider to compile. If it is necessary to include clinical information specific

Continued on page 3…

Documentation FAQ (continued)

…continued from page 2

to the client that requires an individual with credentials/license/registration to furnish, the letter writing could be a billable service. However, this must be clear in the documentation to justify the billing. Be sure to also indicate in the documentation what the purpose of this letter is and how it supports the client's SUD treatment. The Targeted Case Management (70899-120) T1017 code can be used if letter writing without the client present is medically necessary. It is advised that the letter writing be a collaborative process with the client in a session to review the client's treatment progress, identify barriers to progress and additional needs, and reinforce skills being learned. A service with the client in this way could be billed using the SUD Treatment Plan Development/Modification (70899-125) T1007 or Individual Counseling (70899-130) H0004, depending on the focus of the session. These codes are not available for use at the residential or withdrawal management levels of care.

4. My client is stepping down from IOT to ODF. Can I use the same problem list?

The regulations do not make clear that a separate problem list is required. Therefore, if there is an active problem list on file for the client's current episode of care, the requirement is fulfilled. As part of demonstrating that the problem list is current and appropriate for the new level of care, be sure it is reviewed with the client. The progress note for the session should indicate if existing problem list items have been confirmed for their relevance and that additional areas of need were discussed. This service can be claimed using the SUD Treatment Plan Development/Modification (70899-125) T1007 code.

Telehealth Consent

Most programs have a telehealth/telephone consent form that is reviewed as part of a client's intake process at the time of admission. The State does not make explicit how such a document needs to look, but there are some specific items that are required to be included. Please ensure that if your program utilizes a consent form for telehealth/telephone services, it includes the following:

1. The client's right to access covered services through an in-person, face-to-face visit;
2. Use of telehealth and telephone is voluntary, and consent may be withdrawn at any time without it affecting the client's ability to access covered Medi-Cal services in the future;
3. Availability of transportation services through Medi-Cal to in-person visits when other available resources have been reasonably exhausted;
4. Potential limitations or risks related to receiving services through telehealth and telephone as compared to an in-person visit.

Providers who do not utilize a formal document and instead obtain verbal consent prior to starting telehealth/telephone services, must document in the progress note that the above information was explained, and that the client's written or verbal acknowledgement was received.

Scope of Practice

Remember that non-LPHAs cannot diagnose under the DMC-ODS and are limited to establishing the Z55-Z65 codes. This also means that non-LPHAs cannot provide a "provisional" or preliminary SUD diagnosis. The Z55-Z65 codes can be used for billing and on the problem list until a consultation is conducted with a qualified LPHA who can diagnose the client with an SUD diagnosis.

AOB/ATD

Don't forget that the Client Identification Number (CIN) is a required component of the form. If the CIN is unknown at the time the client completes the form, make sure it is obtained and entered as soon as possible so that services can be billed!

Less than 8 minutes

Make sure that services that do not reach 8 minutes in duration are coded as non-billable for those services that are claimed in 15-minute increments. This includes Targeted Case Management (70899-120) T1017. If you provide multiple care coordination services on the same day for the same client, the service time can be combined and billed if it totals 8 minutes or more. See the "Updates" section on page 2 for ways to document the progress note.

Are there questions or topics that you'd like to see addressed in the monthly SUD Newsletter? Feel free to reach out to your assigned consultant or let us know at BHPSUDSupport@ochca.com.

MANAGED CARE SUPPORT TEAM

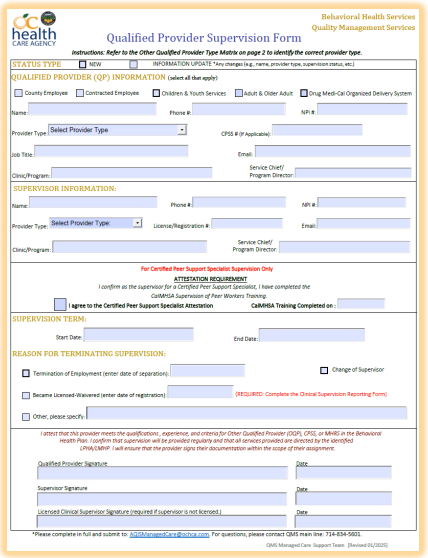
MCST OVERSIGHT

- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- CAL-OPTIMA CREDENTIALING (AOA COUNTY CLINICS)
- SUPERVISION REPORTING FORMS & REQUIREMENTS
- GRIEVANCES & INVESTIGATIONS
- COUNTY CREDENTIALING
- ACCESS LOGS
- MHP & DMC-ODS PROVIDER DIRECTORY
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)

REMINDERS, ANNOUNCEMENTS & UPDATES

QUALIFIED PROVIDER SUPERVISION FORM (QPSF) – EFFECTIVE 3/1/25

- Department of Health Care Services (DHCS) has identified more providers who can serve and bill for Medi-Cal covered services. The "Qualified Provider" types include additional qualifications to provide an opportunity for professional growth and to allow for more providers who can serve the SMHS and DMC-ODS population to be hired in the Behavioral Health Plan (BHP). With the additional types of providers, it also requires a supervisor who can provide direct or functional supervision of the services.
- The "Qualified Provider" types must attest that they are under supervision and submit the form to the MCST to track and monitor. The provider's education and work experiences is what will determine which type of provider the person falls under:
  - ✓ Mental Health Rehabilitation Specialist
  - ✓ Other Qualified Provider II
  - ✓ Other Qualified Provider I
  - ✓ Certified Peer Support Specialist
- If you have questions about determining which provider type best fits your program needs, contact AOA or CYS Support Team via the e-mail below:
  AOA – BHPAOASupport@ochca.com
  CYS – BHPCYSSupport@ochca.com
- The QPSF and County Memo is available and accessible online at:
  MHP: Behavioral Health Plan and Provider Information | Orange County California - Health Care Agency
  DMC-ODS: DMC-ODS For Providers | Orange County California - Health Care Agency :
- Be sure to submit the QPSF form for all your applicable providers to the MCST by **3/31/25**.


Qualified Provider Supervision Form

Behavioral Health Services
Quality Management Services

Instructions: Refer to the Other Qualified Provider Type Matrix on page 2 to identify the correct provider type.

STATUS TYPE: NEW / INFORMATION UPDATE *Any changes (e.g., name, provider type, supervision status, etc.)

QUALIFIED PROVIDER (QP) INFORMATION (select all that apply)

County Employee / Contracted Employee / Children & Youth Services / Adult & Older Adult / Drug Medi-Cal Organized Delivery System

Name: Phone #: NPI #:
Provider Type: Select Provider Type CPSS # (If Applicable):
Job Title: Email:
Clinic/Program: Service Chief/ Program Director:

SUPERVISOR INFORMATION:

Name: Phone #: NPI #:
Provider Type: Select Provider Type License/Registration #: Email:
Clinic/Program: Service Chief/ Program Director:

For Certified Peer Support Specialist Supervision Only
ATTESTATION REQUIREMENT
I confirm as the supervisor for a Certified Peer Support Specialist, I have completed the CalMHSA Supervision of Peer Workers Training.
I agree to the Certified Peer Support Specialist Attestation CalMHSA Training Completed on :

SUPERVISION TERM:
Start Date: End Date:

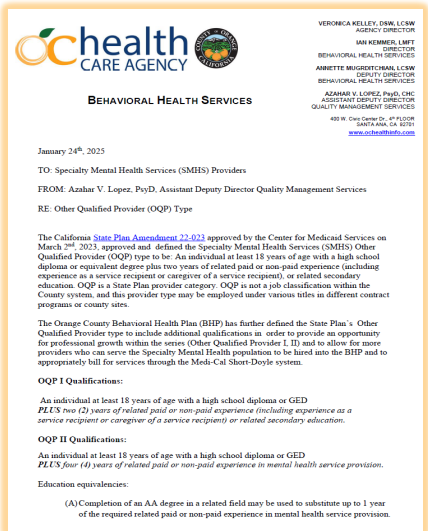
REASON FOR TERMINATING SUPERVISION:
Termination of Employment (enter date of separation): Change of Supervisor
Became Licensed-Waivered (enter date of registration): (REQUIRED: Complete the Clinical Supervision Reporting Form)
Other, please specify:

I attest that this provider meets the qualifications, experience, and criteria for Other Qualified Provider (OQP), CPSS, or MHRS in the Behavioral Health Plan. I confirm that supervision will be provided regularly and that all services provided are directed by the identified LPHA/LMHP. I will ensure that the provider signs their documentation within the scope of their assignment.

Qualified Provider Signature Date
Supervisor Signature Date
Licensed Clinical Supervisor Signature (required if supervisor is not licensed.) Date

*Please complete in full and submit to: AOBMonagedCare@ochca.com For questions, please contact QMS main line: 714-834-5601.

QMS Managed Care Support Team [Revised 01/2025]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January 24th, 2025

TO: Specialty Mental Health Services (SMHS) Providers

FROM: Azahar V. Lopez, PsyD, Assistant Deputy Director Quality Management Services

RE: Other Qualified Provider (OQP) Type

The California State Plan Amendment 22-023 approved by the Center for Medicaid Services on March 2nd, 2023, approved and defined the Specialty Mental Health Services (SMHS) Other Qualified Provider (OQP) type to be: An individual at least 18 years of age with a high school diploma or equivalent degree plus two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient), or related secondary education. OQP is a State Plan provider category. OQP is not a job classification within the County system, and this provider type may be employed under various titles in different contract programs or county sites.

The Orange County Behavioral Health Plan (BHP) has further defined the State Plan's Other Qualified Provider type to include additional qualifications in order to provide an opportunity for professional growth within the series (Other Qualified Provider I, II) and to allow for more providers who can serve the Specialty Mental Health population to be hired into the BHP and to appropriately bill for services through the Medi-Cal Short-Doyle system.

OQP I Qualifications:

An individual at least 18 years of age with a high school diploma or GED
PLUS two (2) years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient) or related secondary education.

OQP II Qualifications:

An individual at least 18 years of age with a high school diploma or GED
PLUS four (4) years of related paid or non-paid experience in mental health service provision.

Education equivalencies:

(A) Completion of an AA degree in a related field may be used to substitute up to 1 year of the required related paid or non-paid experience in mental health service provision.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORMS

There are four types of supervision reporting forms the MCST oversees. Below is a grid listing all the provider types that must submit one of the required supervision reporting forms below:

- ✓ Clinician Supervision Reporting Form
- ✓ Counselor Supervision Reporting Form
- ✓ Medical Supervision Reporting Form
- ✓ Qualified Provider Supervision Form

SUPERVISION REPORTING FORMS

LIST OF PROVIDERS REQUIRED TO SUBMIT A SUPERVISION REPORTING FORM

CLINICIANS	COUNSELORS	MEDICAL PROVIDERS	QUALIFIED PROVIDERS
• Registered ASW • Registered MFT • Registered PCC • Registered/Waivered Psychologist • Psychologist Clinical Trainee • Clinical Social Worker Clinical Trainee • Marriage & Family Therapist Clinical Trainee • Professional Counselor Clinical Trainee • Associate Applicant – BBS 90 Day Rule	• Registered Counselors	• Nurse Practitioner • Nurse Specialist Trainee • Registered Nurse Trainee • Vocational Nurse Trainee • Psychiatric Technician Trainee • Occupational Therapist Trainee • Occupational Therapist Assistant • Pharmacist Trainee • Physician Assistant Trainee • Physician Assistant • Medical Assistant • Licensed Vocational Nurse • Licensed Practical Nurse • Licensed Psychiatric Technician • Certified Nurse Assistant	• Mental Health Rehabilitation Specialist • Other Qualified Provider I • Other Qualified Provider II • Certified Peer Support Specialist

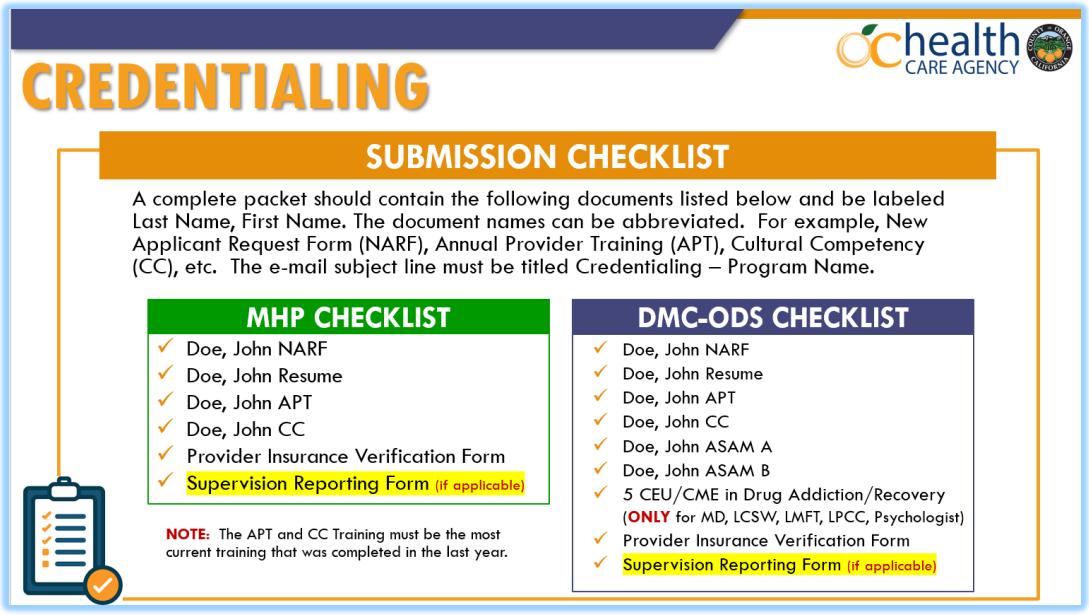
REMINDER

- All required providers must submit the supervision form to the MCST upon commencement (e.g., new hire).
- Any status change requires an updated form to be submitted to the MCST (e.g., separation, change in supervisor, etc.).
- Supervision must be provided regularly.
- Provider's that require supervision are **prohibited** from delivering any Medi-Cal covered services if they have **NOT** submitted their supervision reporting form.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

CREDENTIALING: SUPERVISION REPORTING FORM REQUIRED FOR SUBMISSION

- To prevent any potential deficiency for disallowances or recoupments, the MCST will require the submission of the **Supervision Reporting Form** for the applicable providers to be submitted with the initial credentialing packets, effective **2/1/25**.
- All **new providers** must submit their initial County credentialing packet within 5-10 business days of being hired to the MCST. The newly hired provider must **NOT** deliver any Medi-Cal covered services under their license, waiver, registration and/or certification until they obtain a letter of approval confirming they have been credentialed by the MCST. This means the new hire must **NOT** provide direct treatment or supportive services to a member on their own nor document any services, including non-billable services. The IRIS team will not activate a new provider in the IRIS system without proof of the credentialing approval letter. It is the responsibility of the direct supervisor to review and submit the new hire credentialing packet to the MCST, timely.



CAL-OPTIMA CREDENTIALING FOR AOA COUNTY CLINIC PROVIDERS ONLY

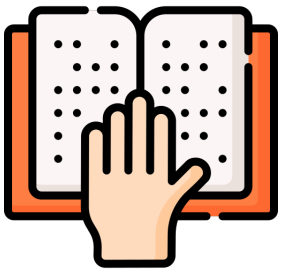
- OneCare and OneCare Connect are CalOptima's two Medicare health plans under the Certified Medicare Advantage Plans (CMAP), and the BHP has many members who have OneCare or OneCare Connect, with secondary Medi-Cal. OneCare and OneCare Connect are the only private insurances that are identified as "in network" in the BHP.
- In 2024, the legislation allowed LPCCs and LMFTs to bill Medicare directly for mental health diagnosis and treatment services. The MCST will be reaching out to the AOA county providers and Service Chiefs to begin the CalOptima credentialing process for the existing and new LMFT and LPCC providers.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

NOW AVAILABLE - RUSSIAN THRESHOLD LANGUAGE

- The DHCS has identified Orange County as meeting the population threshold language for Russian.
- Per DHCS, "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS (Medi-Cal Eligibility Data System), of 3,000 members or five percent of the member population, whichever is lower, in an identified geographic area.
- Quality Management Services (QMS) has completed translating all informing materials in Russian and it is now available and accessible online at:
  MHP: Behavioral Health Plan and Provider Information | Orange County California - Health Care Agency
  DMC-ODS: DMC-ODS For Providers | Orange County California - Health Care Agency
- The 8 threshold languages are English, Vietnamese, Spanish, Korean, Chinese (Simplified), Arabic, Farsi and Russian.

BRAILLE REQUIREMENT



The DHCS has required Orange County to provide member materials in Braille in the 8 threshold languages. The "Grievance & Appeals Poster" and "Grievance Form" are being translated by a vendor through Behavioral Health Training Services (BHTS). QMS is working diligently to have all the member materials to be translated in braille and disseminated to the programs. Stay tuned.

30 DAY RESOLUTION FOR GRIEVANCES

- DHCS is requiring grievances to be resolved within 30 calendar days instead of 90 calendar days to be aligned with the Federal requirements for the Managed Care Plan. This will go into effect **1/1/25**.
- DHCS will be issuing a revised BHIN 18-010E sometime soon.

- The MCST requires program's assistance to quickly respond to our Investigation Representative when requesting supporting evidence (e.g., chart, lab results, medication listing, etc.) and discussing the case to help conclude the grievance. Your cooperation is appreciated to help expedite information needed to resolve the member's grievance, timely.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST GENERAL E-MAIL BOXES

QMS has renamed all the general e-mail addresses and created new ones to enhance the communication and efficiency with serving our providers and members. Please begin using the e-mail addresses listed below for questions and documents to be sent to the appropriate mailboxes. The old e-mail addresses will automatically be forwarded to the new ones for a short period of time. Please update our contact information, as soon as possible.

MCST MAILBOXES	OVERSEES
BHPGrievanceNOABD@ochca.com	Grievances & Investigations; Appeals/Expedited Appeals; State Fair Hearings; NOABDs; MCST Training Requests
BHPManagedCare@ochca.com	Access Logs, Access Log Entry Errors & Corrections; Change of Provider/2nd Opinion; County Credentialing; Cal-Optima Credentialing (AOA County Clinics); Expired Licenses, Waivers, Registrations & Certifications; PAVE (MHP Only)
new BHPProviderDirectory@ochca.com	Provider Directory Notifications; Provider Directory submission for SMHS and DMC-ODS programs by the 15th of every month.
new BHPSupervisionForms@ochca.com	Submission of the Supervision Reporting Forms for Clinicians, Counselor, Medical Professionals and Qualified Providers; Submission of updated Supervision Forms for Change of Supervisor, Separation, License/Registration Change, etc.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** programs are required to schedule a full training to comply with the MCST oversight and DHCS requirements. It is recommended to have the Directors, Managers, Supervisors and Clinical Staff participate in the training to ensure those requirements are met and implemented. Contact the MCST to schedule the training at least a month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a full training about MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and the Service Chief II, Catherine Shreenan at cshreenan@ochca.com.

MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is offering open training sessions for new and existing providers. The 2-hour training is on NOABDs, Grievances, Appeals, State Fair Hearings, 2nd Opinion/Change of Provider, Supervision Reporting Forms and Access Logs.

Please e-mail BHPGrievanceNOABD@ochca.com with Subject Line: MCST Training for MHP or DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

2nd Tuesdays of the Month @ 1 p.m. MCST Training (MHP)
4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

MANAGED CARE SUPPORT TEAM

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Leads: Esmi Carroll, LCSW & Jennifer Fernandez, LCSW

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR MHP
Leads: Araceli Cueva & Elizabeth "Liz" Fraga (Staff Specialists)

CREDENTIALING AND PROVIDER DIRECTORY
Credentialing Lead: Elaine Estrada, LCSW & Ashley Cortez, LCSW
Cal Optima Credentialing Lead: Araceli Cueva & Elizabeth "Liz" Fraga
Provider Directory Leads: Esther Chung & Joanne Pham (Office Specialists)

COMPLIANCE INVESTIGATIONS
Lead: Catherine Shreenan, LMFT & Annette Tran, LCSW

CONTACT INFORMATION

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(714) 834-5601 FAX: (714) 480-0775

E-MAIL ADDRESSES

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BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com

MCST ADMINISTRATORS

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Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II