OC health CARE AGENCY

2025

Behavioral Health Plan Provider Manual




OC Health Care Agency
Behavioral Health Services
Quality Management Services

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GENERAL INFORMATION FOR PROVIDERS

PURPOSE OF THE PROVIDER MANUAL

The purpose of this manual is to inform providers of their obligations under the Orange County Behavioral Health Plan, and to provide essential information for understanding the operations, policies, standards and guidance offered by the Health Care Agency (HCA), Behavioral Health Services (BHS).

MANAGED CARE ORGANIZATION (MCO)

Orange County (OC) is a Prepaid Inpatient Health Plan (PIHP), a type of Managed Care Organization (MCO) which is organized to manage cost, utilization, and quality of care. By contracting with various MCOs, states can reduce their federal health care costs and better manage the utilization of Medi-Cal services.

As a managed care organization, OC HCA is required to have certain elements in place. These include but may not be limited to a network of providers, a credentialing system, member services and 24/7 Access Line, authorization processes, access standards, Notices of Adverse Benefits Determination (or NOABD) process, grievance and appeals process, utilization review process, a process to ensure all appropriate policies and procedures are in place, client informing materials, culturally accessible services, and access for persons with disabilities.

WHAT IS THE BEHAVIORAL HEALTH PLAN?

The Behavioral Health Plan (BHP) refers to the managed care or fee for service delivery system operated by the Health Care Agency, Behavioral Health Services, that provides Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) services to Medi-Cal eligible individuals in Orange County.

NO WRONG DOOR POLICY

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to address clients' needs across the continuum of care. It seeks to ensure that all clients receive coordinated services and improve their health outcomes. The No Wrong Door policy for Behavioral Health Services, which became effective on July 1, 2022, ensures that Medi-Cal clients receive timely mental health and substance abuse services without delay, regardless of the delivery system where they seek care, and

that clients are able to maintain treatment relationships with trusted providers without interruption.

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS (SUD)

When a Behavioral Health Plan (BHP) provider renders clinically appropriate Specialty Mental Health Services, these services are covered by Medi-Cal, regardless of whether or not the client has a co-occurring SUD. The BHP will allow reimbursement for Specialty Mental Health Services provided to a client who meets Specialty Mental Health Services criteria regardless of whether the client has a co-occurring substance use problem. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC-ODS providers in the Drug Medi-Cal Organized Delivery System (DMC-ODS) are covered, regardless of whether the client has a co-occurring mental health condition. Clinically appropriate and Non-Specialty Mental Health Services are covered Medi-Cal services via the Fee-For-Service and Managed Care Plan (MCP) delivery systems, regardless of whether the client has a co-occurring SUD. Additionally, clinically appropriate SUD services such as alcohol and drug screening, assessment, brief interventions, and referral to Medication Assisted Treatment (MAT) delivered by MCP providers are covered by MCPs, regardless of whether the member has a co-occurring mental health condition.

CONCURRENT NON-SMHS AND SMHS

Under certain circumstances, clients may concurrently receive Non-SMHS via a Fee-For-Service (FFS) or MCP provider and SMHS via an BHP provider when the services are clinically appropriate, coordinated, and not duplicative. When a client meets the criteria for both Non-SMHS and SMHS, services should be rendered based on individual clinical needs and established therapeutic relationships. Clients with established relationships with an FFS or MCP provider may continue receiving Non-SMHS from the provider, even if simultaneously receiving SMHS from an BHP provider, and vice versa, as long as the services are coordinated and non-duplicative. Please ensure that you discuss these circumstances with your supervisor to ensure close coordination takes place to avoid duplication of services and billing.

GENERAL INFORMATION FOR PROVIDERS

REQUIRED FORMS GIVEN TO CLIENTS

Programs are required by the State and the County to provide clients enrolling in services with specific additional information. Providers should be familiar with the material so that they can assist clients with the information as appropriate and if requested.

- **Voter Registration Form** is to increase voter registration. The client must attest to the accuracy of the information with their signature. Providers are required to sign if they helped the client complete the form and are not permitted to screen for voter eligibility in any way.

- **Notice of Privacy Practices** is to inform the client about use, access, and disclosure of PHI, the complaint process, and other privacy rights.
- **Car Seat Safety Law** is to inform clients about the benefits and use of child safety seats.
- **Advance Directive Information Sheet** is to inform the client of the importance of having an Advance Directive in the event the client becomes incapacitated.
- **Behavioral Health Plan Member Handbooks** are to inform clients about available Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services, respectively, and how to access them.
- **SMHS & DMC-ODS Provider Directory** is to inform clients about the SMHS and DMC-ODS provider networks. This includes county-operated and contracted organizational providers, provider groups, and individual practitioners.
- **SMHS/DMC-ODS Advisement Checklist** is to document that the previously mentioned informing materials were reviewed with the client.
- **Trafficking Victims Protection Act (TVPA)** information is to inform clients about protections afforded to victims of trafficking and violence. *This form is applicable for SUD programs only.*

Mandated Reporting of Abuse

Under California law, mandated reporters are required to report known or suspected cases of elder, dependent adult, and child abuse. Failure to report can lead to fines and imprisonment. Reporting is an individual responsibility, and supervisors cannot legally prevent clinicians from reporting. Similarly, mandated reporters cannot delegate this authority to others. However, 42 CFR Part 2 introduces additional barriers to meeting this mandate. Consult with your Supervisor or the Office of Compliance for further guidance. It's important to remember that any mandated reporting should never disclose the identity of individuals receiving SUD services.

Adult abuse can take various forms, including physical, sexual, neglect, financial exploitation, abandonment, isolation, abduction, and other treatments that result in physical or emotional harm. It may also involve depriving one of goods or services necessary to avoid physical harm or mental suffering. When encountering abuse, it is important to report immediately by phone as soon as possible and write a report within two (2) days of the telephone report. For victims in long-term care facilities, reports must be filed with as many as four different agencies/entities, depending on the situation.

Child abuse is legally defined as a non-accidental physical injury inflicted upon a child by another person, sexual abuse, willful cruelty or unjustifiable punishment of a child, cruel or inhuman corporal punishment, and neglect.

When encountering abuse, it is important to report immediately by phone as soon as possible and write a report within 36 hours of the telephone report.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996

HIPAA helps to protect from fraud, identity theft, and violation of privacy and ensure protection of Protected Health Information (PHI) by instituting three major rules:

- **Privacy Rule**: HIPAA defines the circumstances under which a person may disclose or use PHI
- **Security Rule**: The HIPAA Security Rule sets out the minimum standards for protecting electronic health information (ePHI). To access that information in electronic format, even those who are technically capable of doing so would have to meet those standards
- **HIPAA Breach Notification Standards**: Provides standards for notification of breach of PHI

HIPAA allows disclosures of PHI *with* written authorization from members or as specifically permitted or required. When disclosing PHI, program staff should only disclose the *minimum necessary* to meet the intent of the disclosure. A client's authorization is not required if there is a bona fide medical emergency, a subpoena with a court order, a crime at a program or a crime against a program staff, documentation with no client identifying information, and for research/review and evaluation. Client authorization is not required for mandated reporting but subsequent disclosures to Social Services Agency or other "investigations" are prohibited.

Tracking PHI Disclosures

Certain disclosures of PHI must be documented in the Disclosure Tracking Log form, as outlined in the policy and procedure (Accounting for Disclosures of PHI P&P). Examples include legally mandated disclosures, such as a Child or Elder Abuse Report. Under HIPAA, if a client requests an accounting of disclosures, these mandated reports must be included in the response to the client. Failure to properly record disclosures prevents accurate reporting and can constitute a HIPAA violation.

Each client's record must include a Disclosure Tracking Log form, even if blank. A blank form confirms no disclosures were made. A missing form can create uncertainty about whether disclosures occurred or were simply not recorded. Providers should seek guidance from a supervisor if clarification is needed.

Revoking an Authorization to Use or Disclose Protected Health Information (ATD) Form

Clients have the right to revoke their ATD form *at any time*, preventing any further disclosure of their PHI. Once a client revokes authorization, program staff must act promptly to ensure compliance and maintain the confidentiality of client records.

To revoke an ATD form, the client must submit a written request using the Revocation of Authorization to Use or Disclose PHI form. Program staff must then take the necessary steps to document the revocation, including drawing a line through the original ATD form, writing "REVOKED" along with the date of revocation, and signing and dating the revision. Additionally, program staff should document this action in a progress note.

For County staff, the revoked authorization must also be submitted to the HCA Custodian of Records (COR) for processing. By ensuring that revocation requests are promptly and properly handled, staff can maintain compliance with HIPAA and 42 CFR Part 2 (if applicable) while upholding the privacy rights of clients.

For County staff, please refer to HCA Custodian of Records for further information. Also, County providers can refer to the ATD Revocation Guide in the BHS Health Information Management section on the BHS SUD EHR website.

COMPLIANCE REQUIREMENTS AND REPORTING PRIVACY BREACHES

The Office of Compliance (OOC)

The Health Care Agency Compliance Program is responsible for ensuring organizational compliance with federal and state regulatory requirements. The compliance program establishes standards of compliance and ethical conduct for HCA staff, provides ongoing support and education, and offers a mechanism by which to report suspected violations. The Office of Compliance (OOC) also works to prevent, detect, and correct potential violations of law and policy. Additionally, the Office of Compliance is responsible for the daily management of HIPAA privacy incidents, risk assessments, breach analysis of unsecured Protected Health Information (PHI), and government reporting. The implementation and effective operation of the HCA Compliance Program ensures that the program adheres to the elements of an effective compliance program established by the Office of Inspector General's (OIG) Federal Sentencing Guidelines. For providers who have not opted into the County's Compliance Program, please consult with your agency's compliance officer.

To report concerns or inquire about compliance matters, contact the OOC at OfficeOfCompliance@ochca.com or call 714-568-5614.

Annual Compliance Training

Each year, the OOC releases a mandatory Annual Compliance Training for all HCA employees and designated individuals. The training covers relevant updates to laws, rules, regulations, HCA's Code of Conduct, policies and procedures, and HIPAA Privacy and Security regulations. New employees must complete the training within 30 days of their start date, while existing providers and designated individuals must complete the training annually within 60 days of its release.

For information on the Annual Compliance Training, please refer to Orange County's HCA Annual Compliance Training.

Compliance Requirements

All programs must have the following compliance policies and procedures in place:

- A Compliance Program that outlines adherence to regulations
- Sanction Screening to ensure that employees and contractors meet legal standards
- Compliance training to educate staff on requirements
- Medical Billing, Coding and Documentation standards
- Compliance Reviews to assess adherence to regulations
- Business Associate Agreements that define how PHI is created, maintained, stored and transmitted

Legal Sanctions for Fraud, Waste and Abuse

HCA is legally and contractually obligated to provide services under the DMC-ODS. Similarly to DMC-ODS's initial approval by Centers for Medicare and Medicaid Services (CMS) via a 1115 waiver, CalAIM is considered a demonstration program within the Medi-Cal system to enhance member care. Approved by CMS in December of 2021 with an effective date of January 1, 2022, to December 31, 2026, the CalAIM waiver was originally approved under the authority of section 1115(a) of the Social Security Act and eventually transitioned into the 1915(a) waiver authority. CalAIM is now establishes the Special Terms and Conditions (STCs) that are the foundation of our system of care. The full text of the CalAIM 1115 and 1915(b) waivers is available via the designated link CalAIM 1115 and 1915(b) Waiver Renewals.

Orange County's HCA BH Integrated Intergovernmental Agreement (IA) between HCA and California Department of Health Care Services (DHCS) grants the State ongoing oversight and monitoring authority over HCA's DMC-ODS operations. This oversight includes verifying fiscal operations, reviewing books and records, conducting annual assessments of service utilization, reviewing billing patterns, and analyzing enrollment shifts to detect potential fraud, waste, or abuse. Similarly, the California Welfare and Institutions Code (WIC) authorizes the State to conduct investigations and review claims for reimbursement and take action – including terminating contracts – for breaches in meeting legal and contractual obligations related to service provision and billing. Adherence to these

rules and regulations is critical to avoid both intentional and inadvertent instances of fraud, waste, or abuse.

Training and Resources to Prevent Fraud, Waste and Abuse

HCA takes the prevention of fraud, waste and abuse seriously. The Office of Compliance (OOC) oversees investigations into any suspected or actual violations of any local, federal, or State laws, billing regulations, the HCA Code of Conduct, and confidentiality policies.

To ensure compliance, the Quality Management Services (QMS) SUD Clinical Records Team provides comprehensive DMC-ODS trainings, some which are listed on the DMC-ODS For Providers webpage.

For a list of trainings to support compliant services, please see the "Required Training" section of this Provider Manual.

PHI SECURITY MEASURES

When working remotely or in the field, maintaining the security and confidentiality of Protected Health Information (PHI) and Personally Identifiable Information (PII) is critical. To minimize the risk of data breaches, staff should carry only the necessary PHI and PII and ensure that all sensitive information is stored securely in a locked device or compartment. If a provider will not be returning to the office at the end of the day, they should bring all materials inside their home and store the materials in a secure location, out of sight and inaccessible to others. PHI or PII must never be left unattended in a vehicle, even if the vehicle is locked or the PHI or PII is hidden. PHI or PII records should not remain at home for more than one night, and upon returning to the office, any field notes containing sensitive information must be promptly shredded after documentation is completed. These practices help ensure the confidentiality and security of sensitive information.

MEDICARE GUIDANCE

BHS documentation and billing for Medi-Cal clients significantly changed following the implementation of CalAIM. Quality Management Services (QMS) shifted its focus to training HCA providers on documenting and billing according to the new CalAIM standards. Notably, while the Medi-Cal requirements were changed, the Medicare documentation and billing requirements remained unchanged. Consequently, we now aim to redirect some of our attention to Medicare. The Office of Inspector General (OIG) regularly publishes a semiannual report to Congress, detailing both spending and instances of misspending of Medicare funds. In their most recent report, the OIG highlighted multiple investigations related to services billed to Medicare that did not adhere to Medicare requirements. As a result, the OIG recommended recouping Medicare funds for these investigated services.

Unlike most services under CalAIM, Medicare continues to require a Care Plan, which Medicare formally refers to as a Plan of Care. For Medicare or Medicare Medi-Cal (Medi-Medi) clients, behavioral health services must be provided under an individualized, written Plan of Care.

Medication Services
When a Medicare or Medi-Medi member is prescribed medications, their prescriber completes an assessment (or Biopsychosocial Assessment for county providers). This assessment, along with the prescriber's individual progress note(s), serve as the Plan of Care and authorizes the medication support services provided to the member.

Rehabilitation Services
For all other mental health services, Medicare members require a brief Medicare Plan of Care completed and signed by the Licensed Mental Health Professional (LMHP) directing services for the individual. The Plan of Care does not require a signature from the prescriber.

Plan of Care Requirements
Documentation on a separate form or Progress Note (please follow your program's instructions) stating

- Problem list items that will be addressed by (provider type or treatment team)
- Services to be provided (please note not all services are covered by Medicare)
- Frequency
- Duration
- Signature of LMHP or (Licensed Practitioner of the Healing Arts (LPHA) for DMC-ODS) directing services for member

MEDICARE PROGRESS NOTE REQUIREMENTS AND PROVIDER TRANSACTION ACCESS NUMBER (PTAN) PROVIDER CONSIDERATIONS

The Medicare progress note requirements include the diagnosis and narrative to support the procedure code billed. Documentation for services must include three elements, though not necessarily on every note: duration, diagnosis and frequency. It is important to note that all services ordered or rendered to Medicare clients must be legibly signed by the provider, along with their professional credentials. Clinicians and Service Chiefs should be vigilant about clients whose insurance switches to Medicare or Medi-Medi during the course of treatment. If this happens, it is essential to verify that the client's clinician(s) are PTAN providers. Behavioral Health Services can only be billed to Medicare by a PTAN provider. PTAN eligible providers include Licensed Clinical Social Workers, Licensed Psychologists, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Medical Doctors/Doctors of Osteopathy, Nurse Practitioners, and Physician Assistants. In certain circumstances, an eligible provider may opt out of the PTAN process;

their services are not eligible to bill Medicare nor MediCal. Non- PTAN providers are providers who are not eligible to bill Medicare and their services will bypass Medicare and be billed to MediCal.

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services (CMS). It is a permanent individual provider number. Health Insurance Portability and Accountability Act (HIPAA)-covered entities completing electronic transactions, healthcare clearinghouses, and large health plans are required by regulation to use only the NPI to identify covered healthcare providers. All individual HIPAA-covered healthcare providers (such as, physicians, pharmacists, physician assistants, nurse practitioners, clinical social workers, marriage and family therapists, professional counselors, physical therapists, occupational therapists, psychologists, and pharmacy technicians) must obtain an NPI for use in all HIPAA standard transactions.

For additional information and assistance, you can reach out via phone, email, or by visiting the website.

MEDICATION MONITORING

At least annually, the State requires an independent review of medication charts for areas of non-compliance. For SMHS, the independent review is completed by a non-treating psychiatrist for medication charts. For DMC-ODS, the independent review is completed by the non-treating physician or physician extender (Nurse Practitioner or Physician's Assistant) for Medication Assisted Treatment (MAT) charts. Direct and immediate feedback is required between the independent non-treating reviewer and the prescriber regarding issues of non-compliance and corrective actions. The Service Chief or Program Director has a responsibility to verify that corrective action has taken place and to submit reports to QMS. QMS is responsible for a final review, tracking, and storing. At the end of each fiscal year, QMS submits a summary report to the State.

The goals of Medication Monitoring are to:

- Increase the effectiveness of medications prescribed
- Reduce inappropriate medication use and the occurrence of adverse effects
- Improve knowledge of the clinical staff about prescribed medications
- Improve client participation, informed consent procedures, and treatment planning
- Encourage the use of the lowest effective level of medication needed to control symptoms and treat the disorder(s) under care

For information on DMC-ODS Medication Monitoring, see 01.02.04 MHRS Medication Monitoring Practices, BHIN 23-054 Medications for Addiction Treatment (MAT) Services Requirements for

Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities and Orange County's HCA BH Integrated Intergovernmental Agreement.

PAYMENT REFORM

On July 1, 2023, CalAIM Behavioral Health Payment Reform was implemented. This reform has changed the way DHCS reimburses counties for Specialty Mental Health Services, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System services. It introduces more Current Procedural Terminology (CPT) codes and rules related to 'Direct Patient Care', place of service, time ranges and limits, telehealth/telephone rules, lockouts, and overriding modifiers. For Specialty Mental Health Services, QMS has developed provider-specific Quick Guides which list the service codes that are allowable for each provider type. For DMC-ODS services, QMS has a CPT coding guide to assist providers based on level of care and type of activity. Changes and corrections are continually coming from the State, and QMS will continue to provide updates, guidance, and follow-up questions to DHCS to ensure that all providers are informed.

QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI)

Each program within the Behavioral Health Plan (BHP) must have a designated Quality Improvement (QI) Coordinator. A program's Quality Assurance/Quality Improvement (QA/QI) staff and the program's Director/Head of Service are the first line of defense, providing their program and staff members with the latest BHP requirements.

Some of the responsibilities of a QA/QI Coordinator are engaging in continuous quality improvement within their program, providing training to program staff to ensure proper documentation and billing of services, preparing the program for the County's monitoring visits, implementing Corrective Action Plans (CAPs), when appropriate, and participating in regular QI Coordinators' meetings with the respective QMS Clinical Records Team.

The QA/QI Coordinator should ensure that the content of the monthly QI Coordinators' meetings, the SMHS/DMC-ODS Newsletters, and any other communication received from QMS Clinical Records Teams, or any other County department is disseminated continually to their program staff as soon as possible.

MONTHLY NEWSLETTERS

Monthly newsletters are issued by the QMS Quality Assurance and Quality Improvement Division. Quality Review Tips (QRTips) is for SMHS providers and the SUDsies Newsletter is for the DMC-ODS providers. The purpose of the newsletters is to keep providers informed about California Code of Regulations Updates, documentation standards, reminders based on chart and billing review

trends and State-mandated monitoring requirements. Both newsletters are disseminated to all their respective Quality Improvement Coordinators every month. Coordinators are responsible for sharing and discussing the topics raised in the newsletter with their providers. It is encouraged to be shared with all providers via email and discussed in staff meetings.

Please refer to Orange County's HCA BH Integrated Intergovernmental Agreement for further information. For SMHS, please refer to the QRTips' monthly newsletter at QRTips | Orange County California - Health Care Agency. For DMC-ODS, please refer to the SUDsies Newsletter section at DMC-ODS For Providers | Orange County California - Health Care Agency.

SPECIALTY MENTAL HEALTH SERVICES (SMHS)

Clinically appropriate Specialty Mental Health Services (SMHS) are covered and reimbursable during the assessment process prior to the determination of a diagnosis or a determination that the client meets the access criteria for SMHS. Importantly, services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates that the client does not meet the criteria for SMHS. Furthermore, the BHP allows reimbursement for SMHS provided during the assessment process, even when the assessment determines that the client does not meet the criteria for SMHS and meets the criteria for Non-Specialty Mental Health Services or mild-to-moderate services through one of the County's Managed Care Plans.

DOCUMENTATION AND BILLING ERRORS

Documentation and billing concerns are often noted by Quality Management Services (QMS). Common examples of documentation and billing errors include:

- No progress note found to substantiate the service that was provided
- Claiming a service for a no-show or canceled appointment
- Documenting a billable service as a 'Note to Chart'
- Discrepancies between claimed and documented services
- Mismatch in service time compared to the time billed
- Billing for services after access criteria were not met
- Lack of evidence in the chart that the diagnosis was formulated by a provider within their scope of practice

Providers who continue to struggle with maintaining documentation standards can discuss training opportunities with their supervisors to improve adherence to the guidelines and requirements.

DOCUMENTATION STANDARDS AND SCOPE OF PRACTICE FOR PROVIDERS

A key aspect of documentation standards as it relates to providing services is that providers must operate within their scope of practice. As defined by the California Code of Regulations, Title 9, and the Mental Health Plan, scope of practice refers to the range of activities and services licensed professionals may do in their licensed practice. It is expected that, within their scope of practice, professionals will provide those services for which they have been adequately trained. Waivered or Registered Mental Health Professionals may direct services, but only under the supervision of a Licensed Mental Health Professional (LMHP). Mental Health Rehabilitation Specialists (MHRS),

under LMHP direction, may provide behavioral health services, including contributing to assessment, but cannot provide psychotherapy services. They can offer Targeted Case Management (TCM), Crisis Intervention, and Rehabilitation Services. It is important to remember that Rehabilitation Specialists are commonly known as 'Mental Health Rehab Specialists and Mental Health Specialists'. The Other Qualified Provider (OQP) provider type as described by DHCS, may encompass the job qualifications of many different job classifications utilized across County and County-contracted programs. If you are unsure whether your position falls under this category, please discuss with your program director and/or reach out to the QMS Clinical Records Teams for guidance. Providers are expected to refer to the Coding and Documentation Manuals and consult with their supervisors and/or QMS for more information and clarity about what services they may legally and ethically provide.

Per DHCS Information Notice 23-068 and supported by the CalAIM initiative, the diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the client's physical and mental health may only be completed by a licensed provider or a registered/waivered provider who is under the direction of a Licensed Mental Health Professional. Mental Health Rehabilitation Specialists (also known as Mental Health Specialists), Mental Health Workers, Peer Specialists and other qualified providers are prohibited from completing these areas. However, the BHP may designate certain other qualified providers to contribute to the assessment, including gathering the client's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

Furthermore, it's important to note that non-registered or non-waivered providers should avoid using language typically associated with psychotherapy. Instead, their interventions and language should focus on behaviors and skill-building. Non-registered or non-waivered providers whose progress notes include terminology indicating services beyond their scope of practice may encounter disallowances or recoupments along with compliance issues. Click here or the picture below for a copy of the grid.

Scope of Practice Grid

	MD, DO, NP, CNS, PA	Licensed or Waivered Psychologist	RN with Masters in MH Nursing or related field *(not certified as CNS)*	ASW, LCSW AMFT, LMFT APCC, or LPCC	Doctorate Psychology Students	Trainee enrolled in Master's program *(post Bachelors)*	Registered Nurse	Licensed Vocational Nurse or Psychiatric Tech	Mental Health Rehabilitation Specialists (MHRS)	Medi-Cal Certified Peer Support Specialists	Other Qualified Provider II (OQP II)	Other Qualified Provider I (OQP I)
Assessment: *Mental health hx + medical hx + substance use hx + exposure, strengths, risks, and barriers to achieving goals and* ***Care Plan***	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~,**	No
Assessment: *Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the person's physical and MH*	Yes	Yes	Yes	Yes	Yes~	Yes~	No	No	No	No	No	No
Problem List/Care Plan ** Diagnosis/Problems added must be within the provider's scope* of practice	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	Yes~ (only the Peer Services Plan of Care)	Yes~	Yes~
Plan Development	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~	Yes~
Medication	Yes	No	No$^{\Psi}$	No	No	No	No$^{\Psi}$	No$^{\Psi}$	No	No	No	No
Psych Testing	No	Yes	No	No	Yes~	No	No	No	No	No	No	No
Psychotherapy *(Individual, Family or Group)*	Yes	Yes	No	Yes	Yes~	Yes~	No	No	No	No	No	No
Mobile Crisis	Yes	Yes	Yes	Yes	Yes~	Yes~,*	Yes~,*	Yes~,*	Yes~,**	Yes$^{\nabla}$,~,**	Yes~,**	Yes~,**
Crisis Intervention	Yes	Yes	Yes	Yes	Yes~	Yes~,*	Yes~,*	Yes~,*	Yes~,**	No	No	No
Crisis Psychotherapy	Yes	Yes	No	Yes	Yes~	Yes~,*	No	No	No	No	No	No
Psychosocial Rehabilitation	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~	No
Intensive Home Based Services	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~	No
Targeted Case Management	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes	No	Yes~	Yes~
Intensive Care Coordination	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~	Yes~$^{\Delta}$
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes~	Yes~	Yes~	Yes~	Yes~	No	Yes~ $^{\times}$	Yes~ $^{\times}$
Self Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes~	No	No
Behavioral Health Prevention Education Service	No	No	No	No	No	No	No	No	No	Yes~	No	No

~ Under direct supervision of a LMHP
* May require close supervision if issues of DTS or DTO are present
** Requires close supervision if issues of DTS or DTO are present
$^{\Delta}$ Integrated Core Practice Model knowledge required
$^{\nabla}$ Certified Peer Support Specialists may only provide crisis services as part of a Mobile Crisis team
$^{\times}$ Requires training in functional behavioral analysis with an emphasis on positive behavioral interventions
$^{\Psi}$ Exception: may bill for injection or other medication services within their scope

7/24/2025

THE ROLE OF THE PROVIDER IN THE BILLING PROCESS

A major role of the provider is to know the rules, know who to ask or where to look if you don't know the rules, and to follow them. This applies to the entire service spectrum, from the very first contact with a client to documentation and billing. The Health Care Agency (HCA) requires and provides a number of staff trainings and resources. Displayed here is a list of available resources that staff can access, which include:

- Documentation Manual,
- Coding Manual,
- Annual Provider Training,
- Annual Compliance Training, and
- Electronic Health Record (EHR) Blog (County employees only)
- Children and Youth Services (CYS) County and Contract Forms and Resource Library | Orange County California - Health Care Agency

For additional information and telephone assistance, you can reach out to:

- Children and Youth Services Support Team
- Adult and Older Adult Services Support Team
- BHS IRIS Help Line, and,
- Managed Care Support Team.

The current assessment process requires the evaluation of seven domains and the utilization of any assessment tools by the Mental Health Professional (MHP), such as the Child and Adolescent Needs and Strengths (CANS) or the Pediatric Symptom Checklist-35 (PSC-35). The current Problem List contains International Classification of Diseases 10th revision (ICD-10) diagnoses and may also include Systematized Nomenclature of Medicine (SNOMED) codes along with Social Drivers of Health, and it is updated periodically to support the medical necessity for ongoing treatment. Care Plans for applicable services (such as TCM, Intensive Care Coordination (ICC), Medi-Cal Certified Peer Support Specialist, and additional services requiring Care Plans like Therapeutic Behavioral Services (TBS) and Short-Term Residential Therapeutic Programs (STRTPs)) may be in Care Plan progress note format. Payment Reform has introduced more CPT codes and rules related to 'Direct Patient Care,' place of service, time ranges, limits, telehealth/telephone services, lockouts, and overriding modifiers. The Electronic Health Records (EHR) system undergoes significant changes as a result of the new CalAIM and Payment Reform rules.

WHAT IS MEDICAL NECESSITY AND ACCESS CRITERIA?

To qualify for BHP services, individuals must meet access criteria, as determined by the score on the Screening Tool by the 24/7 Access Line (also referred to as the Administrative Service Organization or ASO), or by walk-in/call-in to a provider site through an assessment. Services provided to a client of any age must be medically necessary and clinically appropriate to address the client's presenting

condition.

For **clients under 21 years of age**, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate a mental illness or condition. Furthermore, mental health services do not need to be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and can be considered medically necessary and covered as an Early and Periodic Screening Diagnostic and Treatment (EPSDT) service.

For **clients under 21 years of age**, a BHP shall provide SMHS to enrolled clients who meet either of the following criteria:

1. The client has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system and/or juvenile justice system or experiencing homelessness.

OR

2. The client meets both of the following requirements in a) and b), below:
    a) The client has at least one of the following:
        i. a significant impairment,
        ii. a reasonable probability of significant deterioration in an important area of life functioning,
        iii. a reasonable probability of not progressing developmentally as appropriate, and
        iv. a need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

    b) The client's condition as described by the criteria above is due to one of the following:
        i. a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD),
        ii. a suspected mental health disorder that has not yet been diagnosed, and
    i. a significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

For **clients 21 years of age or older**, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant

disability, or to alleviate severe pain. It is important to note that CYS providers should notice that the criteria for medical necessity changes as your client turns 21 years of age.

For **clients 21 years of age or older**, a BHP shall provide covered SMHS for clients who meet both of the following criteria, (1) and (2).

(1) The client has one or both of the following:

a. a significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities,
b. a reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The client's condition, as described in paragraph (1), is due to either of the following:

a. a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD),
b. a suspected mental disorder that has not yet been diagnosed.

In seeking a 'No Wrong Door' approach that addresses client needs across the continuum of care, an 'Included' DSM/ICD-10 diagnosis is no longer mandatory for accessing Specialty Mental Health Services (SMHS). Eligibility criteria for clients under 21 years of age now include those at "high risk for a mental health disorder due to the experience of trauma" as evidenced by a state-approved trauma screening tool, child welfare or juvenile justice involvement, and/or homelessness. Importantly, a mental health diagnosis is not a prerequisite for accessing the covered SMHS. However, this does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, must still include a CMS-approved ICD-10 diagnosis code.

Access Points

Various locations and programs that serve as entry points for individuals trying to access behavioral health services in the county.

1. OC Links (855) 625-4657: Provides 24/7 information and linkage to any of the OC Health Care Agency's Behavioral Health Services programs ranging from prevention to crisis response via phone/chat.

2. 24/7 Access Line (800) 723-8641: Also known as the Administrative Services Organization (ASO), members call to access referral to SMHS or SUD services.

3. County-Operated Children and Youth Services (CYS) and Adult and Older Adult (AOA) Outpatient Clinics

SCREENING AND TRANSITION TOOLS

The Department of Health Care Services (DHCS) has initiated and provided Screening Tools for Medi-Cal Behavioral Health Services. The purpose of these Screening Tools is to ensure that all Medi-Cal clients receive coordinated services across Medi-Cal mental health delivery systems and improved health outcomes. The Screening Tools cannot be altered, nor can additional questions be asked as part of the screening process. A scoring methodology is used to determine whether an individual must be referred to the Managed Care Plan (MCP) or the Behavioral Health Plan (BHP) for a Behavioral Health Assessment. The BHP shall follow the referral determination generated by the score. The scoring methodology as well as detailed instructions for the appropriate application are provided in the tools. The score of the Adult and Youth Screening Tools determines the appropriate delivery system referral for individuals when they contact the 24/7 Access Line.

Screening Tool

Licensed or non-licensed staff are permitted to administer the Screening Tools. The Screening Tools do not have to be administered by an LMHP or LPHA.

The Screening Tools can be administered by clinicians and non-clinicians in alignment with BHP protocols and may be administered in a variety of ways, including in person, by telephone, or by video conference. The Screening Tools are not required for use with clients who are currently receiving behavioral health services. The Screening Tools are not required for use with clients who contact mental health providers directly to seek behavioral health services. It is important to note that the completion of the Adult or Youth Screening Tool is not considered an assessment and therefore cannot be billed as an assessment service. Mental health providers who are contacted directly by individuals seeking behavioral health services are to begin the assessment process and provide services-when medically necessary- during the assessment period without a Screening Tool, consistent with the No Wrong Door Policy for behavioral health services.

Screening Tool by Age Group

The Youth Screening Tool is administered to all individuals under the age of 21. The Youth Screening Tool has two versions depending on who is calling. One version is for the client if he or she is the caller. The second version is for the caregiver if he or she is calling to seek services on behalf of the client. It includes screening questions designed to address the needs of a range of ages within this group. It includes screening questions that are intended to elicit information about the individual's safety, system involvement (including current or past interactions with foster care or the juvenile justice system), life circumstances, and risk. The Adult Screening Tool is to be administered to all individuals 21 years of age and older. It includes screening questions that are intended to elicit information about the individual's safety, clinical experiences, life circumstances, and risk.

Transition of Care Tool

The DHCS initiated the Transition of Care Tool with the intention to streamline the process of referring clients from the BHP to the MCP and vice versa. The Transition of Care Tool was developed to ensure timely and coordinated care during times of transition of service needs. The Transition of Care Tool is to be used when an individual who is receiving behavioral health services from one delivery system experiences a change in their service needs and their existing services need to be transitioned to the other delivery system, or services need to be added to their existing mental health treatment from the other delivery system.

The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all the following actions must be taken: 1) complete the Transition of Care Tool; 2) send the Transition of Care Tool and any relevant supporting documentation to the plan the client is being referred to; and 3) continue to provide necessary behavioral health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

ASSESSMENT AND REASSESSMENT

7-Domain Assessment

The assessment shall include recommendations for medically necessary services and additional provider referrals as clinically determined by a licensed, waivered, registered, and/or under the direction of a Licensed Mental Health Professional (LMHP). The initial assessment and reassessments shall be completed on a comprehensive assessment form that contains the 7 domains as required by CalAIM, as well as a Problem List that meets the CalAIM requirements.

Domain 1: Presenting problem(s), current mental status, history of presenting problem (s), member-identified impairment(s)
Domain 2: Trauma
Domain 3: Behavioral Health History, Co-occurring substance use
Domain 4: Medical History, current medications, co-occurring conditions (other than substance use)
Domain 5: Social and life circumstances, culture/religion/spirituality
Domain 6: Strengths, risk behaviors, and protective factors
Domain 7: Clinical summary and recommendations, diagnostic impression, medical necessity determination/level of care/access criteria

During the initial assessment and reassessments, the providers at the BHP County clinics are to complete the BH Assessment Form which contains the required 7-Domain Assessment and the Diagnosis/Problem List. According to Orange County's BHP, an initial assessment should be completed as expeditiously as possible, in accordance with each client's clinical needs and generally accepted standards of practice. Reassessments are to be completed based on clinical discretion.

Certain programs may have earlier timeline requirements based on the program's needs (i.e., crisis programs and short-term programs). If your program has these earlier requirements, please include your timelines in writing in your policies and procedures. It is expected that reassessments will include progress towards treatment and objectives on the last plan, significant changes and achievements since the last assessment, and newly identified impairments, symptoms, and/or Social Drivers of Health.

Department of Health Care Services Assessment Tools

Welfare and Institutions Code (WIC) section 14707.5 requires the Department of Health Care Services (DHCS) to provide an update regarding the Early and Periodic Screening (EPSDT) Performance Outcomes System. California DHCS has selected two assessment tools as part of the implementation of the Managed Care Final Rule in California. They are the Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) and the Pediatric Symptom Checklist (PSC-35)

Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS)

The California Child and Adolescent Needs and Strengths assessment evaluates clients' needs and strengths, informing treatment planning and collecting outcome data related to behavioral and emotional needs, life domain functioning, risk behaviors, cultural factors, strengths, caregiver resources and needs, and trauma questions. Researchers from both DHCS and the County of Orange analyze the data collected through the CANS, examining individual items and the correlations between them.

Prior to administering the CANS, new providers must obtain certification through the Praed Foundation, which involves passing a vignette exam on the training website. CANS certification is valid for one year and can be renewed. Additionally, both County and Contract Provider employees have been designated as Certified Trainers to assist in training new and existing staff. Additionally, to facilitate the certification process for the CANS, the Quality Management System and the Praed Foundation have developed resources to assist with signing up for the training website as well as passing the certification exam. This exam can be daunting, as it requires a thorough understanding of each item as well as the ability to extract information from a complex vignette.

Collaboration and IRIS Entry

The CANS assessment is required to be administered to clients aged 0–21, including at the initial assessment, every six months, and at discharge. When completing the CANS with a client, clinicians are encouraged to utilize the Child Family Team (CFT) or Intensive Services (IS) Treatment Team process as an opportunity to gather information, including the client, their parents, family members, Social Services Agency (SSA), probation, Wellness Recovery Action Plan (WRAP) providers, and other important individuals in the client's life. Together, this team can develop a plan that takes into account the many needs and strengths presented, as well as the

points of view provided by CFT or IS team members

CANS data is entered into IRIS. In County-operated programs, the CANS is entered into IRIS by the Plan Coordinator, while in Contract programs, Front Office Support staff enter the CANS data into IRIS on behalf of the clinician.

Implementing the CANS Assessment Tool

The implementation of the CANS assessment tool is important for our Child Welfare partners at the SSA. SSA has been integrating the CANS into their operations since April 2022. Effective coordination with SSA is essential, as the CANS will be jointly completed and submitted by both SSA and the County or Contract Providers to the State. As SSA continues to implement the CANS, further guidance and workflow adjustments will be provided. Sharing CANS scores with SSA for a mutual client requires a valid ATD. More information can be found on The Child & Adolescent Needs & Strengths (CANS) | Orange County California - Health Care Agency website.

Pediatric Symptom Checklist (PSC-35)

The Department of Health Care Services has selected the Pediatric Symptom Checklist (PSC-35) as a secondary outcome measure for BHP to administer to clients aged 3 to 18, alongside the CANS. In order to facilitate data gathering, QMS requests that the PSC-35 be entered into IRIS, similar to the CANS. However, there's a crucial distinction: the PSC-35 is completed by a client's caregiver during the assessment period and intervals, even if no caregiver is involved in treatment. Of note, the Pediatric Symptom Checklist (PSC-35) is also a screening tool for clients aged 18 in selected Adult Older Adult programs, to be completed by the client's parent or caregiver.

The PSC-35 screening tool offers a total score at the end. For clients aged 6-17, a score of 28 or higher indicates psychological impairment, while for clients aged 3-5, the cut-off score is 24. It is important to review the results of this screening tool with the client's parent or caregiver, if applicable. If no parent or caregiver is participating in the client's treatment, the form should still be entered into IRIS. This helps researchers capture how many clients have parents and caregivers involved in their care. By entering the PSC-35 into IRIS, we provide valuable feedback to our Federal, State, and County researchers regarding caregiver involvement. More information can be found on the Pediatric Symptom Checklist (PSC) | Orange County California - Health Care Agency website.

Data Entry of CANS and PSC-35

QMS has streamlined data entry workflows and developed tools and reports to assist the provider in accurately entering CANS and PSC-35 assessments. While the CANS and PSC-35 are

valuable measures for treating clients, the data they produce is crucial for measuring clinical outcomes and meeting DHCS and Federal requirements. To improve data quality, double-check the 'Performed-On Date' and check the client's chart for previously completed CANS. IRIS records the date we indicate in the Performed-On Date as the date the form was administered. The decision regarding whether to complete an Initial or Reassessment CANS or PSC-35, or whether to complete the CANS or PSC-35 at all, significantly impacts the assessment process.

Before entering CANS or PSC-35 forms, review the client's chart in IRIS. If there are existing CANS or PSC-35 records, this may affect the timing and form type. In IRIS, this can be done by going to the Form Browser section of the client's chart, and sort by "Encounter – Date," then double-click on a form to see its contents. Entering duplicate form types (e.g., two Initial CANS assessments within a month) will be flagged as an error in the State data collection system. To avoid this, always check existing records in IRIS before entering new documents. For example, in a recent audit, a chart was found to have a Discharge CANS, followed by two Initial CANS, and a Reassessment. This is not the correct order, nor the correct number of CANS.

Both the HCA IT team and the IRIS Liaison team have been conducting audits of charts with CANS and PSC-35 errors. They are actively communicating with programs to address error correction procedures. Additionally, error detail reports are in development to aid in monitoring these issues. If you receive an email regarding error correction, please carefully follow the instructions and feel free to reach out to the IRIS Liaison Team with any questions or concerns. Ensuring timely administration of CANS and PSC-35 assessments is crucial, and consulting with QMS can assist providers in maintaining accurate timelines.

Coordination of Care of CANS and PSC-35 in Medi-Cal Programs

For a majority of the BHP forms and processes, each program is responsible for delivering services and satisfying Medi-Cal billing and documentation requirements. However, CANS and PSC-35 break this mold slightly by carrying across Episodes of Care. This means that if a client is transferred from one program to another, the receiving program becomes responsible for continuing the process mid-stream.

To facilitate this coordination, QMS has created a Coordination of Care Quick Guide, which you can download from the CANS or PSC-35 support web pages. Within the County of Orange BHP, providers are allowed to coordinate care without an explicit ATD, including information related to CANS and PSC-35. It's recommended that programs explicitly address CANS and PSC-35 during the Coordination of Care process. Additionally, when working on a case shared with the Social Services Agency, coordination of CANS information and completion is essential.

THE PROBLEM LIST AND DIAGNOSIS

Problem List

The provider(s) responsible for the client's care shall create and maintain the Problem List. The Problem List should include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) should be included with the diagnosis when applicable
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Any problems identified by a provider acting within their scope of practice, if any
- Problems or illnesses identified by the member and/or significant support person, if any

Include the name and title of the provider who identified, added, or removed the diagnosis/problem, along with the date when the problem was identified, added, or resolved. The Problem List should be updated as clinically appropriate on an ongoing basis, or at least during reassessments, to reflect the current presentation of the client as the Problem List informs treatment.

Diagnosis

The diagnosis must be formulated by a provider operating within their scope of practice under California State law. The documentation must clearly show evidence that the diagnosis was made by someone practicing within their scope of practice. This evidence can be demonstrated through the signature of the person making the diagnosis, along with their license, degree, or job title. It is important to remember that ICD-10 codes are used for all claims related to SMHS. However, the County recommends using the criteria from the DSM-5 to select the appropriate ICD-10 codes that support the documentation of problems addressed in the session. The Problem List shall support the medical necessity of each service provided.

Social Drivers of Health (SDOH)

The CalAIM initiative highlights the importance of addressing clients' Social Drivers of Health (SDOH). SDOH include education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. By addressing an individual’s SDOH, we can provide interventions that may reduce health disparities and inequities.

This, in turn, will reduce the risk factors that negatively impact their mental health and overall functioning.

SNOMED CT Browser

SNOMED is a standardized, multilingual vocabulary of clinical terminology used by physicians and other healthcare providers. The SNOMED CT Browser can be used to search for SNOMED codes, providing additional options for SDOH and other conditions. These SNOMED codes and descriptors can be listed on the Diagnosis/Problem List accompanying the ICD-10 codes. SNOMED codes are to be used if a provider is unable to find an ICD-10 code that accurately represents SDOH, symptoms, or other conditions. Use this link to access the SNOMED CT® Browsers.

THE CARE PLAN

The list of services that require a Care Plan include:

- Targeted Case Management (TCM)
- Intensive Care Coordination (ICC)
- Therapeutic Behavioral Services (TBS)
- Short Term Residential Therapeutic Programs (STRTPs)
- Psychiatric Health Facility (PHF)
- Social Rehabilitation Services, also known as Crisis Residential Services
- Certified Peer Support Services

CalAIM Requirements

The CalAIM requirements of the Targeted Case Management (TCM) Care Plan and the Certified Peer Support Services Plan of Care include:

- Specific goals, treatment, service activities, and assistance to address the objectives of the plan plus the medical, social, educational, and other services needed by the client
- Activities like ensuring the active participation of the client and working with the client (or authorized health care decisionmaker) and others to develop goals
- A course of action to respond to the assessed needs of the client
- Development of a transition plan when the client has achieved the goals of the Care Plan

It is important to remember that even without a Care Plan, TCM can be provided and billed during the assessment period if justified in the progress note.

Medicare and Medi-Medi Care Plans

For Medicare and Medi-Medi clients, all Specialty Mental Health Services (SMHS) are still required to be authorized on a Care Plan. BHP County Clinics are to continue to complete an Interim Care Plan (ICP) and the Legacy Care Plan (currently in EHR) for all Medicare and Medi-Medi clients until further notice is provided by QMS. For Medi-Medi clients, a Targeted Case Management (TCM) Care Plan

must also be completed to align with CalAIM requirements. The ICP and the Legacy Care Plan require a signature from an LMHP directing services for the member.

Care Plan Guidance

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS nor for DMC and DMC-ODS services. Care planning no longer include timelines, but is an ongoing, interactive component of service delivery rather than a one-time event. There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities:

- Children's Crisis Residential Programs (CCRP)
- Community Treatment Facilities (CTF)
- DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated AOD Treatment Facilities
- Enhanced Care Management (ECM)
- Mental Health Rehabilitation Centers (MHRC)
- Behavioral Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)
- Certified Peer Support Services
- Short-Term Residential Therapeutic Programs (STRTPs)
- Social Rehabilitation Programs (SRPs). Includes programs certified by DHCS for:
    - Short-Term Crisis Residential Treatment;
    - Transitional Residential Treatment; and
    - Long Term Residential Treatment
    - Substance Abuse Block Grant (SABG) Programs/Services
- Targeted Case Management (TCM); Intensive Care Coordination (ICC)
- Therapeutic Behavioral Services (TBS)

For SMH, DMC, and DMC-ODS services, programs, or facilities for which care plan requirements remain in effect:

(1) Providers must adhere to all relevant care planning requirements in state or federal law.

(2) The provider shall document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an Electronic Health Record.

TYPES OF SPECIALTY MENTAL HEALTH SERVICES

The most common services provided to a specialty mental health population are:

- **Assessment:** a service activity designed to collect information and evaluate the current status of a client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that client
- **Therapy**: address a client's feelings, emotions, thoughts, and behaviors
- **Rehabilitation:** recovery or resiliency focused service designed to target specific problematic behaviors resulting from a mental health condition
- **Group Therapy/Rehabilitation:** used when multiple clients meet in a group setting for treatment
- **Targeted Case Management:** involve additional community resources, coordination of care, referrals, placements, and tracking progress as related to referrals and linkages
- **Plan Development:** involve a service activity that consists of one or more of the following: the development of client plans, the approval of client plans, and/or monitoring a client's treatment
- **Crisis Intervention:** results from the need for immediate service intervention, which, if not provided, presents an imminent threat to the client or others. Services may include, but are not limited to, assessment, evaluation, collateral, and therapy
- **Crisis Psychotherapy:** provided when a mental health professional is conducting a crisis evaluation and through the use of psychotherapy techniques, is able to de-escalate a crisis and avert a psychiatric hospitalization
- **Medication Support:** services include evaluation, prescribing, administering, dispensing, and monitoring psychiatric medications, which are necessary to alleviate the symptoms of the mental illness
    - Medication services may also include medical education, counseling on the risks and benefits of medication, and monitoring medication side effects
- **Certified Peer Support Specialist Services:** culturally appropriate services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, the development of natural supports, and the identification of strengths. They include but are not limited to prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a Medi-Cal Certified Peer Support Specialist.

Coding Quick Guide by Discipline: Payment Reform Resources | Orange County California - Health Care Agency

Certified Peer Support Specialist

Peer Support Specialist services were implemented by DHCS on July 1, 2023. A Certified Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support

Specialists may be supervised by a Medi-Cal Peer Support Specialist Supervisor; however, the services shall be under the direction of a Behavioral Health Professional. Certified Peer Support Services are defined as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, the development of natural supports, and the identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.

NON-BILLABLE SERVICES

Non-billable services are defined as services that are never paid for by Medi-Cal or Medicare. These services include:

- Travel time
- Documentation time
- Review of internal records
- Supervision
- Waiting
- Clerical services (for example, faxing, copying, and scheduling appointments)
- Providing transportation, except for mobile crisis
- Most letter writing and form completion
- Any activity that is solely academic, vocational, recreational, or social in nature,
- Child, elder, or dependent adult abuse reporting
- Home visits solely for Continuum of Care inspections

Review of Records

The review of records (formerly known as chart review) became effective in July 2023. A review of internal records is no longer billable (the only exceptions are for certain medication management codes). A review of records is now considered an assessment service with its own billing code. It cannot be combined with any other service (the only exceptions are for certain medication management codes). The review of records service billing code is to be billed when a provider, under their scope of practice, conducts a Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes.

Non-Billable Locations

Services provided at some sites are not billable. Outpatient services are locked out against inpatient and 24-hour services except for the date of admission.

Exceptions:

- Youth in Juvenile Hall who have completed court activities and are only staying there until a living situation can be arranged.
- Service provided to individuals who are not institutionalized but are in jail/juvenile detention center/in holding.
- Behavioral Health Links provided to Justice Involved (JI) Medi-Cal members.
- Targeted Case Management Services, solely for the purpose of coordinating placement of the beneficiary on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge. However, it is important to note that while working on securing post-hospitalization placement may be considered part of discharge planning (for example, arranging follow-up care for psychiatric or medical issues), placement is the only portion of 'discharge planning' that is billable.
- Day, 24-hour, inpatient and outpatient services are locked out against each other except for the day of admission with the exception of case management services.
- Peer Support services are not locked out against residential or inpatient.
- Outpatient services are not locked out against therapeutic foster care.

There is no exception for the Institutes for Mental Disease (IMD).

Time

Billing must be based on exact minutes. Estimating the time spent on any service, billable or non-billable, is a violation of the HCA Code of Conduct.

Travel and Transportation Time

Per CalAIM Payment Reform changes, travel time is NOT a billable service. The time a provider spends in the car with the client, during which no billable service is provided, is considered transportation. Transportation is NOT a billable service. The only exception is when a mobile crisis team transports a client to an appropriate level of care or treatment setting. The time a provider spends in the car with a client while also providing a billable service is considered billable service time.

Direct Patient Care

Direct patient care refers to the time spent directly with a client for the purpose of providing healthcare. If the service code billed is a medical consultation code, then direct patient care means time spent with the consultant or members of the client's care team. In some situations, direct patient care may also include time spent with the caregiver, a significant support person, and/or other

professional(s) who are invested in the client's care. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review, quality assurance activities, or other tasks performed by a provider before or after a patient visit.

PROGRESS NOTE DOCUMENTATION

Documentation of services is conducted via the progress note. Progress notes are required for all billable and non-billable services. The progress note documentation should be individualized, clear, concise, and succinct rather than a detailed narrative and contain the required elements. Progress notes must contain a narrative describing the service, including how the service addressed the client's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors). Regardless of the type of note, the same elements are required.

Required Progress Note Elements

Progress Notes shall include the following required elements:

- Type of service rendered
- Narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the services were provided to the client
- Duration of the service
- Location of the client at the time of receiving the service
- Typed or legibly printed name, signature of the service provider, and date of the signature
- ICD-10 code
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
- Next steps, including but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s), and any update to the problem list as appropriate

Documentation Standards

Providers do not need to follow any specific progress note format as long as all of the required elements are included in each progress note. Progress notes shall support the medical necessity of each service provided. Providers are expected to complete accurate billing associated with each completed service. The timeframe in which progress notes shall be completed is within three business days of providing a service, except for crisis services, which shall be completed within one calendar day, with the day of service as day zero. Progress notes indicating patterns of fraud, waste, or abuse will prompt compliance issues.

Signatures

Signing another person's signature is a violation of the HCA Code of Conduct and is illegal. If someone writes a progress note, no one else should alter it. Remember that it is the provider who provided the service who knows what happened. There are a few highly defined situations in which a Service Chief or Manager can amend chart documentation. These situations are specified in Policies and Procedures (P&Ps). Also, never ask a client to sign a blank form of any kind; forms should be completed in full to be reviewed by the client before they sign them.

Electronic Signatures

Under California law, a digital signature is defined as "an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature."

The Uniform Electronic Transactions Act (UETA) indicates "in order to qualify as an electronic signature under the ESIGN Act and UETA, the system used to capture the transaction must keep an associated record that reflects the process by which the signature was created or generate a textual or graphic statement (which is added to the signed record) proving that it was executed with an electronic signature." The UETA gives electronic signatures the same legal weight as handwritten signatures.

Programs must attest to being in compliance with all federal and state requirements for electronic signatures. It is the policy of HCA BHS that after a contracted program receives approval to use electronic signatures, that the program will continue to ensure that all federal and state requirements, including any changes or other updates to those requirements are met.

Expanded Coverage of Services: Expectations and Reimbursement

Coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service is not excluded under any of the following circumstances:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan
- The client has a co-occurring substance use disorder

These types of claims will no longer result in disallowances. This means all services provided prior to the determination of a diagnosis, during the assessment, or prior to the determination of whether

Non-Specialty Mental Health Services or Specialty Mental Health Services access criteria are met or covered and billable/reimbursable, even if the assessment ultimately indicates the client does not meet access criteria for Specialty Mental Health Services.

5150/5585 CERTIFICATION

California Welfare and Institutions Code, Section 5150, specifies that when a person is determined to be a danger to themselves, to others, or to be incapable of self-care, they may be held up to 72 hours in order for a psychiatric evaluation to be completed. Individuals should have the proper training and certification to perform this function. Restricting someone's freedom by having them detained on a 5150/5585 hold is a serious matter, and placing an individual on a hold without active certification can result in huge liability for the agency and immediate consequences for the employee. If you become aware that your certification has expired, you shall immediately notify your Supervisor. A decision will be made at that point about how to handle the lapse in certification. Please note that Quality Management Services (QMS) Inpatient and Designation Support Services (IDSS) Team is to be notified immediately when a provider terminates employment, transfers, or is no longer appropriate for designation status. The provider is responsible to ensure the returning of the designation card to QMS IDSS.

TELEHEALTH SERVICES

The term telehealth is used to describe both synchronous audio-only and synchronous video interactions but does not include asynchronous store and forward communications or remote patient monitoring. A telehealth service is any medically necessary behavioral health service rendered audio-only or synchronous video interaction with a client and/or their authorized representative. **Audio-only** services are identified as services that occur when you speak with a client via information and communication technology such as a telephone and are not able to see the individual. **Synchronous video** services occur when a service is provided via information and communication technology and the provider is able to see the client through an audio-visual platform.

Providers may deliver services via telehealth from anywhere in the community, outside a clinic, or other provider site. The standard of care is the same whether the client is seen in-person, or through telehealth. Providers are expected to obtain the location and address of the client for a service conducted via telehealth. If the client is unable to provide an exact address, the approximate location or cross streets are sufficient. This information is to be documented within each progress note. It is important to document telehealth services in the correct manner to ensure that documentation and billing are as accurate as possible.

IMPORTANT CONSIDERATIONS REGARDING TELEHEALTH SERVICES

All clients receiving services, whether new or existing, must be provided with the [combined] Informed

Consent for Services and Telehealth Consent form. Additionally, for those determined appropriate for and able to engage in telehealth services, the Telehealth Email Acknowledgment form should be completed. The form will need to be reviewed with each client and their verbal consent should be obtained and documented in the progress note.

A few important reminders regarding telehealth include:

- Scope of practice
- Geographic limitations
- Privacy considerations
- Member's right to access covered services in person

Licensed providers and non-licensed staff may provide services via telehealth, as long as the service is within their scope of practice. It is critical that providers DO NOT provide or conduct telehealth services to clients who are located outside of California. It is imperative that providers exercise caution when conducting telehealth services to ensure client privacy is protected. Both the provider and the client should be aware of their surroundings during the telehealth service to minimize any potential Health Insurance Portability and Accountability Act (HIPAA) breaches or violations.

MINOR CONSENT FOR MENTAL HEALTH TREATMENT

According to Family Code §6924, a minor can consent to outpatient mental health treatment and counseling if he or she meets all of the following requirements:

- The minor must be 12 years of age or older
- The minor is mature enough to participate intelligently in the treatment in the opinion of the attending professional person

Minors cannot consent to any of the following services under this statute:

- Inpatient mental health treatment
- Psychotropic drugs
- Convulsive therapy
- Psychosurgery

The mental health treatment or counseling of a minor must include the involvement of the minor's parent or guardian unless the professional person who is treating or counseling the minor determines that the involvement would be inappropriate.

The professional person who is treating or counseling the minor shall state in the client record when the provider attempted to contact the minor's parent or guardian; whether the attempt was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

Involvement of parents or guardians in treatment will necessitate sharing certain confidential information; however, it does not mean that parents or guardians have a right to access confidential

records.

When a minor consents to treatment under this statute, the provider can only share the related mental health records with parents or guardians when the provider has written authorization from the minor.

The minor's parents or guardian are not liable for payment for treatment provided under minor consent unless the parent or guardian participates in the treatment. Family Code §6924 contains no insurance funding restrictions.

ADDITIONAL STATE REQUIREMENTS

Pathways to Well-Being and Intensive Services

- DHCS released BH Info Notice 21-058, which outlines expectations for Pathways to Well-Being (PWB) and Intensive Services (IS).
- Expanded eligibility for ICC/IHBS or Therapeutic Foster Care (TFC) services for PWB subclass member and those that meet medical necessity for Intensive Services is an important reminder in our practice.
- Qualified healthcare professionals with clinical expertise shall make the decision to authorize or deny services based on medical necessity and must clearly document it.
- Additionally, SMHS and providers of ICC/IHBS services must submit the correct HCPCS codes with the HK modifier.
- Ensure timely access for routine referrals within 10 days and urgent referrals within 48 hours.
- No authorization is needed for ICC services, but IHBS/TFC services require authorization.
- Clients must be under 21 years of age to receive ICC and IHBS services.
- Additionally, the PWB/IS eligibility form must be in the chart, and individuals must meet medical necessity criteria to be eligible for PWB/IS.
- Assessment codes can be used for any assessment service, as long as the assessment activity is not part of the CFT meeting.
- Lastly, there should be a reassessment every 90 days to evaluate the child's strengths and needs.
- ICC codes will be used for all ICC-related activities, including developing the ICC care plan and consultations.

Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) Guidelines

- As a result of CalAIM changes, ICC and IHBS (if clinically indicated) can be provided upon completion of the 7-Domain Assessment to establish medical necessity.
- Both the ICC care plan and the PWB/IS eligibility form are completed, and the PWB/IS cohort is registered in IRIS.
- If the client is transferred to your program and has an open PWB/IS cohort registration in IRIS,

the new program can provide ICC and/or IHBS if the previous clinic's/provider's assessment, ICC Care Plan, and IHBS authorization form have already authorized IHBS.

- Additionally, the ICC Care Plan must be reviewed at least once annually.
- When the client turns 21 years of age, they are no longer eligible for ICC/IHBS and therefore would require a TCM CP progress note to continue with targeted case management.

CODING AND DOCUMENTATION MANUALS

The Coding and Documentation Manuals contain information on compliance, documentation, billing, and important reminders. They provide specific progress note examples and descriptions of various service types. The manuals are critical reference tools for providers to code and document according to Specialty Mental Health standards.

Please see coding resources by provider type here: Payment Reform Resources | Orange County California - Health Care Agency

CONTINUITY OF CARE

Per the Department of Health Care Services (DHCS), effective July 1, 2018, Title 42 of the Code of Federal Regulations, Part 438.62, requires the State to have in effect a transition of care policy to ensure continued access to services during a clients transition from Medi-Cal Fee-For-Service (FFS) to a Managed Care Program (MCP) or transition from one managed care entity to another, when the client, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. All eligible Medi-Cal clients who meet medical necessity criteria for Specialty Mental Health Services have the right to request continuity of care and may be eligible to receive continued access to services from an out-of-network provider for up to 12 months.

A Medi-Cal client or client's authorized representative may make a direct request to the BHP for continuity of care verbally, in writing, or via telephone and shall not be required to submit an electronic or written request. To make a request without completing and submitting a form, a client may ask to speak with the Provider Representative, the Service Chief, or the Program Director at any Orange BHP County-operated or contracted clinic or call Quality Management Services (QMS). Clinic staff who receive a continuity of care request from a Medi-Cal client or client's representative may fill out the Continuity of Care Request Form on behalf of the client and submit the form and other associated documentation (ATDs and treatment records) to QMS by emailing. A QMS representative will process the request and get back to the client in writing, no later than 30 days from the date QMS receives the request.

CONTRACT MONITORING

Upon contracting with Orange County, specialty mental health programs are assigned a Contract

Monitor. The Contract Monitor is responsible for ensuring the service provider adheres to contractual agreements and monitors the services, policies and procedures, accuracy of reporting submissions and other administrative activities required by the county. Programs also have a Contract Administrator who specializes in the execution of the contract document and fiscal oversight. The Contract Administrator can field questions related to budgets, rates, invoices, payments, and general boilerplate contract provisions prior to the service exhibits.

As a program's primary liaison, the Contract Monitor's activities may include, but are not limited to:

- Review compliance with all contract requirements
- Complete annual provider evaluations
- Assist program with Medi-Cal certifications and re-certifications
- Technical support
- Conduct an Annual Programmatic Monitoring Review
- Work in tandem with HCA Contract Services and QMS to serve as a liaison between other County departments and the program

SPECIAL INCIDENT REPORT (SIR)

Any incident of a serious nature at a contracted facility requires a Special Incident Report (SIR) form to be submitted to the program's assigned Contract Monitor within 24 hours of the event. In the event of the death of a current client or a client served within the last 6 months, the program needs to report the death directly to the Contract Monitor or other available HCA staff *by phone immediately* upon becoming aware of the death. The program's Contract Monitor can provide an SIR form template with prompts for all required information. The SIR forms must be filled out in their entirety with attention to detail. The narrative description of the event should be distilled to three sentences or less containing only the facts at hand. There is an addendum form that allows for a broader description that can be sent after the initial SIR form, if needed.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

The County of Orange provides Substance Use Disorder (SUD) services to adults who have a substance use disorder and adolescents who either have a substance use disorder or are at risk of developing a substance use disorder. The County of Orange opted into participating in the State's DMC-ODS waiver in 2016 and implemented the DMC-ODS waiver in July 2018. At the time, DMC-ODS was a demonstration project that would allow for greater coordination of care for clients as they move from one level of care to another, with the hopes of increasing the likelihood of successful treatment outcomes. With the California Advancing and Innovating Medi-Cal (CalAIM) initiative in 2022, the State moved towards further streamlining documentation requirements to "improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary care; address equity and disparities; and ensure quality and program integrity" (from BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services).

This Provider Manual has been created for use by all DMC-ODS program's administrative and clinical staff to ensure understanding of DMC-ODS and to ensure our network provides quality and outcome-based services.

For more information, please refer to Orange County's HCA Drug-Medical Organized Delivery System, Orange County's DMC-ODS Implementation Plan and DHCS DMC-ODS website.

INTRODUCTION

DMC-ODS Guidelines

The information and guidance that dictate SUD treatment within the DMC-ODS is delivered at various levels. The federal level guidance comes from the Centers for Medicare and Medicaid Services (CMS). Guidance from CMS will first go to DHCS, where DHCS staff and policy professionals interpret the information received. DHCS then sends out their guidance to all participating DMC-ODS California counties, including the Orange County Health Care Agency (HCA). This Provider Manual, along with other federal, State and local regulations including but not limited to the specific services to be provided, govern delivery of SUD treatment services in Orange County. Regulations, information and guidance may be included in:

- 42 Code of Federal Regulations (CFR) Part 2 Confidentiality of SUD Patient Records
- 42 CFR Part 438 Managed Care
- Health Insurance Portability and Accountability Act (HIPAA)

- DHCS webpage on California Code of Regulations (CCR) Title 9 Counselor Certification Regulations
- DHCS webpage on CCR Title 22 Drug Medi-Cal
- Drug Medi-Cal Organized Delivery System Special Terms and Conditions
- Practice Guidelines (i.e., SUD Perinatal Practice Guidelines and Adolescent Substance Use Disorder Best Practices)
- Orange County's DMC-ODS Implementation Plan
- Orange County's HCA Behavioral Health (BH) Integrated Intergovernmental Agreement
- DHCS Behavioral Health Information Notices
- DHCS webpage on Bulletins, Information Notices and Letters
- SUDsies Newsletter
- SUD Quality Improvement (QI) Coordinators' Meeting
- SUD required trainings
- Health Care Agency's Contract with DMC-ODS providers

Contract Monitoring

Upon contracting with Orange County, SUD programs are assigned a Contract Monitor. The Contract Monitor is a generalist in all the contract requirements and specialist in monitoring a program's services, policies and procedures, personnel files, and condition of your facility. Programs also have a Contract Administrator who specializes in the execution of the contract document and fiscal oversight. The Contract Administrator can field questions related to budgets, rates, invoices, payments, and general boilerplate contract provisions prior to the service exhibits.

As a program's primary liaison, the Contract Monitor's activities may include, but are not limited toill:

- Host a monthly individualized meeting between the program and HCA
- Review compliance with all contract requirements
- Conduct an Annual Programmatic Monitoring Review
- Approve invoices for payment
- Work in tandem with HCA Contract Services and QMS to serve as a liaison between other County departments and the program

Monthly Data and Performance Outcomes Report (MDPOR)

This report template is provided by the Contract Monitor usually in the form of an Excel spreadsheet. It is to be submitted by the program to the assigned Contract Monitor monthly by the 10th calendar day of the month. This form is used to track the program's specific performance outcomes referenced in the program's contract and contains data that may be reported to the County Board of Supervisors when it approves the HCA contracts. A program may need to complete more than one monthly report form if the program contains more than one type of service, or level of care.

Special Incident Report (SIR)

Any incident of a serious nature at a contracted facility requires a Special Incident Report (SIR) form to be submitted to the program's assigned Contract Monitor within 24 hours of the event. In the event of the death of a current client or a client served within the last 6 months, the program needs to report the death directly to the Contract Monitor or other available HCA staff *by phone immediately* upon becoming aware of the death. The program's Contract Monitor can provide an SIR form template with prompts for all required information. The SIR forms must be filled out in their entirety with attention to detail. The narrative description of the event should be distilled to three sentences or less containing only the facts at hand. There is an addendum form that allows for a broader description that can be sent after the initial SIR form, if needed.

Policies and Procedures

As providers within the Orange County network of care, each program contracted to provide DMC-ODS services must have certain policies and procedures in place.

Required Policies and Procedures:

- Admission and Re-Admission Procedures
- Requesting Authorization for Residential Services
- Practices Consistent with the Provision of Culturally Competent Services
- Members' Rights and Protections
- Use of Volunteers/Students
- Coordination/Transition of Care
- Medications for Addiction Treatment (MAT)
- Identification of Over-Payments made to Provider by the County and Re-Payment Process
- Record Retention (Members and Payments/Over-Payments)
- Accountability for Audit Exceptions as listed on Orange County's HCA BH Integrated Intergovernmental Agreement
- Program Integrity
- Dedicated Staff for Routine Internal Monitoring and Audit Compliance
- Other Policies/ Procedures as Guided by Governmental Policy Changes

This is not an exhaustive list of policies and procedures required as there may be additional policies and procedures required by your specific contract. Each program should reach out to their assigned Contract Monitor if there are any questions.
Orange County's Policies and Procedures can be found by visiting BHS Policies and Procedures.

TYPES OF SERVICES

American Society of Addiction Medicine (ASAM) Model

The ASAM Criteria

The ASAM Criteria is a set of guidelines that promote individualized treatment planning and the use of a holistic approach to SUD treatment. It also provides a guide for providers in making objective decisions about a member's admission, continuing care, and movement along the continuum of care.

The ASAM Criteria:

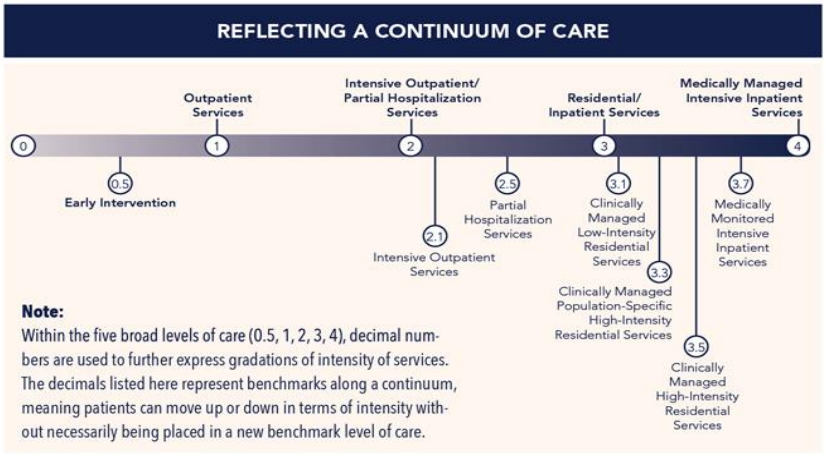
- Assess the member's individualized needs using the six (6) dimensions to ensure a "whole-person" approach.
- Ensure that the services being provided are meeting the member's individualized treatment needs to improve chances of sustainable recovery.
- Follow a comprehensive set of standards for placement, continued service, and transfer of clients with addiction and co-occurring conditions
- Provide outcome-oriented and results-based care in the treatment of addiction

The ASAM Criteria's Continuum of Care

The ASAM Criteria defines standards for the different levels of care (LOC) across the continuum of care. The standards describe the setting, staffing, service intensity, and other core elements at each LOC.

As a client moves through SUD treatment, they are regularly reassessed. The transition and continued service criteria are applied continually to determine if a client is ready to move to another LOC. The client can move to a less intensive LOC, a more intensive LOC, or can continue at the current LOC when indicated by the ASAM criteria.

The currently used continuum of care for the ASAM model 3rd Edition is reflected below:

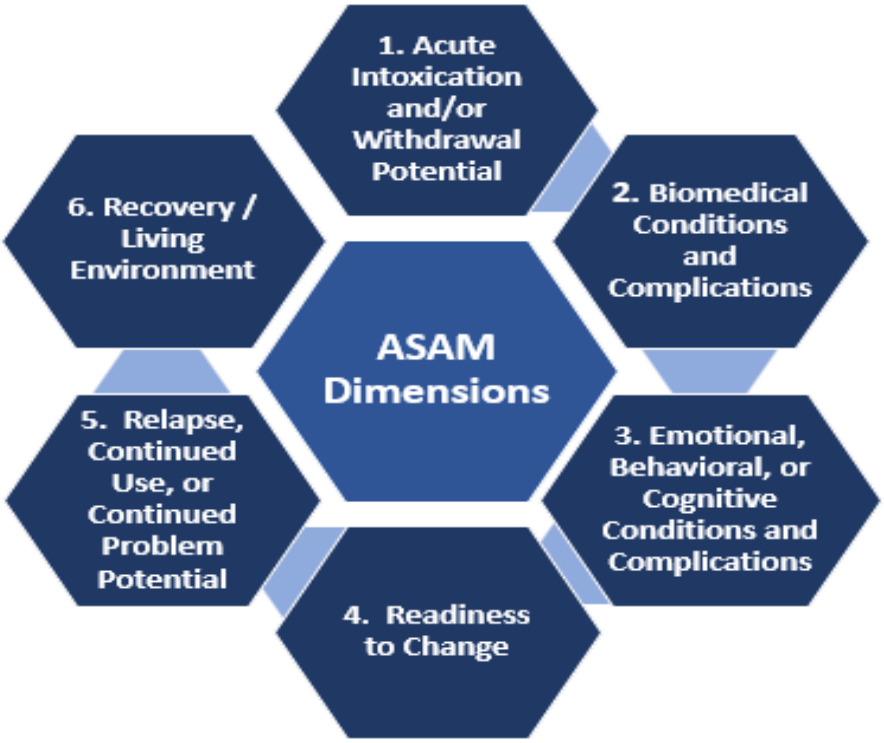


The ASAM Dimensions and Medical Necessity

Each LOC within the ASAM model is designed to meet an individual's specific treatment needs, ensuring appropriate and effective support at every stage of recovery. A service may be considered medically necessary when it is reasonable and necessary to protect life. For SUD, the ASAM dimensions determine the LOC that most likely will assist the client to reduce use, prevent further escalation of use, and/or prevent relapse. Medical necessity is based off the severity in all six (6) dimensions. Each of these dimensions receive a severity rating, which will further inform the appropriate LOC for each individual seeking treatment.

The six (6) dimensions are:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions or Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery and Living Environment



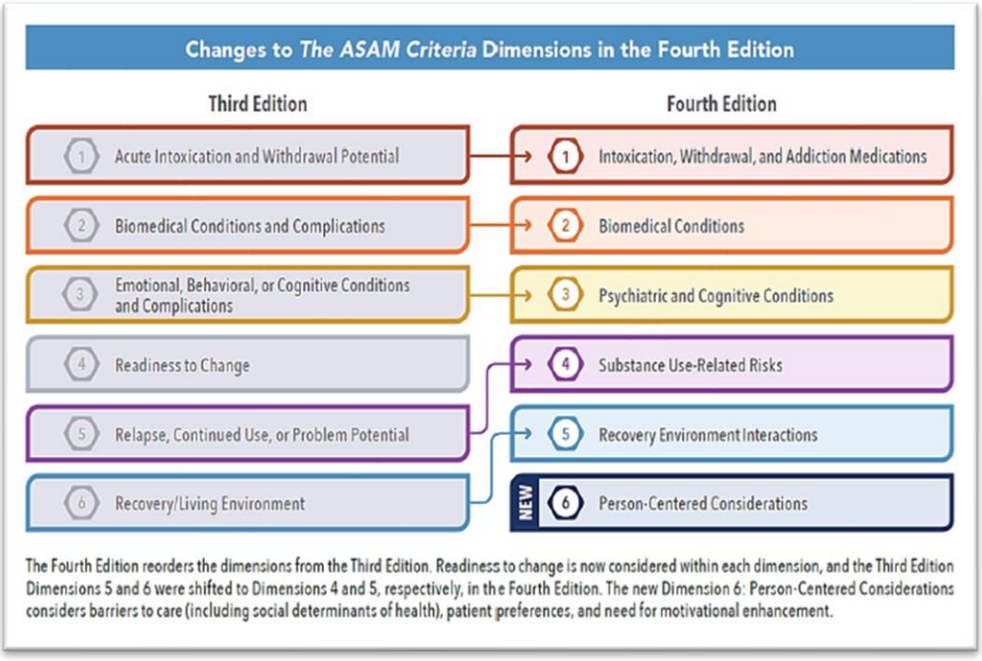
The ASAM 4th Edition

Although the ASAM 4th Edition has already been released, Orange County is still waiting for guidance from DHCS on the roll-out and implementation plan. The dimensions were updated to simplify the language and to align with the updated dimensional admission criteria framework.

Some major changes to note include:

- The explicit consideration of addiction medication needs in Dimension 1
- The Readiness to Change section (Dimension 4 in the 3rd edition) has been removed. While readiness is still an important factor, it does not independently contribute to the LOC recommendation. A client's readiness to change is now considered within each dimension.
- Due to the removal of the Readiness to Change section in the 4th edition, the 3rd edition's Dimensions 5 and 6 were reorganized in the 4th edition.
    - 3rd edition's Dimension 5, Relapse, Continued Use, or Continued Problem Potential, will be the 4th edition's Dimension 4, Substance Use-Related Risks
    - The 3rd edition's Dimension 6, Recovery/Living Environment, will be the 4th edition's Dimension 5, Recovery Environment Interactions
- A new dimension was added. Dimension 6, Person-Centered Considerations, has a clinician or counselor consider the client's barriers to care, client preferences, and the need for motivational enhancement services.

As new guidance comes through from the State regarding these upcoming changes, Orange County's HCA will provide updates on how providers will be impacted. For more information, refer to ASAM - American Society of Addiction Medicine.



DMC-ODS LEVELS OF CARE AND NON-DMC-ODS SUD SERVICES

The County of Orange offers members a full range of SUD treatment services when the services are medically necessary. The County Plan requires for treatment placement decisions to follow the criteria established by the American Society of Addiction Medicine (ASAM). *Partial Hospitalization is not currently offered in Orange County.*

- Outpatient Drug Free (ODF)
- Intensive Outpatient Treatment (IOT)
- Residential Treatment Services
- Withdrawal Management
- Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP)

Additional services may be provided while the client receives treatment services in a LOC if deemed medically necessary.

These additional services include:

- Perinatal and Postpartum Services for pregnant and parenting women
- Recovery Services
- Peer Support Services
- Medication Services
- Medications for Addiction Treatment (or MAT)
- Recovery Incentives (for Outpatient only)
- Adolescent SUD Treatment Services

For more information on the SUD services Orange County offers, please refer to Orange County's HCA DMC-ODS website.

DMC-ODS Covered Services

Orange County DMC-ODS programs provide services to restore clients to their best possible functional level. Some of the DMC-ODS services offered are:

- Assessment
- Care Coordination
- Clinical Consultation
- Family Therapy
- Counseling (Individual and Group)
- Medical Psychotherapy
- Medication Services
- MAT for Opioid Use Disorder (OUD), Alcohol Use Disorder (AUD), and non-Opioid SUDs

- Patient Education
- Peer Support Services
- Perinatal Services
- Recovery Services
- Narcotic Treatment Programs
- SUD Crisis Intervention Services
- Recovery Incentives Programs

All SUD treatment services provided must be medically necessary and recommended by Licensed Practitioners of the Healing Arts (LPHA) working within the scope of their practice.

Non-DMC-ODS SUD Recovery Residences

Subsidized sober housing is available for individuals 18 years and older, who are participating in DMC ODS Outpatient treatment and need stable housing. It is most frequently used as a step-down support for DMC ODS clients completing residential treatment. While at the recovery residence the client needs to be focused on obtaining employment and securing stable housing. At the time of publication, DMC ODS clients are eligible for one (up to a 90 day) stay in a County funded recovery residence bed in a year. This can be subject to change based on funding and demand. To access, the client's treatment counselor must send a request form to the County recovery residence gatekeeper via recoveryres@ochca.com who will approve the referral based on what is available at the time of request.

For more information on the Non-DMC-ODS SUD services, please refer to Orange County's HCA DMC-ODS website.

DMC-ODS LEVELS OF CARE

Outpatient Drug-Free (ODF) Services – LOC 1.0

The Outpatient Drug-Free or ODF LOC is appropriate for clients with less severe symptoms, which may include clients who are more stable upon initial assessment, or clients that may be stepping down from a more intensive LOC. Clinical services that are provided at this LOC may include Recovery Services and Motivational Enhancement Therapy. For ODF, the program requirements are based on the client's age and can be provided in any appropriate setting in the community.

Required hours for ODF depending on whether the client is an adult or an adolescent:

- Adults can receive less than nine (9) hours per week of medically necessary services
- Adolescents can receive less than six (6) hours per week of medically necessary services

Services that May be Provided at ODF - LOC 1.0

- Assessment
- Treatment Planning
- Individual Counseling
- Group Counseling
- Family Therapy
- Care Coordination
- MAT for OUD, AUD, and Non-OUD
- Patient Education
- Recovery Services
- Crisis Intervention Services

For more information on the ODF level of care, please refer to DMC-ODS CalAIM Documentation Manual, BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026, IAP's Overview of SUD Care Clinical Guidelines and Orange County's BH Integrated Intergovernmental Agreement.

Intensive Outpatient Treatment (IOT) - LOC 2.1

The Intensive Outpatient Treatment or IOT LOC is appropriate for clients, when medically necessary, who will benefit from a structured, programming environment. Clinical services provided at the IOT LOC focus on treating multi-dimensional instability. The IOT program requirements are again based on the client's age and can be in any appropriate setting in the community.

Required hours for the IOT LOC depending on whether the client is an adult or an adolescent:

- Adults require *nine (9) or more hours of clinical services per week* when medically necessary
- Adolescents *require six (6) or more hours per week* of clinical services when medically necessary

For both adults and adolescents, there is a maximum of nineteen hours per week of clinical services per week; however, services may exceed the maximum based on individual medical necessity.

Services that May be Provided at IOT - LOC 2.1

- Assessment
- Treatment Planning
- Individual Counseling
- Group Counseling
- Family Therapy

- Care Coordination
- Patient Education
- Medication Services
- MAT for OUD, AUD and Non-OUD
- Crisis Intervention
- Recovery Services

For more information on the IOT level of care, please refer to IAP's Overview of SUD Care Clinical Guidelines, Orange County's HCA BH Integrated Intergovernmental Agreement, the DMC-ODS CalAIM Documentation Manual and BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026.

Residential Treatment Services – LOC 3.1, 3.3 and 3.5

Residential Treatment Services are 24-hour non-medical, non-institutional, short-term treatment programs that provide rehabilitation services when determined medically necessary. There are three levels of care for Residential programs. In Orange County, our programs are either LOC 3.1 or 3.5. To enter a Residential program, the client must have *prior authorization* for Residential Services by the County's Authorization for Residential Treatment (ART) team**.** Residential authorizations are not time limited and are based on medical necessity, with the goal for a Statewide average length of stay of 30 days.

Each Residential LOC requires that every client receive *at least five hours of clinical treatment services per week*. These clinical hours can consist of Individual Counseling and Group Counseling services, including recovery skills, relapse prevention, and other clinical services.

Residential levels of care will be changing when the State releases guidance on how to implement changes in the ASAM 4th Edition. For more information on the ASAM 4th edition, please refer to the ASAM - American Society of Addiction Medicine website.

Services that May be Provided at all Residential - LOC 3.1, 3.3 and 3.5

- To receive the Residential Day Rate, a Residential provider must provide at least one of the daily bundled service components, which *include the following activities*:
    - Assessment
    - Individual Counseling
    - Group Counseling
    - Family Therapy
    - SUD Crisis Intervention

  - Medication Services
  - Patient Education

- *Separate billing* apart from the Residential Day Rate include:
  - Care coordination
  - Recovery services
  - MAT for OUD
  - MAT for AUD and non-Opioid SUDs

Clinically Managed Low Intensity Residential Services - LOC 3.1

LOC 3.1 is appropriate for clients whose recovery requires time spent living in a 24-hour structured, stable environment with trained personnel available. At this LOC, the client can practice coping skills, self-efficacy, and make connections to the community, including resources to employment, education, and resources for family systems. Part of the purpose of the Residential setting is to provide structure for the clients to begin learning and practicing sober life skills in a safe and contained environment. Each Residential LOC requires that every client receive at least five hours of clinical treatment services per week. These clinical hours can consist of Individual Counseling and Group Counseling services, including recovery skills, relapse prevention, and other clinical services. This LOC is intended to prepare the client for Outpatient treatment.

Clinically Managed Population Specific High Intensity Residential Services - LOC 3.3

LOC 3.3 is specifically designed for adults with cognitive or other impairments resulting from substance use or other co-occurring disorders. It is appropriate when a client's temporary or permanent cognitive limitations make it unlikely for them to benefit from other Residential LOC's that offer group therapy and other cognitive-based relapse prevention strategies. This LOC may provide a less intense setting and group treatment sessions for individuals with cognitive or other impairments who may be unable to progress in a full active environment or therapeutic community. To assist these clients, they may receive slower paced, repetitive services until the impairment subsides and/or they are able to progress to another LOC. This LOC provides 24-hour care with trained counselors to stabilize imminent danger. Each Residential LOC requires that every client receive at least five hours of clinical treatment services per week. These clinical hours can consist of Individual Counseling and Group Counseling services, including recovery skills, relapse prevention, and other clinical services. This LOC is also intended to prepare the client for Outpatient treatment.

Clinically Managed High Intensity Residential Services - LOC 3.5

LOC 3.5 is appropriate for clients who have severe social and psychological conditions or are in imminent danger and who cannot safely be treated outside of a 24-hour stable living environment. This LOC provides multi-layered treatment services to clients with psychological problems, unsupportive interpersonal relationships, and clients who may have a criminal justice history. These issues can cause instability that place a client in imminent danger if not in a 24-hour treatment setting. LOC 3.5 provides 24-hour care with trained counselors to stabilize imminent danger and is intended to prepare the client for Outpatient treatment.

*For more information on Residential levels of care, please refer to IAP's Overview of SUD Care Clinical Guidelines, Orange County's HCA BH Integrated Intergovernmental Agreement, SUD Residential Treatment Authorization and Re-authorization P&P, BHIN 21-001 Exhibit A DHCS Level of Care Designation Requirements and BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services Enclosure 1A.

Withdrawal Management (WM) - LOC 3.2

Withdrawal Management services are offered in Residential, non-institutional, non-medical WM programs that utilize a social model detox system to help members during the non-acute detoxification process. The purpose of WM LOC is to maximize the reduction of substance use symptoms and to restore the client to their best possible functional level. The focus is on stabilizing and managing the psychological and physiological symptoms associated with withdrawal.

Withdrawal Management services are provided to clients when medically necessary and are available 24 hours a day, 7 days a week. The average length of stay is 7 days. While at the WM program, the program will provide close, face-to-face physical checks known as observations that must occur for each client *at least once every thirty (30) minutes* with monitoring of the vital signs happening *every six (6) hours for the first seventy-two (72) hours of the client's admission*. The observations must be conducted and documented by personnel who have been trained in detoxification services.

If the client is experiencing acute or severe withdrawal, the client should go to the nearest emergency room.

Services that May be Provided at WM – LOC 3.2

- Assessment
- Care Coordination
- Medication Services
- MAT for Opioid Use Disorder (OUD), Alcohol Use Disorder (AUD) and other Non-Opioid Substance Use Disorders
- Recovery Services

- Observations

It is permissible for Care Coordination, MAT services, Peer Support Services, and Recovery Services (RS) to be provided simultaneously with the client's enrollment in WM when deemed medically necessary.

*For more information on Withdrawal Management, please refer to IAP's Overview of SUD Care Clinical Guidelines, DMC-ODS CalAIM Documentation Manual, BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026, Orange County's HCA BH Integrated Intergovernmental Agreement, BHIN 21-001 Exhibit A DHCS Level of Care Designation Requirements and BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services Enclosure 1A.

Narcotic Treatment Program (NTP)

Provides opioid medication assisted treatment, detoxification and/or maintenance treatment services, including medical evaluations and rehabilitative services. NTP programs are subject to comply with the California Code of Regulations (CCR) Title 9 rules and policies. NTP services are available to individuals 12 years old and older, seven (7) days a week and are provided by licensed NTP facilities. You must be a resident of Orange County to receive NTP services at Orange County NTP sites. NTPs are required to administer, dispense, or prescribe medications to clients covered under DMC-ODS as medically necessary.

Medications that may be provided at an NTP include:

- Methadone
- Buprenorphine (transmucosal and long-acting injectable)
- Naltrexone (oral and long-acting injectable)
- Disulfiram
- Naloxone.

In addition to these medications, NTPs must offer clients a minimum of 50 minutes of counseling services per calendar month. Additional counseling can be provided when deemed medically necessary. Medical necessity for additional services must be documented in the client's records. At any time after admission, the Medical Director may adjust or waive by medical order the minimum number of minutes of counseling services per calendar month. If counseling is adjusted or waived, the Medical Director should document the rationale for the medical order in the client's treatment plan.

For members outside Orange County, occasional courtesy dosing can occur on a case-by-case basis. Members should contact the NTP to determine steps needed to obtain an occasional dose outside their county of residence.

Services that May be Provided at NTP

- Assessment

- Care Coordination
- Counseling (Individual and Group, or Medical Psychotherapy)
- Family Therapy
- Medical Psychotherapy
- Medication Services
- Medications for Addiction Treatment (MAT) for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

For more information on NTPs, please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026, and Title 9 CCR Division 4 Chapter 4 - Narcotic Treatment Programs / Legal Information Institute for further information.

ADDITIONAL DMC-ODS COVERED SERVICES

Perinatal Services

The Outpatient and Residential Providers offering perinatal services provide additional parenting education, referrals, transportation, childcare, and other services, as specified by the DHCS Perinatal Practice Guidelines.

Perinatal services are for clients who are pregnant or postpartum (up to 12 months after the date a pregnancy has ended) regardless of enrollment in a perinatal-specific program. Through these services, women may have access to additional services providing parent education, referral, transportation, childcare, and other services, as specified by the DHCS' SUD Perinatal Practice Guidelines. Programs who choose to offer perinatal services must abide by the SUD Perinatal Practice Guidelines, which can be viewed on the County of Orange Practice Guidelines website, SUD Perinatal Practice Guidelines..

Medical documentation must be on file to justify billing for Perinatal Services (for example, verification of pregnancy from a medical professional working within their scope of practice, or a birth certificate for postpartum services). Perinatal services can be billed for up to 12 months postpartum. Eligibility for using the perinatal code ends on the last day of the month on which the 365th day since the last day of pregnancy falls. An example would be if the 365th day is on June 15th then the last day to use the perinatal billing code would be on June 30th. To claim a service using the Perinatal billing codes the service must be provided in a perinatal-designated facility, *and* there must be medical documentation on file to support the client's pregnancy or post-partum status.

If the client no longer meets this Perinatal definition, the client would be eligible for non-Perinatal services if they meet medical necessity for the designated LOC.

*Please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, BHIN-23-030 SMHS DMC and DMC-ODS Postpartum Claiming and Perinatal Services Network Guidelines P&P for further information.

Recovery Services (RS)

Recovery Services emphasizes the member's role in managing their health and the use of effective self-management support strategies. Members are not required to have an "in remission" diagnosis and do not need to be abstinent from drugs for any specified period to enroll. Members may enroll immediately after incarceration, regardless of whether they received SUD treatment during incarceration. Members may also receive Recovery Services based on their preference. Clients may receive Recovery Services while also receiving treatment services at all LOC, and while the client is also receiving other services including NTP and MAT. Although Recovery Services is a covered component for all treatment levels of care, it is an *exception* and very unusual for a client to receive *both* RS and Residential treatment at the same time. If you have any questions prior to billing RS, please consult the QMS SUD Clinical Records Team.

Services that May be Provided at Recovery Services

- Assessment
- Care Coordination
- Counseling (Individual and Group)
    - Assessment
    - Care Coordination
    - Counseling (Individual and Group)
    - Family Therapy
    - Recovery Monitoring, which includes recovery coaching and monitoring for maximum reduction of SUD
    - Relapse Prevention, which includes interventions intended to teach how to anticipate and cope with the potential for relapse

For further information, please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, the "Recovery Services" section later in this Provider Manual, and BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026.

Peer Support Services

Peer Support Services are culturally competent services that promote recovery, resilience, and self-advocacy that aim to prevent relapse through strength-based coaching, to support linkages to community resources, and to educate clients and their families about SUD conditions and the process of recovery. This is done through structured activities in a group and in individual coaching settings to set recovery goals and to identify steps of how to reach the goals. Peer Support Services are provided to adults and adolescents, 12 years and older who are in treatment for SUD in Orange County. Peer Support Specialists in this program will collaborate with the client's primary counselor and become a part of the treatment team to support the client in meeting their treatment goals. Most services will be provided in the community where clients are located.

A Peer Support Specialist is required by DHCS to have lived experience in one or more of the following:

- Personal experience with SUD
- As a parent/caregiver of someone with behavioral health needs
- As a family member of someone receiving behavioral health services and are in recovery.

Only a Peer Support Specialist who has a current State-approved Medi-Cal Peer Support Specialist Certification and meets ongoing education requirements may claim for services in a Peer Support Services Program. DHCS requires all Peer Support Specialists to be supervised by a Licensed Mental Health Professional (LMHP) or other approved supervisor, depending on the setting. Services must be part of an individualized client plan. They can be provided in any LOC if approved in the treatment plan.

Service Components of Peer Support Services

Individual and group coaching services are provided in the following formats:

- *Educational Skill Building Groups* occur in a supportive environment where the clients and their families learn coping mechanisms and problem-solving skills.
- *Engagement* is when a Peer Support Specialist leads activities and coaches the client to encourage and support the client in their participation with behavioral health treatment.
- *Therapeutic Activity* is a structured, non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support recovery within their communities.

Please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, BHIN-21-075 and BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services, Enclosure 1A, for further information.

Medication Services

Medications Services include prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management and assessing for side effects or results of the medication. Medication Services *do not include* medications for Medication for Addiction Treatment (MAT) for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid SUDs.

Please refer to the MAT Documentation Manual and Orange County's HCA BH Integrated Intergovernmental Agreement for further information.

Medications for Addiction Treatment (MAT) for Opioid Use Disorder (OUD), Alcohol Use Disorder (AUD) and other Non-Opioid Substance Use Disorders

Medications for Addiction Treatment (MAT) are required to use FDA-approved medications and biological products to treat OUD, AUD, and Other Non-Opioid SUDs, in combination with counseling and behavioral therapies. MAT for AUD and non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered with any ASAM LOC. Please note that medical necessity for MAT services *must* be determined by an LPHA Physician, an LPHA Physician Extender (Nurse Practitioner or Physician Assistant), or an LPHA Non-Physician working within their scope of practice.

MAT Services can only be provided by the following classifications working within their scope of practice:

- LPHA Physician (MD or DO)
- Medical Student in Clerkship
- LPHA Physician Extender (Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Pharmacist, Pharmacist Clinical Trainee)
- LPHA Non-Physician (Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee)

Services that May be Provided at MAT for OUD, AUD and Other Non-Opioid SUDs

- Assessment
- Care Coordination
- Counseling (Individual and Group)
- Family Therapy
- Medication
- Patient Education (addiction, treatment, recovery)

- Prescribing, administrating, dispensing, ordering, monitoring, and/or managing the medications used for MAT AUD and non-OSUDs
- Recovery Services
- SUD Crisis Intervention
- Withdrawal Management

Please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, MAT Documentation Manual, DMC-ODS CalAIM Documentation Manual, and BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026 for more information.

MAT Services Requirements for All Levels of Care

All licensed and/or certified SUD recovery or treatment programs are required to develop, implement, and maintain a *DHCS approved* MAT policy that is in compliance with State mandate laws and regulations. Programs must either offer MAT services directly to the client or have an effective referral process in place with NTP or other MAT providers.

For more information on the required MAT assessment and MAT referral process, please refer to the "MAT" section in this Provider Manual. For information on what the contents of the MAT policy needs to contain, please see BHIN 23-054 Medications for Addiction Treatment (MAT) Services Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities. For more information about MAT Services Requirements, please refer to the "Medication Monitoring" section in this Provider Manual, MAT Documentation Manual, and BHIN 23-054 Medications for Addiction Treatment (MAT) Services Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities.

Recovery Incentives (RI) Program

California offers the Recovery Incentives (RI) program which includes Contingency Management (CM) benefits to clients. The RI Program reinforces a client's positive behavior change when the client is meeting their treatment goals (i.e., abstinence from stimulants). This program is an evidence-based treatment for SUD clients with a stimulant use disorder (StimUD). The presence of additional Substance Use Disorders and/or diagnoses does not disqualify a client from receiving RI services. The RI Program is a structured, 24-week Outpatient service, followed by six or more months of additional treatment and recovery support without incentives. The initial 12 weeks of the RI program consist of a series of incentives, such as cash-equivalents (e.g., gift cards), provided to the client when they test negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). Each test must be verified by a Urine Drug Test (UDT).

RI Services are *only* provided at the Outpatient LOC. Clients at the Residential levels of care are not eligible for the RI Program until the day of discharge if, or when they are transitioned to an Outpatient

LOC. RI Services are covered when medically necessary and appropriate as determined by an Initial SUD Assessment showing:

- Moderate or Severe StimUD as defined by the clinical criteria in the DSM
- Clinical determination that Outpatient treatment is appropriate per the ASAM criteria *AND*
- The RI service is medically necessary *and* appropriate

Please refer to BHIN 23-040 Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit for further information.

Adolescent SUD Treatment Services

The Orange County DMC-ODS network of care offers clients under age 21 Outpatient treatment (ODF and IOT) services, Residential LOC 3.1 and 3.5 services, NTP services, and MAT services. Any client under the age of 21 who is screened and determined to be at risk of developing a SUD may receive any service component covered under the Outpatient LOC as early intervention services.

Early Intervention services must be available as needed based on the client's clinical need, even if the client under age 21 is not participating in the full array of Outpatient treatment services. EPSDT services include screening, vision, dental, hearing and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered for adults. All DMC-ODS adolescent providers should collaborate with other adolescent-serving systems or agencies to address the comprehensive needs of adolescents with SUDs and their families.

DMC-ODS adolescent providers are expected to comply with the Adolescent SUD Best Practices Guide.

For a more complete description of the EPSDT services that are available or to have your questions answered, please call Orange County's Children and Youth Services (CYS) Administration between 8:00 a.m. and 5:00 p.m. at (714) 834-5015.

Please refer to Adolescent SUD Best Practices Guide and Compliance with Adolescent/Youth Treatment Guidelines P&P for more information.

ACCESS POINTS INCLUDING SUD TREATMENT FOR PEOPLE WITH DISABILITIES

Access Points

For a member to access DMC-ODS services in Orange County, there are three (3) main access points.

1. 24/7 Access Line (800) 723-8641
   The 24/7 Access Line is a 24-hour, 365-days-a-year service available to respond to calls regarding access to services. The 24/7 Access Line is staffed by registered or certified counselors and LPHAs. The purpose of this service is to link members to SUD services and make referrals, as appropriate.
   Please refer to OC Navigator and BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026 for more information.

2. County-Operated and Contracted Outpatient Clinics

3. Treatment Authorization by the Authorization for Residential Treatment (ART) Team

   Prior authorization for residential services is required based on the DSM and ASAM Criteria. For clients to receive Residential treatment LOC, they must demonstrate severity in functioning that warrants the Residential LOC and be authorized by the County. The County's Authorization for Residential Treatment (ART) team determines, based on client assessment and/or documentation presented by providers, whether a client may be authorized for Residential Treatment.

Please refer to Orange County's HCA BH Integrated Intergovernmental Agreement, and the DMC-ODS CalAIM Documentation Manual. Another resource is Orange County's SUD Residential Treatment Authorization and Re-authorization P&P, which is revised as needed.

For a list of all County and County-Contracted DMC-ODS Residential providers, please visit Orange County's Orange County's DMC-ODS Provider Directory Search.

Access to SUD Treatment for Persons with Disabilities (PWD)

As a network, Orange County's HCA is required to provide proper access to SUD services to persons with disabilities (PWD). While not all providers are required to have full accessibility, OC HCA must ensure that proper access exists within Orange County's DMC-ODS network. Annual assessment of our DMC-ODS network and its accessibility to PWD will be conducted to ensure appropriate services are accessible within our network. If a program does not have the appropriate services to accommodate onsite, the program should link the client to a program who can provide the appropriate services.

Please refer to the Access to Substance Use Disorder Services for Persons with Disabilities P&P for more information.

Access Timelines

Federal standards require services to be made available to members within specific time frames depending on the service. All access points are responsible for making every attempt to link each client within the required time frame. The access timelines are as follows:

- 10 days for Outpatient Services (IOT, ODF)
- 3 days for NTP/OTP
- 48 hours (WM, MAT)

For additional details regarding these requirements, refer to Orange County's HCA BH Integrated Intergovernmental Agreement, and the "Access Logs and Timely Access Standards" section in this Provider Manual.

42 CFR PART 2: SUBSTANCE USE DISORDER CONFIDENTIALITY REGULATIONS

All County-operated and County-Contracted SUD programs must comply with both HIPAA Privacy Rules and 42 CFR Part 2 confidentiality regulations for SUD client records to ensure confidentiality and compliance.

Title 42 Code of Federal Regulations (CFR) Part 2, which is commonly referred to as "42 CFR Part 2" or "Part 2", establishes strict confidentiality protections for SUD records maintained by federally assisted SUD program. These regulations are designed to protect the confidentiality of SUD clients, ensuring they are not made more vulnerable due to the availability of their health records. Just like HIPAA, 42 CFR Part 2 allows disclosures of PHI *with* written authorization from members or as specifically permitted or required. When disclosing PHI, program staff should only disclose the *minimum necessary* to meet the intent of the disclosure.

Protections under 42 CFR Part 2 begin the moment a member applies for or requests SUD treatment, obtains a SUD referral, or receives a SUD diagnosis or SUD treatment. This includes initial contact via voicemail, phone calls, registration forms, or Access Log entries. For individuals in a program covered by 42 CFR Part 2, the confidentiality protections last indefinitely, even after death (Privacy Protections for Deceased Clients from Focus PHI).

Under 42 CFR Part 2, any disclosure of a client's SUD-related information *must include one* of the following redisclosure prohibition statements:

- *"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general*

authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

- *"42 CFR Part 2 prohibits unauthorized disclosure of these records."*

While you may be able to generally communicate with a client directly without a consent on file, *any communication about anything related to SUD would be a breach without a consent on file*. For instance, if a client calls requesting SUD services, a program *must* keep the client on the line and warm link them to another provider since the program does not have a signed consent. The initial program who referred the client cannot contact the new provider where the client was linked or follow-up with the client to ensure linkage occurred *without a signed consent*.

The County will use and disclose protected health information or PHI in accordance with federal and State regulations. While 42 CFR Part 2 generally prohibits disclosure without client consent, exceptions exist in the following circumstances:

- Medical Emergencies: Disclosure of information to medical personnel to the extent necessary to:
  - Meet a bona fide medical emergency where the member's prior written consent cannot be obtained. This applies only if the member is truly incapacitated and unable to provide consent, not when the member refuses to authorize disclosure. A member's refusal to authorize a disclosure to medical personnel is not in itself an emergency, even if the service provider believes the disclosure would be in the member's best interest.
  - Meet a bona fide medical emergency in which a Part 2 program is closed and unable to provide services or obtain the client's prior written consent, during a temporary state of emergency declared by the State or federal authorities due to a natural or major disaster, until such time the Part 2 program resumes operation.
- Court-Ordered Subpoenas: Disclosure is allowed only if authorized by a court order provided the court implements appropriate safeguards to prevent unauthorized use or further disclosure.
- Mandated Reporting: Disclosures required by law, such as reports of child or elder abuse, are permitted.
- Crimes on Program Premises or Against Staff: If a client commits a crime at an SUD program or against program staff, disclosure may be made to law enforcement.
- Research, Reviews and Evaluations: Disclosures may be permitted for these purposes when compliant with regulations.

On July 15, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a final rule amending the regulations outlined in 42 CFR Part 2, effective August 14, 2020. These updates include:

- Amended the definition of "record" to *exclude oral information* received by a non-Part 2 program from a Part 2 program

- Eased the requirement for client record disclosures by allowing members to designate entities as recipients, as well as individuals
- Revised the language on one of the two allowable "Notices to Accompany Disclosure" with client's consent
- Expanded the allowable basis for disclosures with *client's written consent* for payment or health care operations purposes
- Expanded upon the circumstances of when a Part 2 program can release the client's records *without client's consent* during a bona fide medical emergency

For more information on 42 CFR Part 2, please refer to 42 CFR Part 2 - PART 2, FAQs regarding Substance Use Confidentiality Regulations from SAMHSA; Federal Register Vol 89 No 33 Feb 16 2024 Rules and Regulations 42 CFR Part 2 and eCFR : 42 CFR Part 2 -- Confidentiality of Substance Use Disorder Patient Records.

Compliance with HIPAA and 42 CFR Part 2 is critical to protect client privacy and avoid significant consequences for violations. Providers who violate these regulations may include civil monetary penalties depending on the level of culpability. Criminal penalties can also be imposed for intentional violations, leading to fines and imprisonment. Additional consequences may include potential loss of licensure or certification, and clients may take legal action against providers for unauthorized disclosures.

To prevent violations, providers should always consult a supervisor, HCA Custodian of Records, Office of Compliance, QMS Health Information Management (HIM) Team, or their Contract Monitor before disclosing information. Recent regulatory changes are now in effect, and further guidance will be provided as updates become available.

On April 16, 2024, the 42 CFR Part 2 Final Rule became effective. There is a two-year implementation period with a mandated date of compliance for the new rule by February 16, 2026. More information about the Final Rule will be released in the coming year.

For more information on 42 CFR Part 2 Final Rule, U.S. Department Health and Human Services' Fact Sheet 42 CFR Part Final Rule.

AUTHORIZATION TO USE AND DISCLOSE DMC-ODS PHI

A valid Authorization to Use and Disclose PHI (ATD) form is required under the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 for the release of client information. Under 42 CFR Part 2, verbal consent is not valid, and a written consent is always required.

DMC-ODS programs utilize two Authorization to Disclose Protected Health Information (ATD) forms: the DMC-ODS ATD and the Orange County HCA ATD. The HCA ATD is an authorization form used

by a specific program that allows the disclosure of PHI as specified by the client. However, due to stricter requirements under 42 CFR Part 2, a one-time DMC-ODS ATD form is used to facilitate the exchange of PHI between County and Contracted providers during the initial referral process.

The DMC-ODS ATD form is not posted on the HCA intranet, as it is *not intended* to be a universal authorization form. Once a client has been accepted by a specific DMC-ODS provider, program staff must transition to the General ATD form. County providers must use the HCA ATD form, while County-Contracted providers have their own General ATD. The General ATD identifies the exact DMC-ODS program where the member will receive SUD services. Under 42 CFR Part 2, a client consent is required for each disclosure, except in limited circumstances and 42 CFR Part 2 requirements take precedence over HIPAA privacy regulations.

Program staff must ensure they select and complete the appropriate ATD form, making sure all mandatory elements are included. Every field on the ATD should be filled out, even if it does not apply, as omissions or errors can render the form invalid and lead to improper disclosure of PHI or PII. If any changes to the authorization are needed, the client must complete a new ATD form.

A valid ATD form is required when discussing a client's care with individuals outside the program, requesting records from an agency where the client was previously treated, releasing client records to an agency involved in the client's care, or referring a client to another provider for SUD services. Without a valid ATD, requesting or sharing client information may result in a privacy breach and be a violation of HIPAA and 42 CFR Part 2. If an incomplete ATD form is identified, program staff should immediately notify a supervisor to ensure corrective action is taken.

For County providers, if program staff are uncertain about the proper completion of an ATD form, they should consult a supervisor or contact the Office of Compliance (OfficeofCompliance@ochca.com) before requesting or disclosing a client's information. For County-Contracted providers, if program staff are uncertain about the proper completion of an ATD form, they should consult a supervisor or the provider's compliance team.

Electronic Signatures

42 CFR Part 2 indicates a consent may be obtained electronically. It does not provide a definition of what an electronic signature is which results in relying on federal and State definitions along with the requirements needed to be in place for the use of an electronic signature.

The Uniform Electronic Transactions Act (UETA) indicates "in order to qualify as an electronic signature under the ESIGN Act and UETA, the system used to capture the transaction must keep an associated record that reflects the process by which the signature was created or generate a textual or graphic statement (which is added to the signed record) proving that it was executed with an electronic signature."

If Adobe PDF signatures are used:

- there must be a mechanism that tracks or identifies how that signature was obtained to ensure the authenticity of the signer
- the programs/providers must have some sort of mechanism to identify the signer was the actual client

ACCURATE BILLING FOR SERVICES RENDERED TO DMC-ODS MEMBERS

Responsibility and Expectations for Accuracy

Accurate billing practices are essential to maintaining compliance with policies and procedures outlined in the previous section, ensuring that all services are properly documented and reimbursed.

All provider staff, at every level, are responsible for ensuring accuracy in documentation and billing throughout the entire service spectrum – from the first client contact through discharge and beyond. Staff must understand and follow all applicable rules and know where to seek clarification when needed. Accurate documentation is essential for maintaining records of service quality for SUD clients. Providers must correctly describe and code services to ensure compliance. HCA offers various trainings and resources to support accurate documentation and billing.

For more information on trainings, please see the "Required Training" section in this Provider Manual or for resources, please visit the DMC-ODS For Providers website.

Who Can Bill?

Eligible Providers include providers authorized to bill in the DMC-ODS, and they must meet specific licensing, registration, or certification requirements as defined by California State scope of practice statutes.

Licensed Practitioners of the Healing Arts (LPHAs) are professional staff who are licensed, registered, certified, or recognized under California State scope of practice statutes. There are two categories of LPHAs, Physician LPHAs and Non-Physician LPHAs. Clinical trainees may provide services under supervision and within the limitations of their training.

Below is the list of eligible providers who can bill for DMC-ODS as defined in the DMC-ODS Staffing Grid from DHCS. If you have any questions, please consult a supervisor or contact QMS Managed Care Support Team (MCST), the team responsible for credentialing all DMC-ODS providers.

Licensed Practitioner of the Healing Arts (LPHA) – Non-Physicians**:**

Professional staff must be licensed, registered, certified, or otherwise recognized under California State scope-of-practice statutes. They must provide services within their individual scope of practice and receive supervision required by their licensing laws.

This category includes Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social

Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT), and other eligible practitioners working under licensed supervision.

The following providers are classified as LPHAs; however, their scope of practice limits them from diagnosing or delivering certain clinical services better suited for other licensed professionals (e.g., LMFTs, LCSWs, LPCCs). These providers must adhere to the guidelines established by their respective licensing boards:

- Registered Nurses (RNs)
- Registered Nurse Clinical Trainees
- Licensed Vocational Nurses (LVNs)
- Vocational Nurse Clinical Trainees
- Licensed Occupational Therapists (LOTs)
- Occupational Therapist Clinical Trainees
- Pharmacists
- Pharmacist Clinical Trainees
- Licensed Psychiatric Technicians (LPTs)
- Psychiatric Technician Clinical Trainees

LPHA Physicians:

Physicians, as a subcategory of LPHAs, must be licensed, registered, certified, or recognized under the California State scope-of-practice statutes and provide services within their professional limits.

Non-LPHAs (Certified or Registered AOD Counselors):

Defined under Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations, counselors, whether registered or certified Alcohol and/or Drug (AOD) Counselors, are also known as non-LPHAs.

Medical Assistants (MAs):

Medical Assistants must operate under the supervision of a licensed professional.

Scope of Practice Requirements

All professional staff must be licensed, registered, certified, or recognized under California scope of practice statutes, operate within their individual scope of practice, and receive appropriate supervision as required by law.

For example, although RNs are listed as LPHAs in the DMC-ODS Staffing Grid, diagnosing behavioral health disorders is outside their scope-of-practice. Nurses should seek clarification from supervisors, program Medical Directors, or the QMS MCST.

Further details of roles and scope-of-practice are addressed in the DMC-ODS CalAIM Documentation Manual.

If you have questions about eligibility or scope of practice, consult your supervisor or the QMS MCST or QMS SUD Clinical Records Team for assistance.

Qualifications for DMC-ODS Individual Providers

Please review the Managed Care Support Team section of this manual to understand the credentialing and supervision requirements for all Behavioral Health Plan providers. All SUD staff must possess proper qualifications, obtaining certification from DHCS as DMC-ODS providers, if applicable, and completing required training needed before billing.

Clinical trainees do not need to be credentialed, yet they *must* meet all other requirements *before* providing services and/or billing.

Required Initial Trainings

- **ASAM A and B**: Completion of ASAM A and B (or Module I and II) trainings are required for all staff, including Medical Directors (unless Board-certified with an addition subspecialty), before providing DMC-ODS billable services, including Assessments.. Proof of completion must be submitted to the QMS MCST. Although ASAM C is not required, it is recommended.
- **SUD Evidence Based Practices**:
    - Motivational Interviewing (mandatory at least once)
    - One additional training in cognitive behavioral Therapy (CBT), Relapse Prevention, Trauma-Informed Treatment or Psychoeducation

Continuing Education Requirements (required for both LPHAs and non-LPHAs)

- *LPHAs*:
    - **Five (5) addiction-related CEU hours** of continuing education *related to addiction each 12-month period*
        - **Five (5) CMEs** for Medical Directors, physicians, and physician extenders
        - **Five (5) CEUs** for non-medical LPHAs related to addiction medicine *must* be completed *annually* in addition to completing the required number of CMEs or CEUs to maintain one's license to practice.
- *AOD Counselors*: *Must* complete addiction-relation training annually, fulfilling Title 9, Chapter 8 requirements (Chapter 8 - Certification of Alcohol and Other Drug Counselors).

Other Required Trainings

- **California Outcomes Measurement System (CalOMS)**
  - Training required for staff entering CalOMS forms is given by QMS. County providers will receive the training from IRIS, while County-Contracted users receive the training by the Office Coordination Billing Team (OCBT).
  - Clinical CalOMS training is required for providers administering the CalOMS and is available online on the DMC-ODS For Providers webpage.
- **SUD Documentation Training** must be completed *at least once, as required by the County contract*. Providers are strongly encouraged to complete this training to ensure compliance with documentation and billing requirements. This does not mean that a provider cannot provide and bill for services without having taken the training. The expectation is that providers will understand the documentation and billing requirements to be able to deliver and bill for compliant services once they begin providing services to clients. Staff can also review the DMC-ODS CalAIM Documentation Manual (available on the DMC-ODS For Providers website) and attest to its completion. Attestations should be kept on file.
- **Cultural Competence Training** All providers must receive at least one hour of Cultural Competence Training annually or as released.
- **Annual Compliance Training (ACT)** All providers are required to complete a compliance training annually.
- **Annual Provider Training (APT)** The DMC-ODS provider staff shall take the Annual Provider training annually as released. The program shall maintain training records for the APT.
- **Behavioral Health Plan (BHP) Provider Manual** Before providing any services, all DMC-ODS provider staff must review this Provider Manual and be familiar with the content.
- **Withdrawal Management (WM) Training** All personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements set forth in BHIN 21-001 and its accompanying exhibits and any subsequently issued BHINs that supersede BHIN 21-001.

For more information on required trainings, please refer to the Drug Medi-Cal Organized Delivery System Provider Training Requirements P&P, Training Specifically Pertaining to Cultural Competency P&P, The Change Companies, and the DMC-ODS For Providers webpage regularly to find the latest training and resources.

ROLES AND RESPONSIBILITIES FOR SUD PROVIDERS

Licensed Practitioner of the Healing Arts (LPHA)

The LPHA's role is to determine medical necessity and LOC, complete Assessments/Re-Assessments or review non-LPHA Assessments/Re-Assessments. Additionally, the LPHA completes the diagnosis and Case Formulation, maintains a Problem List and treatment planning activities with their scope-of-practice, provides Counseling services (Individual/Group), provides Family Therapy or

Counseling, provides Care Coordination services, documents and retains documentation as appropriate of services provided, and completes Discharge services/planning.

Non-LPHA (AOD Certified/Registered Staff)

Non-LPHA staff, such as AOD certified or registered counselors, may complete certain tasks (e.g., Assessments, Counseling, Care Coordination), but *cannot* diagnose conditions, determine medical necessity, or provide Family Therapy.

Non-LPHAs are responsible for conducting Intake Assessments and Assessments/Re-Assessments (*only* ASAM Assessment and placement information), adding/updating/resolving any issues on the Problem List (or updating treatment planning activities) as appropriate, providing counseling services (individual/group/family), providing care coordination services, documenting services and retaining documentation as appropriate, and completing discharge services/planning.

Please keep in mind that all staff must always act within their scope of practice, including their documentation in progress notes.

Medical Assistants

Medical Assistants are individuals aged 18 or older who meet the education, training, and certification requirements to provide administrative, clerical, and technical support. They operate under the supervision of a licensed physician, physician assistant, or nurse practitioner, who must be physically present on-site at the treatment facility during service delivery. Service providers in these roles must operate within their defined scope of practice and are limited from diagnosing or providing certain clinical services designated for other professionals.

For further details, refer to the standards of the respective licensing boards and Clinical Supervision Requirements.

Support Staff

Support staff, including behavioral technicians or house staff, are non-credentialed or non-licensed employees that are in direct contact with clients. Support staff may provide non-clinical, ancillary services such as supervision of clients, transportation, and recreational support. They are not authorized to deliver or bill for clinical services.

Please refer to the Clinical Supervision requirements in the Managed Care Support Team section of this Manual. Failure to comply with supervision requirements will result in services being disallowed; there are *no* exceptions.

PROPER DOCUMENTATION AND THE PERSONAL OBLIGATION OF EACH INDIVIDUAL

To maintain integrity in billing and compliance, providers must also adhere to proper documentation standards which are essential in demonstrating medical necessity and service delivery.

Medical Necessity

Medical necessity is at the core of all treatment, documentation, and billing in the DMC-ODS. All DMC-ODS services claimed must meet medical necessity. There is a definition of medical necessity for those members 21 years of age or older and for members under 21 years of age:

- For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate the substance use/misuse. Services need not be curative or completely restorative to ameliorate substance use/misuse. Services that sustain, support, improve, or make more tolerable substance use/misuse are considered to ameliorate.

For more information, access the "Medical Necessity" section of the DMC-ODS CalAIM Documentation Manual.

Services During the Assessment Process (Outpatient)

Except for Residential services, covered and clinically appropriate DMC-ODS services are reimbursable until the access criteria and LOC placement determination has been made. This means that for the Outpatient levels of care, we may bill for services before a full assessment is complete, or a diagnosis has been established.

With CalAIM, a full ASAM-based assessment, Brief LOC Screening Tool, or other referral tool for preliminary placement is *not required* to begin receiving DMC-ODS services.

Residential Treatment Services

Due to the prior authorization required for the Residential levels of care, members must receive a multidimensional LOC assessment within 72 hours of admission. The modified ASAM or the brief ASAM screening completed by the BHS Authorization for Residential Treatment (ART) team for the authorization of the Residential levels of care is sufficient. Once the member has been admitted to the Residential LOC that they have been screened and authorized as appropriate for, a comprehensive or full ASAM-based assessment needs to be completed as soon as possible, in accordance with member's clinical needs and generally accepted standards of practice.

Withdrawal Management (WM)

A comprehensive or full ASAM-based assessment is not required at the WM LOC. The Brief LOC Screening Tool is sufficient. However, whatever screening tool is used for admission will require the involvement of an LPHA for determining the diagnosis, LOC placement, and medical necessity. This entails a consultation between the non-LPHA and LPHA as well as separate documentation by the LPHA.

Narcotic Treatment Program (NTP)

A history and physical exam by a medical LPHA, such as might be done at admission, qualifies for the purposes of determining medical necessity. An ASAM-based assessment is still required at NTPs for establishing the appropriate LOC placement. If the ASAM-based assessment is conducted by a non-LPHA, the LPHA must complete a consultation and separate documentation, based on that ASAM-based assessment, to explain the reasoning for the placement. The physical exam, intake, and any subsequent assessment services are all considered part of the dosing service.

For more information see the "Billing Prior to Assessment at Outpatient" section of the DMC-ODS CalAIM Documentation Manual.

Billing During the Assessment Process

One of the requirements for submitting a claim for reimbursement of a DMC-ODS service is the inclusion of the member's qualifying diagnosis. However, at the Outpatient levels of care, the member may begin receiving services even before a diagnosis is established. Since a diagnosis is required for us to bill, there are a few options to allow us the ability to bill services at the Outpatient levels of care prior to the completion of an assessment when a diagnosis has yet to be established. The options are as follows:

- Use the ICD-10 codes Z55-Z65: All providers may use the ICD-10 codes Z55-Z65. The Z55-Z65 codes are, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances."
- Use the ICD-10 code Z03.89: ICD-10 code Z03.89 may be used only by an LPHA. Z03.89 is for an "Encounter for observation for other suspected diseases and conditions ruled out."
- Any clinically appropriate ICD-10 code: All other clinical ICD-10 codes may be used only by an LPHA, including Z codes and codes for "Other specified" and "Unspecified" disorders.

For more information see the "Billing Prior to Assessment at Outpatient" section of the DMC-ODS CalAIM Documentation Manual.

Access Criteria

For members to receive DMC-ODS services (at the Outpatients levels of care, this means to continue to receive services after a full assessment has been completed and a diagnosis is determined), they

must meet the access criteria. Similarly to the definition of medical necessity, the access criteria differ between members 21 years of age and older and members under the age of 21, as follows:

Access Criteria for members 21 years and older: Must meet one (1) of the following criteria to qualify for DMC-ODS services after the initial assessment process:

- Have at least one (1) diagnosis from the DSM-5-TR for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
- Have had at least one (1) diagnosis from the DSM-5-TR for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Access Criteria for members under the age of 21: Based on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid mandate, members who may be "at risk" of developing a SUD may receive SUD treatment. This includes treatment for risky substance use and early engagement services. A SUD diagnosis is not required.

The determination of whether a member meets the access criteria can only be made by an LPHA because the LPHA is the only provider who is permitted to diagnose within the DMC-ODS. NOTE: Even if you are considered an LPHA, scope of practice based on respective licensing boards will need to be adhered to.

For more information, see the "Access Criteria" section of the DMC-ODS CalAIM Documentation Manual.

ASAM-based Assessment

A full ASAM-based assessment is used to demonstrate how the member meets the access criteria, except in the case of youth under the age of 21. Youth under the age of 21 may qualify for prevention and early intervention services without a full assessment. A screening tool, such as the Brief LOC Screening Tool, is acceptable for youth. This means that the ICD-10 codes Z55-Z65 may be applicable to the member under age 21 for their entire early intervention episode of care. However, once the member turns 21, a full ASAM-based assessment establishing a DSM-5-TR SUD diagnosis will be required to continue services at the treatment levels of care.

The full ASAM-based assessment is also used to document the appropriate LOC placement for the member. The member must be assessed across the six ASAM Criteria dimensions to establish the severity of risk that warrants the LOC indicated. Placement determination is *separate and distinct* from determining medical necessity and access criteria. The use of the ASAM-based assessment helps to ensure that members can receive care in the least intensive LOC that is clinically appropriate.

For more information, see the "Level of Care Determination" and "Initial Assessment" sections of the DMC-ODS CalAIM Documentation Manual.

Problem List

With CalAIM, the need for a Treatment Plan has changed to the requirement of a Problem List. All programs and levels of care are required to have a Problem List, except for the NTPs and Peer Support Services.

Due to licensing and certification requirements, the Residential programs will need to continue abiding by the requirements for a Treatment Plan. However, a standalone Treatment Plan is not required. The State has moved towards defining "treatment planning" and "treatment plans" as general terms to describe the activities and requirements of a Treatment Plan. Components of a Treatment Plan may be notated within the Assessment, Problem List, progress note, or other care plan template of a provider's choosing. No matter how or where it is documented, we will need to make sure that the content of the Treatment Plan is able to be produced and communicated to others as needed for care coordination.

For Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) programs, the Treatment Plan requirement remains in place in accordance with the Minimum Quality Treatment Standards. However, just as it is for the Residential programs, a standalone Treatment Plan is not required. Treatment planning requirements must be fulfilled as noted above. This will need to be completed within 30 days of the member's admission to treatment.

Problem List Requirements

- List of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters
- Be added to or amended by Non-LPHA or LPHA (within scope of practice)
- Consideration of member and/or significant support input
- Include name/credentials of provider identifying, adding, and/or resolving the problem along with the date of the addition and/or resolution

Problem List and Care Plan Timelines

The State does not offer a specific timeline for when the Problem List must be completed, nor when or how frequently, it needs to be updated. The understanding is that the Problem List should accurately reflect the member's current presentation and needs. Therefore, at the ODF, IOT, Recovery Services, MAT, and WM programs, the Problem List should be developed as soon as clinically possible, in accordance with each member's clinical needs and generally accepted standards of practice. For the Residential programs, the Treatment Plan requirements established by the State's licensing and certification division, requires that the

documentation of the Treatment Plan elements is developed within 10 days of admission to treatment. NTPs are to continue to follow the requirements as set forth in Title 9.

For more information, see the "Problem List" section of the DMC-ODS CalAIM Documentation Manual.

Diagnosis

The diagnosis must be formulated by a provider operating within their scope of practice under California State law. The documentation must clearly show evidence that the diagnosis was made by someone practicing within their scope of practice. This evidence can be demonstrated through the signature of the person making the diagnosis, along with their license, degree, or job title. It is important to remember that ICD-10 codes are used for all claims related to SMHS. However, the County recommends using the criteria from the DSM-5 to select the appropriate ICD-10 codes that support the documentation of problems addressed in the session. The Problem List shall support the medical necessity of each service provided.

Social Drivers of Health (SDOH)

The CalAIM initiative highlights the importance of addressing clients' Social Drivers of Health (SDOH). SDOH include education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. By addressing an individual's SDOH, we can provide interventions that may reduce health disparities and inequities.
This, in turn, will reduce the risk factors that negatively impact their mental health and overall functioning.

SNOMED CT Browser

SNOMED is a standardized, multilingual vocabulary of clinical terminology used by physicians and other healthcare providers. The SNOMED CT Browser can be used to search for SNOMED codes, providing additional options for SDOH and other conditions. These SNOMED codes and descriptors can be listed on the Diagnosis/Problem List accompanying the ICD-10 codes. SNOMED codes are to be used if a provider is unable to find an ICD-10 code that accurately represents SDOH, symptoms, or other conditions. Use this link to access the SNOMED CT® Browsers.

Physical Exam (PE) Requirement

All members receiving SUD treatment must have had a PE within the 12-month period before their admit date. If they have not had one, the program must help the client to obtain a PE. If a PE has not been performed within the 12-month period prior to the admit date, the LPHA/non-LPHA can include this information on the member's Problem List, or if applicable, incorporate it into the documentation

of Treatment Plan elements. The member should be provided with care coordination to support achievement of the completion of a PE.

If the member had a PE within the 12-month period prior to the admit date, the Physician or Physician Extenders (Nurse Practitioners, Physician Assistants, and their respective Clinical Trainees) must review the PE and document within 30 calendar days of the admit date. The Physician or Physician Extender should advise on any areas of concern regarding a member's physical health or medical treatment, as needed.

If the member had a PE within the 12-month period prior to the admit date, but the provider is unable to obtain a copy for review, it should be documented in the member's chart as to what efforts will be made to try to acquire a copy of the PE.

For more information, see the "What about the Physical Exam?" section of the DMC-ODS CalAIM Documentation Manual.

Re-Assessments

Across all levels of care, the SUD Re-Assessment form can be used in some helpful ways. The SUD Re-Assessment form may serve as an important tool for facilitating efficient transitions within and across programs. For example, in programs that offer multiple levels of care, a completed SUD Re-Assessment to justify a member's discharge from one LOC may be used as the documentation required to establish medical necessity and appropriateness for the next LOC. Likewise, the SUD Re-Assessment can be used to transition the member to another provider in the network. This means that the SUD Re-Assessment can be used as the Initial Assessment for that new LOC if there is sufficient information to support the medical necessity for that LOC.

Residential

Although the State does not explicitly require a Re-Assessment at any specific point in time, the County requires members in a *Residential* program to be re-assessed every 30 calendar days from the date of admission. This is in line with the State licensing and certification requirement for the Residential programs to review and document the member's progress every 30 calendar days.

The County will monitor length of stay in our Residential settings to comply with the requirements set forth by the DHCS. We will not limit or deny Residential stays simply based on how long a member has been in placement; however, we will monitor our averages to ensure we are aligned with the State's goal of 30 days. If we observe patterns, we will work with individual program providers to identify opportunities for quality improvement.

Outpatient

The SUD Re-Assessment form is not restricted for use solely in a Residential program. It can, of course, be completed at any point during the member's treatment at any LOC, whenever

clinically appropriate. Specifically for the Outpatient levels of care, the Re-Assessment is only required if there is a change in the member's condition.

For more information, see the "Re-Assessment" section of the DMC-ODS CalAIM Documentation Manual.

Progress Notes

A progress note is required for all services that are claimed. The progress note documentation must provide enough detail to support the service code selected. For services to be reimbursed, the following are required elements of all progress notes:

- The type of service that was provided
- The date that the service was provided to the member
- Duration of the direct member care for the service
- Start and end time of the service (Residential ONLY)
- Topic of the service (Residential ONLY)
- The location of the member at the time of service
- A brief description* of how the service addressed the member's SUD and/or problems from the Problem List
- A brief summary of next steps* (planned action steps by the provider or the member, collaboration with the member, collaboration with other provider(s), and any update to the Problem List)
- The service provider's typed or printed name, credentials, signature, and date of signature

Brief description and next steps are not required for group sessions/services progress notes. Instead, documentation of the client's response is required for groups. A corresponding group list that indicates the names of all members in attendance is also required. It is advised that each participant list include enough information (i.e., group title/topic, group time/date, etc.) to corroborate the progress note.

For all levels of care except for NTP/OTP, progress notes should be completed within three (3) business days of the service. For NTP/OTP programs, progress notes should be completed within 14 days. Crisis Intervention progress notes should be completed within one (1) calendar day. Date of the service now counts as day zero (0), not day one (1). "Business" days are defined as Monday through Friday, excluding holidays observed by the State of California.

It is important for all providers to complete progress notes timely manner for a complete client record. Not only is this important for clinical integrity, but it is also a DHCS expectation that will be monitored during DMC Postservice PostPayment Utilization Reviews completed by DHCS. Clients have a right to access their records, and we must respond appropriately to records request, which can include current progress notes. For example, under the Privacy Rule, entities that must abide by HIPAA, should ensure that individuals have a right to access their health information within thirty (30)

calendar days of the request. Another example is that, according to the Health and Safety Code, physicians must provide patients with the requested records within fifteen (15) days of receipt of the request. There is also a five (5) day requirement to provide a client with review of their records in the office. If a provider is late with completing their progress notes, then the client will not have a complete record when the record is requested to be produced.

For more information, please refer to Patient Access to Medical Records | Medical Board of California and Individuals' Right under HIPAA to Access their Health Information | HHS.gov.

Daily Note Requirement for Residential Programs

For *Residential* programs, there must be a daily progress note to justify that the services provided on any given day validate the billing for a treatment day. There are a few ways in which a Residential program may demonstrate this:

- A summary note of all services provided to the member for that day or
- A progress note for a qualifying service (i.e., an Assessment, Individual or Group Counseling, Family Therapy, Medication Service, Patient Education, or SUD Crisis Intervention service)

Note: Care Coordination DOES NOT count as it is billed separately.

Direct Patient Care

Direct patient care refers to the time spent directly with a client for the purpose of providing healthcare. If the service code billed is a medical consultation code, then direct patient care means time spent with the consultant or members of the client's care team. In some situations, direct patient care may also include time spent with the caregiver, a significant support person, and/or other professional(s) who are invested in the client's care. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review, quality assurance activities, or other tasks performed by a provider before or after a patient visit.

Signatures

As a reminder, signing another person's signature is a violation of the HCA Code of Conduct and is illegal. If someone writes a progress note, no one else should alter it. Remember that it is the provider who provided the service who knows what happened. There are a few highly defined situations in which a Service Chief or Program Director can amend chart documentation. These situations are specified in Policies and Procedures (P&Ps). Also, never ask a client to sign a blank form of any kind; forms should be completed in full to be reviewed by the client before they sign them.

Telehealth

DMC-ODS services may be provided via telehealth. To do so, there are some requirements we need to be aware of. Telehealth means, "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a member's health care."

Telehealth can be a synchronous or asynchronous interaction. Synchronous interaction is a real-time interaction between a patient and a health care provider located at a distant site. A synchronous interaction can be either an audio-only synchronous interaction (solely via audio such as telephone, internet call without video) or a video synchronous interaction (both audio and visual capabilities). Asynchronous (a.k.a. "Store and Forward") *is the transmission of a member's medical information from an originating site*, where the member is located receiving telehealth services or where the asynchronous store and forward service originates, *to the health care provider at a distant site*, where the provider is providing telehealth services.

For DMC-ODS providers, telehealth can only take place through the synchronous interaction with a client.

To provide services by telehealth, we must have the member's consent. Please be sure that there is documentation of the member's consent, which may be a formal document signed by the member, such as a program's Telehealth Consent Form or a verbal consent obtained at least once prior to starting telehealth services. Providers must document that the following information was explained, and that the member's written or verbal acknowledgement was received that:

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

For more information on the telehealth consent, please refer to the BHS Combined Informed and Telehealth Consent.

Telehealth Progress Note Documentation

If a member is going to receive services via telehealth, the following should be documented in each progress note where this format is used:

- How the member's confidentiality was ensured
- Confirmation of the member's presence in California

- If there is a particular reason as to why the service was conducted via telehealth rather than in person, this should be documented (i.e., member being ill and unable to attend in-person appointment, member unable to obtain transportation to the appointment, etc.)
- Appropriateness of telehealth services to the member to demonstrate that the member will be receiving the same quality of services as he/she/they would in person

For more information, see the "Progress Notes" section of the DMC-ODS CalAIM Documentation Manual.

Medication for Addiction Treatment (MAT)

MAT Requirements Under CalAIM

Under CalAIM, providers from all levels of care are required to either offer Medications for Addiction Treatment or MAT onsite, as part of their program or to have a mechanism for ensuring that members who need MAT can access those services elsewhere. This means that if one of your members would benefit from an evaluation for MAT and your program does not offer this service, then you must provide care coordination to ensure the member is connected to a MAT provider, which may include providing transportation to appointments for MAT. Members may receive MAT in conjunction with any other LOC, including Recovery Services and may access MAT regardless of whether the member is participating in any form of treatment. Each program is to have their own DHCS-approved Policies and Procedures that includes information on facilities to be referred to. If you are unsure if your program offers MAT services or where your members could go to access these services, please consult with your supervisor for guidance.

Referral to MAT

All members must be assessed for a MAT referral using an evidence-based assessment upon admission to a SUD program. A non-LPHA or LPHA within their scope of practice may conduct the evidence-based assessment (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), which must be completed within the first 24 hours of a member's admission. If this assessment indicates that a MAT referral would be beneficial for the member, the member will then need to be linked to a MAT provider and seen by the MAT Physician or Physician Extender (Physician Assistant or Nurse Practitioner) within 48 hours of the member's admission. Care coordination activities such as working closely with the MAT provider and making transportation arrangements to ensure the member is properly linked can be provided and billed for if medically necessary. Once the member is connected to the MAT program, the Physician or Physician Extender (Physician Assistant or Nurse Practitioner), must evaluate the member's medical necessity for MAT, create a plan for administering medication specific to the individual, and prescribe the corresponding medications.

Refer to the DMC-ODS CalAIM Documentation Manual, the CPT Guide, and BHIN 23-054 Medications for Addiction Treatment (MAT) Services Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities.

Recovery Services

Recovery Services emphasizes the member's role in managing their health and the use of effective self-management support strategies. Members are not required to have an "in remission" diagnosis and do not need to be abstinent from drugs for any specified period to enroll. Members may enroll immediately after incarceration, regardless of whether they received SUD treatment during incarceration. Members may also receive Recovery Services based on their preference.

Recovery Services includes Assessment, Care Coordination, Individual Counseling, Group Counseling, Family Therapy, Recovery Monitoring, and Relapse Prevention.

Recovery Services may be delivered while members are receiving other DMC-ODS services and levels of care as clinically appropriate. This means that a member who may be receiving treatment in, for example, Intensive Outpatient Treatment services, may also enroll in Recovery Services. However, this is not a typical scenario. Members receiving MAT, including NTP, may also receive Recovery Services.

For more information, see the "Recovery Services" section of the DMC-ODS CalAIM Documentation Manual.

Discharge

For DMC-ODS, the State does not require Discharge Plans or Discharge Summaries. However, please be aware of other regulations that your program may need to adhere to, such as the AOD Certification Standards, that may require completion of these documents. It is important to also keep in mind that for some programs, the completion of the Discharge Summary may be part of the internal process necessary to close out a client's case or episode of care (EOC).

REIMBURSEMENT RULES AND BILLING GUIDELINES

Documentation/Service Time

Billing must be based on exact minutes. Estimating the time spent on any service, billable or non-billable, is a violation of the HCA Code of Conduct.

Travel and Documentation Time

> Under CalAIM, travel and documentation time is not billable. The State has made explicit that reimbursable services need to be "direct patient care," which "does not include travel time,

administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a client visit" (DHCS DMC-ODS Billing Manual, April 2025).

Although travel and documentation time is no longer billable, it should still be documented and entered in IRIS. Since this information will be used for future fiscal considerations, it is important to continue in the practice of making sure that the travel and documentation time is accurate and appropriate for the content that is documented.

For more information, refer to the DHCS DMC-ODS Billing Manual, April 2025.

Service Time

For billing purposes, the service minutes include any billable face-to-face time, or time spent with the member in person, as well as any billable non-face-to-face time or time spent without the member, performing a billable activity.

For more information, see the "Time Components of a Progress Note" section in the DMC-ODS CalAIM Documentation Manual.

Billable versus Non-Billable

To select the correct service code and bill properly in the DMC-ODS, we need to know the difference between what is considered a billable or non-billable activity.

Billable services are those that are reimbursable by Drug Medi-Cal, such as an individual, group, or care coordination sessions that are medically necessary.

Non-billable services would be those activities that Drug Medi-Cal will never reimburse. Non-billable services may also include services that would have been billable, but there was an error that prevents the service from being reimbursed by Medi-Cal. For example, if it is discovered that a provider's license has expired and services should not have been provided or claimed, we would need to make those services non-billable to ensure that it does not get billed to the State.

For more information, see the "Codes & Types of Services" section of the DMC-ODS CalAIM Documentation Manual.

Payment Reform and Service Codes

Beginning on July 1, 2023, Medi-Cal reimbursement moved from a cost-based to a fee-for-service structure, which resulted in there being a multitude of new billing codes. The billing codes are specific to the type of service, the rendering provider's credentials, the location where the service is provided,

and in some cases, the duration of the service time. The State categorized the available billing codes as follows.

Activity types for billing

- Assessment Services
- Crisis Intervention
- Medication Services
- Individual Counseling
- Group Counseling
- Care Coordination
- Recovery Services
- Supplemental Services
- Family Therapy

For more information on each of these activity types and associated billing codes, see the DMC-ODS CalAIM Documentation Manual and CPT Guide.

Potential Reasons for Disallowances

With the State's focus on fraud, waste, and/or abuse to determine disallowances and corrective action plans, please be mindful of the following ways in which documentation may be scrutinized for potential fraud, waste, and/or abuse:

- Missing or invalid Assignment of Insurance Benefits / Authorization to Disclose (AOB/ATD)
- Services provided out of scope of practice
- Services provided by a non-DMC certified and credentialed provider
- Services provided under a lapsed/expired license/credential/registration
- Assessment services provided without the completion of required trainings (i.e., ASAM A & B)
- Missing appropriate documentation of clinical supervision
- No medical necessity established
- LOC determination not substantiated
- A pattern or egregious instance of there being no initial assessment completed to justify the access criteria
- A pattern or egregious instance of there being no Problem List (or Treatment Plan, if applicable) when it is clinically appropriate and reasonable to expect that it be completed
- No progress note for the date of service claimed
- A pattern of templated documentation
- Patterns in billing without appropriate substantiation (either of time or interventions provided)

The QMS SUD Clinical Records Team will conduct regular, internal reviews to monitor County and County-Contracted providers and ensure compliance with federal and State regulations and HCA

Standards. When the QMS SUD Clinical Records Team identifies deficiencies during their reviews, they will instruct programs on how to either correct the item, if appropriate, or what services need to be repaid.

Programs are free to implement their own internal chart reviews to identify needed corrections and to prevent the potential for fraud, waste, and/or abuse. Each program's QI Coordinator is a resource for programs in preventing and/or correcting deficiencies before they become significant.

For more information, refer to the "Disallowance or Recoupment of Services" section of the DMC-ODS CalAIM Documentation Manual.

DATA COLLECTED FROM ORANGE COUNTY'S PROVIDER NETWORK

Access Logs and Timely Access Standards

The federal network adequacy standards require DMC-ODS to ensure timely access to care based on the urgency of a member's need. Timely access standards define the maximum number of business days within which the DMC-ODS must offer an appointment for medically necessary services upon request by a member or a provider acting on their behalf. Failure to meet this standard requires issuing a *Timely Access NOABD***.**

An Access Log entry is required for all Medi-Cal members seeking services within the DMC-ODS network for the first time via phone or walk-in. Providers must speak directly with the member, their legal guardian, or conservator to schedule services. If consent is given, a representative (e.g., hospital social worker, outreach worker) may schedule the appointment on the member's behalf. Any verbal consent must be documented in the "Referral Comment" section of the Access Log.

Access Timelines

- Urgent (DMC-ODS): Within *48 hours* of first contact.
- Routine (Outpatient): Within *10 business days* of first contact.
- OTP/NTP Programs: Within *3 business days*.
- WM/Detox Services: Within *48 hours* (calendar days)

Access Log Reports and Error Monitoring

Service Chiefs and Program Directors must review Access Log reports *weekly* to correct any timely access errors and ensure that *staff* enter Access Log entries *daily*. MCST runs a monthly IRIS Access Log report for DMC-ODS to check for errors and reconcile them. Any errors identified must be corrected and re-submitted within three (3) business days. MCST may also conduct random reviews to verify programs are generating Access Log encounters daily.

Common Access Logs Errors:

- No Access Log Entry
- Late Access Log Entry

- Data entry errors, such as incorrect dates, misspellings, etc.
- Duplicate entries
- Appointment scheduled outside the required timeframe without issuing an NOABD for Timely Access

For more information, please refer to the Managed Care Support Team section on "Access Logs" in this Provider Manual, BHIN 18-011 Federal Network Adequacy Standards for MHPs and DMC-ODS Pilot Counties, eCFR :: 42 CFR 438.68 -- Network Adequacy Standards, and Bill Text: CA AB205 Chapter 738 Statutes of 2017 | LegiScan.

Treatment Perception Surveys (TPS)

The Treatment Perceptions Survey (TPS) is an annual survey administered by the county to address the data collection needs of the DMC-ODS and support overall quality improvement efforts. The University of California, Los Angeles (UCLA) Integrated Substance Use and Addiction Programs team analyze and disseminate the survey results to the counties.

TPS week is typically every October, and for one (1) week (Monday-Friday), programs are asked to provide every eligible client to complete a survey. There are two (2) surveys for adults and youth, and they are available both online and on paper, and in all County threshold languages. A few months leading up to the survey week, the County will be in contact with programs and provide more detailed instructions on how to disseminate the survey.

For more information, please visit UCLA's Treatment Perceptions Survey website.

CalOMS Guidelines

The California Outcomes Measurement System (CalOMS) is the system that the State of California designed to help meet federal and State guidelines requiring specific data to be collected to measure outcomes in substance abuse treatment. This data helps the State determine whether programs are of actual value to clients and helps track national, State, and local drug trends. The State of California designates specific time frames for when CalOMS data must be captured and transmitted to their system. Late and missing submissions can result in Corrective Action Plans (CAP).

The CalOMS collects data for outcome measures, hence, questions must be specifically worded to maintain data fidelity and integrity. After removing personally identifiable information, the State combines the individual's responses, including their different treatment episodes, to create a clinical snapshot of their progress through treatment. The data collected can show how successful and effective programs are and the data can be used when allocating funding. Providers can utilize the information to track client progress since admission. The CalOMS can provide information that can be helpful in developing treatment and discharge plans. In addition, Orange County's Data Analytics and Evaluation team (DAE) utilize the data to identify trends and improve our system of care. For these reasons, it is important to capture information in an accurate and timely manner.

There are three (3) kinds of CalOMS records – Admission, Annual, and Discharge.

A CalOMS Admission Record is required each time a client enters SUD treatment at a reporting facility. This record must be entered into IRIS within:

- **20 days** for Outpatient programs
- **7 days** for Residential programs

For SUD programs providing services longer than one year, a CalOMS Annual Record is required to assess the client's overall outcomes and how treatment may have improved their lives. The record must be completed, signed, entered into IRIS, and be error-free between 31 and 60 days before the client's Anniversary date each year.

Discharge information must be collected for all members receiving SUD services, regardless of the reason for leaving. This record should be completed no more than two weeks before the planned discharge date and entered into IRIS within 30 days of the last client contact, which may include individual, group, or drug testing services.

There are Eight (8) CalOMS Discharge Status Options:

- Completed Treatment Plan Goals – Referred to another SUD provider, using a CalOMS Standard Discharge record
- Completed Treatment Plan Goals – Not Referred to another SUD provider, using a CalOMS Standard Discharge record
- Left Before Completion with Satisfactory Progress using a CalOMS Standard Discharge record
- Left Before Completion with Unsatisfactory Progress using a CalOMS Standard Discharge record
- Left Before Completion with Satisfactory Progress using a CalOMS Administrative Discharge record
- Left Before Completion with Unsatisfactory Progress using a CalOMS Administrative Discharge record, and then--
- Incarceration and Death – Both require using the CalOMS Administrative Discharge record

CalOMS Reporting Requirements

The State requires each county to submit error-free CalOMS records for each member at admission, annually (if applicable), and at discharge. Submission of each record type within the respective time periods is required of all providers for all members.

The County offers a separate training on CalOMS where we cover these and other topics. The County is expected to reliably and consistency complete all CalOMS data sets on time and correctly. The County's error rate is monitored by the State monthly, and unacceptable error rates result in deficiencies and the need to implement corrective action plans at a system level. The County will work to implement corrective actions locally for providers whose error rate is

consistently above the permitted level by the State. Late submission of records to the State that exceeds the permitted late submission rate is considered a compliance problem and may lead to a process of progressive oversight by DHCS.

To be CalOMS compliant, providers must submit timely and complete CalOMS records. The expectation for timely submission is no more than 5% late submission, and all CalOMS records should be 100% complete. Records that contain errors cannot be submitted; therefore, erroneous records are considered missing records, and missing records will result in compliance deficiencies. Providers can check for any missing CalOMS records by running in IRIS the CalOMS Open Client Report or SUD Caseload Roster. Additionally, QMS runs the Open Admission report from the State database, Behavioral Health Information Systems or BHIS. The Open Admission report indicates the number of months in between submitted records. QMS monitors for any records open more than 12 months without a record. By the anniversary date, either an Annual (if the client remains open) or a Discharge (if the client is no longer being seen) needs to be submitted.

Collecting and submitting accurate data is crucial to the quality assurance and improvement efforts of a managed care organization. It is imperative that all providers in our network have the same understanding of the meaning of each answer to effectively use our dataset in a meaningful and impactful way to evaluate our system.

Monitoring Compliance

Entering accurate and timely information into any CalOMS record is important to develop an accurate portrayal of SUD services provided to the community, comply with federal and State regulations, and adhere to Health Care Agency's expectations. To assist providers in identifying trouble spots within their programs and to monitor their compliance with CalOMS requirements, the following reports are available in IRIS:

- CalOMS Error Detail Report (CEDR)
- CalOMS Open Client Report
- CalOMS Report Card Detail
- CalOMS Report Card Summary
- SUD Caseload Roster

CalOMS trainings are offered throughout the year. For additional information on CalOMS, please contact the QMS SUD Clinical Records Team (bhpsudsupport@ochca.com) or the IRIS Liaison Team (BHSIRISLiaison@ochca.com). An extensive CalOMS training is available for counseling and clinical staff online on the "DMC-ODS For Providers" website.

For more information on CalOMS, please see the CalOMS Clinical Training.

ASAM Level of Care (LOC) Requirements

DMC-ODS Counties are required to use the ASAM Criteria to ensure that eligible members have access to SUD services that best align with their treatment needs. The ASAM Criteria is the standard for assessing a client's needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. A critical element of the DMC-ODS includes providing a continuum of care modeled after the ASAM criteria for SUD treatment services.

A primary goal underlying the ASAM Criteria is for the member to be placed in the most appropriate LOC. The preferable LOC is the least intensive while still meeting treatment objectives and providing safety and security for the member. The DMC-ODS demonstrates how organized SUD care increases the success of DMC members while decreasing other system health care costs by utilizing the ASAM LOC data to monitor appropriate use of the ASAM criteria in the DMC-ODS.

ASAM LOC data submission is cumulative and must be submitted at least once monthly, no later than 45 days after the month of service. LOC data is entered into IRIS via the SUD LOC Summary form for County-Contracted providers and the SUD assessment forms for County providers.

Drug and Alcohol Treatment Access Report (DATAR)

DATAR is a system used by DHCS to collect data on treatment capacity and waiting lists. DATAR supplements CalOMS and helps identify categories of clients awaiting treatment, as well as available facilities. DATAR provides information on a program's capacity to offer various types of SUD treatments, the utilization of that capacity, and the number of clients on the waiting list who couldn't be admitted due to lack of capacity.

All SUD treatment providers receiving funding from DHCS, including certified DMC-ODS providers and licensed NTPs, are required to submit the DATAR form on the 5th of each month to the QMS SUD Clinical Records Team, regardless of whether they receive public funding.

For more information on DATAR, please refer to the DATAR Web Manual 04-15-2014.

ADDITIONAL STATE REQUIREMENTS

Continuity of Care

Per DHCS, 42 CFR 438.62(b) requires DMC-ODS counties to implement a transition of care policy consistent with DHCS policy guidance. DHCS' policy requires DMC-ODS counties allow a member to continue receiving DMC-ODS services with an out-of-network provider when the member's assessment determines that without continued services the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. If this is the case, DMC-ODS treatment services with the existing provider must continue for a period of no more than ninety (90) days unless medical necessity requires services to continue for a longer period of time, which cannot exceed 12 months.

For more information, please see DHCS' MHSUDS Information Notice 18-051 DMC-ODS Transition of Care and OC HCA's Policy and Procedure Continuity of Care and Referrals in SUD Programs.

Minor Consent

Minors, age 12 or older and less than age 18, can consent to medical care and counseling related to SUD treatment without requiring permission from a parent, guardian, or authorized representative. Children under 12 are not eligible for minor consent related to drug or alcohol abuse, sexually transmitted diseases, or outpatient mental health care. The County must ensure minors know that SUD services are available without prior authorization, from any in-network or out-of-network DMC-ODS provider as long as the member is eligible to receive the SUD services, and the provider is eligible and certified to provide SUD services. While minors have the right to consent to these services, providers must inform them of their rights and the availability of SUD services. Providers are also prohibited from disclosing any information related to the minor's consented treatment services without the minor's explicit consent, except in cases where disclosure is legally required. This confidentiality extends to treatment records created during the provision of Minor Consent Services.

Parental Involvement in Treatment

Although minors can independently consent to SUD treatment, providers must assess and document whether involving the minor's parent or guardian would be appropriate. If the provider determines that parental involvement is not in the minor's best interest, this decision must be documented, including the reasoning. When appropriate, the parent or guardian should be included in the minor's treatment planning. The provider must attempt to contact the parent or guardian and document whether the attempt was successful. If the provider decides not to contact them, the reason must also be recorded.

When Parental Consent is Required

There are situations where parental or guardian consent is necessary. For instance, a minor cannot receive replacement narcotic abuse treatment in a SUD program without parental or guardian consent. Additionally, a parent or legal guardian has the right to seek medical care and counseling for a minor's drug-or-alcohol-related problem, even if the minor does not consent to treatment. If a parent or legal guardian requests information about a minor's medical care after seeking treatment on their behalf, the medical provider must disclose relevant medical details. This disclosure is required by law and does not require the minor's consent. Providers are not liable for sharing this information.

Minor Consent for NTPs

Assembly Bill (AB) 816 specifically addresses SUD treatment by allowing minors aged 16 and older to receive Buprenorphine or other medications for opioid use disorder without parental consent in NTPs.

Minor consent for Recovery Incentives (RI) Programs

In California's DMC-ODS, minors aged 12 to 20 can independently consent to participate in the Recovery Incentives Program, also known as Contingency Management (CM), through the Minor Consent program without parental consent. Parental consent is required for minors under 12 to receive RI services. Information obtained from minors seeking RI services under the Minor Consent program is confidential and cannot be disclosed to parents or guardians without the minor's written consent.

Payment Liability

For services where only the minor participates in treatment, the parent or guardian is not financially responsible. However, if the parent or guardian also participates in SUD services, they become liable for payment. These services are supported with State funds only. Federal reimbursement is not available for services provided to minor consent beneficiaries, and counties must cover 100% of the cost for services rendered to these individuals.

Application Process:

- Personal Application: Eligible Minors must apply for limited-scope Minor Consent Services in person or by telephone by completing the MC 4026 form.
- Documentation: If employed or possessing a bank account, minors should provide relevant documents like pay stubs or bank statements.

For more information, please refer to Medi-Cal Eligibility Procedures Manual Family Code Section: 6920-6930. and Bill Text: CA AB816 Minors Consent to Medical Care | LegiScan

INPATIENT AND DESIGNATION SUPPORT SERVICES

CONTENT COMING SOON!

Check back for more information about inpatient services and support to our designated facilities.

MANAGED CARE SUPPORT TEAM (MCST)

OVERVIEW OF MCST

The Managed Care Support Team (MCST) tracks, monitors and provides education regarding the requirements under the Department of Health Care Services (DHCS) and the Federal and State regulations for delivering Medi-Cal covered services in the County of Orange. The MCST ensures compliance among the county and contracted providers under the Behavioral Health Plan (BHP). The areas that the MCST oversees include the following:

- Access Logs
- Provider Directory
- Credentialing and Recredentialing
- CalOptima Credentialing for Adult and Older Adult County Clinic Providers
- PAVE Enrollment for the Specialty Mental Health Services (SMHS) Providers
- Expired Licenses, Waivers, Registrations and Certifications
- Grievances and Investigations
- Notice of Adverse Benefits Decisions
- Appeals and Expedited Appeals
- State Fair Hearings
- Supervision Reporting Forms, Requirement and Process
- Change of Provider and Second Opinion
- Provider Transaction Access Number (PTAN)
- Trainings

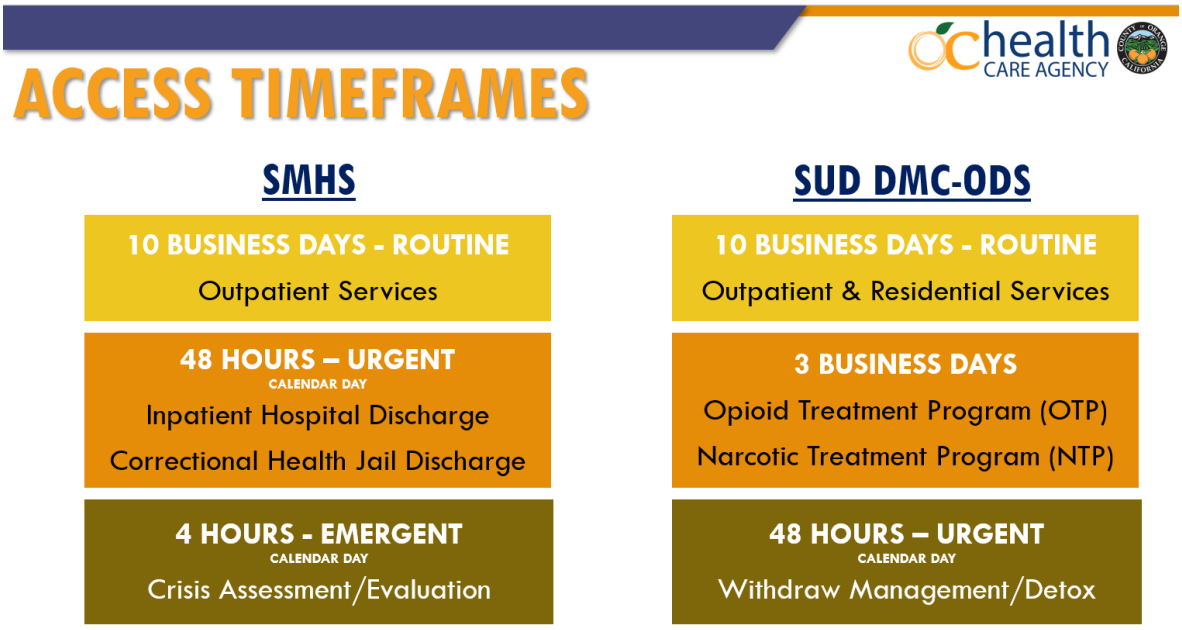
ACCESS LOGS

To meet the Federal Access Standards requirement, providers and program administrators need to enter and monitor data through the Access Log. The Access Log provides data that measures members' access to the Behavioral Health Plan (BHP) services.

From the Access Log entries, the network can determine the availability of 24/7 access to services, number of days between a member's request for services for the first service date, the date of the initial offered appointment, follow-up appointments for the first six (6) physician and non-physician appointments and the date of the accepted appointments. Additionally, the Access Log data captures information about the type of service requested, the level of need for the service, the request for services in non-English languages, and the number of service requests.

The Access Log serves as a tool to demonstrate how efficiently providers initially offer services to the members. Every program that serves as an access point must complete an Access Log entry for all new member requests to start services within the BHP. If a member can access services through a specific place or program, then that "place" qualifies as an access point.

Timely access standards refer to the number of business days in which the BHP must make an appointment available to a member from the date the member, or a provider acting on behalf of the member, requests a medically necessary service. Below is the grid demonstrating the required timeframes the BHP must meet for all new members:



In addition, BHIN 25-013 calculates compliance of timely access standards using the "Date of First Contact to Request Services" and the number of business days between that date and the date of the first offered available appointment that qualifies as a billable service. For example, if a member requests an initial appointment for an outpatient SMHS or an outpatient DMC-ODS service on the first of the month and is offered an appointment on the 11th of the month, the BHP would be considered to have met the 10-business day standard. For a BHP to be compliant with timely access standards, 80% of members must have been offered an appointment within the applicable time frame.

In general, the BHP must ensure the member is provided the service type appointment within the timeframe identified in the SMHS or DMC-ODS grids on the next page. Another example, if the BHP is unable to offer an initial medication appointment (aka Psychiatric Services) at the designated clinic within 15 business days, the provider must look for an appointment at other clinics within the BHP to meet the timely access and distance requirement. If all options have been exhausted and no appointment is available within the 15 business days under the BHP than an NOABD – Timely Access Notice must be issued to the member within 2 business days.

Timely Access Standards for SMHS

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric SMHS	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All Urgent SMHS Appointments	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[30]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[31]	

Timely Access Standards for DMC-ODS Services

Modality Type	Standard
Outpatient Services – Outpatient SUD Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
All Urgent SUD Appointments***	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments with a Non-Physician	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[32]
*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take-home medication, time in treatment requirements are not applicable to buprenorphine patients.) **Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[33] ***All appointments where Withdrawal Management (WM) is offered/utilized shall be considered urgent.	

If you have any questions about the Access Log and NOABDs, please reach out to the MCST for guidance.

PROVIDER DIRECTORY

Network adequacy and the publication of our Provider Directory are related to the managed care requirements outlined in 42 CFR, Part 438. The regulations state that the BHP must provide members with specified information about the network of providers in both paper and electronic form. This includes County-operated programs, contracted organizational providers, provider groups, and individual practitioners.

The data that must be published includes program site information, such as the languages spoken at the facility, Americans with Disabilities Act (ADA) accessibility, types of services offered, and the provider's acceptance status for new members. Additionally, we are required to publish the complete provider list of service delivery staff at each program. This list includes both Licensed Mental Health Professionals (LMHP)/Licensed Practitioner of the Healing Arts (LPHA) and Alcohol and Other Drugs (AOD) Counselors, along with details about their individual credentials, such as licenses, languages spoken, specialties, NPI numbers, and other relevant information. The data must always remain current, and the directory must be updated no later than every 30 days. The directory must be updated sooner if the Plan learns of changes that affect services in the system.

The BHP Provider Directory Handbook:

Behavioral Health Plan and Provider Information | Orange County California - Health Care Agency

The BHP Online Provider Directory:

Medi-Cal MHP Provider Directory - Medi-Cal MHP Provider Directory

CREDENTIALING/RECREDENTIALING

Credentialing

Credentialing is a standard process in health care. It ensures that all providers delivering services within the network possess the necessary qualifications. Credentialing helps make sure that our members receive the highest quality of care by verifying that our providers meet the requirements.

The BHP must ensure each of its network providers qualifies in accordance with current legal, professional, and technical standards. These providers should be appropriately licensed, registered, waivered, and/or certified. The uniform credentialing and recredentialing requirements apply to all licensed, waivered, certified, or registered mental health providers and substance use disorder (SUD) providers employed by or contracting with the BHP to deliver Medi-Cal covered services.

Credentialing and recredentialing is a federal regulation, and it does not permit any Medi-Cal covered services to be delivered until a provider has been fully credentialed by the County.

Below is a list of common providers, typically required to be credentialed:

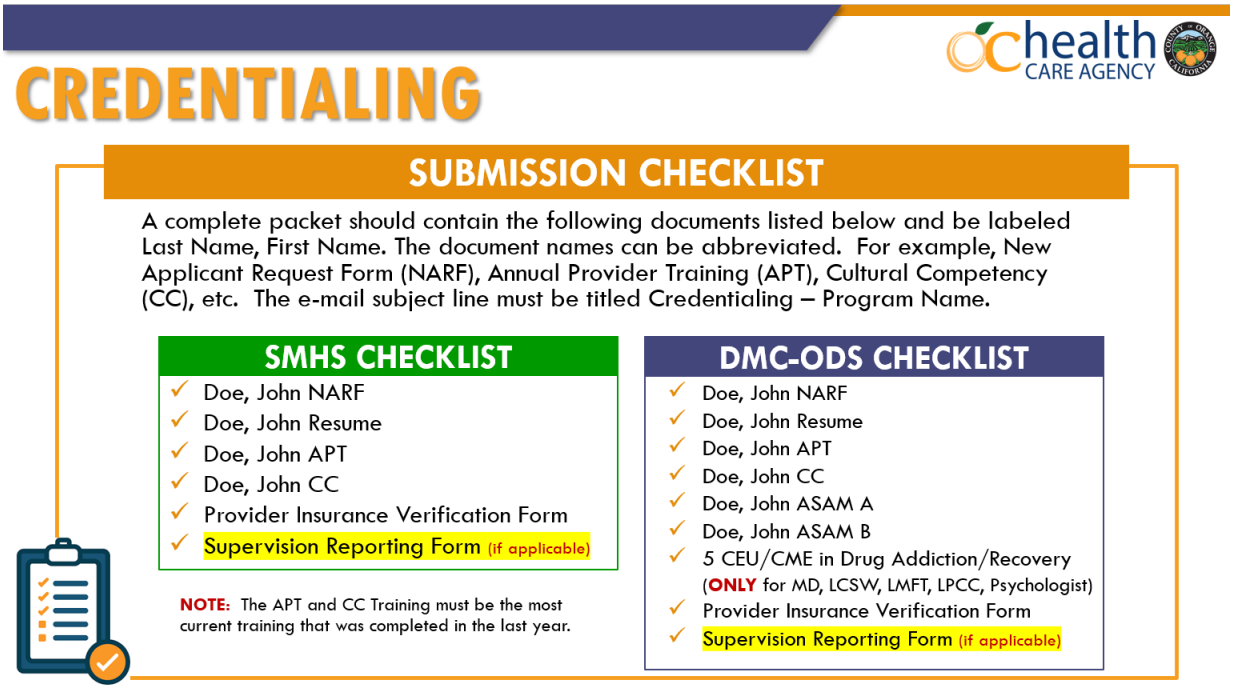
- ✓ Licensed Vocational Nurse (LVN)
- ✓ Licensed Psychiatric Technician (LPT)
- ✓ Certified Nurse Assistant (CNA)
- ✓ Certified/Registered AOD Counselor
- ✓ BBS Licensed (LMFT, LPCC, LCSW)
- ✓ BBS Associate (AMFT, APCC, ACSW)
- ✓ BOP Registered/DHCS Waivered
- ✓ Physician Assistant
- ✓ Psychiatrist
- ✓ Physician
- ✓ Nurse Practitioner
- ✓ Registered Nurse
- ✓ Occupational Therapist
- ✓ Psychologist
- ✓ Pharmacist
- ✓ Certified Medical Assistant
- ✓ Certified Peer Support Specialist

While it is not an exhaustive list, we encourage you to reach out to the MCST to speak with a credentialing representative if you have any uncertainties about a specific provider type.

The credentialing requirement elevates the compliance bar by allowing the delivery of Medi-Cal covered services only by individuals who are properly credentialed. If a provider is not credentialed, they are ineligible to provide any Medi-Cal covered services, including “non-billable” services.

As a result, all new providers:

- Must submit their initial credentialing packet to the MCST within 5-10 business days of being hired. See the submission checklist requirement, on the next page:



- New hires are required to refrain from delivering any Medi-Cal covered services if they are not credentialed and have not received a credentialing approval letter.
- The new hire 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 provider must *NOT* provide direct treatment or supportive services to a member on their own nor document any services, including non-billable services. The Integrated Record Information System (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 provider credentialing packet to the MCST, timely.
- Failing to complete the credentialing requirement upon being hired is a compliance issue that will result in suspension or denial of privileges, recoupment, and possible disciplinary action by the employer.

Credentialing also means ensuring that a provider truly possesses the education and experience they report. This involves verifying specific qualifications from a primary source, including:

- The appropriate license and/or board certification or registration, as required for the particular provider type.
- Evidence of graduation or completion of any required education, as required for the particular provider type.
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type.

- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

For example, obtaining confirmation from the school the person attended to verify that the provider indeed attended the school and that it occurred when the provider claimed.
These primary source requirements must be confirmed by directly contacting the source of the education or experience. Additionally, any gap in employment within the last five years will require an explanation.

Attestation
Credentialing also requires an attestation by each provider regarding all the primary source requirements. As providers progress through the credentialing process, they will be asked to either verify or input information about their professional history into the Health Care Agency's (HCA) credentialing system, as required. When finalizing their credentialing application, providers will be asked to attest to the five items listed below:

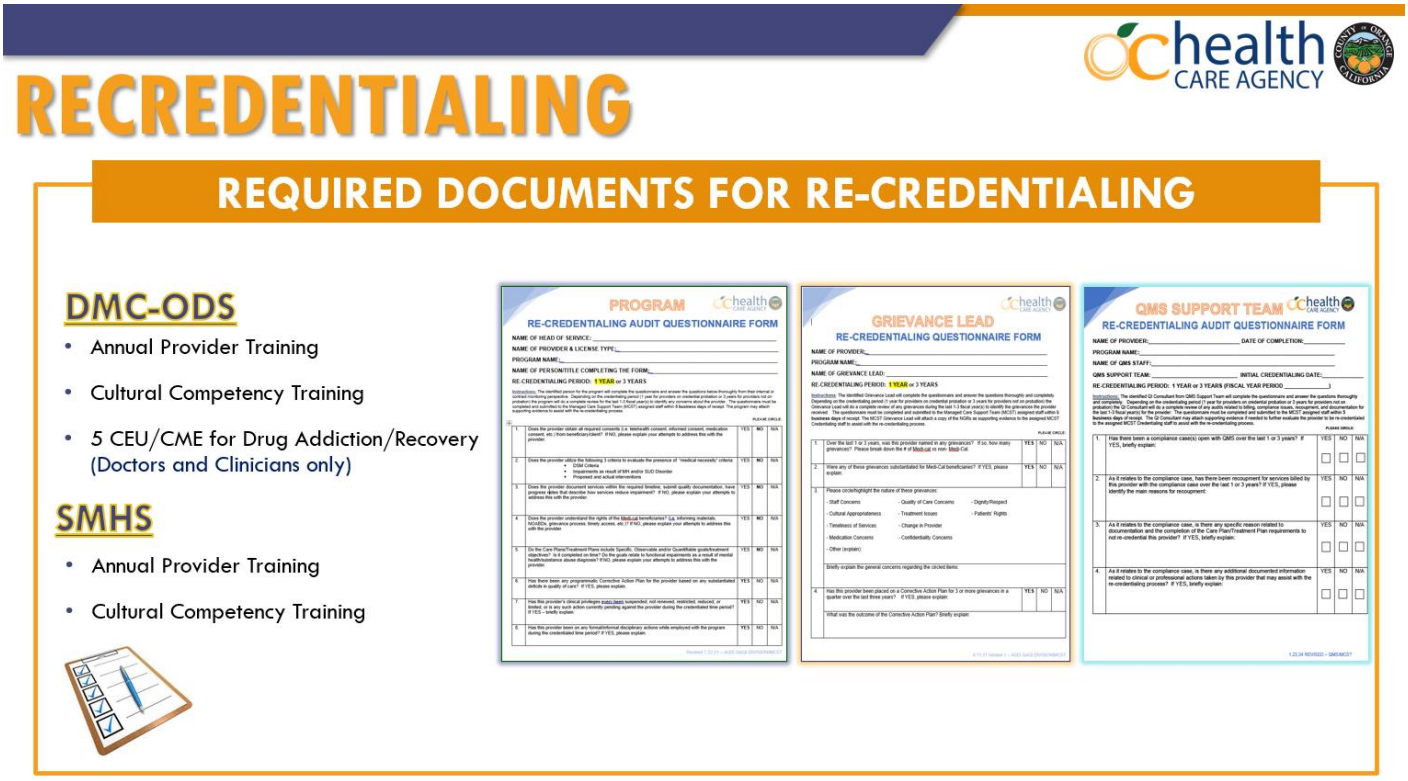
ATTESTATION

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

It's important to note that the answers to these items do not automatically disqualify a provider from becoming credentialed. If necessary, applicants will be referred to their organization's program for assistance.

Recredentialing
Recredentialing must occur every three years to verify that the provider continues to possess valid credentials. During this process, providers are required to submit a newly signed attestation. In addition to the initial credentialing requirements, recredentialing should include documentation that the Behavioral Health Plan has considered information from other sources pertinent to the credentialing process. These sources include quality improvement activities, member grievances, and

medical record reviews.



Credentialing Verification Organization – RLDatix (aka VERGE)
HCA has contracted with a Credentialing Verification Organization (CVO) to perform the verification steps of credentialing, except for making the final credentialing decision. Ultimately, BHS retains responsibility for the final decision. By leveraging the partnership with the CVO, the Plan maintains an ongoing database for each provider.

This database can be updated as new events occur, including license renewals, continuing education certificates, certifications, education, and other relevant information.

By always keeping the profile current, a provider can make their recredentialing process fast and simple.

CALOPTIMA CREDENTIALING (COUNTY PTAN 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 insurance plans that the BHP is "in network" with since it is part of CalOptima. Since the BHP is "in-

network" that means the providers need to be credentialed by CalOptima for the providers' claims to be approved.

The MCST must credential the specific providers with CalOptima who have already acquired a PTAN so that claims will successfully adjudicate, and the BHP can receive reimbursement for both OneCare and OneCare Connect claims as well as the secondary Medi-Cal reimbursements.

These provider types below are the only ones that must be credentialed to bill Medicare under the CMAP:

- ✓ LCSW
- ✓ LPCC
- ✓ LMFT
- ✓ Psychologist
- ✓ Nurse Practitioner
- ✓ Doctor of Osteopathy (Board Certified)
- ✓ Physician Assistant
- ✓ Psychiatrist (Board Certified)
- ✓ Medical Doctor (Board Certified)

The MCST is responsible for coordinating CalOptima credentialing, reconciling, and tracking the identified County providers for re-credentialing. If you are one of the County providers who have acquired a PTAN, you must contact the CalOptima Credentialing Leads at the MCST to initiate the process.

PAVE ENROLLMENT (SPECIALTY MENTAL HEALTH SERVICES PROVIDERS ONLY)

To ensure compliance with the Cures Act and Final Rule mandates, DHCS requires that the BHP ensure all applicable network providers enroll through DHCS' Provider Application and Validation for Enrollment (PAVE) Portal. The intent of the federal regulations is to reduce the incidence of fraud and abuse by ensuring that network providers are individually identified and screened for licensure and certification.

The mental health providers required to be enrolled in PAVE are:

- ✓ Physician Assistant
- ✓ Psychiatrist
- ✓ Physician
- ✓ Pharmacist
- ✓ Nurse Practitioner
- ✓ LMFT
- ✓ LCSW
- ✓ LPCC
- ✓ Psychologist

- ✓ Speech Therapist

The MCST, tracks, reconciles, monitors, and ensures mental health providers in the BHP for SMHS are PAVE enrolled. Contact the PAVE Leads for assistance with initiating the steps prior to delivering any Medi-Cal covered services.

EXPIRED RECORDS: FAILURE TO RENEW AN EXPIRED LICENSE, CERTIFICATION OR REGISTRATION

Failure to meet and maintain all credentialing requirements will result in an email notification from the MCST. This notification will inform you of the suspension and denial of privileges for delivering services that require licensure within the Orange County Health Care Agency. Providing Medi-Cal covered services without proper credentials not only results in the loss of revenue due to disallowed or recouped services but could lead to possible disciplinary action by the provider's Human Resources department. Additionally, QMS will initiate a Deficiency Investigation, necessitating immediate action.

Licensing boards and Certifying Organizations (CO) may renew licenses, certifications, and registrations back to the original expiration. The County cannot assume that the CO or licensing board will renew this retroactively which places the provider at risk of non-compliance. Therefore, the provider is *NOT* to deliver any Medi-Cal covered services if the credentials have expired.

It is important to remember that the provider's reinstatement is not automatic.
The provider must contact MCST and IRIS immediately to reactivate their IRIS access and must provide proof of the license, certification, or registration renewal. Continuing to offer services with an expired license is a compliance issue that requires close monitoring by the provider, program, and Contract Monitors. Lastly, it's essential to remember that reactivation is not retroactive. Providers should refrain from delivering any Medi-Cal covered services if their credentialing is suspended.

GRIEVANCES

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination or an appeal of a denial to expedite an authorization decision. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. When a member expresses dissatisfaction with the BHP, either in person or over the phone, regarding any matter related to the provision of Medi-Cal

services a grievance must be filed.

Members have the right to file grievances whenever they are dissatisfied with any aspect of the services they receive. If a complaint is attached to a Notice of Adverse Benefit Determination (NOABD), it results in an appeal rather than a grievance.

As the grievance process serves as member protection under managed care, the County is required to address, track, resolve, and take action on all grievances. There are strict timelines about what must occur when you receive a grievance. Whenever a plan representative hears or receives an expression of dissatisfaction from a member, it must be treated as a grievance. Consequently, programs should be prepared to provide members with a grievance form or assist them in completing the form if requested on behalf of the member or file the grievance on the member's behalf.

All grievance forms should be sent to the MCST, along with a Grievance Tracking Form (if the member has Medi-Cal). You need to complete and send the Grievance or Appeal Form along with the Grievance Tracking Form via email by the end of the next business day. The MCST uses the additional tracking form to log and monitor all grievances. The tracking form provides the MCST with additional information that is needed to log, investigate, and report on grievances to DHCS. The MCST promptly acknowledges receipt of the grievance by sending a letter within five business days. Subsequently, the MCST investigates the grievance, which may include interviewing those involved in the case and reviewing the case file, among other activities. Because strict timelines must be met to comply with the grievance resolution requirements, the MCST needs your help sending the grievance and tracking forms immediately if you are the recipient of a grievance. The MCST oversees, tracks, and monitors all grievances. As part of this monitoring, corrective action plans are issued to providers who have received three or more substantiated grievances in a quarter.

DHCS requires grievances to be resolved within 30 calendar days to be in alignment with the Federal requirements for the Managed Care Plan. The MCST requires program's assistance to quickly respond to the 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.

If you have further questions or need additional details about the grievance process and the required forms, reach out to MCST.

Discrimination Grievances

Discrimination Grievances are also one of the member's protections. If a member reports a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, we are required to address the Discrimination Grievances, track them, and resolve them.

The member may file a Discrimination Grievance at any time without being required to file with the BHP first and can file the complaint with other entities. With this type of grievance, the MCST works in collaboration with the Office of Compliance County Civil Rights Coordinator to complete the investigation and report it to DHCS.

Transgender, Gender Diverse, or Intersex (TGI) Grievances

Senate Bill (SB) 923 (Chapter 822; Statutes of 2022), known as the Transgender, Gender Diverse or Intersex Inclusive Care Act, added section 14197.09 to the W&I and mandated Department of Health Care Services (DHCS) to require all of its Behavioral Health Plans (BHPs), subcontractor, and downstream subcontractor staff who are in direct contact with members in the delivery of care or member services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or TGI. Trans-inclusive health care means comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

What Does This Mean for the Grievance Process?

The BHIN 25-019 indicates, if a member submits a grievance against the provider or staff for failure to provide trans-inclusive health care, the BHP is required to report the grievance to DHCS quarterly, effective 7/1/25.

BHPs are also required to submit additional information, as specified by DHCS, that verifies the grievance data reported to DHCS on a quarterly basis when the outcomes of the grievance reported are resolved in a member's favor. If the grievance is resolved in the member's favor,

then the individual named in that grievance who is employed by the BHP, must complete a refresher course by retaking the trans-inclusive health cultural competency training immediately AND before they have direct contact with members again. This means the individual is **NOT** permitted to have any phone contact, face-to-face interaction, provide treatment services and is unable to deliver any non-billable/billable services, nor chart in the medical records for ALL members until the TGI training has been completed and submitted to the MCST. BHPs are also required to submit to DHCS verification of the completed refresher training quarterly.

Providers should note that any pattern of repeated complaints against an individual, or multiple complaints against multiple individuals of the BHP gives rise to a presumption that the BHP or its subcontractors, and downstream subcontractors are not providing adequate trans-inclusive care, as required. Such patterns and practices suggest that existing training is ineffective or that the working culture is hostile to trans-inclusive care and requires further remediation, including, but not limited to staff training, staff discipline, and/or re-evaluation of the training curriculum.

NOTICE OF ADVERSE BENEFICIARY DECISIONS (NOABD)

In managed care, members have the right to receive notice whenever the BHP makes a decision that impacts their benefits. As a representative of the Plan, you, as a provider, must issue a NOABD when making a decision that negatively affects the member's interests. The treatment provider should either hand-deliver or mail the original completed NOABD to the Medi-Cal member within two business days. This notice must be accompanied by three enclosure documents: "Your Rights," Language Assistance Taglines, and the Notice of Non-Discrimination.

All NOABDs must be forwarded to the MCST for tracking and logging. NOABDs must be sent with a cover sheet that includes elements the MCST needs to track that are not included in the NOABD itself, such as who issued the notice and how.

Your direct Supervisor or Quality Improvement Coordinator can assist you if you have questions about when or how to issue a NOABD. While you are the first person to write the NOABD, your direct Supervisor or Quality Improvement Coordinator *must review and approve the notice* before it is sent out. Please note that NOABDs are issued to Medi-Cal members only. For non-Medi-Cal members, please consult your supervisor.

The different types of NOABDs providers would issue are:

- Delivery System
- Denial of Authorization for Requested Services
- Timely Access

- Termination
- Modification
- Authorization Delay
- Denial of Payment for a Service Rendered by a Provider (Inpatient only)

NOABD – Delivery System
The NOABD Delivery System is issued to the Medi-Cal member when it is determined that the member's condition does not meet the medical necessity criteria for SMHS or DMC-ODS during the initial assessment period. The NOABD is typically issued after completing the 7-Domain Assessment, but in rare cases, it may occur during the intake appointment. The NOABD must be hand-delivered or mailed at least two business days after the decision.

NOABD – Denial of Authorization for Requested Services
The NOABD Denial shall be issued when the Medi-Cal member is being denied the requested services. The NOABD must indicate the clinical reasons for the decision regarding medical necessity or residential authorization request. It should explicitly state why the services have been denied and why the Medi-Cal member's condition does not meet the medical necessity criteria.

For the BHP, the NOABD shall explicitly state why the Medi-Cal member's condition can continue being treated with the current treatment modality. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

The NOABD must be hand-delivered or mailed within two business days after the decision.
If you believe you need to issue a Denial NOABD, please *consult* the MCST *before doing so*.

NOABD – Timely Access
The NOABD Timely Access is issued when there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service. This type of NOABD is typically generated at access points, for example:

- 24/7 Access Line/Beneficiary Access Line,
- Community providers partner with outpatient clinics, and
- County-operated outpatient clinics.

The NOABD must be hand-delivered or mailed within two business days after the decision.
Please consult with the MCST prior to issuing a NOABD Timely Access. The MCST needs to ensure that all resources within the BHP have been exhausted before a NOABD for timely access can be issued.

NOABD – Termination

The NOABD Termination is issued once the member is in treatment and an action is taken by either the provider or the member that results in the termination of treatment services. The NOABD must be issued when the provider has lost contact with the member, and therefore the member cannot agree nor disagree with the decision that the provider is making to terminate services.

There can be different reasons for issuing the NOABD termination. Some examples include when the member has not participated in services or contacted the program (60 days for the SMHS and 30 days for the DMC-ODS), when a member is deceased, or when a member is admitted to an institution where they are ineligible for further services (such as jail or a long-term hospital). Even when a member decides to end treatment voluntarily, a NOABD is still required if this occurs before completion of treatment, as such action is against the provider's advice and, therefore, "adverse."

The only time we do NOT issue a NOABD termination is when the member successfully completes treatment and agrees with termination.

The treatment provider shall hand-deliver or mail the original, completed NOABD Termination to the Medi-Cal member at least 10 days before the proposed action or when a member submits a written statement to the program asking to discontinue services and states that it is understood that this will result in termination on the same day.

NOABD – Modification

The NOABD Modification is issued to the Medi-Cal member whenever the Plan modifies or limits a provider's request for a service, provided that the member is NOT in agreement. This includes reductions in frequency and/or duration of services, and the approval of alternative treatments and services. For example, if a provider authorizes one individual therapy session per week, but the member prefers two individual therapy sessions instead, an NOABD modification is necessary. Similarly, if the provider authorizes Dialectical Behavior Therapy (DBT), but the member disagrees with receiving this alternative treatment, an NOABD modification should be issued.

The NOABD must be hand-delivered or mailed within two business days after the decision.
Before issuing a NOABD modification, please consult with the MCST.

NOABD – Authorization Delay

The NOABD Authorization Delay should be issued when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential and inpatient services. When the BHP extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the member or provider, and/or those granted when there is a need for additional information from the member or provider, when the extension is in the member's interest.

NOABD – Denial of Payment for a Service Rendered by a Provider (Inpatient Only)

The NOABD is only used for inpatient services when the BHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a member.

For all the rules, exceptions, and timelines of NOABDs, please contact the MCST and ask to speak to the NOABD Leads for guidance.

APPEALS

"Appeal" means a review by the provider of an adverse benefit determination or a denial to expedite an authorization decision.

30 Day Appeals

Federal regulations allow members to file an appeal within 60 calendar days from the date on the NOABD. The BHP is required to provide the member with a written acknowledgment of receipt of the appeal, open an investigation, and resolve it within 30 calendar days.

Expedited Appeals

A member has the right to request an expedited appeal for a resolution within 72 hours. However, the BHP must review the expedited appeal and determine whether taking time for a standard resolution could seriously jeopardize the member's mental health, substance use disorder condition, and/or the member's ability to attain, maintain, or regain maximum function. The Plan may deny the request for expedited resolution of an appeal. When this occurs, the Plan changes it to a standard appeal of 30 calendar days instead of 72 hours.

At any point during the appeal process, the program is required to assist the member with continuing benefits during an appeal of the adverse benefit determination. This means the program must keep the case open and continue to provide services until the investigation has been upheld or overturned. If the appeal is overturned, the member will continue treatment services with the program.

The MCST oversees, tracks, and monitors all appeals. Contact the MCST for more details or questions regarding the appeal process.

STATE FAIR HEARINGS

"State Hearing" means a hearing provided by the State to members pursuant to Cal. Code Regs., tit. 22, § 50951 and 50953 and Cal. Code Regs., tit. 9, § 1810.216.6. State Hearings shall comply with all applicable 42 CFR requirements.

Timeframes for Filing

Federal regulations allow members to request a state hearing within 120 calendar days from the date of the Notice of Adverse Resolution, which informs the beneficiary that the Adverse Benefit Decision has been upheld by the plan.

Method of Filing

Members must exhaust the Plan's appeal process prior to requesting a state hearing. Members have the right to request a state hearing only after receiving notice that the BHP is upholding an adverse benefit determination. If the BHP fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the BHP's appeals process. The enrollee may then initiate a state hearing.

Types of Hearings:

Standard Hearing

The BHP shall notify members that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing.

Expedited Hearing

The Plan shall notify members that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing.

Overturned Decisions

The BHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health conditions require, but no later than 72 hours from the date it receives notice reversing the Plan's adverse benefits determination.

SUPERVISION REPORTING FORMS AND PROCESS

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional (LMHP) or Licensed Practitioner of the Healing Arts (LPHA) according to relevant laws and regulations. The LMHP/LPHA assumes ultimate responsibility for the services provided. All registered or waivered employees, interns, and volunteers must receive mandated supervision and be documented to ensure compliance with regulations.

The MCST encourages all supervisees, clinical and counselor supervisors to seek consultation directly with their certifying organizations and/or licensing boards for questions related to supervision requirements (e.g., collecting hours, face-to-face hours, etc.) and regulations.

The MCST tracks, log and monitor providers supervision reporting forms to ensure the types of providers maintain the necessary supervision needed to deliver Medi-Cal covered services. Including, conducting periodic supervision form reviews to ensure compliance with the supervision requirements.

Providers under required supervision by their licensing board or certifying organization (e.g., Nurse Practitioner, Registered AOD Counselor, AMFT, APCC, Certified Peer Support Specialist, Medical Assistant, etc.) are prohibited from delivering Medi-Cal covered services if they have **NOT** submitted their Supervision Reporting Form. Always secure supervision for the supervisee to prevent any supervision gaps and potential deficiencies for disallowances or recoupments.

Clinical Supervision Requirements in California

Now that you know of the reporting forms, let's now learn about the qualification requirements. To provide clinical supervision in California, individuals must possess a current and active California license that is not under suspension or probation. They should have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision. Additionally, a licensed supervisor needs to complete 15 hours of supervision training to supervise an AMFT and then subsequent 6 hours per renewal period. For further requirements to supervise an AMFT, APCC, or ACSW, please visit the BBS website. The direct Supervisor must ensure that the pre-licensed supervisees submit all required clinical supervision forms and that the licensed Supervisor meets the BBS requirements to provide supervision. Failure to do so may result in services being recouped.

The following providers are required to have supervision, and a Clinical Supervision Reporting Form completed and emailed to the MCST:

- Registered ACSW
- Registered AMFT
- Registered APCC
- Registered Waivered Psychologist
- Psychologist Clinical Trainee
- Clinical Social Worker Trainee
- Marriage Family Therapist Trainee
- Professional Clinical Counselor Trainee
- Associate Applicant – BBS 90 Day Rule

Clinical Supervision Report Form

The Clinical Supervision Reporting Form (CSRF) may require additional documents (e.g., BBS/BOP Supervision Agreement, Clinical Supervision Agreement, Supervisor Self-Assessment Report) to be submitted to the MCST at the start (e.g., new hire). Any change in status requires an updated CSRF to be submitted to the MCST (e.g., separation, name change, change in Clinical/Counselor Supervisor). Continuous supervision is mandatory to ensure there are no gaps. A Clinical Supervisor must always be assigned to the supervisee and maintain supervision notes for their files for audit purposes. Supervision must occur weekly until the supervisee is licensed.

Failure to submit the CSRF and be assigned to a Clinical Supervisor will result in the registered and waivered providers being prohibited from delivering Medi-Cal covered services. Non-independently licensed or certified staff must always be supervised as per their licensing board or certifying organization. Failure to comply will result in disallowed services.
Clinical Supervisors must adhere to supervision requirements outlined by their professional boards.

Supervisors must attest to their qualifications, experience, training, and understanding of relevant laws and regulations, providing documentation as required by Title 16, California Code of Regulations.

Board of Behavioral Science (BBS) 90-Day Rule

This is an option for County Contracted Programs Only. The State Department of Health Care Services (DHCS) will honor the 90-day Board of Behavioral Sciences (BBS) rule and allow practitioners to provide services as if they are registered while they wait for their registration number after the completion of their Live Scan. DHCS has confirmed that Associates are considered “registered” during this 90-day period and can claim Medi-Cal for assessments and therapy services.

If you would like to inquire more about the BBS 90-Day rule, reach out to the Supervision Lead for more information about the eligibility requirements and expectations.

Counselor Supervision Reporting Form and Requirements
Registered Alcohol Other Drugs (AOD) Counselors are required to submit a supervision form to their Counselor Supervisor. Any updates to their supervision status require the submission of an updated form. Counselor Supervisors are responsible for ensuring adequate supervision and must maintain current forms for each supervisee. It is recommended that Counselor Supervisors maintain their files for audit purposes. AOD registered counselors must follow their certifying organization's supervision requirements. AOD Counselors should consult with their supervisors to ensure compliance and proper documentation submission to the MCST.

The following providers who work in Substance Use Treatment programs need to be under supervision and have a Counselor Supervision Reporting Form completed and emailed to the MCST:

- RAC – Registered Addiction Counselor
- CATC I – Certified Addiction Treatment Counselor I
- RADT-I – Registered Alcohol Drug Trainee - I
- RADT-II – Registered Alcohol Drug Trainee II
- RH – Registered Hardship
- RGSI – Registered Graduate Student Interns in SUD
- SUDRC – Substance Use Disorder Certified Counselor
- Intern
- Volunteer

Professional Licensing Waiver (PLW) Requirement
A Professional Licensing Waiver (PLW) is required when an individual has accumulated 48 semester units or 72 quarter units of graduate coursework or has graduated from a doctoral program.

The MCST is required to complete the PLW application for County and County-contracted providers. The PLW allows pre- and post-doctoral candidates to bill Medi-Cal for SMHS while acquiring supervised professional experience to obtain their license. Before obtaining a PLW, a psychologist candidate is considered an Other Qualified Provider. As such, they can offer the following services:

- Mental Health Services, excluding therapy
- Targeted Case Management (TCM)
- Crisis Intervention
- Crisis Stabilization

These services must be conducted under the direction of a Licensed Mental Health Professional (LMHP) within their respective scope of practice, and all documentation must be co-signed.

Once DHCS grants the PLW, all mental health services can be provided and billed to Medi-Cal. The PLW remains valid for five years, cannot be renewed, and cannot be transferred to another County.

When applying for the Professional Licensing Waiver, the Service Chief or Program Director should submit the applicant's resume, official transcript, and program start date to the MCST via email at BHPSupervisionForms@ochca.com with the subject line: 'Time Sensitive: PLW'. If you would like to inquire more about this topic, reach out to the Supervision Lead for more information about the eligibility requirements and expectations.

Medical Supervision Reporting Form

Certain medical professionals are required to submit a supervision form to their supervisor. Any updates to their supervision status require the submission of an updated form. Supervisors are responsible for ensuring adequate supervision and must maintain current forms for each Supervisee. It is recommended that Supervisors maintain their files for audit purposes. Medical providers must follow their certifying organization or licensing board's supervision requirements. Medical providers should consult with their supervisors to ensure compliance and proper documentation submission to the MCST.

The following medical providers need to be under supervision:

- Nurse Practitioner
- Nurse Specialist Trainee
- Registered Nurse Trainee
- Vocational Nurse Trainee
- Psychiatric Technician Trainee
- Occupational Therapist Trainee
- Pharmacist Trainee
- Physician Assistant Trainee
- Medical Assistant
- Licensed Practical Nurse
- Licensed Vocational Nurse
- Certified Nurse Assistant
- Licensed Psychiatric Technician
- Physician Assistant
- Occupational Therapist Assistant

Qualified Provider Reporting Form

The California State Plan Amendment 22-023 approved by the Center for Medicaid Services on March 2nd, 2023, approved and defined the 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 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.

The following qualified providers need to be under supervision:

- **Mental Health Rehabilitation Specialist (MHRS)** are not an independent provider. Every MHRS requires close supervision if issues of Danger to Self (DTS) or Danger to Others (DTO) are present and if the MHRS direct supervisor is not an LPHA/LMHP then the supervision form requires an LPHA/LMHP signature.

- **OQP I/II** are not an independent provider. Every OQPI/II requires close supervision if issues of DTS or DTO are present and if the OQP I/II direct supervisor is not an LPHA/LMHP then the supervision form requires an LPHA/LMHP signature.

  The OQP is required to be under the direction of a mental health provider. According to the State Plan Amendment, approved on March 2, 2023, and effective July 1, 2022:

  "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service provided. Services are provided under the direction of a physician, a licensed or waivered psychologist; a licensed, waivered or registered social worker; a licensed, waivered or registered marriage and family therapist; a licensed, waivered or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner). All providers of Rehabilitative Mental Health Services must act within the scope of their professional license and applicable state law.

- **Certified Peer Support Specialist (CPSS)** are not an independent provider. The CPSS must be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory Training within 60 days of beginning to supervise a Medi-Cal Peer Support

Specialist. If the CPSS direct supervisor is not an LPHA/LMHP then the supervision form requires an LPHA/LMHP signature.

Below is a grid, to help identify what you may be classified under based on your work experience and education. If you have questions about determining which provider type best fits your program needs, contact the Clinical Records Support Team for assistance. Click here or the grid below for a larger copy.

Other Qualified Provider Type Matrix

BEHAVIORAL HEALTH PLAN PROVIDER TYPE	Mental Health Rehabilitation Specialist (MHRS) Specialty Mental Health Services (SMHS) ONLY	Other Qualified Provider II SMHS ONLY	Other Qualified Provider I SMHS ONLY	Certified Peer Support Specialist (CPSS)
EDUCATION	BA/BS or AA (in a related field) +2 years post AA clinical experience	High School Diploma or GED	High School Diploma or GED	High School Diploma or GED
WORK EXPERIENCE	Plus, four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. NOTE: Up to 2 years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.	Plus, four years of related paid or non-paid experience in mental health service provision. NOTE: (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. (B) Completion of an BA/BS degree in a related field may be used to substitute up to 2 years of the required related paid or non-paid experience in mental health service provision.	Two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient).	Certification from CalMHSA
OTHER QUALIFICATIONS	Age 18+	Age 18+	Age 18 +	Age 18+
ALLOWABLE SERVICES	•Contribute to Assessment: Mental Health History, Medication History; Substance Use, Strengths, Risks, Barriers •Problem List/Care Plan •Rehabilitation •Targeted Case Management •Intensive Home-Based Services •Intensive Care Coordination •Mobile Crisis •Crisis Intervention	•Contribute to Assessment: Mental Health History, Medication History; Substance Use, Strengths, Risks, Barriers •Problem List/Care Plan •Rehabilitation •Targeted Case Management •Intensive Home-Based Services •Intensive Care Coordination	•Problem List/Care Plan •Targeted Case Management •Intensive Case Coordination	•Problem List •Self-Help/Peer Services •Behavioral Health Prevention Education Services •Mobile Crisis •Peer Support Specialist Plan of Care
All Specialty Mental Health Services MUST be reccomended by physicians or other LPHAs/LMHPs acting within their scope of practice and in accord with medical necessity.				
SUPERVISION REQUIREMENTS	•MHRS requires close supervision if issues of DTS or DTO are present. •If the MHRS direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•OQP II requires close supervision if issues of DTS or DTO are present. •If the OQP II direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•OQP I requires close supervision if issues of DTS or DTO are present. •If the OQP I direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•Medi-Cal Peer Support Specialists must be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory training within 60 days of begining to supervise a Medi-Cal Peer Support Specialist. •If the Medi-Cal Peer Support direct supervisor is NOT an LPHA/LMHP then, the Qualified Provider Supervision Form requires an LPHA/LMHP signature.
NOTE: If you have questions about determining which provider type best fits your program needs, contact your support team at BHPAOASupport@ochca.com or BHPCYSSupport@ochca.com.				

MCST:Updated 03/2025

CHANGE OF PROVIDER AND 2ND OPINION

When a member requests either a change of provider or a second opinion, the BHP has a uniform process to track these requests as part of the DHCS contract. For County Contracted programs a "Request for a Change of Provider/2nd Opinion Log" must be maintained at each clinic/program and completed when the request occurs. Each County Contracted program administrator is required to submit the completed log to the MCST every quarter for review and monitoring. For the County Clinics, the “Request for a Change of Provider/2nd Opinion” is completed for each member request using the IRIS PowerForm.

Member requests for change of provider are directed to the supervisor or provider representative. Requests are reviewed by the MCST quarterly and may also be reviewed at the BHS Community Quality Improvement Committee (CQIC) meetings. Instances of three or more requests to change from a particular provider within a quarter are brought to the attention of supervisor and program manager for follow up.

Members have the right to request and receive a second opinion upon receiving notification from the BHP that he or she does not meet medical necessity for SMHS. Second opinion can be rendered by another clinician at the same clinic or at a different clinic. See grid below for general guidance about the Change of Provider and 2nd Opinion:

CHANGE OF PROVIDER/2ND OPINION

CHANGE OF PROVIDER

- Members and/or legal guardians in Behavioral Health Plan, when initially referred for treatment, shall be offered a choice of providers, whenever possible.
- After initial provider selection and referral, a beneficiary and/or legal guardian may request a change of provider at any time.
- The member and/or legal guardian shall be advised by the clinician regarding the request.
- The request will be directed to the Service Chief/Program Director or Provider Representative. Every effort shall be made to accommodate requests for a provider change.

2ND OPINION

- When a member and/or legal guardian requests a second opinion, it shall be rendered by another licensed mental health professional at the program site or at a different clinic.
- If the second opinion is rendered at the same clinic, then the Service Chief/Program Director or Provider Representative will designate the clinician in charge of completing this evaluation.
- If the second opinion is rendered at a different clinic, then the County Program Manager will designate a County operated or County contracted clinic to render the second opinion evaluation.
- The clinician rendering the second opinion shall have the appropriate clinical expertise and shall not have been involved in the initial evaluation or be a subordinate of any such provider.
- Once the second opinion has been completed, the beneficiary will return to their primary provider.
- The second opinion will be provided at no cost to the beneficiary.

For more information about the process, contact the Change of Provider/2nd Opinion Leads for consultation and inquiries about the process. Initiating a Change of Provider/2nd Opinion may have additional requirements, such as filing a grievance and/or issuing an NOABD for certain circumstances.

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)

A *PTAN* is a Medicare-only number issued to providers by Medicare Administrative Contractors (MACs) upon enrollment to Medicare. *MACs* issue an approval/notification letter, including *PTAN* information, when an enrollment is approved. A PTAN is essential for identifying Medicare service providers, ensuring compliance, and facilitating claims processing. It acts as a unique identifier assigned to healthcare providers by Medicare. The MCST is required to PTAN all eligible Medicare providers in the SMHS and DMC-ODS Adult & Older Adult (AOA) County Clinics to be reimbursed for Medicare and Medi-Medi covered services.

If you are a county LPHA/LMHP provider, you may be eligible to be PTAN. Please contact the PTAN Lead at BHPPTAN@ocha.com to initiate the process.

TRAININGS

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 administrators to schedule the training at least a month prior to delivering Medi-Cal covered services.

The MCST is also offering open training sessions for new and existing providers. The 3-hour training covers NOABDs, Grievances, Appeals, State Fair Hearings, 2nd Opinion/Change of Provider, Supervision Reporting and Access Logs. E-mail the MCST representative to send the invitation to attend the training via Microsoft Teams.

2nd Tuesdays of the Month @ 1 p.m. MCST Training (SMHS)

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

The Credential/Recredentialing and Provider Directory training is an additional training required for program administrators and supervisors to attend. This training is offered by the assigned MCST credentialing representative.

In addition, a refresher training on specific topics is available upon request.

MCST E-MAIL ADDRESSES

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 (SMHS Only); Personnel Action Notification (PAN)
BHPProviderDirectory@ochca.com	Provider Directory Notifications; Provider Directory submission for SMHS and DMC-ODS programs by the 15th of every month.
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, Mental Health Professional Licensing Waivers for Psychology Candidates, etc.
BHPPTAN@ochca.com	Provider Transaction Access Number (PTAN) enrollment and inquiries.

INTEGRATED RECORDS INFORMATION SYSTEM (IRIS)

The Integrated Records Information System (IRIS) is a database used by Health Care Agency Behavioral Health Services, Correctional Health Services and Public Health Services. IRIS includes the Electronic Health Record (EHR) for County-operated BHS programs, as well as the database that processes all of the information for county and contracted billing.

FREQUENTLY USED TERMS (FOR COUNTY PROVIDERS)

Citrix Workspace is a secure digital platform that allows county employees to access county applications, desktops, and data from any device. Employees using Citrix Workspace should follow all security protocols, including multifactor authentication and data protection policies, to safeguard county and client information. Citrix Workspace

Powerchart (Cerner Millenium) is the Electronic Health Record (EHR) system used by our organization to document, store, and manage client/patient information securely. It allows providers to access real time data, track medical histories, enter orders and facilitate coordinated care across programs and departments. Employees using Powerchart must follow all privacy, security, and compliance guidelines, including HIPAA regulations & 42 CFR Part 2, to protect client/patient information.

For BHS, we are currently using IRIS specifically for Client Information, Registration, Billing, Reporting and Appointment Scheduling.

- **Registration** allows us to track client demographic information such as ethnicity, language, gender, etc. as well as the client's health plan information.
- Our advanced **Billing** system interfaces with the State to send a HIPAA compliant Medi-Cal billing file for County and Contract providers and can accept the adjudicated response from the State. We are also able to bill Medicare for County programs.
- IRIS **Scheduling** allows staff to make an appointment with anyone on the client's Treatment Team, which is the standard of care in BHS.

LOGIN AND SECURITY (FOR COUNTY PROVIDERS)

For security purposes, employees will require multiple logins and passwords to access various systems.

Computer Login (Microsoft)- Use the username and password provided to you. You will receive a county issued email address, which will be linked to your username.

Citrix Workspace Login: Uses the same username and password as your Microsoft Login.

Cerner Millenium Powerchart Login: Once your profile is created, you will receive an email with your assigned unique username, which consists of your 1-3 initials and last name. You will be required to create your own password.

Password Requirement & Security Policies:

- Passwords must be updated every 90 days.
- You cannot reuse any of your last 10 passwords.
- Passwords must be at least 12 characters long and contain:
- Uppercase and Lowercase letters
- At least one number
- At least one special character (e.g. !,*,@,#,$)

IT Security: Please refer to the Annual Provider Training and Cyber Security Training

EHR TRAINING (FOR COUNTY PROVIDERS)

How soon do you get trained?

As soon as your Powerchart profile has been built and validated, you will receive an email stating that your profile has been completed and an outlook invite to the next available training. Please refrain from entering your profile before you have received an email with your User Log-in and password as your profile has not been validated yet and it may create unnecessary issues. Trainings occur once per month; please see the training calendar on the blog linked on the next page. Please note you will be placed in co-sign position prior to training, after training or at your Service Chief's discretion, you will be moved out of co-sign position.

Pre-requisites for training

- Shadowing: Prior to attending training, class participants should spend several days shadowing the clinic super user partner(s) or another strong user in the clinic to ensure they are familiar with how the clinic does business and uses the EHR.
- Scheduling: Prior to attending training, class participants should have practiced scheduling and are familiar with how to make appointments prior to the training.

EHR Blog/Website

You must be on the county network to have access to the EHR Websites. You will find Blogs, Quick guides, SC Resources, Super User information, and Quick links to various departments like the IRIS Team, IT, Managed Care, HIM Team and Doc Support. Subscribe and add as a Favorite to receive the email blasts with the most recent EHR updates.

- For AOA/CYS/PEI/CAC Programs, click here for the website.
- For SUD Programs, click here for the website.

The Role of Super User

A Super User is a person who has been identified by a clinic's Service Chief as able to learn new EHR processes easily and share them with other staff. We invite you to participate in our Super User meetings every other month to develop your EHR expertise with several goals in mind:

- Act as an initial support to staff at the EHR clinics who have easy to answer questions or just need reminders of processes they may have not done recently.
- Ensure every clinic is being updated on any changes or improvements to the system.
- Have the opportunity to provide feedback to us to help us further improve the system in ways that support your business needs.
- Share EHR related questions from your clinic.
    - Provide EHR training to staff in your area of responsibility, when asked, for new or enhanced system features.
    - Assist users in modifying proxy and network printer settings in Powerchart.

All meeting Notes and Attachments from Super User meetings are posted on our Blog on the Super User page https://bhsehrinfo.ochca.com/faqs-2/what-is-a-super-user/

USER SUPPORT

For County Users

- HCA Service Desk (IT) *(any issues with account lockouts/password resets, hardware, software, network issues)*

714-834-3128 option 1
servicedesk@ochca.com

- IRIS Liaison Team (EHR) (*any issues within Powerchart, i.e., error correction, SCHED lock out, chart lock out etc.*)
  (714) 347-0388 option 2
  BHSIRISLiaison@ochca.com *(Please note: our team does not have VPN capabilities so in order to assist you we may ask you to share your screen with us via MS Teams.)*

  BHPNetworkAdequacy@ochca.com

  BHPPTAN@ochca.com

- Office Coordination Team (Front Office) *(All front office functions i.e. REG, RCA)*
  (714) 834-6007 option 3
  BHPBillingSupport@ochca.com
- Managed Care Support Team *(Credentialing, Access Log, NOABD, Supervision, grievances, Provider Directory)*
  714-834-5601 option 4
  BHPManagedCare@ochca.com

  BHPGrievanceNOABD@ochca.com

  BHPSupervisionForms@ochca.com

  BHPProviderDirector@ochca.com

- AOA Support Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPAOASupport@ochca.com
- CYS Support Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPCYSSupport@ochca.com
- SUD Clinical Records Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPSUDSupport@ochca.com
- Health Information Management (HIM) Team *(Organization of the Legal Health Record, Creating Scan Types, Release of Records, Authorizations to Disclose (ATDs), Child Abuse reports)*
  (714) 834-8608
  BHSHIM@ochca.com

For Contract Users

Please defer to your contract monitor for any questions.

- HCA Service Desk (IT) *(any issues with account lockouts/password resets)*
  714-834-3128 option 1
  servicedesk@ochca.com
- IRIS Liaison Team (EHR) (*setting up a new provider in our system*)
  (714) 347-0388 option 2
  BHSIRISLiaison@ochca.com
- Office Coordination Billing Team *(All front office functions i.e. REG, RCA)*
  (714) 834-6007 option 3
  BHPBillingSupport@ochca.com
- Managed Care Support Team *(Credentialing, Access Log, NOABD, Supervision, grievances, Provider Directory)*
  714-834-5601 option 4
  BHPManagedCare@ochca.com

  BHPGrievanceNOABD@ochca.com

  BHPSupervisionForms@ochca.com

  BHPProviderDirector@ochca.com
- AOA Support Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPAOASupport@ochca.com
- CYS Support Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPCYSSupport@ochca.com
- SUD Clinical Records Team (Documentation) *(How to bill, what to bill, what to write)*
  714-834-5601
  BHPSUDSupport@ochca.com

  Health Information Management (HIM) Team *(Organization of the Legal Health Record, Creating Scan Types, Release of Records, Authorizations to Disclose (ATDs), Child Abuse reports)*
  (714) 834-8608
  BHSHIM@ochca.com

NEW USER ACCOUNT SET UP

The Service Chief (for County-operated programs) or Program Director (for contracted programs) should follow these steps to create a new IRIS account for a new provider.

Step 1. This step is for County providers only, contract providers go to Step 2. Submit NAR to request all applications/services new staff will need, including email, any shared mailboxes, network drives, and IRIS PowerChart Prod (PowerChart P0623)

Step 2. Complete the PAN form.

Ensure the PAN is fully completed by filling in these required fields:

Last name	Full Time status
First name	Start Date
Middle name (if applicable)	Supervisor name
Email address	Primary work address
Phone number	Green NACT Fields

Step 3. Ensure all required trainings are completed by your provider.

Step 4. If provider is licensed, make sure their PAVEs are submitted, **then skip to step 5.**

- All SUD providers will either need to be listed on the PAVE SCA or PAVE SUDTP for licensed providers.

Step 5. If provider is not licensed, make sure to have the Supervision Reporting Form for their discipline/license type completed and signed.

Step 6. Check NPPES to ensure the following data is accurate:

- Provider name should be spelled out in its entirety and match the provider's license/credential.
- Middle Initials are not allowed. Middle names need to be spelled out entirely or removed.
- Ensure the correct taxonomy code with CA as the issuing state is the only taxonomy code on NPPES. (reference the provider position matrix in the PAN)
    - The only time an additional taxonomy code may be allowed is if provider is working at multiple locations serving in different capacities. IRIS would need to know where the provider is working and what type of services they are providing in another role.

Step 7. County providers only, submit a Schedule Template, **Contract providers go to Step 8**

- Schedule Templates can be found on the BHS EHR blog.
- Create template for individual provider.

Step 8. Once all forms and trainings have been completed, please send email with all attachments to the Managed Care Support Team and IRIS Liaison inboxes.

STAFF REQUIREMENTS

Ensure the following are accurate at all times

- Name on License and NPPES match
    - No middle initials allowed. Please spell middle name out entirely.
- NPPES has the correct taxonomy code as the only and primary taxonomy code with CA as the issuing state.
    - If you need assistance with what taxonomy code you should have listed on NPPES, please ask your Service Chief or Program Administrator or check the provider position matrix located in the PAN form.
        - If you need assistance making changes to your taxonomy code on NPPES please reference the NPI quick guide located in the PAN form.
    - The only time an additional taxonomy code may be allowed is if the provider is working at multiple locations serving in different capacities. IRIS would need to know where the provider is working at and what type of services they are providing in another role.
- PAVE Application is completed- (licensed providers only)
    - SUD providers who aren't licensed will be included in the Program SCA PAVE.

NAME AND CREDENTIAL CHANGES

Step 1. SC or Program Admin to submit PAN with updated information to IRIS Liaison and Managed Care Team inboxes.

Step 2. Ensure the following information is correct

- License/Credential must reflect new credential and/or Name
- NPPES registry must reflect new taxonomy code and/or Name

Step 3. Depending on the type of credential/name change you will need the following:

New Clinical Supervision Reporting Form (CSRF).

- Name change for provider who is required to be under supervision

- If a license number changes for a provider under same credential (ex. an AMFT remains an AMFT but there is a license number change).
- Credential change for a provider that was an intern/trainee now registered provider (ex. MFT Trainee to AMFT)
- Credential change from qualified provider to registered provider (ex. MHRS/OQP to AMFT)

PAVE application * Medi-Cal billing Programs only

- Cred Change for **registered** providers who become **licensed** (ex. AMFT to LMFT)

Credentialing Approval * Medi-Cal billing Programs only

- Credential change from provider intern to registered provider (ex. MFT Trainee to AMFT)
- Credential change from qualified provider to registered provider (ex. MHRS/ OQP I/II to AMFT)
- If provider goes from registered to licensed, a new Credentialing Approval would not be required. (ex: AMFT to LMFT)

STAFF TRANSFER

SC or Program Admin submit transfer PAN.

- Ensure you are letting us know if the provider is transferring into or out of your program.
- Please add date they transferred programs
- Ensure you are adding the initial start date with your program.
    - (ex. Behavioral Health Employees with the county maintain their start date throughout their career. A transfer date would indicate when they moved to another program)
    - (ex. A Telecare provider keeps their original start date if it is within the same Orange County Telecare organization. We would need the start date listed on PAN included with transfer date.)

STAFF TERMINATION

SC or Program Admin submit PAN or email notification to the IRIS Liaison Team with separation date.

- Do not submit a separation PAN if your provider is transferring to another program within your organization. (ex. County to County or Telecare to another Telecare)
- A separation PAN is appropriate if:
    - Provider has completely terminated working with program
    - Is moving from one division to another (AMHS to SUD or CYS)
    - Is moving from County to Contract or vice versa

- Is moving from one program type to another (Telecare to Clarvida)

CYS CONTRACT OUTPATIENT INTAKE APPOINTMENT SCHEDULES

Identify the type of user and submit the documents outlined below to the appropriate team.

For Current Non-Clinical Users (Office Staff/Billing Staff) who are already using IRIS for billing and creating/modifying encounters no extra documents are necessary; however, further defaults and training will be needed.

For New Non-Clinical Office Support Users, submit the documents listed below to the Office Coordination Billing Team (OCBT) @ bhpbillingsupport@ochca.com

1. PAN Form
2. NAR/Token Request Form

OCBT will send the SCHED Defaults book to new users, enabling them to establish their defaults. Additionally, they will copy the Data Analytics System Support Team to include in the next training for new SCHED users. Users should have their defaults set before attending the training.

Current Clinical Staff that are already in IRIS as "provider only" or "Current Admin/QA Staff" submit the documents listed below to the Data Analytics Support Team at bhsirisliaison@ochca.com

1. NAR/Token Request Form; In body of email include: "Change IRIS position to *BHS Contract Provider Access Log*"

New Clinical Staff who will be providing services and scheduling intake appointments or New Admin Staff submit the documents listed below to the Data Analytics Support Team at bhsirisliaison@ochca.com

1. PAN Form, select New Clinical Staff and in comments include "*BHS Contract Provider Access Log position to access SCHED*"
2. NAR/Token Request Form

All other required/application documents to add provider in IRIS; APT, Clinical Supervision Forms, PAVE application, follow the Provider Position Matrix to select the appropriate taxonomy on provider's NPPES registry etc.

Requests processed by the Data Analytics Support Team will receive their log in details and SCHED Defaults book enabling new users to establish their defaults. Users should have their defaults set before attending the training.

In person CYS Outpatient Trainings are held the last Tuesday of each month, users will receive a meeting invite a week prior to the training with location and parking details.

If you need further clarification or assistance, contact the appropriate team:

- Front Office/Billing Staff: bhpbillingsupport@ochca.com or (714) 834-3128, option 3
- Clinical Staff: bhsirisliaison@ochca.com or (714) 834-3128, option 2
- Token Request (once Token is set up) IT Service Desk at (714) 834-3128, option 1

BILLING

The clients, State, and Federal government expect documentation and billing to accurately reflect the treatment that was provided. Inaccurate documentation and billing can lead to fraud, waste, and abuse concerns. Therefore, it is the personal obligation of everyone involved in this process to ensure that billing is accurate.

CONTENT COMING SOON!

Check back for more information on this topic from the Office Coordination and Billing Team.

HEALTH INFORMATION MANAGEMENT

BHS Health Information Management (HIM) is a Behavioral Health Services department under Quality Management Services. Functions of this department are only applicable to County operated programs.

HIM MISSION STATEMENT

To safeguard the privacy and confidentiality of Behavioral Health Services (BHS) Protected Health Information (PHI) while promoting patient access to their Electronic Health Record (EHR) and facilitate continuity of care for service providers. HIM provides centralized, accurate and timely document retrieval and review, in compliance with Federal, State and Local laws and regulations.

To ensure continuous learning and remain compliant with changes in laws and the fast-moving pace of technology, as related to patient access, interoperability, and disclosure of sensitive protected health information.

ACTIVITIES

- Process, review and redact behavioral health client records that are retained electronically by county programs
- Manage the BHS Record Set categorization of documents within the EHR for appropriate privacy and security, and for document retrieval or release
- Provide support and training to county behavioral health staff for HIM functions in the EHR
- Identify and correct misfiled documents within the EHR
- Manage the centralized retention of sensitive documents not retained in the EHR
- Provide Subject Matter Expertise (SME) for the design, implementation and upgrade of EHR applications
- Provide support to the Health Care Agency Custodian of Records (COR) and CEO Risk Management for Legal Holds and Public Record Access requests

For BHS County programs: Provide centralized processing, review, and redaction for client record requests.

- Receive behavioral health program record requests from clients, third parties, the judicial system, insurance companies, Social Security Administration (SSA) and Social Security Income (SSI) Outreach

- Prior to disclosure, specialized staff thoroughly review the details of the Record Request and the Authorization to Disclose Protected Health Information (ATD), check the EHR for duplicate client charts and retrieve health information records
- Licensed behavioral health clinicians apply specialized knowledge and technical skills to review records for sensitive types of information such as Mental Health, SUD and AIDS/HIV
- Licensed behavioral health clinicians redact documents in accordance with healthcare guidelines required by Federal and California State Privacy & Confidentiality laws
- Staff collaborate with the HCA Custodian of Records, SSA and SSI Outreach to ensure compliant, accurate, and timely release of records
- Staff consult with the HCA Office of Compliance and HCA County Counsel when needed
- Conduct Quality Assurance reviews for EHR document accuracy and retention
- Coordinate EHR Scan Type changes and updates to EHR Scan Cover Sheets for county behavioral health programs
- Create user guides for Authorization to Disclose Protected Health Information forms (ATDs) and other HIM related topics (e.g. Abuse Report Documents, Scanning Documents into the EHR, etc.)
- Provide individualized guidance and training for staff on HIM related topics
- Recommend improvements for systemic business workflows or technical issues that contribute to errors with client PHI, data and documentation

Collaborate with HCA Information Technology, other QMS Teams and BHS Program staff to implement changes

HIM GUIDES, PROCEDURES AND FORMS

- BHS/HIM ATD Revocation Guide
- BHS Records Redaction
- Expired and Invalid ATD Guide
- APS/CPS Documents Procedure
    - APS/CPS Documents Routing Slip
- HIM/BHS Intra-HCA Record Request for Continuity of Care Procedure

RELATED LINKS

- **Custodian of Records**
- **Office of Compliance**

CAL AIM INITIATIVES

ENHANCED CARE MANAGEMENT

Enhanced Care Management (ECM) is a new Medi-Cal benefit available to select populations of focus that addresses the clinical and non-clinical needs of the highest-utilizing members through intensive coordination of health and health-related services. ECM meets members wherever they are - on the street, in a shelter, in their doctor's office or at home. Members have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems, making it easier for them to get the right care at the right time.

ECM Criteria for Medi-Cal Managed Care Plan (MCP) Members

ECM is available to specific Populations of Focus determined by the Department of Health Care Services (DHCS). Qualifying members must meet the following criteria:

1. Active enrollment in a Medi-Cal Managed Care Plan (MCP)
   - CalOptima Health
   - Kaiser Permanente
2. Populations of Focus:
   - Adults and their Families Experiencing Homelessness
   - Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly "High Utilizers")
   - Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
   - Individuals Transitioning from Incarceration (some WPC counties)
   - Adults and their Families Experiencing Homelessness
   - Adults At Risk for Avoidable Hospital or ED Utilization
   - Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization
   - Adult Nursing Facility Residents Transitioning to the Community
   - Children and Youth Populations of Focus

Referral of Enhance Care Management Services

Referral source from **Non-County** FSP and PACT Programs

CalOptima Health – Submit completed ECM Referral Form to CalOptima Health br email with subject line (ECM Referral) to CalAIMReferral@calptima.org, fax 714-338-3145, or call CalOptima Health Customer Service 1-800-587-8088. Visit Referral Forms for CalOptima Health ECM referral forms.

Kaiser Permanente- Send completed referral form by email with subject line (ECM Referral) to RegCareCoordCaseMgmt@kp.org, or call member services at 1-866-551-9616. Visit

https://kpov.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/ncal/ever/enhanced-care-management-community-supports-referral-form.pdf for Kaiser Permanente ECM referral forms.

ECM Referral source from County FSP and PACT Programs

County FSP and PACT providers submit completed ECM Referral Form to OCHCA CalAIM Service Support CalAIMSupport@ochca.com or call 714-834-4011 for service support with subject line (ECM Referral).

COMMUNITY SUPPORTS SERVICES

Community Supports Services are services provided by Medi-Cal managed care plans (MCP) to address Medi-Cal members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. Members may receive a Community Supports service if they meet the eligibility criteria and if the MCP determines it is a medically appropriate and cost-effective alternative to services covered under the California Medicaid State Plan. MCPs are encouraged to offer as many of the following 15 Community Supports as possible. Each Community Supports has its own set of eligibility criteria to meet.

- Transitional Rent
- Housing Transition Navigation
- Housing Deposit
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite)
- Respite Services;
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers; and
- Asthma Remediation

REFERRAL FOR COMMUNITY SUPPORTS SERVICES (CALOPTIMA HEALTH/KAISER)

CS Referral source from Non-County FSP and PACT Programs

CalOptima Health – Submit completed Community Supports Referral Form to CalOptima Health by email with subject line (Community Supports Referral) to CalAIMReferral@calptima.org, or fax 714-338-3145, or call CalOptima Health Customer Service 1-800-587-8088. Visit Referral Forms for CalOptima Health CS referral forms.

Kaiser Permanente- Send completed referral form by email with subject line (Community Supports Referral) to RegCareCoordCaseMgmt@kp.org, or call member services at 1-866-551-9616. Click here for information and referral forms related to Kaiser Permanente, Enhanced Care Management, Community Supports and Community Health Workers.

CS Referral source from County FSP and PACT Programs

County FSP and PACT providers submit completed Community Supports Referral Form with subject line (Community Supports Referral) to OCHCA CalAIM Service Support CalAIMSupport@ochca.com or call 714-834-4011 for service support

JUSTICE INVOLVED INITIATIVE (BEHAVIORAL HEALTH LINKS)

Orange County Health Care Agency Behavioral Health Services is providing Behavioral Health Links to Justice Involved Medi-Cal members who plan to reside in Orange County post-release from incarceration and who meet eligibility criteria for Specialty Mental Health Services or Drug Medi-Cal Organized Delivery System.

Members who meet eligibility criteria will be provided an appointment for the Professional-to-Professional Warm Handoff between the pre-release provider, the post-release provider and the Justice Involved member. At the Professional-to-Professional Warm Handoff, the member and their pre-release provider will be given an appointment for the post-release intake.

For more information visit our website at: Cal AIM Justice Involved Initiative: Behavioral Health Links for Orange County | Orange County California - Health Care Agency

RESOURCES & CONTACT INFORMATION

POLICIES & PROCEDURES

BHS Policies and Procedures (P&Ps) are available to all providers via the County website or from Contract Monitors. P&Ps explain the requirements for conducting business within SMHS and DMC-ODS behavioral health plans. P&Ps are reviewed, developed, and updated as necessary. The reasons for editing P&Ps include changes in business practices, client and agency needs, and laws and regulations. Providers are expected to review P&Ps and be familiar with those that directly impact operations specific to one's role within the agency.

Links to P&Ps specific to both the Health Care Agency at-large and to Behavioral Health Services can be found on the County Intranet here: Health Care Agency P&Ps - OCHCA Intranet.

Links to P&Ps specific to Behavioral Health Services can be found on OCHealthinfo.com here: BHS Policies and Procedures.

PRACTICE GUIDELINES

Orange County offers services that are based on valid and reliable clinical evidence or a consensus of providers in the field. We consider the needs of our members and adopt practice guidelines in consultation with our network of healthcare providers. Practices are reviewed and updated periodically to ensure their relevance to the clients we serve. You can review all the County's practice guidelines by clicking on the link, BHS Practice Guidelines.

QMS E-MAIL BOXES

Please email the group mailboxes below to ensure your questions arrive to the correct team rather than to an individual team member who may be out of the office or otherwise unavailable.

QMS Team	CURRENT EMAIL ADDRESS	OVERSEES
Managed Care Support Team (MCST)	BHPGrievanceNOABD@ochca.com	Grievances & Investigations; Appeals/Expedited Appeals; State Fair Hearings; NOABDs
Managed Care Support Team (MCST)	BHPManagedCare@ochca.com	Access Logs, Errors & Corrections; Change of Provider/2nd Opinion; County Credentialing; Cal-Optima Credentialing (AOA County Clinics); Expired Licenses, Waivers, Registrations & Certifications; PAVE (SMHS Only)

Managed Care Support Team (MCST)	BHPSupervisionForms@ochca.com	Supervision Reporting Forms for Clinicians, Counselors, Medical Professionals and Qualified Providers
Managed Care Support Team (MCST)	BHPProviderDirectory@ochca.com	Provider Directory notifications and Program submissions
Health Information Management (HIM)	BHSHIM@ochca.com	County-Operated SMHS and SUD DMC programs Use Related: Centralized Retention of Abuse Reports & Related Documents; Centralized Processing of Client Record Requests, Clinical Document Reviews, and Redactions; Release of Information, ATDs, Restrictions, and Revocations; IRIS Scan Types, Scan Cover Sheets, and Scan Types Crosswalks; Record Quality Assurance and Correction Activity.
Data Analytics Support Team	BHSIRISLiaison@ochca.com	IRIS & EHR Processes (County); CalOMS - Data Entry Questions (County)
Data Analytics Support Team	BHPNetworkAdequacy@ochca.com	NACT
CalAIM	calaimsupport@ochca.com	CalAIM/ECM Referrals, Forms, and Questions
Support Team - AOA	SMHSClinicalRecords@ochca.com	ALL inquiries for Adult and Older Adult (AOA) Services intended for the AOA Support Team (including AOA Documentation Support; Provider Support; Program Referrals; Certified Reviewer Applications)
Support Team - SUD	BHPSUDSupport@ochca.com	ALL inquiries for DMC-ODS and SUD intended for the SUD Support Team (including CalOMS Questions (clinical based); DMC-ODS Clinical Chart Reviews; SUD Documentation Support & SUD Newsletter Questions; DHCS audits of DMC-ODS Providers; DATAR Submissions; DMC-ODS ATD; Medication Monitoring; Treatment Perception Surveys; Master Provider File (MPF) Updates; PAVE for DMC-ODS providers)

Support Team - CYS	SMHSClinicalRecords@ochca.com	ALL inquiries for Children and Youth Services (CYS) intended for the CYS Support Team (including CYS Documentation Support; Provider Support; Program Referrals; Certified Reviewer Applications)
Billing Team (BT)	BHPBillingSupport@ochca.com	IRIS Billing; Office Support; CalOMS - Data Entry Questions (Contract programs)
Inpatient & Designation Support Services (IDSS)	BHPIDSS@ochca.com	General Questions regarding Designation
Inpatient & Designation Support Services (IDSS)	BHPDesignation@ochca.com	Inpatient Involuntary Hold Designations; LPS Facility Designation; Outpatient Involuntary Hold Designations.
MediCal Certification Team	BHPCertifications@ochca.com	SMHS Medi-Cal Certification
QI Systems	qisystems@ochca.com	EBP, QAPI, MBHO; HEDIS/POM; and BHP QI Support related questions for all SMHS and DMC-ODS programs

COMMON ACRONYMS

Please refer to the list below for common acronyms used in the Orange County Behavioral Health Plan or used within the systems the BHP collaborates with.

Acronym	Meaning	Note
AAP	American Academy of Pediatrics	
AB	Assembly Bill	
ABC	Allied Behavioral Care	
ABN	Advance Beneficiary Notice of Noncoverage	
ACA	Affordable Care Act	
ACP	Accountability Commitment Program	a.k.a. house arrest
ACSW	Associate Clinical Social Worker	
ACT	Annual Compliance Training	

ADA	Americans with Disabilities Act	
ADAS	Alcohol and Drug Abuse Services	
ADL	Activities of Daily Living	
ADP	Alcohol and Drug Program	i.e., Medi-Cal ADP
AG	Attorney General	
ALOS	Average Length of Stay	
AMA	American Medical Association	
AMFT	Associate Marriage and Family Therapist	
AOA	Adult and Older Adult	
AOABH	Adult and Older Adult Behavioral Health	
AOB	Assignment of Benefits	
AOC	Agency Operations Center	
AoD	Accounting of Disclosures	HIPAA Privacy Rule
AOD	Alcohol and Other Drugs	
AOS	Adult Outpatient Services	
AOT	Assisted Outpatient Treatment	
APA	American Psychological Association	
APCC	Associate Professional Clinical Counselor	
APT	Annual Provider Training	
ARF	Adult Residential Facilities	
ART	Authorization for Residential Treatment	
ASAM	American Society of Addiction Medicine	
ASCMI	Authorization to Share Confidential Medi-Cal Information	
ASO	Administrative Services Organization	
ATD	Authorization to Use/Disclose Protected Health Information	
ATLAS	Addiction Treatment Locator, Analysis and Standards	

AUD	Alcohol Use Disorder	
BA	Business Associate	
BAA	Business Associate Agreement	
BAL	Beneficiary Access Line	
BBS	Board of Behavioral Sciences	
BHCIP	Behavioral Health Continuum Infrastructure Funding	
BHEC	Behavioral Health Equity Committee	
BHIN	Behavioral Health Information Notice	
BHP	Behavioral Health Plan	
BHS	Behavioral Health Services	
BHSDR	Behavioral Health Services Disaster Response	
BHT	Behavioral Health Transition	
BHTC	Behavioral Health Training Center	
CAC	Crisis and Acute Care	
CAH	Command Auditory Hallucinations	
CalAIM	California Advancing and Innovating Medi-Cal	
CalOMS (Tx)	California Outcomes Measurement System	For SUD Treatment
CANS	Child and Adolescent Needs and Strengths	
CAP	Corrective Action Plan	
CAR	Child Abuse Registry	
CARF	Commission on Accreditation of Rehabilitation Facilities	
CAT	Crisis Assessment Team	
CBC	Criminal Background Checks	
CBHDA	County Behavioral Health Directors Association	For California
CC	Cultural Competency	
CCE	Community Care Expansion	

CCPU	Continuing Care Placement Unit	
CCRP/CMPP	County Compassionate Release/Medical Probation	
CCS	Community Counseling Services	
CDC	Centers for Disease Control and Prevention	
CDM	Cerner Defined Mnemonic (Billing)	
CDPH	California Department of Public Health	
CDSS	California Department of Social Services	
CE	Covered Entity	
CEST	Client Evaluation of Self-Treatment	
CEU	Continuing Education Unit	
CFR	Code of Federal Regulations	
CFT	Child and Family Team	
CHR	Clinical High Risk	
CISM	Critical Incident Stress Management	
CIT	Crisis Intervention Training	
CITED	Capacity, Infrastructure, Transition, Expansion and Development	
CLAS	Culturally and Linguistically Appropriate Services (Office of Minority Health)	
CLIA	Clinical Laboratory Improvement Amendments/Act	
CM	Contingency Management	
CMAP	Certified Medicare Advantage Plan	
CMS	Centers of Medicare/Medicaid Services	
CNA	Certified Nurse Assistant	
CO	Certifying Organization	
COB	Coordination of Benefits	
CONREP	Conditional Release Program	
COR	Custodian of Records	

CORE	Collaborative Options for Resource Efficacy	
CPE	Certified Public Expenditure	
CPM	Core Practice Model	
CPS	Child Protective Services	
CPSS	Certified Peer Support Specialist	
CPT	Common Procedural Terminology (CPT codes)	
CQIC	Community Quality Improvement Committee	
CR	Concurrent Review	
CRF	Court Replacement Facility	
CRP	Crisis Residential (Treatment) Program	
CRR	California Code of Regulations	
CRS	Crisis Residential Services	
CSA	Clinical Supervision Agreement	
CSI	Client and Services Information	
CSJ	Continuing Services Justification	
CSOC	Children's System of Care	
CSRF	Clinical Supervision Reporting Form	
CSU	Crisis Stabilization Unit	
CTCP	California Tobacco Control Program	
CTF	Community Treatment Facility	
CVO	Credentialing Verification Organization (Verge Health is what we use)	
CWS/CMS	Child Welfare System / Case Management System	Used by SSA CFS
CYS	Children and Youth Services	
DAPPER	Dimensional Assessment for Patient Placement Engagement and Recovery	
DAT	Data Analytics Team	
DATAR	Drug and Alcohol Treatment Access Report	

DCA	Department of Consumer Affairs	
DD	Dual Diagnosis OR Developmentally Disabled	
DHCS	California Department of Health Care Services	
DHHS	Department of Health and Human Services	
DLP	Data Loss Prevention	
DMC-ODS	Drug Medi-Cal – Organized Delivery System	
DOE	Department of Education	
DOI	Department of Insurance	
DOJ	Department of Justice	
DPC	Deputy Probation Counselor	
DPO	Deputy Probation Officer	
DRS	Designated Record Set	
DSH	Direct Service Hours	
DSM	Diagnostic and Statistical Manual of Mental Disorders	
DSS	Department of Social Services	
DSW	Disaster Service Worker	
DTO	Danger to Others	
DTS	Danger to Self	
E&R	Expenditure Report	
EBC	Emotional Behavioral Cognitive	
EBP	Evidence Based Practice	
ECM	Enhanced Care Management	
ED	Emergency Department OR Emotional Disturbance	
EEOC	Equal Employment Opportunity Commission	
EHR	Electronic Health Record	
EMDR	Eye Movement Desensitization and Reprocessing	

EMR	Electronic Medical Record	
EOB	Explanation of Benefits	
EOC	Episode of Care OR Evidence of Coverage	
EOP	Enhanced Outpatient Program	
EPSDT	Early Periodic Screening, Diagnostic and Treatment	
EQR	External Quality Review	
EQRO	External Quality Review Organization	
ESH	Emergency Shelter Home	
FAQ	Frequently Asked Questions	
FCA	False Claims Act	
FDA	Food and Drug Administration	
FFP	Federal Financial Participation	
FFS	Fee-For-Service	
FIN	Financial Identification Number	
FIT	Feedback-Informed Treatment	
FORE	Foundation for Opioid Response Efforts	
FQHC	Federally Qualified Health Center	
FSN	Family Support Network	
FSP	Full-Service Partnerships	
FTE	Full-Time Equivalent	
FWA	Fraud, Waste and Abuse	
GAAP	Generally Accepted Accounting Principles	
GD	Grave Disability	
GIRP	Goal Intervention Response Plan	
HCA	Health Care Agency	
HCAI	Department of Health Care Access and Information	

HCBS	Home and Community-Based Services	
HCPC	Healthcare Common Procedure Code (Billing)	
HCPCS	Healthcare Common Procedure Coding System	
HHP	Health Homes Program	
HHS	Health and Human Services	
HIM	Health Information Management	
HIPAA	Health Insurance Portability and Accountability Act of 1996	
HMO	Health Maintenance Organization	
HOS	Head of Service	
HSC	Health and Safety Code	
HUT	High Utilizer	
IA	Intergovernmental Agreement	
IBNR	Incurred But Not Reported	
IC	Intake Coordinator	
ICC	Intensive Care Coordination	
ICD	International Classification of Diseases (ICD-10)	
ICF	Interim Care Facility	
ICF/DD	Intermediate Care Facility for the Developmentally Disabled	
ICP	Interim Care Plan	
ICPC	Interstate Compact for Placement of Children	
IEP	Individualized Educational Plan	
IHBS	Intensive Home-Based Services	
IHCP	Indian Health Care Provider	
IHCS	In-Home Crisis Stabilization	
ILP	Independent Living Program	
IMCE	Indian Managed Care Entities	

IMS	Incidental Medical Services	
IOT	Intensive Outpatient Treatment	
IP	Implementation Plan	
IPS	Inpatient Services	
IRIS	Integrated Record Information System	
IRT	Interagency Review Team	
IS	Intensive Services	
ISCA	Information System Capacity Assessment	
ISDEAA	Indian Self-Determination and Education Assistance Act of 1975	
ITFC	Intensive Treatment Foster Care	
ITP	Individual Transition Plan	
JCWP	Juvenile County Ward Program	
LAC	Legal Action Center	
LCSW	Licensed Clinical Social Worker	
LD	Learning Disability	
LLOS	Longer Length of Stay	
LMFT	Licensed Marriage and Family Therapist	
LMHP	Licensed Mental Health Professional	
LOA	Letter of Agreement (Residentials)	
LOC	Level of Care	
LOS	Length of Stay	
LOT	Licensed Occupational Therapist	
LPCC	Licensed Professional Clinical Counselor	
LPHA	Licensed Practitioner of the Healing Arts	
LPS	Lanterman-Petris-Short (LPS) Act	
LPT	Licensed Psychiatric Technician	

LTC	Long-Term Care	
LTSS	Long-Term Services and Supports	
LVN	Licensed Vocational Nurse	
MA	Master Agreement OR Medical Assistant	
MAC	Medicare Administrative Contractors	
MAT	Medication Assisted Treatment	
MBU	Medical Billing Unit	
MC	Medi-Cal	
MCBHD	Medi-Cal Behavioral Health Division	
MCHIP	Medicaid Children's Health Insurance Program	
MCO	Managed Care Organization	
MCP	Managed Care Plan	
MCPAR	Managed Care Program Annual Report	
MCST	Managed Care Support Team	
MDPOR	Monthly Data and Performance Outcome Report	
MDT	Multidisciplinary Team	
MHBG	Community Mental Health Services Block Grant	
MHP	Mental Health Plan	
MHRC	Mental Health Rehabilitation Center	
MHRP	Mental Health Recovery Plan	
MHRS	Mental Health and Recovery Services	
MHSA	Mental Health Services Act	
MHSAOAR	Mental Health Services Act Outcomes and Accountability Review	
MHSUD	Mental Health and Substance Use Disorder (Dept. in DHCS)	
MOU	Memorandum of Understanding	
MPF	Master Provider File	

MRT	Medi-Cal Review Team	
MSA	Master Services Agreement	
MSE	Mental Status Exam	
MSRF	Medical Supervision Reporting Form	
NACT	Network Adequacy Certification Tool	
NAR	Notice of Appeal Resolution	
NARF	New Applicant Request Form	
NCSACW	National Center on Substance Abuse and Child Welfare	
NDP	Naloxone Distribution Project	
NGR	Notice of Grievance Resolution	
NOABD	Notice of Adverse Benefit Determination	
NPI	National Provider Identifier	
NPPES	National Plan & Provider Enumeration System	
NQTL	Non-Quantitative Treatment Limitation	
NTP	Narcotics Treatment Program	
OA	Open Access	
OAHA	Office of Administrative Hearings and Appeals	
OAS PACT	Older Adult Services Program for Assertive Community Treatment	
OCBT	Office Coordination Billing Team	
OCC	Office of Care Coordination	
OCDE	Orange County Department of Education	
OCEA	Orange County Employee's Association	
OCFC	Orangewood Children and Family Center	
ODF	Outpatient Drug Free	
OHC	Other Health Coverage	
OIG	Office of Inspector General	

OMB	Office of Management and Budget	
OOC	Office of Compliance	
OP	Outpatient	
OQP	Other Qualified Provider	
ORP	Ordering Referring Prescribing	
OSP	Office of Suicide Prevention	
OTP (and non-OTP)	Opioid Treatment Program / non-Opioid Treatment Programs	
OUD	Opioid Use Disorder	
P&P	Policy and Procedure	
PACT	Program for Assertive Community Treatment	
PAHP	Prepaid Ambulatory Health Plan	
PAN	Personnel Action Notification	
PATH	Providing Access and Transforming Health Initiative	
PAVE	Provider Application and Validation for Enrollment	
PBM	Pharmacy Benefit Management	
PCCM	Primary Care Case Manager	
PCCM Entity	Primary Care Case Management Entity	
PCP	Primary Care Physician	
PD	Public Defender OR Police Department OR Probation Department	
PECOS	Provider Enrollment Chain and Ownership System (for PTANs)	
PED	Provider Enrollment Division	
PERM	Payment Error Rate Measurement	
PG	Practice Guidelines	
PHF	Psychiatric Health Facility	
PHI	Protected Health Information	

PI	Paranoid Ideation	
PIHP	Prepaid Inpatient Health Plan	
PLW	Professional Licensing Waiver	
PMIS	Provider Management Information System	
POF	Point of Focus	
POM	Performance Outcome Measure	
PPC	Provider Preventable Conditions	
PPG	Perinatal Practice Guidelines	
PR	Penetration Rate	
PRA	Public Records Act	
PRAS	Patients' Rights Advocacy Services	
PSC	Pediatric Symptom Checklist OR Personal Services Contractor	
PSPP	Post-service Postpayment	
PTAN	Provider Transaction Access Number (Medicare)	
PWB	Pathways to Well Being	
PWD	Persons With Disabilities	
QA/QI	Quality Assurance & Quality Improvement	
QA/UR	Quality Assurance and Utilization Review	
QAPI	Quality Assessment and Performance Improvement	
QI	Quality Improvement	
QM	Quality Management	
QMS	Quality Management Services	
QRTips	Quality Review Tips	
QTL	Quantitative Treatment Limitation	
RAC	Registered Addiction Counselor	
RADT	Registered Alcohol Drug Trainee	

RCA	Revenue Cycle Application	
RCFE	Residential Care Facilities for the Elderly	
RCOC	Regional Center of Orange County	
RFA	Request for Application	
RFI	Request for Information	
RFP	Request for Proposal	
RGSI	Registered Graduate Student Intern	
RH	Registered Hardship	
RHC	Rural Health Clinic	
RI	Recovery Incentives	
RN	Registered Nurse	
ROP	Regional Occupational Program	
RS	Recovery Services	
RTC	Residential Treatment Center	
RTF	Recovery or Treatment Facilities	
RTIS	Responding to Internal Stimuli	
SABG	Substance Abuse Prevention and Treatment Block Grant	
SAMHSA	Substance Abuse and Mental Health Services Administration	
SAPT	Substance Abuse Prevention and Treatment	
SB	Senate Bill	
SBIRT	Screening, Brief Intervention, and Referral to Treatment	
SDMC	Short Doyle/Medi-Cal	
SDOH	Social Drivers of Health	
SED	Severe Emotional Disturbance	
SIR	Special Incident Report	
SMA	State Medicaid Agency	

SMART	Specific Measurable Attainable Realistic Time-Bound	
SME	Subject Matter Expert	
SMHS	Specialty Mental Health Services	
SMI	Serious Mental Illness	
SNOMED	Systemized Nomenclature of Medicine	
SOAP	Subjective, Objective, Assessment, Plan	
SPA	Service Provider Area	
SPA	State Plan Amendment	
SPF	Strategic Prevention Framework	
SPMI	Serious Persistent Mental Illness	
SSA	Social Security Administration, OR Social Services Agency	
SSI	Supplemental Security Income	
STC	Special Terms and Conditions	
StimUD	Stimulant Use Disorder	
STRTP	Short-Term Residential Therapeutic Programs	
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant	
SUD	Substance Use Disorder	
SUDCRS	Substance Use Disorder Cost Report System	
SWOT	Strengths, Weaknesses, Opportunities and Threats	
TADT	Timely Access Data Tool	
TAR	Treatment Authorization Request	
TAT	Turnaround Time	
TAY	Transitional Aged Youth	
TBS	Therapeutic Behavioral Services	
TCM	Targeted Case Management	
TFC	Therapeutic Foster Care	

TGI	Transgender, Gender Diverse, or Intersex	
TIC	Trauma-Informed Care	
TLS	Transport Layer Security	
TPS	Treatment Perception Survey	
TUD	Tobacco Use Disorder	
UDT	Urine Drug Test	
UETA	Uniform Electronic Transactions Act	
UIO	Urban Indian Organizations	
UM	Utilization Management	
WCM	Whole Child Model	
WET	Workforce, Education, and Training	
WIC	Welfare & Institutions Code, *OR* Women and Infant Children	
WLR	Waiting List Record	
WM	Withdrawal Management	
WPC	Whole Person Care	
WRAP	Wellness Recovery Action Plan	
YTG	Youth Treatment Guidelines	