SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

November 2025

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DMC-ODS Office Hours

A voluntary and informal space to ask questions and discuss documentation requirements. Occurs virtually on the second Wednesday (2pm) & fourth Thursday* (10am) of every month.

Upcoming meeting: November 12, 2025 & December 11, 2025

**No Thursday Office Hours November and December*

WHAT'S NEW?

Claim Denials

We were recently made aware of some claims that the State denied due to lockout rules. As a reminder, non-overridable lockout codes are those outpatient codes that cannot be billed together under any circumstances.

The **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/100/101) G2011/G0396/G0397** code series cannot be used together on the same day. For example, Provider A cannot bill both SUD Structured Assessment, 5-14 Min (70899-102) G2011 and SUD Structured Assessment, 30+ Min (70899-101) G0397 on the same day. One of these claims will be automatically denied.

These codes are also locked out from use with the **SUD Screening (70899-105) H0049** code. For example, Provider A cannot bill using this code if Provider B bills using SUD Structured Assessment, 15-30 Min (70899-100) G0396 on the same day. One of these claims will be automatically denied.

If you provide multiple assessment encounters to the same client on the same day, remember to combine the total service minutes in one claim. For example, administering the evidence-based MAT assessment in the same service or on the

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Training & Resources Access

Training Requests

TATS Training Request Form

To be utilized by administrators (i.e., Service Chief, Program Director, QI Coordinator, etc.) to request a training on documentation and service codes!

DMC-ODS Payment Reform 2024 - CPT Guide (version 2):
DMC-ODS Payment Reform 2024 CPT Guide v2.pdf (ochealthinfo.com)

SUD Documentation Manual
DMC-ODS_CalAIM_Doc_Manual.pdf

MAT Documentation Manual
FINAL_CalAIM_MAT_Documentation_Manual_v3_11.6.24.pdf

DISCLAIMER: These documents are tools created to assist with various QA/QI regulatory requirements. They are NOT all-encompassing documents. Providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements. If you are unsure about the current guidance, please reach out to BHPSUDSupport@ochca.com

WHAT'S NEW? (continued)

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same day as the ASAM-based assessment. Both of these activities are assessment services that can be combined into one claim. In this case, if the bulk of the service is related to the ASAM-based assessment, the **SUD Assessment (70899-103) H0001** code should be used to capture the total service time. If it is an intake service where intake paperwork is reviewed and signed with time spent gathering minimal assessment information and completing the evidence-based MAT assessment, the SUD Screening (70899-105) H0049 code can be used for the total service time.

Assessment Code Tip:

If the predominant assessment activity (including multiple separate encounters on the same day) is related to completing the ASAM-based assessment at the outpatient levels of care, use SUD Assessment (70899-103) H0001.

Outpatient and 24-hour services lockouts

Another reason for the denied claims resulted from outpatient services being claimed on the same day as residential treatment days. Please remember that outpatient and 24-hour service codes can only be claimed on the same day for the date of admission or discharge. For example, a client's outpatient assessment service can only be claimed if it is on the date of discharge from the residential program.

Please note, the State advises that transitions between levels of care occur no later than 10 business days from the time of assessment or re-assessment. Therefore, once it is determined that the client needs a step up or step down to a different level of care, the transition should take place as quickly as possible. Any delays in transitions should be clearly documented. A client who is receiving residential treatment where a re-assessment determines that the client is ready for the IOT level of care, should be transitioned so that no more than 10 days are claimed from this point. For the period of transition, the client must maintain engagement in treatment services (e.g., attending individual and group services as deemed appropriate based on their treatment needs).

To prevent these types of denials, please be sure to refer to the CPT Guide and the State's Service Table.

Documentation FAQ

1. Does the LPHA need to sign the non-LPHA's care coordination progress notes?

No, this is not a requirement. The licensed provider is responsible for supervising the care coordination service component. The State has not indicated how this must be demonstrated. Programs may use their discretion to determine how to comply with this standard. Therefore, it is LPHAs may co-sign the non-LPHA's care coordination progress note. At this time, it is also sufficient to fulfill this requirement by having the LPHA document how care coordination is medically necessary for each client in the LPHA's required write-up or Case Formulation to the assessment or in the consultation with the non-LPHA where the client's overall treatment needs are discussed.

2. Is the Annual Justification still required for NTPs?

Under the revised regulations effective October 1, 2025, there is no longer specific language about an annual justification. The requirement is for an in-person physical examination of a patient at least annually from the date of the patient's initial or last physical examination. This annual physical examination must also include a review and evaluation of the results of the last physical examination, the care plan, medication dosing and response to treatment, other substance use disorder treatment needs and identified treatment goals as well as relevant physical and psychiatric treatment needs. Essentially, what was previously captured by the annual justification remains necessary. A patient may decline to undergo the physical examination, with their signature on a waiver. If the signature is unable to be obtained, there must be documentation in the chart explaining this.

3. What code should we use if only the intake paperwork is reviewed with a client?

If there is no screening or minimal assessment activity conducted

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Documentation FAQ (continued)

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and the service is solely for reviewing and obtaining signatures on intake documents to admit the client, the Targeted Case Management, 15 Min (70899-120) T1017 code is appropriate. However, this is likely a rare scenario. In most cases, you are likely obtaining some information about the client that will be used to broadly screen for appropriateness of admission to your program. One example is if you are going to use a Z55-65 code or other diagnosis to claim the intake service, you have acquired some assessment/screening information to determine this. Remember that this minimal screening makes the intake service more appropriate for billing using the SUD Screening (70899-105) H0049 code.

Clarification: Peer Support Specialist Supervision

There have been some questions coming up about who is eligible to provide supervision for a Peer Support Specialist. Clinical supervision is not required to be provided by an LPHA. It is permissible for an AOD Counselor to be a Medi-Cal Peer Support Specialist Supervisor. However, if the supervisor is not a Behavioral Health Professional, there must be a qualified LPHA who is directing services. A qualified LPHA is either a Physician, Nurse Practitioner, Registered Nurse, Licensed Clinical Psychologist, Licensed/Registered Clinical Social Worker, Licensed/Registered Professional Clinical Counselor, Licensed/Registered Marriage and Family Therapist, or Licensed Occupational Therapist. "Under the direction" means that the qualified LPHA directing services is acting as a clinical team leader, providing direct or functional supervision of service delivery, and assumes ultimate responsibility for the Peer Support Services provided. Currently, there is no explicit guidance on how this should be documented. Providers should ensure that they can readily demonstrate to State auditors that each service by the Peer has been under the direction of an appropriate LPHA.

REMINDERS

Progress Note for Each Claim

Each claim must have a corresponding progress note. Be sure that all required items that must be included in each progress note are evident (e.g., duration of the service, the location of the client, rendering provider's printed name/signature/date of signature, etc.). Claims without the appropriate, supporting documentation will be disallowed and result in recoupment.

Templated Time

Even when the billing is by units of 15-minute increments, the actual duration of the service encounter must be in exact minutes. Do not round up or down to the nearest quarter-hour. Additionally, be mindful that the total number of service minutes is not the same for all of your services (e.g., all assessment services being 90 minutes). Remember that each service is expected to be individualized to the needs of each client and the time spent should reflect this.

Contracted Providers ONLY: Documentation Time

Documentation and travel time no longer needs to be entered into IRIS. However, the *date of documentation* is still required in IRIS. This date should match the date of signature by the rendering provider on the progress note. The provider is attesting to the accuracy and completion of the service documentation with their signature and date. The date of documentation is important for demonstrating compliance with the 3-day timeline for progress notes.

Recovery Services Codes

Don't forget that there are specific billing codes for Recovery Services. All services (i.e., assessment, individual coaching/monitoring, collateral, care coordination, etc.) provided in Recovery Services must be claimed using Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) H2017; Psychosocial Rehabilitation, Group, per 15 Min (70899-123) H2017; Recovery Services, 1 Hr (70899-124) H2035; and Community Support Services, per 15 Min (70899-121) H2015.

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- INFORMING MATERIALS, GRIEVANCES & INVESTIGATIONS
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CAL-OPTIMA CREDENTIALING (AOA PTAN COUNTY PROVIDERS)
- SUPERVISION REPORTING FORMS & REQUIREMENTS
- PROFESSIONAL LICENSING WAIVERS
- COUNTY CREDENTIALING/RECREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS
- PROVIDER DIRECTORY
- PAVE ENROLLMENT (SMHS PROVIDERS ONLY)
- PROVIDER TRANSACTION ACCESS NUMBER (PTAN)

REMINDERS, ANNOUNCEMENTS & UPDATES

PROVIDER DIRECTORY TRANSITION TO THE 274 USER INTERFACE

Beginning November 1, 2025, monthly submissions for the Behavioral Health Plan Provider Directory will transition to the 274 User Interface (274 UI) for all providers. This platform aligns with several data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT). This will help support improved data consistency and streamlined reporting for both the NACT and Provider Directory. The monthly Excel spreadsheet for the Provider Directory will no longer be required for submission starting **November 2025.**

This transition will have the program administrators from county and county-contracted programs, be responsible for entering and updating data through the 274 UI monthly. To support this change, training materials will be distributed in September/October 2025 to the Service Chiefs and Contract Monitors. Contract Monitors will be working closely with the county-contracted staff who currently access the county network with a token to publish a shortcut to the 274 UI site using the Citrix desktop to access and enter the data requirements for the NACT and Provider Directory.

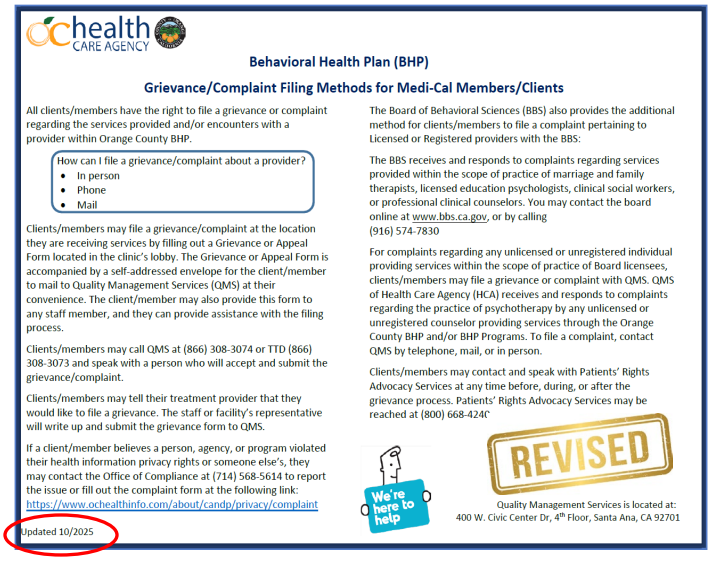
All updates made in the 274 UI by program administrators will automatically reflect on the newly enhanced Provider Directory website.

https://bhproviderdirectory.ochca.com

This transition represents a significant advancement in streamlining and enhancing the efficiency of data collection for both providers and the MCST. To review the DHCS Provider Directory requirements, please refer to the BHIN 25-026.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

GRIEVANCE/COMPLAINT FILING METHODS FOR MEDI-CAL MEMBERS/CLIENTS



Behavioral Health Plan (BHP)

Grievance/Complaint Filing Methods for Medi-Cal Members/Clients

All clients/members have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within Orange County BHP.

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Clients/members may file a grievance/complaint at the location they are receiving services by filling out a Grievance or Appeal Form located in the clinic's lobby. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the client/member to mail to Quality Management Services (QMS) at their convenience. The client/member may also provide this form to any staff member, and they can provide assistance with the filing process.

Clients/members may call QMS at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint.

Clients/members may tell their treatment provider that they would like to file a grievance. The staff or facility's representative will write up and submit the grievance form to QMS.

If a client/member believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance at (714) 568-5614 to report the issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

Updated 10/2025

The Board of Behavioral Sciences (BBS) also provides the additional method for clients/members to file a complaint pertaining to Licensed or Registered providers with the BBS:

The BBS receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, clients/members may file a grievance or complaint with QMS. QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County BHP and/or BHP Programs. To file a complaint, contact QMS by telephone, mail, or in person.

Clients/members may contact and speak with Patients' Rights Advocacy Services at any time before, during, or after the grievance process. Patients' Rights Advocacy Services may be reached at (800) 668-424C

We're here to help

REVISED

Quality Management Services is located at: 400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

The **Grievance/Complaint Filing Methods for Medi-Cal Members/Clients Fact Sheet** for SMHS and DMC-ODS has been revised to reflect minor updates from DHCS and BBS. You may provide this handout upon the member's initial entry into services and when they are inquiring about the various methods for filing a grievance. The revised handout is currently available in English and will be available in all the threshold languages soon. To access the handouts, visit the hyperlinks below:

SMHS:

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

DMC-ODS:

DMC-ODS For Providers | Orange County California - Health Care Agency

This new manual provides comprehensive guidance to support both prospective and existing programs in meeting the requirements for delivering Medi-Cal covered services under the County Behavioral Health Plan during the processes of opening, relocating, or closing.

Hyperlink: QA/QI Trainings and Documentation Support | Orange County California - Health Care Agency

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

All **new providers** must submit their initial County credentialing packet within 5-10 business days of being hired to the MCST. The newly hired provider must **NOT** deliver any Medi-Cal covered services under their license, waiver, registration and/or certification until they have received an e-mail from VERGE/RLDatix indicating that they have successfully completed their application and attested. It is the responsibility of the designated administrator to review and submit all the required documents for the new hire credentialing packet including the supervision reporting form for the applicable providers to the MCST, timely. Once the provider attest, the credentialing process is automatically expedited and approved within an average of 3-5 business days.

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER

Effective November 1, 2025, QMS will implement an OPTIONAL process that allows providers to begin delivering Medi-Cal covered services even SOONER!

Once a provider receives a confirmation email from **VERGE/RLDatix** indicating successful submission of their online credentialing application and attestation, they may have the option to begin delivering Medi-Cal covered services. The **attestation date** of the application will serve as the **provisional start date** for service delivery, pending full credentialing approval. See the example e-mail below that will allow the new provider the option to begin delivering Medi-Cal covered services:

Practitioner	[redacted]
Status	Sent
Date	11/22/2025
Address/Email	[redacted]
Subject	Application Successfully Submitted
Body	Dear [redacted], Your County of Orange Health Care Agency application has been successfully submitted! Please note that the contents of your online credentialing application have now been locked from editing to avoid any unintentional changes during the verification process. If you need to make additional changes to your application, please contact our Customer Support line at 843-628-4168, Option 1 or by email to CredSupport@RLDatix.com and a member of our staff will be happy to assist you. Over the next several weeks we will be processing your application in preparation for review by the organization that you are applying. As questions sometimes arise through the verification process, please know that we may contact you for additional clarifications about your application if necessary. Thank you for your time and assistance with this matter. If you have any questions regarding your application, please do not hesitate to ask. Sincerely, Verge Health Credentialing Ph. (843) 628-4168, Option 1 Fax:(888) 455-7886 CredSupport@RLDatix.com

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER (CONTINUED)

Please be aware:

- ✓ This provisional start date is contingent upon the new provider ultimately receiving an official credentialing approval letter.
- ✓ If any issues arise during the credentialing process—such as findings on the **OIG Exclusion List** or delays caused by the provider (e.g., failure to respond to VERGE's requests for additional information)—and are not approved within **30 days**, a **credentialing denial letter** will be issued. In such cases, the provider must immediately cease all services, and any services rendered during the provisional period may be subject to **recoupment and corrective actions**.
- ✓ Utilizing the attestation date to begin delivering Medi-Cal covered services is **optional** and you may wait to begin delivering Medi-Cal covered services upon receiving the credentialing approval letter.
- ✓ **Choosing the option of providing services before the final credentialing approval is at the program discretion.**

To avoid delays or compliance issues, it is critical that both the provider and the designated administrator remain vigilant in monitoring and responding promptly to all communications from VERGE/RLDatix and the MCST.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

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

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is offering open training sessions for new and existing providers. The 3-hour training is on NOABDs, Grievances, Appeals, State Fair Hearings, 2nd Opinion/Change of Provider, Supervision Reporting Forms and Access Logs.

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

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

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER

Leads: Esmi Carroll, LCSW & Jennifer Fernandez, LCSW

SUPERVISION REPORTING FORMS

Lead: Esmi Carroll, LCSW

ACCESS LOGS

Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR SMHS

Leads: Araceli Cueva & Elizabeth "Liz" Fraga (Staff Specialists)

CREDENTIALING AND PROVIDER DIRECTORY

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

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)

Lead: Boris Nieto, Staff Assistant

COMPLIANCE INVESTIGATIONS

Lead: Catherine Shreenan, LMFT & Annette Tran, LCSW

CONTACT INFORMATION

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E-MAIL ADDRESSES

BHPGrievanceNOABD@ochca.com
BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com
BHPPTAN@ochca.com

MCST ADMINISTRATORS

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Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II