November 2025

QRTips

Behavioral Health Services
Quality Management Services

Collateral Contact vs. Family Therapy

Collateral Contact	Family psychotherapy (conjoint psychotherapy) (with patient present) 90847-4
Specialty Mental Health Services such as plan development, psychosocial rehabilitation, and targeted case management may be provided to significant supportive person(s) if the purpose of the collateral's participation is focused on the recovery and treatment needs of the client. Assessments and crises may also involve significant supportive person(s).	Family counseling sessions in which both the client and family member(s), including loved ones/significant others identified by the client, are present. The purpose of this type of therapy is to address relational patterns, communication challenges, and family dynamics that directly impact the client's mental health condition.
Documentation should include who the service was provided with, and a brief description of how the service addressed the client's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors)	Documentation should include who was present, what problems were addressed with the client and family member(s), and the therapeutic interventions used to address those problems.

TRAININGS & MEETINGS

Online Training:
BHP Annual Provider Training

SMHS QA/QI Coordinators' Meeting

Teams Meeting
1/8/2026
10:00 AM – 12:00 PM

SMHS Documentation Office Hours

Teams Meeting
1st & 3rd Thursday of the Month
10:00 AM - 10:50 AM
Email SMHSClincalRecords@ochca.com for invitation

Helpful Links:

QMS Support Team
TATS Training Request Form
BHS EHR Blog Posts
Medi-Cal Certification

Reminder: Certified Peer Support Specialist Plan of Care

Peer support services must be based on an approved plan of care that includes specific individualized goals. Peer support services include one or more of the following service components:

- Educational skill building groups
- Engagement
- Therapeutic activity (structured non-clinical activity)

ONLY Certified Peer Support Specialists may provide peer support services.

Peer Support Specialists shall provide services under the direction of a behavioral health professional. Behavioral health professionals must be licensed, waivered, or registered.

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, progress note, or the provider may use a dedicated care plan template within an Electronic Health Record. However, to support delivery of coordinated care, the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems.

References: BHIN 22-019, FY2022-2023 Annual Provider Training, BHIN 23-068, 2024 Annual Provider Training, BHIN 25-010, 2025 Provider Manual

Important News: Lockout for Psychiatric Inpatient Hospitalization

QMS has recently learned that lockouts for psychiatric inpatient hospitalization no longer apply for most procedure codes. Previous guidance was that only TCM could be billed for placement planning during a psychiatric inpatient hospitalization however the state has updated their guidance. Moving forward eligible services such as plan development, assessment, targeted case management, psychotherapy, etc. can be provided during a psychiatric inpatient hospitalization as long as the service is medically necessary. A full list of procedures codes that are allowed are in your provider specific quick guides under the "Lockouts" tab. Lockouts will be under the Table tab in upcoming quick guides.

Quick guides link: Payment Reform Resources | Orange County California - Health Care Agency

Example:

Code	Service (Brief Definition) Based on 2024 Rules	Outpatient Non-Overridable Lockout Codes (Always locked out with Column A)	Outpatient Overridable Lockouts with Appropriate Modifiers (Overridable Modifiers for codes with * are: 59, XE, XP or XU Overridable Modifiers for codes with ** are: 27, 59, XE, XP or XU)	Locked Out against #1 Inpatient #2 Residential #3 Psychiatric Health Facility
H0032 70899-422	Mental health service plan development by non-physicians, 15 minutes	None	None	#2, #3
T1017 70899-412	Targeted case management, 15 minutes	None	None	Not lockout
H2017 70899-423 or 429	Psychosocial rehabilitation, 15 minutes	None	None	#2, #3

< > ••• Place of Service Codes | CSW,MFT,PCC Lockouts | Modifiers | +

Coding Tip: Case Consultations and Treatment Team Meetings

Plan Development is a service to develop or update a client's course of treatment and the monitoring of the client's treatment progress. Plan Development can occur with the client and/or with other treatment team members. The following plan development codes can be used for case consultations and treatment team meetings.

<table>
<tr>
<th>Case Consultation with another
Treatment Team Member</th>
<th>Treatment Team Meeting
(with at least 3 distinct provider types present)</th>
</tr>
<tr>
<td>Name of service: Mental health service plan development by non-physician

Service Code: 70899-422 (H0032)

(8 minutes minimum)

May be billed by: CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MHRS, NP, NP-CT, Other, PA, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, RN, RN-CT

• One-on-one consultation with another treatment team member
• Consultation with other treatment team members but does not meet criteria for another plan development code

NOTE: This code may also be used for treatment planning with client and/or significant support person(s)</td>
<td>Name of service: Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30-1440 minutes, participation by non-physician qualified health care professional

Service Code: 99366-4

May be billed by: CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MA, NP, NP-CT, PA, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, RN, RN-CT</td>
</tr>
<tr>
<td rowspan="2">Name of service: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, <u>directed by a physician</u> or other qualified health care professional, per calendar month, with the following <u>required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team</u>, 20-1440 minutes.

Service code: 99484-4

May be billed by: CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT</td>
<td>Name of service: Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30-1440 minutes; participation by physician

Service code: 99367-4

May be billed by MD/DO, MD/DO-Clerks</td>
</tr>
<tr>
<td>Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30-1440 minutes; participation by nonphysician qualified health care professional

Service code: 99368-4

May be billed by: CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MA, NP, NP-CT, PA, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, RN, RN-CT</td>
</tr>
</table>

Can I Bill for Attending an Appointment/Event with a Client?

In the occasion that a member of the treatment team attends an appointment or an event with a client, the service and how that service addresses the client's behavioral health needs should be clearly documented in the progress note in order to bill for it. The service time must be justified by the documentation as well. This applies to all provider types, including Certified Peer Support Specialists.

For example, if an RN attends a medical appointment with the client's consent to inform the medical professional about the client's current medication and medical issues on the client's behalf because the client is unable to due to the client's mental health symptoms, this service may be billable. However, the RN should only account for the time spent providing the medication support service and not the duration of the whole appointment.

If the RN consults with the medical professional with the client's consent, with or without the client present, to integrate objectives with the client's mental health treatment plan, the consultation may be billable. Similarly, the RN should only account for the duration of the consultation and not the duration of the whole appointment.

If the duration of the whole appointment is captured as service time, the progress note should clearly indicate all the interventions provided and how the interventions addressed the client's behavioral health needs. Please keep in mind that a progress note should only contain services of one type. If different services were provided, such as a medication support service and a plan development service, to capture the consultation in the above example, the services should be documented on separate progress notes.

To summarize, practitioners may bill for time spent delivering a mental health **service** and should not bill for (or document at length about) time spent with a client during an appointment or event that the client is attending. To bill for minutes of time spent with the client when mental health service is not being provided would be fraudulent and wasteful.

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.

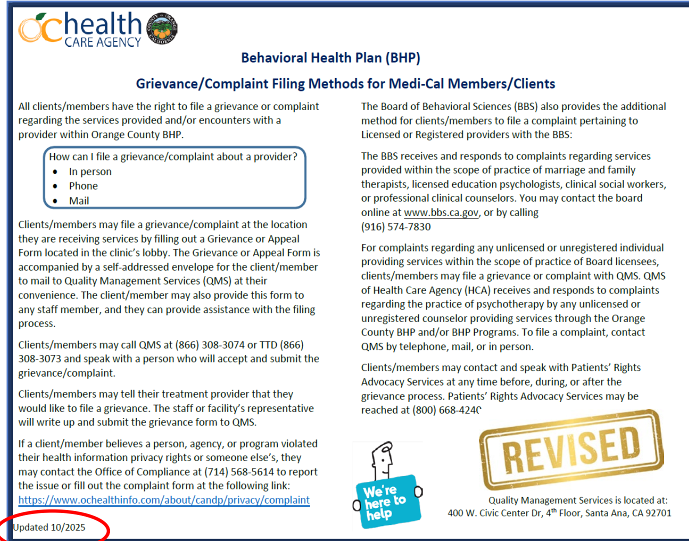
All updates made in the 274 UI by program administrators will automatically reflect on the newly enhanced Provider Directory website.

CHECK IT OUT https://bhpproviderdirectory.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



OC health CARE AGENCY

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

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

Updated 10/2025

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.

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

400 W. Civic Center Drive., 4th floor
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480-0755

E-MAIL ADDRESSES

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

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II

Reminder to Service Chiefs & Supervisors: Please submit monthly program and provider updates for the Provider Directory and send to: BHPProviderDirectory@ochca.com and BHSIRISLiaison@ochca.com. Review QRTips in staff meetings and include in your meeting minutes.

***Disclaimer**: Quality Management Services (QMS) develops and distributes the monthly QRTips newsletter to all Specialty Mental Health Service (SMHS) providers as a tool to assist with various Quality Assurance (QA) and Quality Improvement (QI) regulatory requirements. The newsletter is NOT an all-encompassing document. Providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.*

QMS MAILBOXES

Please email questions to the group mailboxes to ensure emails arrive to the correct team rather than an individual team member who may be out on vacation, unexpectedly away from work, or otherwise unavailable.

Group Mailbox	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)
BHPSupervisionForms@ochca.com	Submission of supervision reporting forms for clinicians, counselors, medical professionals & other qualified providers ● Submission of updated supervision forms for change of supervisor, separation, license/registration change ● Mental Health Professional licensing waivers
BHPProviderDirectory@ochca.com	Provider Directory notifications ● Provider Directory submission for SMHS & DMC-ODS programs
BHSHIM@ochca.com	County-operated SMHS & DMC-ODS programs use related: Centralized Retention of Abuse Reports & Related Documents ● Centralized processing of client record requests and clinical document review & redaction ● Release of Information, ATDs, restrictions & revocations ● IRIS Scan Types, Scan Cover Sheets & Scan Types crosswalks ● Record quality assurance & correction activity
BHSIRISLiaison@ochca.com	EHR support, design & maintenance ● Add/delete/modify program organizations ● Add/delete/maintain all county & contract rendering provider profiles in IRIS ● Register eligible clinicians & doctors with CMS
BHPNetworkAdequacy@ochca.com	Manage MHP and DMC-ODS 274 data & requirements ● Support of MHP county & contract user interface for 274 submissions
BHPPTAN@ochca.com	Assist in maintaining PTAN status of eligible clinicians & doctors
SMHSClinicalRecords@ochca.com	Chart reviews ● Corrective Action Plan (CAP) assistance ● Documentation & coding support ● Use of downtime forms ● Scope of practice guidance ● QRTips newsletter
BHPSUDSupport@ochca.com	SUD documentation support ● CalOMS (clinical questions) & DATAR ● DMC-ODS reviews ● MPF updates ● PAVE (County SUD Clinics)
CalAIMSupport@ochca.com	Enhanced Care Management
BHPBillingSupport@ochca.com	IRIS billing ● Office support
BHPIDSS@ochca.com	General questions regarding designation
BHPDesignation@ochca.com	Inpatient involuntary hold designation ● LPS facility designation ● Outpatient involuntary hold designation
BHPCertifications@ochca.com	SMHS Medi-Cal certification
BHSInpatient@ochca.com	Inpatient TARs ● Hospital communications ● ASO / Carelon communication
BHPUMCCC@ochca.com	Utilization management of Out of Network (and in network) complex care coordination. Typically for ECT, TMS, eating disorders
QISystems@ochca.com	CANS/PSC-35 data entry issues ● QA/QI Meeting invite requests