SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

March 2026

SUD Clinical Chart Review Team

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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 Monday (11am) of every month.

Upcoming meetings: March 11, 2026 at 2pm & March 23, 2026 at 11am

WHAT'S NEW?

Requirements for Admission Agreements & "Return to Use" Plans

The Department of Health Care Services (DHCS) has released BHIN 26-006 in February to notify SUD facilities of updates to requirements for admission agreements and "return to use" plans, which arose out of Assembly Bill 1037 that amended sections of the Health and Safety Code. The premise for the changes is rooted in the understanding that the inability to abstain completely from use, relapse, lapse, and reengagement with alcohol or other drugs are symptoms of the condition of SUDs.

The changes went into effect on January 1, 2026. A summary of the main points are as follows:

- Any person seeking treatment cannot be denied admission based solely on that person having consumed, used, or otherwise been under the influence of alcohol or other drugs
- Admission agreements are not required to contain an abstinence or sobriety requirement, to ensure accessibility to care to more individuals with SUD
- Clients are not required to be discharged due to relapse, lapses, and momentary reengagement with alcohol or other drugs
- Facilities must develop and maintain policies that address "return to use" and the development of a plan that prioritizes the individual maintaining some level of connection to treatment and consider

Continued on page 2...

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!

*Coming Soon…*Updated DMC-ODS Payment Reform 2026 - CPT Guide

Please refer to the State's FY 25-26 Service Table here for the most accurate information on billing codes.

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?

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options to avoid complete disconnection from treatment.

Be sure to check out **BHIN 26-006** and update your program's admission agreements and "return to use" plans accordingly!

Non-Overridable lockouts

A **Non-Overridable Lockout** means that there are certain service billing codes that cannot be claimed together on the same day under any circumstances. This means that there are no exceptions and will lead to a denial by the State!

The predominant claim denials that we have observed due to a non-overridable lockout include:

SUD Structured Assessment, 5-14 Min (70899-102) G2011 *cannot be claimed with* SUD Structured Assessment, 15-30 Min (70899-100) G0396, SUD Structured Assessment, 30+ Min (70899-101) G0397

SUD Structured Assessment, 15-30 Min (70899-100) G0396 *cannot be claimed with* SUD Structured Assessment, 30+ Min (70899-101) G0397, SUD Structured Assessment, 5-14 Min (70899-102) G2011, SUD Screening (70899-105) H0049, SUD Brief Intervention, 15 Min (70899-117) H0050, SUD Recovery Incentives, 15 Min (70899-118) H0050

SUD Structured Assessment, 30+ Min (70899-101) G0397 *cannot be claimed with* SUD Structured Assessment, 15-30 Min (70899-100) G0396, SUD Structured Assessment, 5-14 Min (70899-102) G2011, SUD Screening (70899-105) H0049, SUD Brief Intervention, 15 Min (70899-117) H0050, SUD Recovery Incentives, 15 Min (70899-118) H0050

SUD Screening (70899-105) H0049 *cannot be claimed with* SUD Structured Assessment, 15-30 Min (70899-100) G0396, SUD Structured Assessment, 30+ Min (70899-101) G0397

SUD Brief Intervention, 15 Min (70899-117) and SUD Recovery Incentives, 15 Min (70899-118) H0050 *cannot be claimed with* SUD Structured Assessment, 15-30 Min (70899-100) G0396, SUD Structured Assessment, 30+ Min (70899-101) G0397

24-Hour Service & Outpatient Lockouts:

Residential 3.1 (90899-638) H0019, Residential 3.3 (90899-844) H0019, Residential 3.5 (90899-674) H0019 cannot be claimed with any outpatient services* EXCEPT on the date

Continued on page 3…

Documentation FAQ

1. What are the requirements for the disclosure of HIV-related information?

We must abide by the California Health & Safety Code requirements, which states that for Protected Health Information (PHI) related to HIV/AIDS, any disclosure requires specific, written consent from the client for each release. Authorizations to Disclose (ATDs) for treatment, payment, and healthcare operations (TPO), is not an exception for HIV/AIDS PHI. Therefore, a TPO ATD that states, "My treating providers," is not acceptable for releasing HIV/AIDS PHI. Releasing HIV/AIDS PHI for the purposes of TPO requires a written consent for each provider that the HIV/AIDS PHI is being released to.

2. Can I use the Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013 supplemental code if I speak my client's preferred language and interpret for a family session that I provide?

No. This code can only be used if an outside interpreter is used. This code cannot be claimed if you are the primary service provider AND providing interpretation. Doing so would be considered fraud, waste, and/or abuse. It is permissible for the outside interpreter to be another staff member of your program. It is advised that the name and credentials or title of the sign language or oral interpreter be included in the documentation to help justify the use of this supplemental code. This code is not available at the residential or withdrawal management levels of care.

3. Does the primary counselor need to provide the one treatment service required to claim a treatment day at the residential and withdrawal management levels of care?

No. The State does not specify requirements on who must provide the qualifying service. Therefore, it does not need to be the primary counselor. Please keep in mind that we must abide

Continued on page 3…

Documentation FAQ (continued)

…continued from page 2

by the allowable provider types/disciplines for the types of services as outlined in the State's service table on the MedCCC website. For example, only certain provider types/disciplines are permitted to provide family therapy. As is the case for all services, interventions provided must be within the scope of practice of the provider.

Non-Overridable lockouts

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of admission and discharge

WM Residential Withdrawal Management 3.2 (90899-779) H0012 cannot be claimed with any outpatient services* EXCEPT on the date of admission and discharge

** The only exception to this is Care Coordination, Peer Support Services, Recovery Services, and MAT.*

Please refer to the State's service table on the MedCCC website for all non-overridable lockouts for each service billing code!

⚠ Pay particular attention to Column J ("Outpatient Non-Overridable Lockout Codes"). Codes in this column cannot be used together with the corresponding service billing code in Column A on the same day. If these codes are used on the same day, the claim that is processed second will be denied! If the claim is denied, providers will not be reimbursed for services rendered in these situations.

Residential Stay Based on Medical Necessity

As a reminder, there are no pre-determined lengths of stay (such as a "90-day program"). Residential lengths of stay are solely based on the client's medical necessity for the higher intensity level of care. The State's goal is 30 days. Therefore, providers should not be having clients "commit to 90 days." It is very important that documentation in the client's chart (such as the re-assessment every 30 days) shows how the client continues to need this level of care. Treatment days claimed without documentation to support medical necessity are subject to disallowance/recoupment.

Discharge Summaries are NOT Billable

Remember that solely completing discharge summaries is not a reimbursable activity because discharge summaries are not a DMC-ODS requirement. You may complete the discharge summary with the client in a termination/discharge session, which could be billable as an individual counseling service at the outpatient levels of care.

Modifiers for Service Billing Codes

A modifier gets added to a service billing code to essentially describe aspects of that specific service. Modifiers can impact how a service should be billed or who can bill. In some cases, if the appropriate modifier is not attached, this can cause a service to be denied. For example, there are modifiers that must be used when specific combinations of service codes are used on the same day (such as in the case of an overridable lockout).

Ultimately, it is the responsibility of the rendering service provider to ensure that the applicable modifier is attached to the claim, based on the service provided and supporting documentation.

Please refer to the State's service table on the MedCCC website for descriptions of each allowable modifier and the codes they may be used with!

Pay particular attention to Column K ("Outpatient Overridable Lockouts with Appropriate Modifiers"). Codes in this column cannot be used together on the same day *unless the appropriate modifier is used*. This is a situation where a claim may be denied if the modifier(s) are missing!

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 274 USER INTERFACE

Monthly submissions for the Behavioral Health Plan Provider Directory have transitioned to the 274 User Interface (274 UI) for all providers. This platform aligns with key data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT), supporting improved data consistency and streamlined reporting for both the NACT and the Provider Directory.

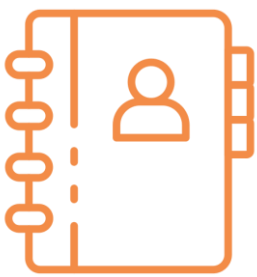
With this transition, program administrators from county and county-contracted programs are now be responsible for entering and updating provider data in the 274 UI monthly. Providers will receive automated email notifications on the 1st of each month, prompting them to submit updates. If a submission is not completed by the 15th, another reminder email will be sent.

Remember to review each provider listed under your assigned sites every month. Submit updates as needed. If no changes are required, select the "NO CHANGE" button on each provider's profile to confirm your review. This step allows the MCST to verify compliance and ensure administrators are completing monthly reviews for all assigned providers.

IMPORTANT: If no activity is recorded for your program and provider reviews for three consecutive months, a Notice of Deficiency may be issued for non-compliance with DHCS BHIN-25-026 requirements.

For questions, you may e-mail:

- Provider Directory: BHPProviderDirectory@ochca.com
- NACT: BHPNetworkAdequacy@ochca.com



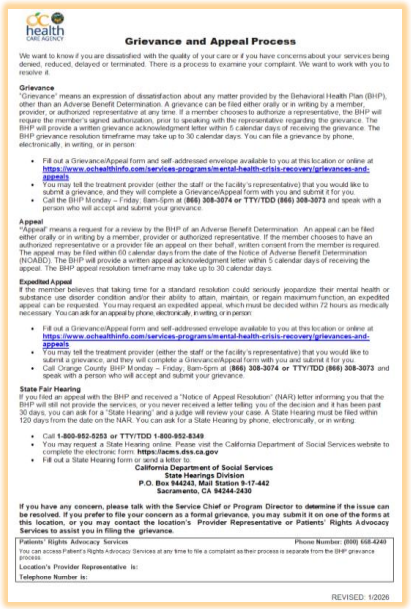
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

REVISED: GRIEVANCE & APPEAL POSTERS (REGULAR AND LARGE PRINT)

The grievance and appeal posters have been revised (1/2026) and are readily available on the QMS website. DHCS issued BHIN 25-015 to provide updated guidance regarding the grievance and appeal process, including revised member notice templates and compliance with federal and state regulations.

KEY POINTS

- ✓ The Grievance and Appeal Poster must be prominently displayed in provider locations.
- ✓ Materials, including posters, must be available in alternate formats such as large print and in all threshold languages to ensure accessibility.
- ✓ Providers are expected to make these materials available without requiring members to request them, supporting accessibility and compliance.



ochealth CARE AGENCY

Grievance and Appeal Process

We want to know if you are dissatisfied with the quality of your care or if you have concerns about your services being denied, reduced, delayed or terminated. There is a process to examine your complaint. We want to work with you to resolve it.

Grievance

"Grievance" means an expression of dissatisfaction about any matter provided by the Behavioral Health Plan (BHP), other than an Adverse Benefit Determination. A grievance can be filed either orally or in writing by a member, provider, or authorized representative at any time. If a member chooses to authorize a representative, the BHP will require the member's signed authorization, prior to speaking with the representative regarding the grievance. The BHP will provide a written grievance acknowledgment letter within 5 calendar days of receiving the grievance. The BHP grievance resolution timeframe may take up to 30 calendar days. You can file a grievance by phone, electronically, in writing, or in person:

- Fill out a Grievance/Appeal form and self-addressed envelope available to you at this location or online at https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/grievances-and-appeals
- You may tell the treatment provider (either the staff or the facility's representative) that you would like to submit a grievance, and they will complete a Grievance/Appeal form with you and submit it for you.
- Call the BHP Monday – Friday, 8am-5pm at **(866) 308-3074 or TTY/TDD (866) 308-3073** and speak with a person who will accept and submit your grievance.

Appeal

"Appeal" means a request for a review by the BHP of an Adverse Benefit Determination. An appeal can be filed either orally or in writing by a member, provider or authorized representative. If the member chooses to have an authorized representative or a provider file an appeal on their behalf, written consent from the member is required. The appeal may be filed within 60 calendar days from the date of the Notice of Adverse Benefit Determination (NOABD). The BHP will provide a written appeal acknowledgment letter within 5 calendar days of receiving the appeal. The BHP appeal resolution timeframe may take up to 30 calendar days.

Expedited Appeal

If the member believes that taking time for a standard resolution could seriously jeopardize their mental health or substance use disorder condition and/or their ability to attain, maintain, or regain maximum function, an expedited appeal can be requested. You may request an expedited appeal, which must be decided within 72 hours as medically necessary. You can ask for an appeal by phone, electronically, in writing, or in person:

- Fill out a Grievance/Appeal form and self-addressed envelope available to you at this location or online at https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/grievances-and-appeals
- You may tell the treatment provider (either the staff or the facility's representative) that you would like to submit a grievance, and they will complete a Grievance/Appeal form with you and submit it for you.
- Call Orange County BHP Monday – Friday, 8am-5pm at **(866) 308-3074 or TTY/TDD (866) 308-3073** and speak with a person who will accept and submit your grievance.

State Fair Hearing

If you filed an appeal with the BHP and received a "Notice of Appeal Resolution" (NAR) letter informing you that the BHP will still not provide the services, or you never received a letter telling you of the decision and it has been past 30 days, you can ask for a "State Hearing" and a judge will review your case. A State Hearing must be filed within 120 days from the date on the NAR. You can ask for a State Hearing by phone, electronically, or in writing:

- Call **1-800-952-5253 or TTY/TDD 1-800-952-8349**
- You may request a State Hearing online. Please visit the California Department of Social Services website to complete the electronic form: **https://acms.dss.ca.gov**
- Fill out a State Hearing form or send a letter to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-442
Sacramento, CA 94244-2430

If you have any concern, please talk with the Service Chief or Program Director to determine if the issue can be resolved. If you prefer to file your concern as a formal grievance, you may submit it on one of the forms at this location, or you may contact the location's Provider Representative or Patients' Rights Advocacy Services to assist you in filing the grievance.

Patients' Rights Advocacy Services — Phone Number: (800) 668-4240
You can access Patient's Rights Advocacy Services at any time to file a complaint as their process is separate from the BHP grievance process.
Location's Provider Representative is:
Telephone Number is:

REVISED: 1/2026

Link to Access the SMHS Grievance & Appeal Posters:
Behavioral Health Plan and Provider Information | Orange County California - Health Care Agency

Link to Access the DMC-ODS Grievance & Appeal Posters:
DMC-ODS For Providers | Orange County California - Health Care Agency

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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)

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING REQUIREMENTS

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.

COUNTY CREDENTIALING

PROVIDERS REQUIRED TO BE COUNTY CREDENTIALED:

NOTE: Any provider who works in a job classification that requires a license, waiver, certification and/or registration and delivers Medi-Cal covered services must be credentialed by the County. This list is not exhaustive, please inquire with the MCST for further guidance.

- ✓ Licensed Vocational Nurse
- ✓ Licensed Psychiatric Technician
- ✓ Certified Nurse Assistant
- ✓ Certified Medical Assistant
- ✓ 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 Peer Support Specialist

COUNTY CREDENTIALING

SUBMISSION CHECKLIST

A complete packet should contain the following documents listed below and be labeled Last Name, First Name. The document names can be abbreviated. For example, New Applicant Request Form (NARF), Annual Provider Training (APT), Cultural Competency (CC), etc. The e-mail subject line must be titled Credentialing – Program Name.

SMHS CHECKLIST

- ✓ Doe, John NARF
- ✓ Doe, John Resume
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if applicable)

NOTE: The APT and CC Training must be the most current training that was completed in the last year.

DMC-ODS CHECKLIST

- ✓ Doe, John NARF
- ✓ Doe, John Resume
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Doe, John ASAM A
- ✓ Doe, John ASAM B
- ✓ 5 CEU/CME in Drug Addiction/Recovery (**ONLY** for MD, LCSW, LMFT, LPCC, Psychologist)
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if applicable)

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORM REQUIREMENT

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

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

SUPERVISION REPORTING FORMS

LIST OF PROVIDERS REQUIRED TO SUBMIT A SUPERVISION REPORTING FORM

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

REMINDER

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

MANAGED CARE SUPPORT TEAM

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

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

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II

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 ● Transitional rent
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	**Quality Standards and Clinical Practice Team** (QSCP) – EBPs, QAPI, BHA ● **HEDIS/POM** – CalOMS, CANS/PSC-35 ● **BHP QI Support** – QI related questions for SMHS and DMC-ODS programs (including DATAR, med monitoring)