April 2026 QRTips

Behavioral Health Services
Quality Management Services

Reminders

Telehealth Email Acknowledgement Form

County and contract providers must obtain client's consent to receive emails from the BHP with telehealth appointment information, if applicable. Similarly, if a program utilizes other alternative methods of communication, such as text messages, the program is responsible for informing their clients and obtaining consent.

Licensed Vocational Nurse (LVN) & Licensed Psychiatric Technician (LPT)—Effective 7/1/23

On 6/10/25, DHCS added LVN, LVN Clinical Trainee, LPT and LPT Clinical Trainee as allowable provider types to the following codes:

96372 Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1-15 mins
96373 Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes
96374 Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375 Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes
96376 Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug
96377 Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes

Update

Licensed Occupational Therapists (LOT)—Effective 7/1/23

On 3/1/26, DHCS added LOT and LOT Clinical Trainee as allowable provider types to the following codes:

96125 Standardized Cognitive Performance Testing, per hour
96127 Brief emotional/behavioral assessment
99366 Med team conference w/ interdisciplinary team, face-to-face w/ client and/or family
99368 Med team conference w/ interdisciplinary team, client and/of family not present

Provider Type Coding Quick Guide

TRAININGS & MEETINGS

Online Training:
BHP Annual Provider Training

SMHS QA/QI Coordinators' Meeting

Teams Meeting
4/9/2026
10:00 AM – 12:00 PM

SMHS Documentation Office Hours

Teams Meeting
1st Thursday
at 10:00 AM – 10:50 AM
&
3rd Wednesday
at 3:00 PM – 3:50 PM
of every month

Email
SMHSClinicalRecords@ochca.com
for invitation

Helpful Links:

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

Telehealth

(Q&A from March 2026)

Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth and must explain the following:

- The client has a right to access covered services in person
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the client's ability to access covered services in the future
- Non-medical transportation benefits are available for in-person visits
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

County: This information is found in the combined Informed Consent for Services and Telehealth Consent.

Reference: BHIN 23-018

Does "telehealth" include services by phone?

Yes. In BHIN 23-018, DHCS refers to "telehealth" as synchronous audio-only (e.g., telephone) and synchronous video interactions (e.g., Teams, Zoom).

Can you bill specialty mental health services via telehealth if the client is out of state?

No. Out-of-state specialty mental health services cannot be billed to SD/MC except when it is customary practice to receive medical services in a border community outside the State.

Reference: Title 9, CCR, § 1810.355(b) and Cal. Code Regs. Tit. 22, § 51006

Can you provide telehealth services with a parent, guardian, support person, or agency who is out of state?

As stated above, out-of-state specialty mental health services cannot be billed. However, gathering information from someone who is out of state for a client who is in California may be clinically appropriate and billable. For example:

- Gathering information for the comprehensive assessment from a parent, guardian, or support person who is currently out of state or from an out-of-state agency where client received care.
- Gathering program information from an out-of-state agency where a client will be moving to in order to support coordinate of care.

Do we need to document the physical address of their location?

The clinician should "verbally obtain and document the client's full name and address of present location at the beginning of each telehealth session."

Reference: Cal. Code Regs. Tit. 16, § 1815.5 - Standards of Practice for Telehealth, BBS Telehealth Best Practice Guidance Documents

If the client is home at the time of the telehealth session, the client's full name is present on the progress note, and the client's home address is correct in the client's chart, the provider may document "home" as client's location.

Does that mean only clinicians need to obtain and document the client's address? Does this only apply to therapy services?

Obtaining and documenting the client's address applies to all telehealth services by all provider types, including case management.

If a client is calling from out of state with a crisis, do you recommend documenting it as a non-billable service?

If the provider assists with a crisis while the client is out of state, such as searching for resources or calling the police in client's current location, document the service as non-billable.

What if you learn that the client is out of state after a service has been provided?

Please confirm the client is in the state of California prior to providing telehealth services so this doesn't happen. However, if this does happen, document the service as non-billable.

Targeted Case Management (TCM)

(Continued from March 2026 QRTips)

The DHCS definition of TCM can be broken into four parts; understanding each one is critical for accurately capturing TCM services provided.

1. "Targeted case management is a service that **assists a member to access** needed **medical, educational, social, prevocational, vocational, rehabilitative** or **other community services**."

Medical

- External psychiatrist/medication management
- Primary care
- Dental services

Prevocational/vocational

- Job training programs
- Employment placement services
- Apprenticeship or trade school

Educational

- Special education resource programs
- Parenting classes
- GED or adult education enrollment
- English as a Second Language classes

Rehabilitative

- Substance use recovery programs
- Residential treatment programs
- Individual or group therapy
- Wraparound services

Social

- SNAP/CalFRESH
- Housing assistance
- Social Security benefit programs
- Domestic violence or family support services

Other community services

- Transportation
- After school programs
- Opportunities to socialize and practice skills learned
- Legal aid or tenant rights services

Note: Those who provide TCM services should be able to find the client's needs in the comprehensive assessment, Problem List, and the TCM Care Plan. For example, the client's social needs might be indicated under presenting problem, living arrangement, financial, trauma, and/or treatment recommendations.

Targeted Case Management (TCM)
(Continued)

2. The service activities may include but are not limited to, **communication, coordination**, and **referral**; **monitoring service delivery** to ensure patient access to service and the service delivery system; **monitoring** the **member's progress in accessing needed services**; **placement services** and **plan management**.
   - Examples found in March 2026 QRTips.

3. TCM services may be **face-to-face** or by **telehealth** with the **member** or **significant support persons** and may be provided **anywhere in the community**.
   - TCM services should be focused on the client's needs.

4. Additionally, services may be provided by any person determined by the BHP to be qualified to provide the service, consistent with the **scope of practice and state law**.
   - All disciplines can provide TCM services except Certified Peer Support Specialists.
   - TCM services will be most commonly provided by Mental Health Rehabilitation Specialists (MHRS) and Other Qualified Providers (OQPs).
   - All disciplines should work at the top of their job classification.
   - If you are not sure which discipline you are, please ask your supervisor.

Documentation

Progress note requirement: Brief description of how the service addressed the client's behavioral health needs.

Write **1-2 short sentences** explaining **what you did** and **how it helped the client**

- ✓ Use simple, everyday language
- ✓ Link your action to the problem list or a behavioral health issue from the problem list
- ✓ Make clear **why YOU** as a professional **had to do this service**
- ✓ Ensure that the **activities described** in the progress note **justify the duration of the service**

Examples:

- "Helped the client apply for housing assistance to reduce stress and sleep disruption that worsened anxiety."
- "Coordinated with the clinic to schedule client's medication management appointment to address mood instability related to depression."
- "Discussed options for transportation so client can attend therapy and stay engaged in treatment to manage PTSD symptoms."

Targeted Case Management (TCM)
(Continued)

Documentation

Progress note requirement: Brief summary of next steps

Write **1-2 short sentences** simple, everyday language

- ✓ Use simple, everyday language
- ✓ Be specific
- ✓ Connect to the care plan goals

Examples:

- "Client will bring income documents to next meeting to complete benefit application."
- "I will follow up with the housing coordinator next week."
- "Plan to review progress on therapy attendance during next visit."
- Client will try using public transit route provided to reach appointments on Tuesday."

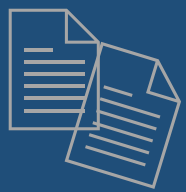
Assessment Reminders:

"To ensure that clients receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to **complete initial assessments and subsequent assessments as expeditiously as possible**, in accordance with each client's clinical needs and generally accepted standards of practice."

- If unable to complete the comprehensive assessment within a reasonable time, document reasons for delay (related to client, not staff)

"Assessments shall be **updated as clinically appropriate**, such as when the client's condition changes."

- The comprehensive assessment is shared within the BHP. Updates/reassessments shall be completed if clinically appropriate. Billing for a service that is not medically necessary or clinically appropriate may be seen as **waste**.
- It may be clinically appropriate to **review** the comprehensive assessment with the client for accuracy upon receiving the client from another program if the client was recently assessed rather than conducting a full reassessment.



Progress Note Reminders:

"Each progress note shall provide sufficient detail to **support the service code(s) selected for the service type(s)** as indicated by the service code description(s)"

- Description of medically necessary intervention(s) documented should read as the service type selected and meet the criteria for the service code selected.
- For example, a therapy service should include therapeutic interventions that focus primarily on symptom reduction and restoration of functioning. If family therapy service code is selected, therapeutic interventions should address the client and family member(s) present in session.

Reference: BHIN 23-068

BHS QMS Billing Team

DHCS Medi-Cal Claim Submission Timely Filing Limits

- **Initial Claim:** Must be submitted within 12 months from the month of service.
- **Replacement Claim:** Must be submitted within 15 months from the month of service (only if the initial claim was submitted within one year of the service date).

County-to-State Claim (837 File) Submission Schedule:

- **Medi-Cal ADP Claim Submissions:** Occur every Tuesday. All charges should be entered or corrected by the end of day Monday.
- **Medi-Cal Short Doyle Claim Submissions:** Occur every Wednesday. All charges should be entered or corrected by the end of day Tuesday.

DHCS Billing Corner: Understanding M80 Denials & PCCN Requirements

M80 Lockout Denials
An M80 denial occurs when DHCS identifies a pair of procedure codes that **cannot be billed together** for the same member on the same day.

How to Prevent M80 Denials

- Reference the Service Table on MEDCCC Library
- Apply correct overridable modifiers (such as 59, XE, XP, XU) for distinct services
- Clearly document when services are separate and independent
- Review M80 denials promptly and submit corrections

PCCN Reminder
When submitting a **replacement** or **void** claim, the **Payer Claim Control Number (PCCN)** must be included from a previously processed claim.

Why It Matters

- Ensures DHCS can link your correction to the previously processed claim
- Reduces preventable rejections and speeds up payment
- Supports accurate record-keeping and auditing

Bottom Line:
Avoiding M80 denials and including the PCCN on all corrected claims are simple but crucial steps to ensuring clean claims and timely DHCS payments.

Important Update

The DHCS FY 25-26 Service Tables have been updated as of March 2026.

- The Medicare COB requirement has been removed from procedure codes T2021 and T2024. **However, if you are substituting another code that *does* require Medicare COB, you must bill Medicare first, following the guidance provided in the "Medicare COB Required?" column.**

Helpful Resources

- **BHS QMS BT Contract Provider Web Portal**
  BHS Contract Provider Claims/Billing Resources | Orange County California - Health Care Agency
- **Aid Code Chart**
  MedCCC – Library
- **Medi-Cal Eligibility Verification**
  DHCS - Provider Portal
- **Medi-Cal Service Table**
  MedCCC – Library
- **Medicare Advantage Plans**
  Medicare Advantage Plans
- **Medicare COB Requirements**
  SMHS:
  Specialty Mental Health Services Billing Manual SFY 2025-26
  DMC:
  DMC-ODS Billing Manual SFY 2025-26
- **Share of Cost Spend Down Guide**
  Share of Cost (SOC) (share)

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

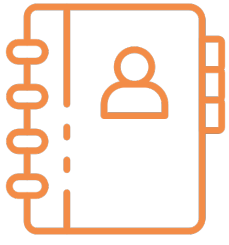
PROVIDER DIRECTORY 274 USER INTERFACE

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, providers and program administrators from county and county-contracted programs are 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.

Program administrators are to review each provider listed under their assigned site(s) 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

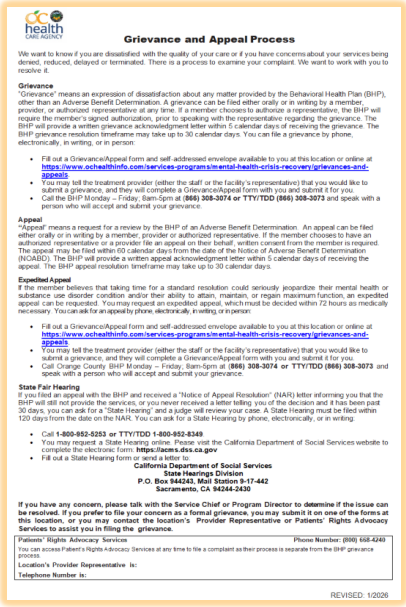
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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 and printed on 8x14 legal size paper.
- ✓ Materials, including posters, must be available in alternate formats such as large print (11x17) 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.



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://iacms.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

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

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.

BHPBillingSupport@ochca.com	IRIS Billing ● Office Support
BHPCertifications@ochca.com	SMHS Medi-Cal Certifications ● PAVE (SUD and JI) ● MPF/OOCR Updates
BHPDesignation@ochca.com	Inpatient Involuntary Hold Designation ● LPS Facility Designation ● Outpatient Involuntary Hold Designation
BHPGrievanceNOABD@ochca.com	Grievances & Investigations ● Appeals/Expedited Appeals ● State Fair Hearings ● NOABDs ● MCST Training Requests
BHPIDSS@ochca.com	General Questions Regarding Designation
BHPIRISFrontOfficeSupport@ochca.com	County Front Office Operational Support – Guidance on Front Office Procedures and Non-Technical EHR Workflow Inquiries
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)
BHPNetworkAdequacy@ochca.com	Manage SMHS & DMC-ODS 274 Data ● Support of MHP County & Contract User Interface for 274 Submissions
BHPProviderDirectory@ochca.com	Provider Directory Notifications ● Provider Directory Submission for SMHS & DMC-ODS Programs
BHPPTAN@ochca.com	Assist in Maintaining PTAN Status of Eligible Clinicians & Doctors
BHPSUDSupport@ochca.com	DMC-ODS Clinical Chart Reviews ● Corrective Action Plan (CAP) Assistance ● Documentation & Coding Support ● Use of Downtime Forms ● Scope of Practice Guidance ● SUDsies Newsletter ● DMC-ODS Documentation Training Requests
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
BHPUMCCC@ochca.com	Utilization Management of Out-of-Network (and In-Network) Complex Care Coordination Typically for ECT, TMS, Eating Disorders
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 Documentation Review & Redaction ● Release of Information, ATDs, Restrictions & Revocations ● IRIS Scan Types, Scan Cover Sheets & Scan Types Crosswalks ● Record Quality Assurance & Correction Activity
BHSInpatient@ochca.com	Inpatient TARs ● Hospital Communications ● ASO/Carelon Communication
BHSIRISLiaison@ochca.com	EHR Support, Design & Maintenance ● Add/Delete/Modify Program Organizations ● Add/Delete/Maintain All County & Contract Rendering Provider and Front Office Staff Profiles in IRIS ● Manage SMHS & DMC-ODS 274 Requirements
BHSPandP@ochca.com	New BHS P&P needs ● BHS P&P updates
CalAIMSupport@ochca.com	Enhanced Care Management (ECM) ● Transitional Rent
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, Medication Monitoring); QA/QI Meeting Invite Requests
QMSSpecialProjects@ochca.com	BHP Provider Manual ● Member Handbook ● Intake/Advisement Checklist ● Justice Involved SME
SMHSClinicalRecords@ochca.com	SMHS Clinical Chart reviews ● Corrective Action Plan (CAP) Assistance ● Documentation & Coding Support ● Use of Downtime Forms ● Scope of Practice Guidance ● QRTips Newsletter ● SMHS Documentation Training Requests