



2026

# Behavioral Health Plan Provider Manual



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# GENERAL INFORMATION FOR PROVIDERS

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# GENERAL INFORMATION FOR PROVIDERS

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## PURPOSE OF THE PROVIDER MANUAL

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

## MANAGED CARE ORGANIZATION (MCO)

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

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

## WHAT IS THE BEHAVIORAL HEALTH PLAN?

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

## NO WRONG DOOR POLICY

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

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

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

When a BHP provider renders clinically appropriate Specialty Mental Health Services, these services are covered by Medi-Cal, regardless of whether the client has a co-occurring SUD. The BHP will allow reimbursement for Specialty Mental Health Services provided to a client who meets Specialty Mental Health Services criteria regardless of whether the client has a co-occurring substance use problem. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC-ODS providers in the Drug Medi-Cal Organized Delivery System (DMC-ODS) are covered, regardless of whether the client has a co-occurring mental health condition. Clinically appropriate and Non-Specialty Mental Health Services are covered Medi-Cal services via the Fee-For-Service and Managed Care Plan (MCP) delivery systems, regardless of whether the client has a co-occurring SUD. Additionally, clinically appropriate SUD services such as alcohol and drug screening, assessment, brief interventions, and referral to Medication Assisted Treatment (MAT) delivered by MCP providers are covered by MCPs, regardless of whether the member has a co-occurring mental health condition.

### CONCURRENT NON-SMHS AND SMHS

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

## GENERAL INFORMATION FOR PROVIDERS

### REQUIRED FORMS GIVEN TO CLIENTS

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

- **Voter Registration Form** is to increase voter registration. The client shall attest to the accuracy of the information with their signature. Providers are required to sign if they help the client complete the form and are not permitted to screen for voter eligibility in any way.
- **Notice of Privacy Practices** is to inform the client about use, access, and disclosure of

Protected Health Information (PHI), the complaint process, and other privacy rights.

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

### **Mandated Reporting of Abuse**

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

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

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

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

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

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

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

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

### Tracking PHI Disclosures

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

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

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

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

To revoke an ATD form, the client shall submit a written request using the Revocation of Authorization to Use or Disclose PHI form. Program staff shall then take the necessary steps to

document the revocation, including drawing a line through the original ATD form, writing “REVOKED” along with the date of revocation, and signing and dating the revision. Additionally, program staff should document this action in a progress note.

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

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

### COMPLIANCE REQUIREMENTS AND REPORTING PRIVACY BREACHES

#### The Office of Compliance (OOC)

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

To report concerns or inquire about compliance matters, contact the OOC at [OfficeOfCompliance@ochca.com](mailto:OfficeOfCompliance@ochca.com) or call (714) 568-5614.

#### Annual Compliance Training

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

For information on the Annual Compliance Training, please refer to [Orange County's HCA Annual Compliance Training](#).

### **Compliance Requirements**

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

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

### **Legal Sanctions for Fraud, Waste and Abuse**

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

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

### **Training and Resources to Prevent Fraud, Waste and Abuse**

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

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

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

### PHI SECURITY MEASURES

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

### MEDICARE GUIDANCE

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

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

### Medication Services

When a Medicare or Medi-Medi member is prescribed medications, their prescriber completes an assessment (or Biopsychosocial Assessment for county providers). This assessment, along with the

prescriber's individual progress note(s), serves as the Plan of Care and authorizes the medication support services provided to the member.

### **Rehabilitation Services**

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

### **Plan of Care Requirements**

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

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

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

The Medicare progress note requirements include the diagnosis and narrative to support the procedure code billed. Documentation for services shall include three elements, though not necessarily on every note: duration, diagnosis and frequency. It is important to note that all services ordered or rendered to Medicare clients shall be legibly signed by the provider, along with their professional credentials. Clinicians and Service Chiefs should be vigilant about clients whose insurance switches to Medicare or Medi-Medi during treatment. If this happens, it is essential to verify that the client's clinician(s) are PTAN providers. Behavioral Health Services can only be billed to Medicare by a PTAN provider. PTAN eligible providers include Licensed Clinical Social Workers, Licensed Psychologists, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Medical Doctors/Doctors of Osteopathy, Nurse Practitioners, and Physician Assistants. In certain circumstances, an eligible provider may opt out of the PTAN process; their services are not eligible to bill Medicare nor MediCal. Non-PTAN providers are providers who are not eligible to bill Medicare, and their services will bypass Medicare and be billed to MediCal.

### **NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER**

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services (CMS). It is a permanent individual provider number. Health Insurance Portability and Accountability Act (HIPAA)-

covered entities completing electronic transactions, healthcare clearinghouses, and large health plans are required by regulation to use only the NPI to identify covered healthcare providers. All individual HIPAA-covered healthcare providers (such as, physicians, pharmacists, physician assistants, nurse practitioners, clinical social workers, marriage and family therapists, professional counselors, physical therapists, occupational therapists, psychologists, and pharmacy technicians) shall obtain an NPI for use in all HIPAA standard transactions.

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

### MEDICATION MONITORING

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

The goals of Medication Monitoring are to:

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

For information on DMC-ODS Medication Monitoring, see [01.02.04 MHRS Medication Monitoring Practices](#), [BHIN 23-054 Medications for Addiction Treatment \(MAT\) Services Requirements for Licensed and/or Certified Substance Use Disorder \(SUD\) Recovery or Treatment Facilities](#) and [Orange County's HCA BH Integrated Intergovernmental Agreement](#).

### PAYMENT REFORM

On July 1, 2023, CalAIM Behavioral Health Payment Reform was implemented. This reform has changed the way DHCS reimburses counties for Specialty Mental Health Services, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System services. It introduces more Current Procedural

Terminology (CPT) codes and rules related to ‘Direct Patient Care’, place of service, time ranges and limits, telehealth/telephone rules, lockouts, and overriding modifiers. For Specialty Mental Health Services, QMS has developed provider-specific Quick Guides which list the service codes that are allowable for each provider type. For DMC-ODS services, QMS has a CPT coding guide to assist providers based on level of care and type of activity. Changes and corrections are continually coming from the State, and QMS will continue to provide updates, guidance, and follow-up questions to DHCS to ensure that all providers are informed.

### **QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) COORDINATORS**

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

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

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

### **MONTHLY NEWSLETTERS**

Monthly newsletters are issued by the QMS. Quality Review Tips (QRTips) is the monthly newsletter for SMHS providers and the SUDsies Newsletter is for the DMC-ODS providers. The purpose of the newsletters is to keep providers informed about California Code of Regulations Updates, documentation standards, reminders based on chart and billing review trends and State-mandated monitoring requirements. Both newsletters are disseminated to all Quality Improvement Coordinators every month. Coordinators are responsible for sharing and discussing the topics raised in the newsletter with their providers. It is encouraged that the newsletters be shared with all providers via email and discussed in staff meetings.

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

## **SPECIALTY MENTAL HEALTH SERVICES (SMHS)**

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

### **DOCUMENTATION AND BILLING ERRORS**

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

- Service does not substantiate medical necessity
- Service provided was not within the provider's scope of practice
- Service claimed does not match the service documented
- Units of service claimed differed from service time claimed in progress note
- Non-reimbursable service provided
- No progress note found to substantiate the service that was provided
- Claiming a service for a no-show or canceled appointment
- Documenting a billable service as a 'Note to Chart'
- Billing for services other than linkage after access criteria was not met
- Lack of evidence in the chart that the diagnosis was formulated by a provider within their scope of practice

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

### **DOCUMENTATION STANDARDS AND SCOPE OF PRACTICE FOR PROVIDERS**

A key aspect of documentation standards as it relates to providing services is that providers shall operate within their scope of practice. As defined by the California Code of Regulations, Title 9, and the Mental Health Plan, scope of practice refers to the range of activities and services professionals may perform based on state licensing, education, and training. Waivered or Registered Mental Health Professionals may direct services, but only under the supervision of a Licensed Mental Health Professional (LMHP). Mental Health Rehabilitation Specialists (MHRS) and Other Qualified Providers

(OQPs), under LMHP direction, may provide behavioral health services, including contributing to assessment, but cannot provide psychotherapy services. They can offer assessment, plan development, Targeted Case Management (TCM), rehabilitation and crisis services. MHRS are commonly known as Rehabilitation Specialists or Mental Health Specialists. OQPs may encompass many different job classifications utilized across county and county-contracted programs. If you are unsure whether your position falls under this category, please discuss it with your service chief or program director and/or reach out to the QMS Clinical Records Teams for guidance. Providers are expected to consult with their supervisors and/or QMS for more information and clarity about what services they may legally and ethically provide.

Per [DHCS Information Notice 23-068](#) and supported by the CalAIM initiative, the diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the client's physical and mental health may only be completed by a licensed provider or a registered/waivered provider who is under the direction of a LMHP. The BHP may designate certain other qualified providers, except Certified Peer Support Specialists, to contribute to the assessment, including gathering the client's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

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

| Scope of Practice Grid                                                                                                                             |                        |                                                                   |                                                       |                                                                     |          |                                                         |          |          |       |       |          |          |             |                                                          |       |
|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------|----------|---------------------------------------------------------|----------|----------|-------|-------|----------|----------|-------------|----------------------------------------------------------|-------|
|                                                                                                                                                    | MD, DO,<br>NP, CHS, PA | Licensed or<br>Waived<br>Psychologist/<br>Behavioral<br>Therapist | Licensed,<br>Waived or<br>Registered<br>CSW, MFT, PCC | Clinical Trainers<br>enrolled in CDE,<br>MFT, PCC Waiver<br>program | Pharm    | RN with Master's in<br>MFT training or<br>related field | RN       | LVN/LPT  | LOT   | MA    | AOD      | MHRS     | OQP         | CPSS                                                     | CHW   |
| <b>FORMS</b>                                                                                                                                       |                        |                                                                   |                                                       |                                                                     |          |                                                         |          |          |       |       |          |          |             |                                                          |       |
| Assessment: Mental health hx + medical hx + substance<br>use hx + exposure, strengths, risks, and barriers to<br>achieving goals and Care Plan     | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes      | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~, ^    | No                                                       | No    |
| Assessment: Diagnosis, MSE, medication hx, assessment<br>of relevant conditions and psychosocial factors affecting<br>the person's physical and MH | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | No       | Yes                                                     | No       | No       | No    | No    | No       | No       | No          | No                                                       | No    |
| Problem List/Care Plan<br>Diagnosis/Problems added must<br>be within the provider's scope of practice                                              | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes      | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~       | Yes ~<br>(Peer Support<br>Services<br>Plan of Care ONLY) | No    |
| <b>SERVICES</b>                                                                                                                                    |                        |                                                                   |                                                       |                                                                     |          |                                                         |          |          |       |       |          |          |             |                                                          |       |
| Assessment                                                                                                                                         | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes      | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~, ^    | No                                                       | No    |
| Community Health Worker Services                                                                                                                   | No                     | No                                                                | No                                                    | No                                                                  | No       | No                                                      | No       | No       | No    | No    | No       | No       | No          | No                                                       | Yes ~ |
| Crisis Intervention                                                                                                                                | Yes                    | Yes                                                               | Yes                                                   | Yes ~, +                                                            | Yes ~    | Yes                                                     | Yes ~, + | Yes ~, + | Yes   | No    | Yes =    | Yes ~    | Yes ~, +, ^ | No                                                       | No    |
| Crisis Psychotherapy                                                                                                                               | Yes                    | Yes                                                               | Yes                                                   | Yes ~, +                                                            | No       | No                                                      | No       | No       | No    | No    | No       | No       | No          | No                                                       | No    |
| Medication                                                                                                                                         | Yes                    | No ~                                                              | No ~                                                  | No ~                                                                | No ~     | No ~                                                    | No ~     | No ~     | No ~  | No ~  | No ~     | No ~     | No ~        | No ~                                                     | No    |
| Mobile Crisis                                                                                                                                      | Yes ~                  | Yes ~                                                             | Yes ~                                                 | Yes ~, +                                                            | Yes ~, + | Yes ~, +                                                | Yes ~, + | Yes ~, + | Yes ~ | No    | Yes ~, = | Yes ~, + | Yes ~, +, ^ | Yes ~, +, ^                                              | No    |
| Plan Development                                                                                                                                   | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes      | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~       | No                                                       | No    |
| Psych Testing                                                                                                                                      | Yes                    | No                                                                | No                                                    | No                                                                  | No       | No                                                      | No       | No       | No    | No    | No       | No       | No          | No                                                       | No    |
| Psychosocial Rehabilitation                                                                                                                        | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes ~    | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~, ^    | No                                                       | No    |
| Psychotherapy (Individual, Family or Group)                                                                                                        | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | No       | No                                                      | No       | No       | No    | No    | No       | No       | No          | No                                                       | No    |
| Targeted Case Management                                                                                                                           | Yes                    | Yes                                                               | Yes                                                   | Yes ~                                                               | Yes      | Yes                                                     | Yes ~    | Yes ~    | Yes   | Yes + | Yes =    | Yes ~    | Yes ~       | No                                                       | No    |
| Therapeutic Behavioral Services                                                                                                                    | Yes ~                  | Yes ~                                                             | Yes ~                                                 | Yes ~, +                                                            | Yes ~    | Yes ~                                                   | Yes ~    | Yes ~, + | Yes ~ | No    | Yes ~, = | Yes ~, + | Yes ~, +    | No                                                       | No    |
| Peer Support Services                                                                                                                              | No                     | No                                                                | No                                                    | No                                                                  | No       | No                                                      | No       | No       | No    | No    | No       | No       | No          | Yes ~                                                    | No    |

~ Under direct supervision of an LMHP  
+ Supervision requirements depend on the counselor's certification status and the type of facility in which they work  
= May require close supervision if issues of DTB or DTB are present  
~ Requires close supervision if issues of DTB or DTB are present  
~ Exception: May bill for injection or other medication support services within scope  
+ Exception: May bill for medication support service within scope  
+ Exception: May bill for medication therapy management service by pharmacist  
3. Providers must have required mobile crisis training  
~ Requires training in functional behavioral analysis with an emphasis on positive behavioral interventions  
+ The licensed physician, nurse practitioner, or physician assistant must be physically present in the facility during the provision of services by a medical assistant  
^ These services are recommended for providers with four years of related paid or non-paid experience in mental health service provisions

Director Psychology Services must be under the immediate supervision of a LMHP  
Intensive Home Based Services (IHBS) provider qualifications are the same as those allowed for mental health services, and as approved by the MHSP  
"Licensed Mental Health Professionals" means: Licensed physicians, licensed psychologists (includes waived psychologists), licensed clinical social workers (includes waived or registered clinical social workers), LPTCs (includes waived or registered professional clinical counselors), licensed marriage and family therapists (includes waived or registered marriage and family therapists), registered nurses (includes certified nurse specialists and nurse practitioners), licensed vocational nurses, and licensed psychiatric technicians, and licensed occupational therapists. (BHSB 24-023)  
"Waived/Registered Professional" means:  
(1) For a psychologist candidate, "waived" means an individual who either (1) is gaining the experience required for licensure or (2) was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by the Department of Health Care Services to the extent authorized under state law.  
(2) For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, "registered" means a candidate for licensure who is registered or has submitted a registration application and is in the process of obtaining registration in accordance with the criteria established by the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, and "waived" means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination and who has been granted a professional licensing waiver approved by the Department of Health Care Services to the extent authorized under state law.

#### Other Qualified Provider

An individual at least 18 years of age with a high school diploma or equivalent degree plus two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient), or related secondary education. Completion of an AA degree in a related field may be used to substitute up to one year of the required related paid or non-paid experience in mental health services provision. Completion of an BA/BS degree in a related field may be used to substitute up to two years of the required related paid or non-paid experience in mental health service provision. County recommends four years of related paid or non-paid experience in mental health service provisions to perform assessment, rehabilitation, Intensive Home-Based Services (IHBS), and crisis intervention services.

#### Certified Peer Support Specialist

Peer Support Specialist services were implemented by DHCS on July 1, 2023. A Certified Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and shall meet ongoing education requirements. Peer Support Specialists may be supervised by a Medi-Cal Peer Support Specialist Supervisor; however, the services shall be under the direction of a Behavioral Health Professional.

Allowable services by provider type can be found here: [Coding Quick Guide by Discipline: Payment Reform Resources | Orange County California - Health Care Agency](#)

### THE ROLE OF THE PROVIDER IN THE BILLING PROCESS

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

- [Quality Assurance & Quality Improvement \(QA/QI\) Division](#) website,
- [SMHS Resource Library](#)
- [Annual Compliance Training](#), and
- [Electronic Health Record \(EHR\) Blog](#) (County employees only)

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

- [Clinical Records Review Team](#)
- [Technical Assistance and Training Support Team](#)
- [BHS IRIS Help Line](#), and,
- [Managed Care Support Team](#).

The current assessment process requires the evaluation of seven domains and the utilization of any assessment tools by the Mental Health Professional (MHP), such as the Child and Adolescent Needs

and Strengths (CANS) or the Pediatric Symptom Checklist-35 (PSC-35). The current Problem List requires International Classification of Diseases 10<sup>th</sup> revision (ICD-10) diagnoses and may also include Systematized Nomenclature of Medicine (SNOMED) codes along with Social Drivers of Health and is updated periodically to support the medical necessity for ongoing treatment. Care Plans for applicable services (such as TCM, Intensive Care Coordination (ICC), Medi-Cal Certified Peer Support Specialist, Therapeutic Behavioral Services (TBS) and Short-Term Residential Therapeutic Programs (STRTPs)) may be notated in a progress note or a dedicated care plan template. Payment Reform has introduced additional CPT codes and new rules related to direct patient care, place of service, time ranges, limits, telehealth and telephone services, lockouts, and overriding modifiers. As a result, the Electronic Health Records (EHR) system has undergone significant changes because of CalAIM and Payment Reform rules.

### WHAT IS MEDICAL NECESSITY AND ACCESS CRITERIA?

To qualify for SMHS, individuals shall meet access criteria as determined by a comprehensive assessment completed by a licensed, registered, waived, and/or under the direction of an LMHP. Services provided to a client of any age shall be medically necessary and clinically appropriate to address the client's presenting condition.

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

For **clients under 21 years of age**, a BHP shall provide all medically necessary SMHS to enrolled clients who meet either of the following criteria, (1) or (2) below:

The member has a condition placing them at high risk for mental health disorder due to experience of trauma evidenced by any of the following:

1. Scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

**OR**

2. The client meets both of the following requirements in a) and b), below:
  - a) The client has at least one of the following:
    - i. A significant impairment.

- ii. A reasonable probability of significant deterioration in an important area of life functioning.
- iii. A reasonable probability of not progressing developmentally as appropriate.
- iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

**AND**

b) The client's condition as described in subparagraph (2) above is due to one of the following:

- i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD).
- ii. A suspected mental health disorder that has not yet been diagnosed.
- i. A significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

A list of DHCS-approved youth trauma screening tools can be found in BHIN 26-002 Enclosure 1

For **clients 21 years of age or older**, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. The provider should note that the access criteria for medical necessity changes as the client turns 21 years of age.

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

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

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

**AND**

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

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

In seeking a ‘No Wrong Door’ approach that addresses client needs across the continuum of care, an

'included' DSM/ICD-10 mental health diagnosis is no longer mandatory for accessing SMHS. Access criteria for clients under 21 years of age now include those at "high risk for a mental health disorder due to the experience of trauma" as evidenced by a state-approved trauma screening tool, child welfare or juvenile justice involvement, and/or homelessness. However, in cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, CMS approved ICD-10 diagnoses for "Other specified" and "Unspecified" disorders or Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out." This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, shall still include a CMS-approved ICD-10 diagnosis code.

### **Expanded Coverage of Services: Expectations and Reimbursement**

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

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

These types of claims will no longer result in disallowances. This means all services provided prior to the determination of a diagnosis, during the assessment, or prior to the determination of whether Non-Specialty Mental Health Services or SMHS access criteria are met or covered and billable/reimbursable, even if the assessment ultimately indicates the client does not meet access criteria for SMHS.

### **Access Points**

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

1. OC Links (855) 625-4657: Provides 24/7 information and linkage to any of the OC Health Care Agency's Behavioral Health Services programs ranging from prevention to crisis response via phone/chat.
2. 24/7 Access Line (800) 723-8641, also known as the Administrative Services Organization (ASO): Members call to access referral to SMHS or SUD services.
3. County-Operated Children and Youth Services (CYS) and Adult and Older Adult (AOA) Outpatient Clinics

## SCREENING AND TRANSITION TOOLS

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

### Screening Tool

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

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

### Screening Tool by Age Group

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

## Transition of Care Tool

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

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

## ASSESSMENT AND REASSESSMENT

### 7-Domain Assessment

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

Domain 1: Presenting problem(s), current mental status, history of presenting problem (s), member-identified impairment(s)

Domain 2: Trauma

Domain 3: Behavioral health history, co-occurring substance use

Domain 4: Medical history, current medications, co-occurring conditions (other than substance use)

Domain 5: Social and life circumstances, culture/religion/spirituality

Domain 6: Strengths, risk behaviors, and protective factors

Domain 7: Clinical summary and recommendations, diagnostic impression, medical necessity determination/level of care/access criteria

During the initial assessment and reassessments, the providers at the BHP County clinics are to complete the BH Assessment form which contains the required seven domains and the Diagnosis/Problem List. According to Orange County's BHP, an initial assessment should be

completed as expeditiously as possible, in accordance with each client's clinical needs and generally accepted standards of practice. Reassessments are to be completed based on clinical discretion. Certain programs may have earlier timeline requirements based on the program's needs (i.e., crisis programs and short-term programs). If your program has these earlier requirements, please include your timelines in writing in your policies and procedures. It is expected that reassessments will include progress towards treatment and objectives on the last plan, significant changes and achievements since the last assessment, and newly identified impairments, symptoms, and/or Social Drivers of Health.

### **Department of Health Care Services Assessment Tools**

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

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

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

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

#### Collaboration and IRIS Entry

The CANS assessment is required to be administered to clients aged 0–21, including at the initial assessment, every six months, and at discharge. When completing the CANS with a client, clinicians are encouraged to utilize the Child Family Team (CFT) or Intensive Services (IS) Treatment Team process as an opportunity to gather information, including the client, their parents, family members, Social Services Agency (SSA), probation, Wellness Recovery Action

Plan (WRAP) providers, and other important individuals in the client's life. Together, this team can develop a plan that considers the many needs and strengths presented, as well as the points of view provided by CFT or IS team members

In county-operated programs, the CANS is entered into IRIS by the Plan Coordinator, while in contract programs, front office support staff enter the CANS data into IRIS on behalf of the clinician.

#### Implementing the CANS Assessment Tool

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

#### Pediatric Symptom Checklist (PSC-35)

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

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

#### Data Entry of CANS and PSC-35

QMS has streamlined data entry workflows and developed tools and reports to assist the provider

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

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

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

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

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

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

## THE PROBLEM LIST AND DIAGNOSIS

### Problem List

The provider(s) responsible for the client's care shall create and maintain the Problem List. The Problem List may include symptoms, conditions, diagnoses, social drivers, or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The Problem List should be updated as clinically appropriate to reflect the client's current presentation. The Problem List should include, but is not limited to, the following:

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

Include the name and title (or credentials) of the provider who identified, added, or resolved the diagnosis/problem, along with the date the problem was identified, added, or resolved. A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the provider (within their scope of practice) during that service encounter and subsequently add it to the problem list. The Problem List should be updated as clinically appropriate on an ongoing basis, to reflect the current presentation of the client as the Problem List informs treatment.

### Diagnosis

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

### Social Drivers of Health (SDOH)

The CalAIM initiative highlights the importance of addressing clients' Social Drivers of Health (SDOH). SDOH-related z codes ranging from Z55-Z65 are the ICD-10 diagnosis codes used to document SDOH. SDOH are conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. By addressing an individual's SDOH, we can provide interventions that may reduce health disparities and inequities. This, in turn, will reduce the risk factors that negatively impact their mental

health and overall functioning.

### SNOMED CT Browser

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

## THE CARE PLAN

### Care Plan Guidance

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS nor for DMC and DMC-ODS services. Care planning is now an ongoing, interactive component of service delivery rather than a one-time event. For programs, services, and facility types for where federal or state law continues to require care plans, ensure compliance. Specific care planning activities include:

- Behavioral Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)
- Certified Peer Support Services
- Children's Crisis Residential Programs (CCRP)
- Community Treatment Facilities (CTF)
- DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated Alcohol and Other Drug Treatment Facilities
- Enhanced Care Management (ECM)
- Intensive Care Coordination (ICC)
- Mental Health Rehabilitation Centers (MHRC)
- Psychiatric Health Facility (PHF)
- Short Term Residential Therapeutic Programs (STRTPs)
- Social Rehabilitation Programs – includes programs certified by DHCS for:
  - Short-Term Crisis Residential Treatment
  - Transitional Residential Treatment
  - Long-Term Residential Treatment
- Targeted Case Management (TCM)
- Therapeutic Behavioral Services (TBS)

#### **Targeted Case Management (TCM)**

TCM within SMHS requires the development and periodic revision of a specific care plan that is based on the information collected through the assessment. The TCM Care Plan shall include specific goals, treatment, service activities, and assistance to address the objectives of the plan plus the medical, social, educational, and other services needed by the client

- Activities such as ensuring the active participation of the client and working with the client (or authorized health care decisionmaker) and others to develop goals
- A course of action to respond to the assessed needs of the client
- Development of a transition plan when the client has achieved the goals of the care plan

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

#### **Certified Peer Support Services Plan of Care**

Peer support services shall be based on an approved plan of care that includes specific individualized goals. The plan of care shall be documented within the client's clinical record. Medi-Cal Certified Peer Support Specialists shall provide services under the direction of a Behavioral Health Professional who is licensed, waived, or registered. All SMHS, including Medi-Cal Peer Support Services, shall be medically necessary and recommended by physicians or LMHPs acting within their scope of practice.

Medi-Cal Peer Support Services are limited to the following three service components. Services provided shall fit within at least one of those service components:

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

#### **Medicare and Medi-Medi Care Plans**

For Medicare and Medi-Medi clients, all SMHS are still required to be authorized on a care plan. BHP County Clinics are to continue to complete an Interim Care Plan (ICP) and the Legacy Care Plan (currently in EHR) for all Medicare and Medi-Medi clients until further notice is provided by QMS. The ICP and Legacy Care Plan require a signature from an LMHP directing services for the client. The care plan shall also include problem list items that will be addressed by the provider or treatment team, services to be provided, frequency and duration of those services. For Medi-Medi clients, a Targeted Case Management (TCM) Care Plan shall also be completed to align with CalAIM requirements.

## **TYPES OF SPECIALTY MENTAL HEALTH SERVICES**

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

- **Assessment:** a service activity designed to collect information and evaluate the status of a client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that client.
- **Therapy:** a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning to improve coping and adaptation and reduce functional impairments.
- **Rehabilitation:** recovery or resiliency focused service which addresses a mental health need. Service may include aiding in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client.
- **Group Therapy/Rehabilitation:** a service provided when multiple clients meet in a group setting for treatment.
- **Targeted Case Management:** referral and linkage service to connect clients to community resources. This includes identifying appropriate resources and assisting a client with a warm handoff to obtain ongoing support.
- **Plan Development:** a service to develop or update a client's course of treatment, documentation of the recommended course of treatment, and monitoring a client's treatment progress.
- **Crisis Intervention:** an unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. The goal of crisis intervention is to stabilize an immediate crisis. This service includes one or more of the following service components:
  - assessment
  - therapy
  - referral and linkages
- **Crisis Psychotherapy:** provided when a mental health professional is conducting a crisis evaluation and using psychotherapy techniques, can de-escalate a crisis and avert a psychiatric hospitalization.
- **Medication Support:** services include evaluation, prescribing, administering, dispensing, and monitoring psychiatric medications that are necessary to alleviate the suffering and symptoms of behavioral health conditions.
  - Medication services may also include medical education, counseling on the risks and benefits of medication, and monitoring medication side effects.
- **Certified Peer Support Specialist Services:** culturally appropriate individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and the identification of strengths. Services aim to prevent relapse, empower clients through strength-based coaching, support linkages, and to educate clients and their families about their conditions and the process of recovery.

### NON-BILLABLE SERVICES

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

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

### Review of Records

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

### Non-Billable Locations

Services provided at some sites are not billable. Lockouts can be found under the “Table” tab of the Provider Type Quick Guides.

Exceptions:

- Youth in Juvenile Hall, who have completed court activities and are only staying there until a living situation can be arranged.
- Service provided to individuals who are not institutionalized but are in jail/juvenile detention center/in holding.
- Behavioral Health Links provided to Justice Involved (JI) Medi-Cal members.
- Targeted Case Management and Peer Support Services are not locked out against inpatient

psychiatric hospitalizations, residential, crisis residential, or psychiatric health facilities.

- Day, 24-hour, inpatient and outpatient services are locked out against each other except for the day of admission apart from case management services.
- Outpatient services are not locked out against therapeutic foster care.

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

### Time

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

### Travel and Transportation Time

Per CalAIM Payment Reform, travel time is NOT a billable service. The time a provider spends in the car with the client, during which no billable service is provided, is considered transportation.

Transportation is NOT a billable service. The only exception is when a mobile crisis team transports a client to an appropriate level of care or treatment setting. The time a provider spends in the car with a client while also providing a billable service is considered billable service time.

### Direct Patient Care

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

### PROGRESS NOTE DOCUMENTATION

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

### **Required Progress Note Elements**

Progress Notes shall include the following required elements:

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

### **Documentation Standards**

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

### **Signatures**

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

## Electronic Signatures

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

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

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

## 5150/5585 CERTIFICATION

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

## TELEHEALTH SERVICES

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

provider is able to see the client through an audio-visual platform.

Each progress note should indicate:

- That the service was provided through telehealth
- That the service is medically necessary and clinically appropriate telehealth delivery
- That the client was located in California and the provider verified the client's location

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

### **IMPORTANT CONSIDERATIONS REGARDING TELEHEALTH SERVICES**

All clients receiving services, whether new or existing, shall be provided with the [combined] Informed Consent for Services and Telehealth Consent form. Additionally, for those determined appropriate for and able to engage in telehealth services, the Telehealth Email Acknowledgment form should be completed. The forms will need to be reviewed with each client, and their consent should be obtained and documented in a progress note.

Important reminders regarding telehealth include:

- Ensure services are within the provider's scope of practice
- Observe geographic limitations (do not provide telehealth to clients outside California)
- Maintain privacy considerations
- Inform members of their right to access covered services in person

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

### **MINOR CONSENT FOR MENTAL HEALTH TREATMENT**

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

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

attending professional person

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

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

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

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

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

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

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

## **ADDITIONAL STATE REQUIREMENTS**

### **Pathways to Well-Being and Intensive Services**

- DHCS released BH Info Notice 21-058, which outlines expectations for Pathways to Well-Being (PWB) and Intensive Services (IS).
- Expanded eligibility for ICC/IHBS or Therapeutic Foster Care (TFC) services for PWB subclass member and those that meet medical necessity for Intensive Services is an important reminder in our practice.
- Qualified healthcare professionals with clinical expertise shall make the decision to authorize or deny services based on medical necessity and shall clearly document the decision.
- Providers of ICC/IHBS services shall submit the correct HCPCS codes with the HK modifier.
- Ensure timely access for routine referrals within 10 days and urgent referrals within 48 hours.
- No authorization is needed for ICC services, but IHBS/TFC services require authorization.
- Clients shall be under 21 years of age to receive ICC and IHBS services.
- Additionally, the PWB/IS eligibility form shall be in the chart, and individuals shall meet medical

necessity criteria to be eligible for PWB/IS.

- Assessment codes can be used for any assessment service, if the assessment activity is not part of the CFT meeting.
- Lastly, there should be a reassessment every 90 days to evaluate the child's strengths and needs.
- ICC codes will be used for all ICC-related activities, including developing the ICC care plan and consultations.

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

- As a result of CalAIM changes, ICC and IHBS (if clinically indicated) can be provided upon completion of the 7-Domain Assessment to establish medical necessity.
- Both the ICC care plan and the PWB/IS eligibility form are completed, and the PWB/IS cohort is registered in IRIS.
- If the client is transferred to your program and has an open PWB/IS cohort registration in IRIS, the new program can provide ICC and/or IHBS if the previous clinic's/provider's assessment, ICC Care Plan, and IHBS authorization form have already authorized IHBS.
- Additionally, the ICC Care Plan shall be reviewed at least once annually.
- When the client turns 21 years of age, they are no longer eligible for ICC/IHBS and therefore would require a TCM CP progress note to continue with targeted case management.

## **CONTINUITY OF CARE**

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

A Medi-Cal client or client's authorized representative may make a direct request to the BHP for continuity of care verbally, in writing, or via telephone and shall not be required to submit an electronic or written request. To make a request without completing and submitting a form, a client may ask to speak with the Provider Representative, the Service Chief, or the Program Director at any Orange BHP County-operated or contracted clinic or call QMS. Clinic staff who receive a continuity of care request from a Medi-Cal client or client's representative may fill out the Continuity of Care

Request Form on behalf of the client and submit the form and other associated documentation (ATDs and treatment records) to QMS by emailing the appropriate address. A QMS representative will process the request and get back to the client in writing, no later than 30 days from the date QMS receives the request.

### CONTRACT MONITORING

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

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

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

### SPECIAL INCIDENT REPORT (SIR)

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

## DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

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

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

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

### INTRODUCTION

#### DMC-ODS Guidelines

The information and guidance that dictate SUD treatment within the DMC-ODS are delivered at various levels. Federal guidance comes from the Centers for Medicare and Medicaid Services (CMS), which is then interpreted by the California Department of Health Care Services (DHCS). DHCS staff and policy professionals interpret and distribute this information to all participating DMC-ODS California counties, including the HCA. This Provider Manual, along with other federal, state and local regulations including but not limited to the specific services to be provided, governs the delivery of SUD treatment services in Orange County. Regulations, information and guidance may be included in (but not limited to):

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

- Drug Medi-Cal Organized Delivery System Special Terms and Conditions
- Practice Guidelines (i.e., SUD Perinatal Practice Guidelines and Adolescent Substance Use Disorder Best Practices)
- Orange County's DMC-ODS Implementation Plan
- DHCS Behavioral Health Information Notices
- HCA SUDsies Monthly Newsletters
- HCA Quality Improvement (QI) Coordinators' Meeting
- Required trainings for SUD providers
- HCA's individualized contract with each DMC-ODS provider

### Contract Monitoring

Upon contracting with Orange County, SUD programs are assigned a Contract Monitor. The Contract Monitor is a generalist in all contract requirements for each specific program and a specialist in monitoring that program's services, policies and procedures, personnel files, and condition of facilities. As a program's primary liaison, the Contract Monitor's activities may include, but are not limited to:

- Hosting monthly monitoring meetings individualized to each program
- Reviewing compliance with all contractual requirements
- Conducting Annual Programmatic Monitoring Reviews
- Approving invoices for payment
- Collaborating and advocating for the program with other HCA divisions (i.e., Contract Services, QMS)

Programs are also assigned a Contract Administrator who specializes in the execution of the contract and fiscal oversight. The Contract Administrator can address issues related to budgets, rates, invoices, payments, and general boilerplate contract provisions.

### Monthly Data and Performance Outcomes Report (MDPOR)

This report is required to be completed monthly. The template is provided by the program's Contract Monitor. It shall be completed and sent to the program's assigned Contract Monitor by the 10<sup>th</sup> calendar day of each month. This form is used to track the program's specific contractual performance outcomes and contains data that may be reported to the County Board of Supervisors when it reviews the HCA contracts for approval. A program may need to complete more than one monthly report form if the program contains more than one type of service or level of care (LOC).

### Special Incident Report (SIR)

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

### Policies and Procedures

As providers within the Orange County network of care, each program contracted to provide DMC-ODS services shall have certain policies and procedures in place. Each program should consult their individualized contract and/or their program monitor to determine what policies and procedures are required for each facility and level of care. Orange County's Policies and Procedures can be found by visiting [BHS Policies and Procedures](#).

### TYPES OF SERVICES

#### American Society of Addiction Medicine (ASAM) Criteria

The ASAM Criteria is a set of guidelines that promote individualized treatment and care planning with the use of a holistic approach to SUD treatment by:

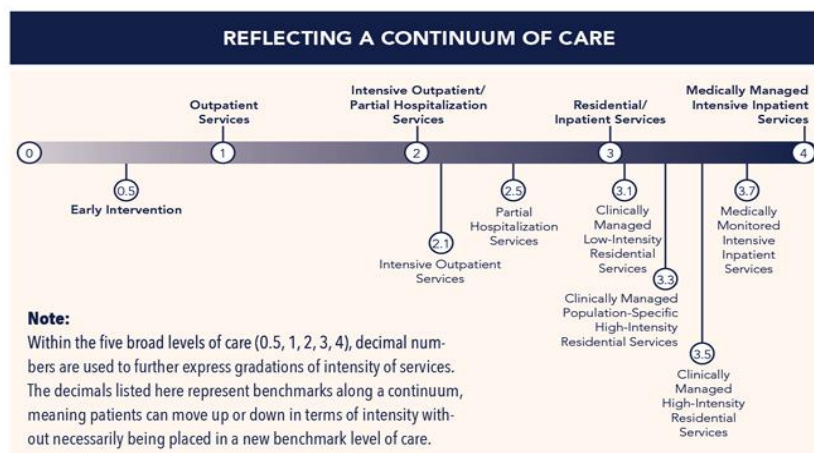
- Assisting service providers in making decisions regarding the medical necessity and clinical appropriateness of SUD services individualized for each member, ensuring a whole-person approach.
- Ensuring that the services provided meet the members' individualized treatment needs on an ongoing basis to improve the chances of sustainable recovery.
- Following a comprehensive set of standards for placement, continued service, and transitions of care for SUD treatment.
- Identifying areas that may require coordination of care for members with SUD, including members with physical/medical issues, co-occurring mental health disorders, and/or Social Determinants of Health (SDOH) that can impact treatment outcomes.
- Providing outcome-oriented and results-based care in SUD treatment.

### The ASAM Criteria's Continuum of Care

The ASAM Criteria defines standards for the different levels of care (LOCs) across a continuum of care. The standards outlined in the guidelines describe the setting, staffing, service intensity, and other core elements required and/or recommended at each LOC.

The model requires consistent and ongoing reassessment of each member to ensure they can transition to another LOC (higher or lower intensity) or discharge/complete treatment based on their own individualized progress.

The ASAM Continuum of Care (3<sup>rd</sup> Edition) is reflected below:



***\*\*Note:*** DMC counties, DMC-ODS plans, and providers may continue to utilize ASAM assessment tools that are currently in use, (i.e., free ASAM Criteria® Assessment Interview Guide, ASAM CONTINUUM software), until forthcoming DHCS guidance is released and updated tools utilizing the ASAM Criteria 4th Edition are available and can be implemented statewide.

The Continuum of Care is designed to assist providers in identifying and addressing each member's individualized needs for SUD treatment and other issues that may influence treatment outcomes, ensuring appropriate and effective support at every stage of recovery.

For SUD, the ASAM's six (6) dimensions provide ample information to determine the LOC that most likely will assist the client to reduce use, prevent further escalation of use, and/or prevent return to use. For adults, a service may be considered medically necessary when it is reasonable and necessary to protect life. Each of these dimensions is explored with the client and then given a severity rating. The severity ratings are then evaluated and, when looked at all together, assist providers in determining the appropriate LOC and treatment needs for each individual seeking SUD treatment. The

six (6) dimensions include information in the following areas:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions or Complications

4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery and Living Environment



## The ASAM 4<sup>th</sup> Edition

Although the ASAM 4<sup>th</sup> Edition has already been released, Orange County is still waiting for guidance from DHCS on the roll-out and implementation plan. The dimensions were updated to simplify the language and to align with the updated dimensional admission criteria framework. As new guidance comes through from the State regarding these upcoming changes, Orange County's HCA will provide updates on how providers will be impacted. For more information, refer to [ASAM - American Society of Addiction Medicine](#).

## **DMC-ODS LEVELS OF CARE (LOCs)**

The County of Orange offers members a full range of SUD treatment services along the Continuum of Care. The County Plan requires treatment decisions to be based on the ASAM criteria. The following is a list of the LOCs within the OC HCA network of care:

- LOC 1.0: Outpatient Drug Free (ODF)
- LOC 2.1: Intensive Outpatient Treatment (IOT)
- LOC 3.1, 3.3, 3.5: Residential Treatment Services

- LOC 3.2: Withdrawal Management
- Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP)

NOTE: *Partial Hospitalization (LOC 3.7) is not currently offered in Orange County within the DMC-ODS network.*

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

These additional services include:

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

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

### **DMC-ODS Covered Services**

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

- Assessment
- Care Coordination
- Clinical Consultation
- Family Therapy
- Counseling (Individual and Group)
- Medical Psychotherapy
- Medication Services
- MAT for Opioid Use Disorder (OUD), Alcohol Use Disorder (AUD), and non-Opioid SUDs
- Patient Education
- Peer Support Services
- Perinatal Services
- Recovery Services
- Narcotic Treatment Programs
- SUD Crisis Intervention Services

- Recovery Incentives Programs

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

### **Non-DMC-ODS SUD Recovery Residences**

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

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

## **DMC-ODS LEVELS OF CARE**

### **Outpatient Drug-Free (ODF) Services – LOC 1.0**

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

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

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

#### Services that May be Provided at ODF - LOC 1.0

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

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

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

### **Intensive Outpatient Treatment (IOT) - LOC 2.1**

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

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

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

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

### Services that May be Provided at IOT - LOC 2.1

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

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

### **Residential Treatment Services – LOC 3.1, 3.3 and 3.5**

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

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

Residential levels of care will change when the State releases guidance on how to implement changes in the ASAM 4<sup>th</sup> Edition. For more information on the ASAM 4<sup>th</sup> edition, please refer to the [ASAM - American Society of Addiction Medicine](#) website.

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

- To receive the Residential Day Rate, a Residential provider shall provide at least one of the daily bundled service components, which *include the following activities*:
  - Assessment
  - Individual Counseling
  - Group Counseling
  - Family Therapy
  - SUD Crisis Intervention
  - Medication Services
  - Patient Education
- *Separate billing* apart from the Residential Day Rate include:
  - Care coordination
  - Recovery services

- MAT for OUD
- MAT for AUD and non-Opioid SUDs

### Clinically Managed Low Intensity Residential Services - LOC 3.1

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

### Clinically Managed Population Specific High Intensity Residential Services - LOC 3.3

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

### Clinically Managed High Intensity Residential Services - LOC 3.5

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

in a 24-hour treatment setting. LOC 3.5 provides 24-hour care with trained counselors to stabilize imminent danger and is intended to prepare the client for Outpatient treatment.

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

### **Withdrawal Management (WM) - LOC 3.2**

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

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

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

#### Services that May be Provided at WM – LOC 3.2

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

To receive the Withdrawal Management day rate, a Withdrawal Management provider shall provide at least one of the daily bundled service components (including on the date of discharge), which *include the following activities*:

- Assessment
- Individual Counseling

- Group Counseling
- Family Therapy
- Patient Education
- SUD Crisis Intervention

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

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

### **Narcotic Treatment Program (NTP)**

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

Medications that may be provided at an NTP include:

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

In addition to these medications, NTPs shall offer clients a minimum of 45 minutes of counseling services per calendar month. Additional counseling can be provided when deemed medically necessary. Medical necessity for additional services shall be documented in the client's records. At any time after admission, the Medical Director may adjust or waive by medical order the minimum number of minutes of counseling services per calendar month. If counseling is adjusted or waived, the Medical Director should document the rationale for the medical order in the client's treatment plan.

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

### Services that May be Provided at NTP

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

Dosing services include the following activities in the bundled rate (not separately billable):

- Physical Exam
- Drug Screening
- Intake Assessment
- Medical Director Supervision
- TB, Syphilis, HIV, and Hepatitis C Tests
- Dosing
- Ingredient Costs

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

## **ADDITIONAL DMC-ODS COVERED SERVICES**

### **Perinatal Services**

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

Perinatal services are for clients who are pregnant or postpartum (up to 12 months after the date a pregnancy has ended) regardless of enrollment in a perinatal-specific program. Through these

services, women may have access to additional services providing parent education, referral, transportation, childcare, and other services, as specified by the DHCS' SUD Perinatal Practice Guidelines. Programs who choose to offer perinatal services shall abide by the SUD Perinatal Practice Guidelines, which can be viewed on the County of Orange Practice Guidelines website, [SUD Perinatal Practice Guidelines](#). To claim a service using the Perinatal billing codes the service shall be provided in a perinatal-designated facility, *and* there shall be medical documentation on file to support the client's pregnancy or post-partum status (for example, verification of pregnancy from a medical professional working within their scope of practice, or a birth certificate for postpartum services). Perinatal services can be billed for up to 12 months postpartum.

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

### **Recovery Services (RS)**

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

#### Services that May be Provided at Recovery Services

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

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

### Peer Support Services

Peer Support Services are culturally competent services that:

- Promote recovery, resilience, and self-advocacy
- Aim to prevent relapse through strength-based coaching
- Support linkages to community resources
- Educate clients and their families about SUD conditions and the process of recovery.

Peer Support Services are offered through structured activities in a group and in individual coaching settings to set recovery goals and to identify steps in how to reach the goals. Peer Support Services are provided to adults and adolescents 12 years and older in Orange County as a standalone service or provided with other DMC-ODS services or levels of care. If clients are receiving other DMC-ODS services, Peer Support Specialists in this program will collaborate with the client's primary counselor and become a part of the treatment team to support the client in meeting their treatment goals. Most services will be provided in the community where clients are located.

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

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

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

#### Service Components of Peer Support Services

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

- *Educational Skill Building Groups* occur in a supportive environment where the clients and their families learn coping mechanisms and problem-solving skills.
- *Engagement* is when a Peer Support Specialist leads activities and coaches the client to encourage and support the client in their participation with behavioral health treatment.

- *Therapeutic Activity* is a structured, non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support recovery within their communities.

Please refer to BHIN 25-010, Orange County's HCA BH Integrated Intergovernmental Agreement, BHIN-21-075 and BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services, Enclosure 1A, for further information.

### **Medication Services**

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

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

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

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

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

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

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

- Assessment
- Care Coordination
- Counseling (Individual and Group)
- Family Therapy
- Medication Services
- Patient Education (addiction, treatment, recovery)
- Recovery Services
- SUD Crisis Intervention
- Withdrawal Management

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

### **MAT Requirements for All Levels of Care**

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

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

### **Recovery Incentives (RI) Program**

California offers the Recovery Incentives (RI) program which includes Contingency Management (CM) benefits to clients. The RI Program reinforces a client's positive behavior change when the client is meeting their treatment goals (i.e., abstinence from stimulants). This program is an evidence-based treatment for SUD clients with a stimulant use disorder (StimUD). The presence of additional Substance Use Disorders and/or diagnoses does not disqualify a client from receiving RI services. The RI Program is a structured, 24-week Outpatient service, followed by six or more months of

additional treatment and recovery support without incentives. The initial 12 weeks of the RI program consist of a series of incentives, such as cash-equivalents (e.g., gift cards), provided to the client when they test negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). Each test shall be verified by a Urine Drug Test (UDT).

RI Services are *only* provided at the Outpatient LOC. Clients at the Residential LOCs are not eligible for the RI Program until the day of discharge if, or when they are transitioned to an Outpatient LOC. RI Services are covered when medically necessary and clinically appropriate as determined by an Initial SUD Assessment showing:

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

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

### Adolescent SUD Treatment Services

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

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

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

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

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

### ACCESS POINTS INCLUDING SUD TREATMENT FOR PEOPLE WITH DISABILITIES

#### Access Points

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

1. 24/7 Access Line (800) 723-8641

The 24/7 Access Line is available 24 hours a day, 365-days-a-year service available to respond to calls regarding access to services. The 24/7 Access Line is staffed by registered or certified counselors and LPHAs. The purpose of this service is to link members to SUD services and make referrals, as appropriate.

Please refer to OC Navigator and BHIN 24-001 DMC-ODS Requirements for the Period of 2022-2026 for more information.

2. County-Operated and Contracted Outpatient Clinics

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

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

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

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

#### Access to SUD Treatment for Persons with Disabilities (PWD)

As a network, Orange County's HCA is required to provide proper access to SUD services to persons with disabilities (PWD). While not all providers are required to have full accessibility, OC HCA shall ensure that proper access exists within Orange County's DMC-ODS network. Annual assessment of

our DMC-ODS network and its accessibility to PWD will be conducted to ensure appropriate services are accessible within our network. If a program does not have the appropriate services to accommodate onsite, the program should link the client to a program who can provide the appropriate services.

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

### Access Timelines

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

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

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

## 42 CFR PART 2: SUBSTANCE USE DISORDER CONFIDENTIALITY REGULATIONS

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

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

Protections under 42 CFR Part 2 begin the moment a member:

- Applies for or requests SUD treatment
- Obtains a SUD referral
- Receives a SUD diagnosis or SUD treatment.

Protections include initial contact via voicemail, phone calls, registration forms, or Access Log entries. For individuals in a program covered by 42 CFR Part 2, the confidentiality protections last indefinitely, even after death (Privacy Protections for Deceased Clients from Focus PHI).

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

- *“This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”*
- *“42 CFR Part 2 prohibits unauthorized disclosure of these records.”*

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

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

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

On February 8, 2024, the U.S. Department of Health and Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR Part 2, to align certain aspects of Part 2 with HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). effective February 16, 2026. Updates include:

- Allowing a single consent for all future uses and disclosures for treatment, payment, and healthcare operations
- Allowing HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations
- Permitting disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule
- Restricting the use of records in testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order
- Providing new rights for patients under Part 2 to obtain an accounting of disclosures and to request restrictions on certain disclosures
- Aligning Part 2 Patient Notice requirements with the requirements of the HIPAA Notice of Privacy Practices

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

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

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

### AUTHORIZATION TO USE AND DISCLOSE DMC-ODS PHI

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

DMC-ODS programs utilize two Authorization to Disclose Protected Health Information (ATD) forms: the DMC-ODS ATD and the Orange County HCA ATD. The HCA ATD is an authorization form used by a specific program that allows the disclosure of PHI as specified by the client. However, due to stricter requirements under 42 CFR Part 2, a one-time DMC-ODS ATD form is used to facilitate the exchange of PHI between County and Contracted providers during the initial referral process.

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

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

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

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

### Electronic Signatures

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

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

If Adobe PDF signatures are used:

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

## ACCURATE BILLING FOR SERVICES RENDERED TO DMC-ODS MEMBERS

### Responsibility and Expectations for Accuracy

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

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

For more information on trainings, please see the “Required Training” section in this Provider Manual or for resources, please visit the [DMC-ODS For Providers website](#).

### Who Can Bill?

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

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

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

### Licensed Practitioner of the Healing Arts (LPHA):

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

This category includes Physicians (Medical Doctor/Doctor of Osteopathy), Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT), Licensed Vocational Nurses (LVN), Licensed Occupational Therapists (LOT), and Licensed Psychiatric Technicians (LPT). Medical Students in Clerkship, registered individuals and Clinical Trainees shall be working under licensed supervision.

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

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

### Non-LPHAs (Certified or Registered AOD Counselors):

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

### Medical Assistants (MAs):

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

### Certified Peer Support Specialists (CPSSs):

Shall complete the required curriculum and training as well as pass the Medi-Cal Peer Support Specialist certification examination. CPSSs shall be supervised by an individual who has completed a DHCS-approved Peer Support Supervisory training.

### Other Qualified Providers (OQPs):

Eligible to provide a limited number of activities and shall be properly supervised.

### **Scope of Practice Requirements**

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

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

Note the DMC-ODS Scope of Practice Grid below. [Click here](#) or the picture below for a copy of the grid.

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

## Quality Management Services – Provider Manual

### DMC-ODS Scope of Practice Grid

|                                                                                                     | MD,<br>DO,<br>Medical<br>Clerk,<br>PA, NP | ASW,<br>LCSW,<br>AMFT,<br>LMFT,<br>APCC,<br>LPCC | AOD<br>Counselor<br>(registered or<br>certified) | Clinical<br>Trainee<br>enrolled in<br>Master's<br>program | Licensed<br>Psychologist | Doctorate<br>Psychology<br>Student | RN   | LVN,<br>LPT | MA*  | Certified<br>Peer<br>Support<br>Specialist<br>(CPSS) | Other<br>Qualified<br>Provider<br>(OQP) | Community<br>Health<br>Worker<br>(CHW) | Pharmacist | LOT  |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------|--------------------------|------------------------------------|------|-------------|------|------------------------------------------------------|-----------------------------------------|----------------------------------------|------------|------|
| Assessment<br>brief, ASAM                                                                           | Yes                                       | Yes                                              | Yes*                                             | Yes                                                       | Yes                      | Yes                                | Yes* | Yes*        | Yes* | Yes*                                                 | Yes*                                    | Yes*                                   | Yes*       | Yes* |
| SUD Diagnosis/LOC<br>determination                                                                  | Yes                                       | Yes                                              | No                                               | Yes                                                       | Yes                      | Yes                                | No   | No          | No   | No                                                   | No                                      | No                                     | No         | No   |
| Problem List/Care Plan<br>diagnoses added must<br>have been established<br>within scope of practice | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes  | Yes         | Yes  | Yes                                                  | Yes                                     | Yes                                    | Yes        | Yes  |
| Plan Development &<br>Modification                                                                  | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes* | Yes*        | No   | Yes*                                                 | No                                      | No                                     | No         | Yes* |
| Care Coordination                                                                                   | Yes                                       | Yes                                              | Yes**                                            | Yes                                                       | Yes                      | Yes                                | Yes  | Yes         | Yes  | Yes*                                                 | Yes                                     | Yes*                                   | Yes        | Yes  |
| Medication Services                                                                                 | Yes                                       | No                                               | No                                               | No                                                        | No                       | No                                 | Yes  | Yes         | Yes  | No                                                   | No                                      | No                                     | Yes        | No   |
| Brief Intervention<br>(individual)                                                                  | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes  | Yes         | No   | Yes                                                  | Yes                                     | No                                     | Yes        | Yes  |
| Counseling (individual,<br>group, family)                                                           | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes* | No          | No   | No                                                   | No                                      | No                                     | No         | Yes* |
| Family Therapy                                                                                      | Yes                                       | Yes                                              | No                                               | Yes                                                       | Yes                      | Yes                                | No   | No          | No   | No                                                   | No                                      | No                                     | No         | No   |
| Crisis Intervention                                                                                 | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes* | Yes*        | No   | No                                                   | No                                      | No                                     | No         | Yes* |
| Drug Testing                                                                                        | Yes                                       | No                                               | No                                               | No                                                        | No                       | No                                 | Yes  | Yes         | Yes  | No                                                   | No                                      | No                                     | Yes        | No   |
| Patient Education and<br>Skills Training                                                            | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | No                                 | Yes  | Yes         | Yes  | No                                                   | Yes                                     | Yes                                    | No         | Yes  |
| Recovery Services                                                                                   | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes*                     | Yes*                               | Yes* | Yes         | Yes* | No                                                   | Yes                                     | No                                     | Yes        | Yes* |
| Observations<br>ONLY with completion of<br>required specific detox<br>training prior to provision   | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes  | Yes         | Yes  | Yes                                                  | Yes                                     | Yes                                    | Yes        | Yes  |
| Peer Support Services                                                                               | No                                        | No                                               | No                                               | No                                                        | No                       | No                                 | No   | No          | No   | Yes                                                  | No                                      | No                                     | No         | No   |
| Recovery Incentives                                                                                 | Yes                                       | Yes                                              | Yes                                              | Yes                                                       | Yes                      | Yes                                | Yes  | Yes         | No   | Yes                                                  | Yes                                     | No                                     | Yes        | Yes  |
| Natural<br>Helper/Traditional<br>Health Care Practices                                              | No                                        | No                                               | No                                               | No                                                        | No                       | No                                 | No   | No          | No   | No                                                   | No                                      | No                                     | No         | No   |

\*Licensed professional must be physically present and on-site during provision of all services

^Specific to Peer Support Services Plan of Care

\*Within scope of practice – limited capacity for assessment/treatment planning/counseling/skills training/care coordination

\*\*Under supervision by a licensed professional

\*Limited capacity due to billing code restrictions

**DISCLAIMER:** This grid is intended to be used as a guide as it only broadly captures the activities or service types that can be performed by each provider type and should not be the sole source of reference for determining specifics on scope of practice and what is appropriate to bill. Providers are expected to have a thorough understanding of what is within their scope, according to their respective licensing board/bodies, prior to providing DMC-ODS services. Providers are responsible for adhering to all local, state, and federal regulations.

## Qualifications for DMC-ODS Individual Providers

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

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

## Required Initial Trainings

- **ASAM A and B:** Completion of ASAM A and B (or Module I and II) trainings are required for all staff, including Medical Directors (unless Board-certified with an addition subspecialty), before providing DMC-ODS billable services, including assessments. Proof of completion shall be submitted to the QMS MCST. Although ASAM C is not required, it is recommended.
- **SUD Evidence Based Practices:**

- Motivational Interviewing (mandatory at least once)
- One additional training in cognitive behavioral Therapy (CBT), Relapse Prevention, Trauma-Informed Treatment or Psychoeducation

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

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

### Other Required Trainings

- **California Outcomes Measurement System (CalOMS)**
  - Training required for staff entering CalOMS forms is given by QMS. County providers will receive the training from IRIS, while County-Contracted users receive the training by the Office Coordination Billing Team (OCBT).
  - Clinical CalOMS training is required for providers administering the CalOMS and is available online on the DMC-ODS For Providers webpage.
- **SUD Documentation Training** shall be completed *at least once, as required by the County contract* by reviewing the DMC-ODS CalAIM Documentation Manual (available on the DMC-ODS For Providers website) and attest to its completion. Attestations should be kept on file.. Providers are strongly encouraged to complete this training to ensure compliance with documentation and billing requirements. The expectation is that providers will understand the documentation and billing requirements to be able to deliver and bill for compliant services once they begin providing services to clients.
- **Cultural Competence Training** All providers shall receive at least one hour of Cultural Competence Training annually or as released.
- **Annual Compliance Training (ACT)** All providers are required to complete compliance training annually.
- **Annual Provider Training (APT)** The DMC-ODS provider staff shall take the Annual Provider training annually as released. The program shall maintain training records for the APT.
- **Behavioral Health Plan (BHP) Provider Manual** Before providing any services, all DMC-ODS provider staff shall review this Provider Manual and be familiar with the content.
- **Withdrawal Management (WM) Training** All personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements

set forth in BHIN 21-001 and its accompanying exhibits and any subsequently issued BHINs that supersede BHIN 21-001.

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

## ROLES AND RESPONSIBILITIES FOR SUD PROVIDERS

### Licensed Practitioner of the Healing Arts (LPHA)

The LPHA's role includes:

- Determining medical necessity and LOC
- Completing or reviewing assessments/re-assessments
- Completing the diagnosis and case formulation
- Maintaining the Problem List and treatment planning activities within their scope-of-practice
- Providing counseling services (Individual/Group)
- Providing family therapy or counseling
- Providing care coordination services
- Documenting and retaining documentation as appropriate for services provided
- Completing discharge services/planning.

### Non-LPHA (AOD Certified/Registered Staff)

Non-LPHA staff, such as AOD certified or registered counselors, may complete certain tasks (e.g., Assessments, Counseling, Care Coordination), but *cannot* diagnose conditions, determine medical necessity, or provide Family Therapy. Certified or registered AOD Counselors are permitted to perform aspects of care coordination activities, but a licensed provider is responsible for supervising this specific service component.

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

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

### Medical Assistants

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

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

### Support Staff

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

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

## PROPER DOCUMENTATION AND THE PERSONAL OBLIGATION OF EACH INDIVIDUAL

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

### Medical Necessity

Medical necessity is at the core of all treatment, documentation, and billing in the DMC-ODS. All DMC-ODS services claimed shall meet medical necessity. The definition of medical necessity is as follows:

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

For more information, access the “Medical Necessity” section of the [DMC-ODS CalAIM Documentation Manual](#).

### **Services During the Assessment Process (Outpatient)**

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

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

### **Residential Treatment Services**

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

### **Withdrawal Management (WM)**

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

### **Narcotic Treatment Program (NTP)**

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

For more information see the “Billing Prior to Assessment at Outpatient” section of the [DMC-ODS CalAIM Documentation Manual](#).

### Billing During the Assessment Process

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

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

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

### Access Criteria

For members to receive DMC-ODS services (at the Outpatients levels of care, this means to continue to receive services after a full assessment has been completed and a diagnosis is determined), they shall meet the access criteria. Similar to the definition of medical necessity, the access criteria differ between members 21 years of age and older and members under the age of 21, as follows:

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

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

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

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

For more information, see the “Access Criteria” section of the [DMC-ODS CalAIM Documentation Manual](#).

### ASAM-based Assessment

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

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

For more information, see the “Level of Care Determination” and “Initial Assessment” sections of the [DMC-ODS CalAIM Documentation Manual](#).

### Problem List

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

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

For Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) programs, the Treatment Plan requirement remains in place in accordance with the Minimum Quality Treatment Standards. However, just as it is for the Residential programs, a standalone Treatment Plan is not required. Treatment planning requirements shall be fulfilled as noted above. This will need to be completed within 10 days of the member's admission to treatment and treatment progress is to be reviewed every 30 days, according to licensing and certification standards.

### Problem List Requirements

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

### Problem List and Care Plan Timelines

The State does not offer a specific timeline for when the Problem List shall be completed, nor when or how frequently, it needs to be updated. The understanding is that the Problem List should accurately reflect the members' current presentation and needs. Therefore, at the ODF, IOT, Recovery Services, MAT, and WM programs, the Problem List should be developed as soon as clinically possible, in accordance with each member's clinical needs and generally accepted standards of practice. For the Residential programs, the Treatment Plan requirements established by the State's licensing and certification division requires that the documentation of the Treatment Plan elements is developed within 10 days of admission to treatment. NTPs are to continue to follow the requirements set forth in Title 9.

For more information, see the "Problem List" section of the [DMC-ODS CalAIM Documentation Manual](#).

### **Diagnosis**

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

### **Social Drivers of Health (SDOH)**

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

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

### **SNOMED CT Browser**

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

### **Physical Exam (PE) Requirement**

All members receiving SUD treatment shall have had a PE within the 12-month period before their admit date. If they have not had one, the program shall help the client to obtain a PE. If a PE has not been performed within the 12-month period prior to the admit date, the LPHA/non-LPHA can include this information on the member's Problem List, or if applicable, incorporate it into the documentation of Treatment Plan elements. The member should be provided with care coordination to support achievement of the completion of a PE.

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

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

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

### **Re-Assessments**

Across all levels of care, the SUD Re-Assessment form can be used in some helpful ways. The SUD Re-Assessment form may serve as an important tool for facilitating efficient transitions within and across programs. For example, in programs that offer multiple levels of care, a completed SUD Re-

Assessment to justify a member's discharge from one LOC may be used as the documentation required to establish medical necessity and appropriateness for the next LOC. Likewise, the SUD Re-Assessment can be used to transition the member to another provider in the network. This means that the SUD Re-Assessment can be used as the Initial Assessment for that new LOC if there is sufficient information to support the medical necessity for that LOC.

### Residential

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

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

### Outpatient

The SUD Re-Assessment form is not restricted for use solely in a Residential program. It can, of course, be completed at any point during the member's treatment at any LOC, whenever clinically appropriate. Specifically for the Outpatient levels of care, the Re-Assessment is only required if there is a change in the member's condition.

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

### **Progress Notes**

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

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

- The service provider's typed or printed name, credentials, signature, and date of signature

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

For all levels of care except for NTP/OTP, progress notes should be completed within three (3) business days of the service. For NTP/OTP programs, progress notes should be completed within 14 days. Crisis Intervention progress notes should be completed within one (1) calendar day. The date of the service counts as day zero (0). "Business" days are defined as Monday through Friday, excluding holidays observed by the State of California.

It is important for all providers to complete progress notes in a timely manner for a complete client record. Not only is this important for clinical integrity, but it is also a DHCS expectation that will be monitored during DMC Postservice PostPayment Utilization Reviews completed by DHCS. Clients have a right to access their records, and we shall respond appropriately to record requests, which can include current progress notes. For example, under the Privacy Rule, entities that shall abide by HIPAA should ensure that individuals have a right to access their health information within thirty (30) calendar days of the request. Another example is that, according to the Health and Safety Code, physicians shall provide patients with the requested records within fifteen (15) days of receipt of the request. There is also a five (5) day requirement to provide a client with review of their records in the office. If a provider is late with completing their progress notes, then the client will not have a complete record when the record is requested to be produced.

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

### Daily Note Requirement for Residential Programs

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

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

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

### **Direct Patient Care**

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

### Signatures

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

### Telehealth

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

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

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

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

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

For more information on the telehealth consent, please refer to the [BHS Combined Informed and Telehealth Consent](#).

### Telehealth Progress Note Documentation

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

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

For more information, see the "Progress Notes" section of the [DMC-ODS CalAIM Documentation Manual](#).

### **Medication for Addiction Treatment (MAT)**

#### MAT Requirements Under CalAIM

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

services or where your members could go to access these services, please consult with your supervisor for guidance.

### Referral to MAT

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

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

### **Recovery Services**

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

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

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

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

### Discharge

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

## REIMBURSEMENT RULES AND BILLING GUIDELINES

### Documentation/Service Time

Billing shall be based on exact minutes. Estimating the time spent on any service, whether billable or non-billable, is a violation of the HCA Code of Conduct and may be considered fraudulent.

#### Travel and Documentation Time

Under CalAIM, travel and documentation time is not billable. The State has given explicit guidance that reimbursable services need to be “direct patient care,” which “does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a client visit” (DHCS DMC-ODS Billing Manual, July 2025).

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

For more information, refer to the (DHCS DMC-ODS Billing Manual, July 2025).

#### Service Time

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

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

### Billable versus Non-Billable

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

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

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

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

### Payment Reform and Service Codes

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

#### Activity types for billing

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

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

### Potential Reasons for Disallowances

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

- Missing or invalid Assignment of Insurance Benefits / Authorization to Disclose (AOB/ATD)
- Services provided out of scope of practice of the rendering provider

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

The QMS SUD Clinical Records Review Team (CRRT) will conduct regular, internal reviews to monitor County and County-Contracted providers and ensure compliance with federal and State regulations and HCA Standards. When the QMS SUD Clinical Records Review Team identifies deficiencies during their reviews, they will instruct programs on how to either correct the item, if appropriate, or what services need to be repaid.

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

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

## DATA COLLECTED FROM ORANGE COUNTY'S PROVIDER NETWORK

### Access Logs and Timely Access Standards

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

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

### Access Timelines

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

### Access Log Reports and Error Monitoring

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

#### Common Access Logs Errors:

- No Access Log Entry
- Late Access Log Entry
- Data entry errors, such as incorrect dates, misspellings, etc.
- Duplicate entries
- Appointment scheduled outside the required timeframe without issuing an NOABD for Timely Access

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

### **Treatment Perception Surveys (TPS)**

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

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

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

### CalOMS Guidelines

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

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

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

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

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

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

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

There are Eight (8) CalOMS Discharge Status Options:

- Completed Treatment Plan Goals – Referred to another SUD provider, using a CalOMS Standard Discharge record
- Completed Treatment Plan Goals – Not Referred to another SUD provider, using a CalOMS Standard Discharge record
- Left Before Completion with Satisfactory Progress using a CalOMS Standard Discharge record
- Left Before Completion with Unsatisfactory Progress using a CalOMS Standard Discharge record

- Left Before Completion with Satisfactory Progress using a CalOMS Administrative Discharge record
- Left Before Completion with Unsatisfactory Progress using a CalOMS Administrative Discharge record, and then--
- Incarceration and Death – Both require using the CalOMS Administrative Discharge record

### CalOMS Reporting Requirements

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

The County offers training on CalOMS where we cover these and other topics. The County is expected to reliably and consistently complete all CalOMS data sets on time and correctly. The County's error rate is monitored by the State monthly, and unacceptable error rates result in deficiencies and the need to implement corrective action plans at a system level. The County will work to implement corrective actions locally for providers whose error rate is consistently above the permitted level by the State. Late submission of records to the State that exceeds the permitted late submission rate is considered a compliance problem and may lead to a process of progressive oversight by DHCS.

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

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

### Monitoring Compliance

Entering accurate and timely information into any CalOMS record is important to develop an accurate portrayal of SUD services provided to the community, comply with federal and State regulations, and adhere to Health Care Agency's expectations. To assist providers in

identifying trouble spots within their programs and to monitor their compliance with CalOMS requirements, the following reports are available in IRIS:

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

CalOMS training sessions are offered throughout the year. For additional information on CalOMS, please contact the QMS SUD Clinical Records Team ([bhpsudsupport@ochca.com](mailto:bhpsudsupport@ochca.com)) or the IRIS Support Team ([BHSIRISLiaison@ochca.com](mailto:BHSIRISLiaison@ochca.com)). An extensive CalOMS training is available for counseling and clinical staff online on the [“DMC-ODS For Providers” website](#).

For more information on CalOMS, please see the [CalOMS Clinical Training](#).

### **ASAM Level of Care (LOC) Requirements**

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

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

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

### **Drug and Alcohol Treatment Access Report (DATAR)**

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

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

For more information on DATAR, please refer to the [DATAR Web Manual 04-15-2014](#).

### ADDITIONAL STATE REQUIREMENTS

#### Continuity of Care

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

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

#### Minor Consent

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

#### Parental Involvement in Treatment

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

guardian and document whether the attempt was successful. If the provider decides not to contact them, the reason shall also be recorded.

### When Parental Consent is Required

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

### Minor Consent for NTPs

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

### Minor consent for Recovery Incentives (RI) Programs

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

### Payment Liability

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

#### *Application Process:*

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

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

# INPATIENT AND CRISIS AND ACUTE CARE (CAC) SUPPORT

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## OVERVIEW OF INPATIENT CAC SUPPORT

Inpatient & Crisis and Acute Care (CAC) Support oversees matters related to both inpatient and outpatient Lanterman Petris Short (LPS) designation and psychiatric hospitalizations. The team consists of licensed mental health clinicians, a licensed psychologist, registered nurses (RNs), and administrative support staff. The following are descriptions of each sub-unit under the overarching Inpatient and Designation Support Services (IDSS) umbrella:

## INPATIENT AND OUTPATIENT LPS DESIGNATION

The designation support team is responsible for overseeing all inpatient and outpatient LPS designations within Orange County. This includes both individual and facility designations. All applications for LPS designation field through this team to ensure that they meet the minimum requirements necessary to become designated. This team additionally provides all designation trainings and exams to adequately vet appropriateness of designating county, contracted, and community partners. Designation also provides guidance on implementation of changes to Welfare & Institutions Code (WIC) 5150/5585, and the LPS Act more generally, or any overarching legal guidelines related to LPS provided by the state or federal government.

## DESIGNATION UTILIZATION MANAGEMENT AND COMPLEX CARE COORDINATION (UMCCC)

The UMCCC team is responsible for fielding all requests for external services unavailable within the Behavioral Health Plan (BHP). Members whose needs transcend one area of focus or who present with severe symptoms that cannot be managed at levels of care provided within the system of care, can have their treatment requests submitted for specific services (e.g. eating disorder high levels of care, ECT, TMS), which the UMCCC team reviews and makes determinations on in concert with medical staff and the use of level of care assessment tools, like LOCUS.

## **TREATMENT AUTHORIZATION REQUEST (TAR)**

The TAR team reviews authorization requests for voluntary and involuntary psychiatric hospitalization stays of its members and adjudicates those requests before they are forwarded for final processing by the state or for payment by the county.

## **CONTRACTS**

The following three contracts are monitored and overseen by this team:

- A) Caredon Administrative Service Organization (ASO): Caredon operates the 24/7 Medi-Cal member Access Line, conducts concurrent review for inpatient psychiatric hospitalizations, and manages a network of providers who serve OC Medi-Cal members outside of the established network.
- B) Patients' Rights Advocacy Services (PRAS)
- C) Certification Review Hearing Officers

# MANAGED CARE SUPPORT TEAM (MCST)

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## OVERVIEW OF MCST

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

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

## ACCESS LOGS

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

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

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

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

| ACCESS TIMEFRAMES                                                                                                             |  |           |  |
|-------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| <u>SMHS</u>                                                                                                                   |  | <u>SUD DMC-ODS</u>                                                                           |  |
| <b>10 BUSINESS DAYS - ROUTINE</b><br>Outpatient Services                                                                      |  | <b>10 BUSINESS DAYS - ROUTINE</b><br>Outpatient & Residential Services                       |  |
| <b>48 HOURS – URGENT</b><br><small>CALENDAR DAY</small><br>Inpatient Hospital Discharge<br>Correctional Health Jail Discharge |  | <b>3 BUSINESS DAYS</b><br>Opioid Treatment Program (OTP)<br>Narcotic Treatment Program (NTP) |  |
| <b>4 HOURS - EMERGENT</b><br><small>CALENDAR DAY</small><br>Crisis Assessment/Evaluation                                      |  | <b>48 HOURS – URGENT</b><br><small>CALENDAR DAY</small><br>Withdraw Management/Detox         |  |

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

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

### Timely Access Standards for SMHS

| Service Type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Standard*                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| Outpatient Non-Urgent Non-Psychiatric SMHS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Offered an appointment within 10 business days of request for services.                                              |
| Psychiatric Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Offered an appointment within 15 business days of request for services.                                              |
| All Urgent SMHS Appointments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <u><b>Urgent Appointments**</b></u><br>48 hours without prior authorization.<br>96 hours with prior authorization.   |
| Non-urgent Follow-up Appointments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment. <sup>30</sup> |
| <p>*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section 1300.67.2.2(c)(5)(H).</p> <p>** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.<sup>31</sup></p> |                                                                                                                      |

### Timely Access Standards for DMC-ODS Services

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

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

### PROVIDER DIRECTORY

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

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



The BHP Online Provider Directory & Booklet:

[Provider Directory](#)

### CREDENTIALING/RECREREDENTIALING

#### Credentialing

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

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

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

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

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

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

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

As a result, all new providers:

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

# 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)



- New hires are required to refrain from delivering any Medi-Cal covered services if they are not credentialed and have not received a credentialing approval letter.
- The new hire shall **NOT** deliver any Medi-Cal covered services under their license, waiver, registration, and/or certification until they obtain a letter of approval confirming they have been credentialed by the MCST. This means the new provider shall **NOT** provide direct treatment or supportive services to a member on their own nor document any services, including non-billable services. The Electronic Health Records System Support Team (EHR SST) will not activate a new provider in the IRIS system without proof of the credentialing approval letter. It is the responsibility of the direct supervisor to review and submit the new provider credentialing packet to the MCST, timely.
- Failing to complete the credentialing requirement upon being hired is a compliance issue that will result in suspension or denial of privileges, recoupment, and possible disciplinary action by the employer.

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

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

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

For example, obtaining confirmation from the school the person attended to verify that the provider indeed attended the school and that it occurred when the provider claimed.

These primary source requirements shall be confirmed by directly contacting the source of the education or experience. Additionally, any gap in employment within the last five years will require an explanation.

### Attestation

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

#### ATTESTATION

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

**ATTESTATION**

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

### Recredentialing

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

medical record reviews.

# RE-CREDENTIALING

## REQUIRED DOCUMENTS FOR RE-CREDENTIALING

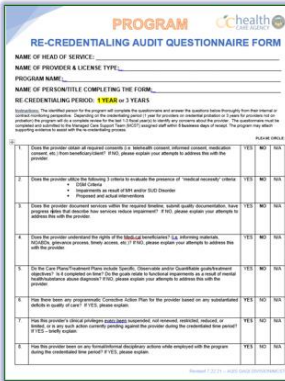
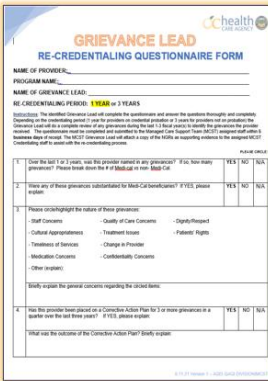
### DMC-ODS

- Annual Provider Training
- Cultural Competency Training
- 5 CEU/CME for Drug Addiction/Recovery (Doctors and Clinicians only)

### SMHS

- Annual Provider Training
- Cultural Competency Training






## Credentialing Verification Organization – RLDatix (aka VERGE)

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

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

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

## CALOPTIMA CREDENTIALING (COUNTY PTAN PROVIDERS ONLY)

OneCare and OneCare Connect are CalOptima's two Medicare health plans under the Certified Medicare Advantage Plans (CMAP), and the BHP has many members who have OneCare or OneCare Connect, with secondary Medi-Cal. OneCare and OneCare Connect are the only private insurance plans that the BHP is "in network" with since it is part of CalOptima. Since the BHP is "in-

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network” that means the providers need to be credentialed by CalOptima for the providers’ claims to be approved.

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

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

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

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

### **PAVE ENROLLMENT (SPECIALTY MENTAL HEALTH SERVICES PROVIDERS ONLY)**

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

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

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

### ✓ Speech Therapist

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

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

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



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

It is important to remember that the provider's reinstatement is not automatic.

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

### GRIEVANCES

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination or an appeal of a denial to expedite an authorization decision. Grievances may include, but are not limited to:

- The quality of care or services provided
- Aspects of interpersonal relationships (e.g., rudeness of a provider or employee)
- Failure to respect the member's rights, regardless of whether remedial action is requested.

When a member expresses dissatisfaction with the BHP, either in person or over the phone, regarding any matter related to the provision of Medi-Cal services, a grievance shall be filed.

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

As the grievance process serves as member protection under managed care, the County is required to address, track, resolve, and take action on all grievances. There are strict timelines about what shall occur when you receive a grievance. Whenever a plan representative hears or receives an expression of dissatisfaction from a member, it shall be treated as a grievance.



Consequently, programs should be prepared to provide members with a grievance form or assist them in completing the form if requested on behalf of the member or file the grievance on the member's behalf.

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

DHCS requires grievances to be resolved within 30 calendar days to be aligned with the Federal requirements for the Managed Care Plan. The MCST requires program's assistance to quickly respond to the Investigation Representative when requesting supporting evidence (e.g., chart, lab results, medication listing, etc.) and discussing the case to help conclude the grievance. Your cooperation is appreciated to help expedite information needed to resolve the member's grievance, timely.

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

### Discrimination Grievances

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



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

### Transgender, Gender Diverse, or Intersex (TGI) Grievances

Senate Bill (SB) 923 (Chapter 822; Statutes of 2022), known as the Transgender, Gender Diverse or Intersex Inclusive Care Act, added section 14197.09 to the W&I and mandated Department of Health Care Services (DHCS) to require all of its Behavioral Health Plans (BHPs), subcontractor, and downstream subcontractor staff who are in direct contact with members in the delivery of care or member services to complete



evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or TGI. Trans-inclusive health care means comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

#### What Does This Mean for the Grievance Process?

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

BHPs are also required to submit additional information, as specified by DHCS, that verifies the grievance data reported to DHCS on a quarterly basis when the outcomes of the grievance

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

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

### NOTICE OF ADVERSE BENEFICIARY DECISIONS (NOABD)

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

- Your Rights
- Language Assistance Taglines
- Notice of Non-Discrimination.

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

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

The different types of NOABDs providers would issue are:

- Delivery System
- Denial of Authorization for Requested Services
- Timely Access
- Termination
- Modification
- Authorization Delay
- Denial of Payment for a Service Rendered by a Provider (Inpatient only)

### **NOABD – Delivery System**

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

### **NOABD – Denial of Authorization for Requested Services**

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

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

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

### **NOABD – Timely Access**

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

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

The NOABD shall be hand-delivered or mailed within two business days after the decision.

Please consult with the MCST prior to issuing a NOABD Timely Access. The MCST needs to ensure that all resources within the BHP have been exhausted before a NOABD for timely access can be issued.

**NOABD – Termination**

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

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

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

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

**NOABD – Modification**

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

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

**NOABD – Authorization Delay**

The NOABD Authorization Delay should be issued when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential and

inpatient services. When the BHP extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the member or provider, and/or those granted when there is a need for additional information from the member or provider, when the extension is in the member's interest.

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

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

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

## **APPEALS**



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

### **30 Day Appeals**

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

### **Expedited Appeals**

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



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

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

questions regarding the appeal process.

## STATE FAIR HEARINGS

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



### Timeframes for Filing

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

### Method of Filing

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

### Types of Hearings:

#### Standard Hearing

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

#### Expedited Hearing

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

## Overtaken Decisions

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

## SUPERVISION REPORTING FORMS AND PROCESS



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

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

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

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

- Clinical Supervision Reporting Form
- Counselor Supervision Reporting Form
- Medical Supervision Reporting Form
- Qualified Provider Supervision Form

Be sure to review the below list to identify which type of supervision reporting form you will need to submit to the MCST:

**LIST OF PROVIDERS REQUIRED TO SUBMIT A SUPERVISION REPORTING FORM**

| CLINICIANS                                                                                                                                                                                                                                                                                                                                                                                                   | COUNSELORS                                                              | MEDICAL PROVIDERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | QUALIFIED PROVIDERS                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Registered ASW</li> <li>Registered MFT</li> <li>Registered PCC</li> <li>Registered/Waivered Psychologist</li> <li>Psychologist Clinical Trainee</li> <li>Clinical Social Worker Clinical Trainee</li> <li>Marriage &amp; Family Therapist Clinical Trainee</li> <li>Professional Counselor Clinical Trainee</li> <li>Associate Applicant – BBS 90 Day Rule</li> </ul> | <ul style="list-style-type: none"> <li>Registered Counselors</li> </ul> | <ul style="list-style-type: none"> <li>Nurse Practitioner</li> <li>Nurse Specialist Trainee</li> <li>Registered Nurse Trainee</li> <li>Vocational Nurse Trainee</li> <li>Psychiatric Technician Trainee</li> <li>Occupational Therapist Trainee</li> <li>Occupational Therapist Assistant</li> <li>Pharmacist Trainee</li> <li>Physician Assistant Trainee</li> <li>Physician Assistant</li> <li>Medical Assistant</li> <li>Licensed Vocational Nurse</li> <li>Licensed Practical Nurse</li> <li>Licensed Psychiatric Technician</li> <li>Certified Nurse Assistant</li> </ul> | <ul style="list-style-type: none"> <li>Mental Health Rehabilitation Specialist</li> <li>Other Qualified Provider</li> <li>Certified Peer Support Specialist</li> </ul> |

### Clinical Supervision Requirements in California

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

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

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

**Clinical Supervision Report Form**

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

Failure to submit the CSRF and be assigned to a Clinical Supervisor will result in the registered and waived providers being prohibited from delivering Medi-Cal covered services. Non-independently licensed or certified staff shall always be supervised as per their licensing board or certifying organization. Failure to comply will result in disallowed services.

Clinical Supervisors shall adhere to supervision requirements outlined by their professional boards.

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

**Board of Behavioral Science (BBS) 90-Day Rule**

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

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

**Counselor Supervision Reporting Form and Requirements**

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

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

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

### **Professional Licensing Waiver (PLW) Requirement**

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

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

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

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

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

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

### **Medical Supervision Reporting Form**

Certain medical professionals are required to submit a supervision form to their supervisor. Any updates to their supervision status require the submission of an updated form. Supervisors are responsible for ensuring adequate supervision and shall maintain current forms for each Supervisee. It is recommended that Supervisors maintain their files for audit purposes. Medical providers shall

follow their certifying organization or licensing board's supervision requirements. Medical providers should consult with their supervisors to ensure compliance and proper documentation submission to the MCST.

The following medical providers need to be under supervision:

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

### **Qualified Provider Reporting Form**

The California State Plan Amendment 22-023 approved by the Center for Medicaid Services on March 2nd, 2023, approved and defined the SMHS Other Qualified Provider (OQP) type to be: An individual at least 18 years of age with a high school diploma or equivalent degree plus two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient), or related secondary education. OQP is a State Plan provider category. OQP is not a job classification within the County system, and this provider type may be employed under various titles in different contract programs or county sites.

The following qualified providers need to be under supervision:

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

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

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

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

- **Certified Peer Support Specialist (CPSS)** is not an independent provider. The CPSS shall be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory Training within 60 days of beginning to supervise a Medi-Cal Peer Support Specialist. If the CPSS direct supervisor is not an LPHA/LMHP then the supervision form requires an LPHA/LMHP signature.
- **Enhanced Community Health Worker (EHCW)** is not an independent provider. The EHCW shall be supervised by a Medi-Cal enrolled provider. The supervisor shall determine if the EHCW’s lived experience aligns with the community being served and track, monitor and ensure this provider meets the certificate or work experience pathway requirements.

On the next page, is a grid for SMHS and DMC-ODS, to help identify what you may be classified under based on your work experience and education. If you have questions about determining which provider type best fits your program needs, contact the Clinical Records Support Team for assistance. [Click here](#) or the grid below for a larger copy.

## Other Qualified Providers (OQP) Matrix for SMHS

| BEHAVIORAL HEALTH PLAN PROVIDER TYPE                                                                                                                                                                                                   | Mental Health Rehabilitation Specialist (MHRS)                                                                                                                                                                                                                                                                                                                                                  | Other Qualified Provider (OQP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Certified Peer Support Specialist (CPSS)                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EDUCATION                                                                                                                                                                                                                              | BA/BS or AA (in a related field) +2 years post AA clinical experience                                                                                                                                                                                                                                                                                                                           | High School Diploma or GED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | High School Diploma or GED                                                                                                                                                                                                                                                                                                                                                                                                 |
| WORK EXPERIENCE                                                                                                                                                                                                                        | <p>Plus, four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.</p> <p>NOTE: Up to 2 years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.</p>                                                                                  | <p>Plus, two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient), or related secondary education.</p> <p>NOTE: (A) Completion of an AA degree in a related field may be used to substitute up to 1 year of the required related paid or non-paid experience in mental health services provision. (B) Completion of an BA/BS degree in a related field may be used to substitute up to 2 years of the required related paid or non-paid experience in mental health service provision.</p> | Certification from CalMHSA                                                                                                                                                                                                                                                                                                                                                                                                 |
| OTHER QUALIFICATIONS                                                                                                                                                                                                                   | Age 18+                                                                                                                                                                                                                                                                                                                                                                                         | Age 18+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Age 18+                                                                                                                                                                                                                                                                                                                                                                                                                    |
| SERVICES                                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>•Contribute to Assessment: Mental Health History, Medical History; Substance Use, Strengths, Risks, Barriers</li> <li>•Problem List/Care Plan</li> <li>•Rehabilitation</li> <li>•Targeted Case Management</li> <li>•Intensive Home-Based Services</li> <li>•Intensive Case Coordination</li> <li>•Mobile Crisis</li> <li>•Crisis Intervention</li> </ul> | <ul style="list-style-type: none"> <li>•Contribute to Assessment: Mental Health History, Medical History; Substance Use, Strengths, Risks, Barriers*</li> <li>•Rehabilitation*</li> <li>•Intensive Home-Based Services*</li> <li>•Problem List/Care Plan</li> <li>•Targeted Case Management</li> <li>•Intensive Case Coordination</li> </ul> <p>*These services are recommended for providers with four years of related paid or non-paid experience in mental health service provisions.</p>                                                                        | <ul style="list-style-type: none"> <li>•Problem List</li> <li>•Self-Help/Peer Services</li> <li>•Behavioral Health Prevention Education Services</li> <li>•Mobile Crisis</li> <li>•Peer Support Specialist Plan of Care</li> </ul>                                                                                                                                                                                         |
| <b>All Specialty Mental Health Services MUST be recommended by physicians or other LMHPs acting within their scope of practice and in accord with medical necessity.</b>                                                               |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                            |
| SUPERVISION REQUIREMENTS                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>•MHRS requires close supervision if issues of DTS or DTO are present.</li> <li>•If the MHRS direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.</li> </ul>                                                                                                                                        | <ul style="list-style-type: none"> <li>•OQP requires close supervision if issues of DTS or DTO are present.</li> <li>•If the OQP direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.</li> </ul>                                                                                                                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>•Medi-Cal Peer Support Specialists must be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory training within 60 days of beginning to supervise a Medi-Cal Peer Support Specialist.</li> <li>•If the Medi-Cal Peer Support direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.</li> </ul> |
| NOTE: If you have questions about determining which provider type best fits your program needs, contact at SMHSClinicalRecords@ochca.com. You may also reach out to request the SMHS Scope of Practice Matrix for additional guidance. |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Other Qualified Providers (OQP) Matrix for DMC-ODS                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                       | Other Qualified Provider (OQP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Certified Peer Support Specialist (CPSS)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>QUALIFICATIONS</b>                                                                                                                 | Age 18+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Age 18+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>EDUCATION</b>                                                                                                                      | High School Diploma or GED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | High School Diploma or GED                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>WORK EXPERIENCE</b>                                                                                                                | plus TWO (2) years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient), or related secondary education.                                                                                                                                                                                                                                                                                                                                 | Be self-identified as having experience with the process of recovery from SUD, either as a consumer of these services or as the parent/caregiver/family member of a consumer and be willing to share their experience<br><br>Completion of curriculum and training requirements for a Medi-Cal Peer Support Specialist and pass a Medi-Cal Peer Support Specialist certification examination provided by a DHCS-approved Certification Program.                                                  |
| <b>ALL DMC-ODS SERVICES MUST BE RECOMMENDED BY AN LPHA ACTING WITHIN THEIR SCOPE OF PRACTICE AND IN ACCORD WITH MEDICAL NECESSITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>SUPERVISION REQUIREMENTS</b>                                                                                                       | <ul style="list-style-type: none"> <li>OQPs require close supervision if issues of harm to self/others or imminent relapse are present.</li> <li>If the OQP's direct supervisor is NOT an LPHA, then the Other Qualified Provider Supervision Form requires an LPHA signature.</li> </ul>                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>CPSS must be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory training within 60 days of beginning to supervise a CPSS.</li> <li>If CPSS direct supervisor is NOT an LPHA, then the Qualified Provider Supervision Form requires an LPHA signature.</li> </ul>                                                                                                                                                       |
| <b>ALLOWABLE SERVICES</b>                                                                                                             | <ul style="list-style-type: none"> <li>Contribute to Assessment as reported by client (e.g., history of use, medical/mental health history, family history, education, vocation, living arrangements, etc.)</li> <li>Brief Individual Intervention</li> <li>Psychoeducation</li> <li>Skills Training &amp; Development</li> <li>Patient Education</li> <li>Care Coordination (with supervision by licensed provider)</li> <li>Recovery Services</li> <li>Observations (with appropriate training)</li> </ul> | <ul style="list-style-type: none"> <li>Contribute to Assessment, Problem list as reported by client (e.g., history of use, medical/mental health history, family history, education, vocation, living arrangements, etc.)</li> <li>Develop Plan of Care (specific to Peer Support Services)</li> <li>Brief Individual Intervention</li> <li>Individual Self-Help/Peer Services (including engagement, advocacy, resource navigation, etc.)</li> <li>Educational Skill Building Groups</li> </ul> |

**NOTE:** If you have questions about determining which provider type best fits your program needs, contact the SUD Support Team at [BHPSUDSupport@ochca.com](mailto:BHPSUDSupport@ochca.com)

## CHANGE OF PROVIDER AND 2<sup>ND</sup> OPINION

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

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

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



## CHANGE OF PROVIDER/2<sup>ND</sup> OPINION

### CHANGE OF PROVIDER

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

### 2<sup>ND</sup> OPINION

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

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

### PROVIDER TRANSACTION ACCESS NUMBER (PTAN)



A PTAN is a Medicare-only number issued to providers by Medicare Administrative Contractors (MACs) upon enrollment to Medicare. MACs issue an approval/notification letter, including PTAN information, when an enrollment is approved. A PTAN is essential for identifying Medicare service providers, ensuring compliance, and facilitating claims processing. It acts as a unique identifier assigned to healthcare providers by

Medicare. The MCST is required to PTAN all eligible Medicare providers in the SMHS and DMC-ODS Adult & Older Adult (AOA) County Clinics to be reimbursed for Medicare and Medi-Medi covered services.

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

### TRAININGS

New programs are required to schedule a full training to comply with the MCST oversight and DHCS requirements. It is recommended to have the Directors, Managers, Supervisors and Clinical Staff participate in the training to ensure those requirements are met and implemented. Contact the MCST administrators to schedule the training at least a month prior to delivering Medi-Cal covered services.



The MCST is also offering open training sessions for new and existing providers. The 3-hour training covers:

- NOABDs
- Grievances
- Appeals
- State Fair Hearings
- Second Opinion/Change of Provider
- Supervision Reporting
- Access Logs.

E-mail the MCST representative to send the invitation to attend the training via Microsoft Teams. Training takes place on the second Tuesdays of the Month @ 1 p.m. for SMHS and the fourth Tuesdays of the Month @ 1 p.m. for DMC-ODS.

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

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



## MCST E-MAIL ADDRESSES

| MCST MAILBOXES                               | OVERSEES                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>BHPGrievanceNOABD@ochca.com</u></b>    | Grievances & Investigations; Appeals/Expedited Appeals; State Fair Hearings; NOABDs; MCST Training Requests                                                                                                                                                                                                     |
| <b><u>BHPManagedCare@ochca.com</u></b>       | Access Logs, Access Log Entry Errors & Corrections; Change of Provider/2 <sup>nd</sup> Opinion; County Credentialing; Cal-Optima Credentialing (AOA County Clinics); Expired Licenses, Waivers, Registrations & Certifications; PAVE (SMHS Only); Personnel Action Notification (PAN)                           |
| <b><u>BHPProviderDirectory@ochca.com</u></b> | Provider Directory Notifications; Provider Directory submission for SMHS and DMC-ODS programs by the 15 <sup>th</sup> of every month.                                                                                                                                                                           |
| <b><u>BHPSupervisionForms@ochca.com</u></b>  | Submission of the Supervision Reporting Forms for Clinicians, Counselor, Medical Professionals and Qualified Providers; Submission of updated Supervision Forms for Change of Supervisor, Separation, License/Registration Change, Mental Health Professional Licensing Waivers for Psychology Candidates, etc. |
| <b><u>BHPPTAN@ochca.com</u></b>              | Provider Transaction Access Number (PTAN) enrollment and inquiries.                                                                                                                                                                                                                                             |



# INTEGRATED RECORDS INFORMATION SYSTEM (IRIS)

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

## FREQUENTLY USED TERMS (FOR COUNTY PROVIDERS)

**Citrix** Workspace is a secure digital platform that allows county employees to access county applications, desktops, and data from any device. Employees using Citrix Workspace should follow all security protocols, including multi-factor authentication and data protection policies, to safeguard county and client information. [Citrix Workspace](#)

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

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

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

## LOGIN AND SECURITY (FOR COUNTY PROVIDERS)

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

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

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

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

### Password Requirement & Security Policies:

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

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

## **EHR TRAINING (FOR COUNTY PROVIDERS)**

### **How soon do you get trained?**

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

### Pre-requisites for training

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

### EHR Blog/Website

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

- For AOA/CYS/CAC/Forensics Programs, [click here](#) for the website.
- For SUD Programs, [click here](#) for the website.

### The Role of Super User

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

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

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

## USER SUPPORT

### For County Users

- HCA Service Desk (IT) (*any issues with account lockouts/password resets, hardware, software, network issues*):  
714-834-3128 option 1  
[servicedesk@ochca.com](mailto:servicedesk@ochca.com)

- IRIS Support Team (EHR) (*any issues within Powerchart, i.e., error correction, SCHED lock out, chart lock out etc.*):  
(714) 347-0388 option 2  
[BHSIRISLiaison@ochca.com](mailto:BHSIRISLiaison@ochca.com) (*Please note: our team does not have VPN capabilities so in order to assist you we may ask you to share your screen with us via MS Teams.*)  
[BHPNetworkAdequacy@ochca.com](mailto:BHPNetworkAdequacy@ochca.com)  
[BHPPTAN@ochca.com](mailto:BHPPTAN@ochca.com)
- Office Coordination Team (Front Office) (*All front office functions i.e. REG, RCA*):  
(714) 834-6007 option 3  
[BHPBillingSupport@ochca.com](mailto:BHPBillingSupport@ochca.com)

### For Contract Users

*Please refer to your contract monitor for any questions.*

- HCA Service Desk (IT) (*any issues with account lockouts/password resets*)  
714-834-3128 option 1  
[servicedesk@ochca.com](mailto:servicedesk@ochca.com)
- IRIS Support Team (EHR) (*setting up a new provider in our system*)  
(714) 347-0388 option 2  
[BHSIRISLiaison@ochca.com](mailto:BHSIRISLiaison@ochca.com)
- Office Coordination Billing Team (*All front office functions i.e. REG, RCA*)  
(714) 834-6007 option 3  
[BHPBillingSupport@ochca.com](mailto:BHPBillingSupport@ochca.com)

### NEW USER ACCOUNT SET UP

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

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

**Step 2.** Complete the PAN form.

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

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

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

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

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

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

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

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

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

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

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

### STAFF REQUIREMENTS

Ensure the following are accurate at all times:

- Name on License and NPPES shall match.
- Middle initials are not allowed; please spell middle name out entirely.
- NPPES shall have the correct taxonomy code as the only and primary taxonomy code with CA as the issuing state.
  - If you need assistance with what taxonomy code you should have listed on NPPES, please ask your Service Chief or Program Administrator or check the provider position matrix located in the PAN form.
    - If you need assistance making changes to your taxonomy code on NPPES please reference the NPI quick guide located in the PAN form.
  - The only time an additional taxonomy code may be allowed is if the provider works at multiple locations serving in different capacities. IRIS would need to know where the provider is working and what type of services they are providing in another role.
- PAVE Application is completed- (licensed providers only)
  - SUD providers who aren't licensed will be included in the Program SCA PAVE.

### NAME AND CREDENTIAL CHANGES

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

**Step 2.** Ensure the following information is correct

- License/credential shall reflect new credential and/or name
- NPPES registry shall reflect new taxonomy code and/or name

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

New Clinical Supervision Reporting Form (CSRF).

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

PAVE application \* Medi-Cal billing Programs only

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

Credentialing Approval \* Medi-Cal billing Programs only

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

### STAFF TRANSFER

SC or Program Admin submit transfer PAN.

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

### STAFF TERMINATION

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

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

### CYS CONTRACT OUTPATIENT INTAKE APPOINTMENT SCHEDULES

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

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

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

1. PAN Form
2. NAR/Token Request Form

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

**Current Clinical Staff** that are already in IRIS as “provider only” or “Current Admin/QA Staff” submit the documents listed below to the Data Analytics Support Team at [bhsirisliaison@ochca.com](mailto:bhsirisliaison@ochca.com)

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

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

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

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

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

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

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

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

## BILLING

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The Billing Team is responsible for providing oversight and monitoring of Behavioral Health Contract Providers' billing to Short-Doyle Medi-Cal, including Specialty Mental Health and DMC-ODS. In addition, the team provides training and support to contract front office and billing staff on the use of IRIS applications, the revenue cycle, registration conversation, and related procedures.

The Billing Team ensures that all billing complies with federal and state regulations, as well as HIPAA guidelines. They also support HCA IT with IRIS updates and projects, and assist Programs, Program Support, the Office of Compliance, and other QMS units with IRIS-related issues.

### FOR THE OPENING OF A PROVIDER

1. The Billing Team will coordinate with the System Support Team and IT on billing code org assignment.
2. Once IT assigns billing codes to the new org in IRIS, the Billing Team will test all billing codes in IRIS Charge Entry for different provider types, rates, nightly ops jobs, etc.
3. The Billing Team will notify the System Support Team once all testing has passed.
4. The Program will complete a Personnel Action Notification (PAN) for all front office staff, billers, and administrative staff, and submit it to the System Support Team.
5. When a PAN is processed, the System Support Team will notify the Billing Team that the user has been added to IRIS.
6. The Billing Team will enroll users in all required training before IRIS access is granted.
7. Users will be granted IRIS access on the day initial training is completed.

### FOR THE RELOCATION OF A PROVIDER

1. If the program is moving and renaming, the Billing Team will ensure orgs are added to claim rules, nightly ops jobs, transmission jobs, etc.
2. The Billing Team will monitor any Pending Provider Certification holds where applicable and coordinate with the System Support Team to ensure timely release and compliance with filing deadlines.

### FOR THE CLOSURE OF A PROVIDER

In preparation for the closure of a location, the Program should:

1. Work all billing queues.
2. Resolve all pending claims.

3. The Billing Team will notify the Certification Team once all billing queues have been cleared.

## BILLING REGULATIONS AND REQUIREMENTS

Medi-Cal is California's Medicaid program, administered by the Department of Health Care Services (DHCS). Billing regulations are governed by both state and federal laws, and counties shall follow strict compliance protocols when submitting claims for reimbursement.

**General Billing Info:** Orange County adheres to state Medi-Cal guidelines, with a strong emphasis on verifying eligibility and maintaining proper documentation for behavioral health services.

- **Claim Timeliness-Original Claims (DMC/SMH)**

The timeline for initial submission of a Specialty Mental Health Medi-Cal claim is critical. Original claims shall be submitted within 12 months of the month of services (W&I Code, Section 14705 and 42 CFR Section 447.45(d)). An original claim submitted after 12 months from the month of service without a DHCS-approved Delay Reason Code (DRC) will be denied.

- **Replacing Approved and Denied Claims (DMC/SMH)**

Replacement claims are claims that correct previously submitted claims. An MHP may submit a claim to replace an approved or denied claim no later than 15 months after the month of service. SD/MC will deny a replacement claim submitted more than 15 months after the month of service.

## Third-Party Billing

It is the provider's responsibility to bill all third-party insurance outside of IRIS. Coordination of Benefits (COB) is required by Medi-Cal with some exceptions. Medi-Cal is the payer of the last resort. This means that providers shall submit claims to Medicare or a member's other health coverage for Medi-Cal eligible services before submitting a claim to Medi-Cal. Please consult the DHCS Billing Manuals and Service Tables under the MedCCC Library.

## Revenue Cycle Application (RCA)

All billable services are processed through the IRIS Revenue Cycle Application (RCA) work queues. If there are claims and/or services that need correction, the encounter (FIN) will appear in the RCA work queue and be accessible to the user. If no processes need to be completed, the encounter won't appear in the work queue. Billing staff should monitor and work in the RCA queues on a regular basis, so services do not become too late to bill. New user access is granted when a PAN is processed.

**TRAINING**

New front office and billing staff are required to complete the following training sessions:

- MHP/SUD EHR & Financial (County)
- MHP/SUD NON-EHR & Financial (Contract Providers)
- Revenue Cycle Billing Queues (Contract Providers)

**RESOURCES****DCHS CalAIM References and Manuals**

[MedCCC - Library](#)

**OC HCA QMS Billing Team Webpage for Contract Providers**

[BHS Contract Provider Claims/Billing Resources | Orange County California - Health Care Agency](#)

**Contact Information****BHS Billing Support Office hours:**

Monday-Friday 8:30 AM-5:00PM

Phone: 714-834-6007 Option #3

E-mail: [BHPBillingSupport@ochca.com](mailto:BHPBillingSupport@ochca.com)

**BHS System Support Office hours:**

Monday-Friday 8:30 AM-5:00PM

Phone: 714-834-6007 Option #2

E-mail: [BHPBillingSupport@ochca.com](mailto:BHPBillingSupport@ochca.com)

# HEALTH INFORMATION MANAGEMENT

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

### HIM MISSION STATEMENT

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

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

### ACTIVITIES

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

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

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

### HIM GUIDES, PROCEDURES AND FORMS

- [BHS/HIM ATD Revocation Guide](#)
- [BHS Records Redaction](#)
- [Expired and Invalid ATD Guide](#)
- [APS/CPS Documents Procedure](#)
  - [APS/CPS Documents Routing Slip](#)

- HIM/BHS Intra-HCA Record Request for Continuity of Care Procedure

## RELATED LINKS

- Custodian of Records
- Office of Compliance

# CAL AIM INITIATIVES

## ENHANCED CARE MANAGEMENT

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

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

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

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

### Referral of Enhance Care Management Services

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

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

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

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

### **ECM Referral source from County FSP and PACT Programs**

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

## **COMMUNITY SUPPORTS SERVICES**

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

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

**REFERRAL FOR COMMUNITY SUPPORTS SERVICES (CALOPTIMA HEALTH/KAISER)****CS Referral source from Non-County FSP and PACT Programs**

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

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

**CS Referral source from County FSP and PACT Programs**

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

**JUSTICE INVOLVED INITIATIVE (BEHAVIORAL HEALTH LINKS)**

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

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

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

## RESOURCES & CONTACT INFORMATION

### POLICIES & PROCEDURES

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

Links to P&Ps specific to both the Health Care Agency at large and to Behavioral Health Services can be found on the HCA SharePoint here: [HCA Agencywide Policy & Procedures](#).

Links to P&Ps specific to Behavioral Health Services can be found on OCHalthinfo.com here: [BHS Policies and Procedures](#).

### PRACTICE GUIDELINES

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

### QMS E-MAIL BOXES

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

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

## RESOURCES & CONTACT INFORMATION

### Quality Management Services – Provider Manual

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

## RESOURCES & CONTACT INFORMATION

### Quality Management Services – Provider Manual

|                                                            |                                                                                  |                                                                                                              |
|------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <b>–Technical Assistance and Training Support Team</b>     | <a href="mailto:SMHSClinicalRecords@ochca.com">SMHSClinicalRecords@ochca.com</a> | SMHS documentation and coding support, scope of practice guidance, QRTips newsletter                         |
| <b>Billing Team (BT)</b>                                   | <a href="mailto:BHPBillingSupport@ochca.com">BHPBillingSupport@ochca.com</a>     | IRIS Billing; Office Support; CalOMS - Data Entry Questions (Contract programs)                              |
| <b>Inpatient &amp; Designation Support Services (IDSS)</b> | <a href="mailto:BHPIDSS@ochca.com">BHPIDSS@ochca.com</a>                         | General Questions regarding Designation                                                                      |
| <b>Inpatient &amp; Designation Support Services (IDSS)</b> | <a href="mailto:BHPDesignation@ochca.com">BHPDesignation@ochca.com</a>           | Inpatient Involuntary Hold Designations; LPS Facility Designation; Outpatient Involuntary Hold Designations. |
| <b>MediCal Certification Team</b>                          | <a href="mailto:BHPCertifications@ochca.com">BHPCertifications@ochca.com</a>     | SMHS Medi-Cal Certification                                                                                  |
| <b>QI Systems</b>                                          | <a href="mailto:qisystems@ochca.com">qisystems@ochca.com</a>                     | EBP, QAPI, MBHO; HEDIS/POM; and BHP QI Support related questions for all SMHS and DMC-ODS programs           |

## QMS UNIT DESCRIPTIONS

### INPATIENT/CRISIS & ACUTE CARE (CAC) SUPPORT

**TAR:** Treatment Authorization Request - this team reviews records from Inpatient Hospitals, for both voluntary psychiatric admissions and involuntary holds for the purpose of determining payment eligibility. The team consists of Licensed Practitioners of the Healing Arts (LPHA) who evaluate medical necessity and support staff who facilitate the administrative review process.

**Contracts:** The following four contracts are monitored and managed by this unit. Carelon (Administrative Service Organization - ASO), which operates the 24/7 Medi-Cal member access line, conducts concurrent reviews for inpatient psychiatric stays, and manages a small network of individual providers who serve BHP members outside of the established program network. The unit also manages the following contracts: Patients' Rights Advocacy Services (PRAS), Certification Review Hearing Officers and Pharmacy Benefit contract.

**CAC Support:** Technical Assistance and Support to the Crisis programs. This is assigned to LPHA.

**UMCCC:** Utilization Management Complex Care Coordination. Coordinates care of BHP members that require coordination between BHP and MCP (and sometimes other external or internal providers). The team collaborates with Carelon to provide eating disorder treatment and the intensive levels of care, Transcranial Magnetic Stimulation (TMS) services and Electroconvulsive Therapy (ECT) to members

based on medical necessity. The team also works directly with program on addressing complex clinical care needs for members.

Designation: Focus is on the designation of both individuals and facilities. Individual designation involves training on Welfare and Institutions Code (WIC) 5150/5585 and the County approval process. Facility designation involves consulting with facilities to ensure they have the required infrastructure to accept patients on involuntary holds and to conduct all required actions under the Lanterman-Petris-Short (LPS) act. This function is staffed by LPHA.

## CLINICAL RECORDS

### **Health Information Management (HIM):**

HIM handles requests for release of clinical records for County operated programs. Reasons range from a member wanting their records to court orders to produce records or external coordination of care. This team is staffed by LPHA who review the records for clinical appropriateness and by Staff Specialists who support the review process. The team collaborates with the HCA Custodian of Records routinely.

### **Technical Assistance and Training Support (TATS):**

This team provides guidance regarding documentation, education on changes to documentation requirements, addition of services that are billable, addition of provider categories and what they can bill for, development of the Annual Provider Training (APT) and BHP Documentation Manual, and any other regulatory or quality assurance update that relates to the BHP programs' clinical records. The team is also responsible for consulting with providers to develop Corrective Actions Plans (CAP) in response to Department of Health Care Services (DHCS) reviews and coordinating submission to the state and for monitoring and attesting to completion for the CAP. The team is staffed by LPHA.

### **Clinical Records Review Team:**

This function is responsible for conducting routine chart/clinical records reviews of all BHP programs and producing written documentation of findings from the reviews. They produce monitoring reports and corrective action plans (CAP) for County reviews that are submitted to DHCS, and the team is also responsible for tracking and submitting corrections.

## MANAGED CARE SUPPORT TEAM:

Manages various managed care requirements under Code of Federal Regulations (CFR) Part 438, which includes compliance with beneficiary informing and member rights requirement, provider network standards, timely access to services, requests for second opinions and member grievances and

appeals. The team manages a contract with the BHP's Credentialing Verification Organization (CVO), RL Datix, and maintains the provider directory, including tracking compliance with supervision requirements for applicable provider types. The team oversees the issuance of Notices of Adverse Benefit Determination (NOABD) and any appeals that members may file. They represent the BHP in State Hearings, and they track and submit quarterly monitoring reports to DHCS. The team maintains access to Medi-Cal provider enrollment for Specialty Mental Health Services (SMHS) providers through the Provider Application and Validation of Eligibility (PAVE) state system and processes Provider Transaction Access Number (PTAN) applications for Medicare billing for County operated programs. The function is staffed by LPHA and non LPHA staff who handle complex administrative processes.

### **QI SYSTEMS:**

This unit is responsible for supporting BHS complex quality improvement processes and activities related to the various DHCS initiatives under Behavioral Health Transformation, including California Advancing and Innovating Medi-Cal (CalAIM), Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH CONNECT), Population Health Management (PHM), the DHCS Comprehensive Quality Strategy and others to enable process and system improvement across BHP programs. The work is done through inter-related teams that each have a main focus. This team is staffed by LPHA and specialized staff. The roles are as follows.

#### **Quality Standards and Clinical Practice Team:**

Evidenced Based Programs (EBP) focus is on the development of subject matter expertise on EBP that are required to be implemented in our county system of care to fidelity as part of BH CONNECT as well as the Behavioral Health Services Act (BHSA).

Quality Assessment and Performance Improvement (QAPI) program. Consists of the QMS work plan for improvement of quality of services for our members. It reflects both required activities and county defined goals. The plan is developed and evaluated annually and then submitted to DHCS in compliance with the BHP Contract. The items in this plan are to be monitored and integrated into QMS activities so that our plan is in the forefront of QI/QA activities throughout the year.

BHA - Behavioral Health Accreditation (BHA) – As part of BH CONNECT, the county opted in to work on improving on National Committee of Quality Assurance (NCQA) BHA standards which were previously measured through self-assessment. This unit focuses on deliverables for meeting NCQA requirements for Managed Behavioral Health Organizations and DHCS defined Reform, Access and Outcomes goals. The BHA standards describe relationships and themes across standards for Care Coordination (CC) and Quality Management and Improvement (QI) that recognize requirement implications for members/patients, staff, partners, and other stakeholders and define opportunities for quality improvement and performance sustainability.

### **HEDIS/POM:**

This unit focuses on developing expertise on HEDIS and supporting system improvement across BHS that will result in positive impacts on the county's BHP HEDIS and performance outcome ratings. This team is composed of LPHA.

HEDIS: The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. HEDIS® tracks how well health care organizations perform when providing or facilitating the use of important health services to enrolled populations. HEDIS® MY (measurement year) 2025 includes 87 measures across 6 domains: (Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Health Plan Descriptive Information, and Measures Reported Using Electronic Clinical Data Systems).

DHCS has transitioned to using HEDIS measures and performance outcomes to evaluate the quality of BHP systems operated by counties. For this initial year, DHCS has selected five of the measures for Specialty Mental Health Services (SMHS) and four for Drug Medi-Cal Organized Delivery System (DMC-ODS). DHCS has also narrowed the topics for Performance Improvement Projects (PIP) under the QAPI workplan to those included in HEDIS. It is expected that as plans meet various standards, the selected measures may change from year to year.

Performance Outcome Measures: The unit focuses on all outcome measures used by BHS under the BHP contract or by regulation. These include the California Outcomes Measurement System (CalOMS) under Substance Use Disorder (SUD) programs, the Child and Adolescent Needs and Strengths (California CANS 50) and the Pediatric Symptom Checklist (PSC 35) under Children/Youth SMHS, and others likely to become an area of focus or be added in the future.

### **Certifications and Special Projects:**

Medi-Cal Certification Team: Programs that wish to bill Medi-Cal under the Specialty Mental Health (SMH) Short Doyle system shall go through a process by which the program becomes "certified" to bill Medi-Cal for services rendered. This process includes the program submitting items such as: Fire Department clearance, Program Description, hours of operation, scheduling of staff and establishing what services are intended to be provided. County operated programs are certified directly by DHCS. Contracted programs are certified through the delegated authority of County staff from the Certification team. This team provides technical assistance to programs, reviews operational policies and conducts certification site visits. The function is staffed by some LPHA and specialized staff.

Special Projects: This team focuses on time limited projects or projects that cross several of the other QMS teams' areas of focus, such as updating the member handbook, coordinating translations, updating policies and procedures, assisting with new program development, such

as the CalAIM Justice Involved initiatives and other work that may be periodic or limited in scope. The team also supports Medi-Cal certification for Specialty Mental Health Programs (SMHS) and the BHS process for developing and establishing BHS Practice Guidelines.

#### **BHP QI Support:**

This team focuses on supporting the SMHS and SUD BHP provider network in implementing activities and initiatives at their local sites by managing and coordinating routine quality improvement meetings, presentations, newsletters, and other activities that may be necessary to support the work across the other teams in this unit, including reviewing and tracking DHCS Information Notices and acting on new guidance as appropriate.

#### **Cal-AIM Support:**

This team focuses on interacting with the Managed Care Plans (MCP) for the implementation of Cal-AIM MCP benefits such as Enhanced Care Management (ECM) and Community Supports (CS) for BHP members. The team also works on coordinating grant application processes when appropriate and supporting other QMS teams in the implementation of MCP Cal-AIM processes, such as coordinating the transitional rent and/or housing benefit for BHP members. This work is assigned to professional, non LPHA staff.

### **BUSINESS SERVICES DIVISION:**

This team supports wide range of billing and claiming processes that include County BHP revenue cycle management and contracted provider billing support, as well as coordination of County operated sites' front office operations, ranging from clerical to complex financial activities to support county billing of services, and supporting the electronic health record maintenance and workflows between BHS and the HCA IT department to enable documentation of services and claiming.

#### **Contracted Provider Claims Monitoring and Support:**

This function supports contracted behavioral health providers by ensuring accurate and compliant Medi-Cal claims processing within the IRIS system. The team reviews claims for completeness, provides feedback through structured queues, and monitors charge routing to ensure correct financial posting. They offer real-time technical support and training, onboard new providers with system access and workflow orientation, and validate billing configurations. The Provider Billing unit tracks claims denials, facilitates corrections, and reconciles claims to prevent revenue loss. It delivers ongoing education on Medi-Cal, CalAIM, and DHCS compliance, conducts billing documentation quality audits, and supports providers through custom dashboards and performance monitoring. This team partners closely with County monitoring staff and program partners to communicate billing requirements across the provider network and to support contract oversight activities. Acting as a liaison, the team addresses

billing issues, aligns services with contract terms, and channels provider feedback into system improvement requests. It also helps train county staff and collaborates with internal teams to build a unified billing support structure.

#### **Clinic Office Coordination:**

County operated SUD and Adult/Older Adult mental health clinics' office support staff report through QMS to ensure consistent operations and workflows to support county program billing and Medi-Cal program compliance. The Office Coordination unit is staffed by a Program Supervisor II who oversees five Office Supervisors that supervise lower-level office support staff in the operation of support functions across county operated sites. Their role includes registering members and clients into the county BHP electronic records system (IRIS), collecting necessary intake paperwork, conducting financial evaluations, managing appointments and collaborating with county clinical program staff to support a positive experience for members and clients receiving care at county operated programs. This team's activities are essential in supporting claiming and billing for county operated staff, in alignment with state mandates. This team works closely with the Provider billing function of this unit to ensure consistent application of billing policies and workflows. This unit also provides indirect support to office support staff from Children/Youth, Crisis/Acute care and Forensics programs to support consistent communication and implementation of processes.

**IRIS Support Team:** The team delivers comprehensive support, design, maintenance, and implementation services for the BHS Electronic Health Record (EHR) system, named internally the Integrated Records Information System (IRIS). They collaborate across Behavioral Health Services (BHS) programs, other Quality Management Services (QMS) teams and HCA Information Technology (IT) to ensure EHR functionality aligns with operational needs. The team works to develop system enhancements in response to evolving state and local requirements, along with IT. The team safeguards data integrity, evaluates program needs, and creates effective EHR solutions, including instructional materials and training on how to use the IRIS system for Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) program staff. Ongoing assistance is provided through the EHR Support Line and individualized training.

The team manages provider organizational structures within the EHR to allow programs to register and submit claims and maintains all County and Contract users and provider profiles in IRIS via the Personnel Action Notification (PAN) process, ensuring accurate access for service documentation and claims submission. The team also oversees the collection, compilation, and submission of annual SMHS and SUD Network Adequacy Certification Tool (NACT) reports, working closely with the Data Analytics and Evaluation (DAE) team to meet reporting requirements and partners with IT to support the development of user interfaces and other technology solutions to enable staff to accurately enter provider data and other requirements.

### COMMON ACRONYMS

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

| <u>Acronym</u> | <u>Meaning</u>                            | <u>Note</u>         |
|----------------|-------------------------------------------|---------------------|
| AAP            | American Academy of Pediatrics            |                     |
| AB             | Assembly Bill                             |                     |
| ABC            | Allied Behavioral Care                    |                     |
| ABN            | Advance Beneficiary Notice of Noncoverage |                     |
| ACA            | Affordable Care Act                       |                     |
| ACP            | Accountability Commitment Program         | a.k.a. house arrest |
| ACSW           | Associate Clinical Social Worker          |                     |
| ACT            | Annual Compliance Training                |                     |
| ADA            | Americans with Disabilities Act           |                     |
| ADAS           | Alcohol and Drug Abuse Services           |                     |
| ADL            | Activities of Daily Living                |                     |
| ADP            | Alcohol and Drug Program                  | i.e., Medi-Cal ADP  |
| AG             | Attorney General                          |                     |
| ALOS           | Average Length of Stay                    |                     |
| AMA            | American Medical Association              |                     |
| AMFT           | Associate Marriage and Family Therapist   |                     |
| AOA            | Adult and Older Adult                     |                     |
| AOABH          | Adult and Older Adult Behavioral Health   |                     |
| AOB            | Assignment of Benefits                    |                     |
| AOC            | Agency Operations Center                  |                     |
| AoD            | Accounting of Disclosures                 | HIPAA Privacy Rule  |
| AOD            | Alcohol and Other Drugs                   |                     |

## RESOURCES & CONTACT INFORMATION

### *Quality Management Services – Provider Manual*

|       |                                                            |  |
|-------|------------------------------------------------------------|--|
| AOS   | Adult Outpatient Services                                  |  |
| AOT   | Assisted Outpatient Treatment                              |  |
| APA   | American Psychological Association                         |  |
| APCC  | Associate Professional Clinical Counselor                  |  |
| APT   | Annual Provider Training                                   |  |
| ARF   | Adult Residential Facilities                               |  |
| ART   | Authorization for Residential Treatment                    |  |
| ASAM  | American Society of Addiction Medicine                     |  |
| ASCM  | Authorization to Share Confidential Medi-Cal Information   |  |
| ASO   | Administrative Services Organization                       |  |
| ATD   | Authorization to Use/Disclose Protected Health Information |  |
| ATLAS | Addiction Treatment Locator, Analysis and Standards        |  |
| AUD   | Alcohol Use Disorder                                       |  |
| BA    | Business Associate                                         |  |
| BAA   | Business Associate Agreement                               |  |
| BAL   | Beneficiary Access Line                                    |  |
| BBS   | Board of Behavioral Sciences                               |  |
| BHCIP | Behavioral Health Continuum Infrastructure Funding         |  |
| BHEC  | Behavioral Health Equity Committee                         |  |
| BHIN  | Behavioral Health Information Notice                       |  |
| BHP   | Behavioral Health Plan                                     |  |
| BHS   | Behavioral Health Services                                 |  |
| BHSDR | Behavioral Health Services Disaster Response               |  |
| BHT   | Behavioral Health Transition                               |  |
| BHTC  | Behavioral Health Training Center                          |  |
| CAC   | Crisis and Acute Care                                      |  |

## RESOURCES & CONTACT INFORMATION

### Quality Management Services – Provider Manual

|             |                                                          |                   |
|-------------|----------------------------------------------------------|-------------------|
| CAH         | Command Auditory Hallucinations                          |                   |
| CalAIM      | California Advancing and Innovating Medi-Cal             |                   |
| CalOMS (Tx) | California Outcomes Measurement System                   | For SUD Treatment |
| CANS        | Child and Adolescent Needs and Strengths                 |                   |
| CAP         | Corrective Action Plan                                   |                   |
| CAR         | Child Abuse Registry                                     |                   |
| CARF        | Commission on Accreditation of Rehabilitation Facilities |                   |
| CAT         | Crisis Assessment Team                                   |                   |
| CBC         | Criminal Background Checks                               |                   |
| CBHDA       | County Behavioral Health Directors Association           | For California    |
| CC          | Cultural Competency                                      |                   |
| CCE         | Community Care Expansion                                 |                   |
| CCPU        | Continuing Care Placement Unit                           |                   |
| CCRP/CMPP   | County Compassionate Release/Medical Probation           |                   |
| CCS         | Community Counseling Services                            |                   |
| CDC         | Centers for Disease Control and Prevention               |                   |
| CDM         | Cerner Defined Mnemonic (Billing)                        |                   |
| CDPH        | California Department of Public Health                   |                   |
| CDSS        | California Department of Social Services                 |                   |
| CE          | Covered Entity                                           |                   |
| CEST        | Client Evaluation of Self-Treatment                      |                   |
| CEU         | Continuing Education Unit                                |                   |
| CFR         | Code of Federal Regulations                              |                   |
| CFT         | Child and Family Team                                    |                   |
| CHR         | Clinical High Risk                                       |                   |
| CISM        | Critical Incident Stress Management                      |                   |

## RESOURCES & CONTACT INFORMATION

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|        |                                                                                |  |
|--------|--------------------------------------------------------------------------------|--|
| CIT    | Crisis Intervention Training                                                   |  |
| CITED  | Capacity, Infrastructure, Transition, Expansion and Development                |  |
| CLAS   | Culturally and Linguistically Appropriate Services (Office of Minority Health) |  |
| CLIA   | Clinical Laboratory Improvement Amendments/Act                                 |  |
| CM     | Contingency Management                                                         |  |
| CMAP   | Certified Medicare Advantage Plan                                              |  |
| CMS    | Centers of Medicare/Medicaid Services                                          |  |
| CNA    | Certified Nurse Assistant                                                      |  |
| CO     | Certifying Organization                                                        |  |
| COB    | Coordination of Benefits                                                       |  |
| CONREP | Conditional Release Program                                                    |  |
| COR    | Custodian of Records                                                           |  |
| CORE   | Collaborative Options for Resource Efficacy                                    |  |
| CPE    | Certified Public Expenditure                                                   |  |
| CPM    | Core Practice Model                                                            |  |
| CPS    | Child Protective Services                                                      |  |
| CPSS   | Certified Peer Support Specialist                                              |  |
| CPT    | Common Procedural Terminology (CPT codes)                                      |  |
| CQIC   | Community Quality Improvement Committee                                        |  |
| CR     | Concurrent Review                                                              |  |
| CRF    | Court Replacement Facility                                                     |  |
| CRP    | Crisis Residential (Treatment) Program                                         |  |
| CRR    | California Code of Regulations                                                 |  |
| CRS    | Crisis Residential Services                                                    |  |
| CSA    | Clinical Supervision Agreement                                                 |  |
| CSI    | Client and Services Information                                                |  |

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|         |                                                                       |                 |
|---------|-----------------------------------------------------------------------|-----------------|
| CSJ     | Continuing Services Justification                                     |                 |
| CSOC    | Children's System of Care                                             |                 |
| CSRF    | Clinical Supervision Reporting Form                                   |                 |
| CSU     | Crisis Stabilization Unit                                             |                 |
| CTCP    | California Tobacco Control Program                                    |                 |
| CTF     | Community Treatment Facility                                          |                 |
| CVO     | Credentialing Verification Organization (Verge Health is what we use) |                 |
| CWS/CMS | Child Welfare System / Case Management System                         | Used by SSA CFS |
| CYS     | Children and Youth Services                                           |                 |
| DAPPER  | Dimensional Assessment for Patient Placement Engagement and Recovery  |                 |
| DAT     | Data Analytics Team                                                   |                 |
| DATAR   | Drug and Alcohol Treatment Access Report                              |                 |
| DCA     | Department of Consumer Affairs                                        |                 |
| DD      | Dual Diagnosis OR Developmentally Disabled                            |                 |
| DHCS    | California Department of Health Care Services                         |                 |
| DHHS    | Department of Health and Human Services                               |                 |
| DLP     | Data Loss Prevention                                                  |                 |
| DMC-ODS | Drug Medi-Cal – Organized Delivery System                             |                 |
| DOE     | Department of Education                                               |                 |
| DOI     | Department of Insurance                                               |                 |
| DOJ     | Department of Justice                                                 |                 |
| DPC     | Deputy Probation Counselor                                            |                 |
| DPO     | Deputy Probation Officer                                              |                 |
| DRS     | Designated Record Set                                                 |                 |
| DSH     | Direct Service Hours                                                  |                 |
| DSM     | Diagnostic and Statistical Manual of Mental Disorders                 |                 |

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|       |                                                    |  |
|-------|----------------------------------------------------|--|
| DSS   | Department of Social Services                      |  |
| DSW   | Disaster Service Worker                            |  |
| DTO   | Danger to Others                                   |  |
| DTS   | Danger to Self                                     |  |
| E&R   | Expenditure Report                                 |  |
| EBC   | Emotional Behavioral Cognitive                     |  |
| EBP   | Evidence Based Practice                            |  |
| ECM   | Enhanced Care Management                           |  |
| ED    | Emergency Department OR Emotional Disturbance      |  |
| EEOC  | Equal Employment Opportunity Commission            |  |
| EHR   | Electronic Health Record                           |  |
| EMDR  | Eye Movement Desensitization and Reprocessing      |  |
| EMR   | Electronic Medical Record                          |  |
| EOB   | Explanation of Benefits                            |  |
| EOC   | Episode of Care OR Evidence of Coverage            |  |
| EOP   | Enhanced Outpatient Program                        |  |
| EPSDT | Early Periodic Screening, Diagnostic and Treatment |  |
| EQR   | External Quality Review                            |  |
| EQRO  | External Quality Review Organization               |  |
| ESH   | Emergency Shelter Home                             |  |
| FAQ   | Frequently Asked Questions                         |  |
| FCA   | False Claims Act                                   |  |
| FDA   | Food and Drug Administration                       |  |
| FFP   | Federal Financial Participation                    |  |
| FFS   | Fee-For-Service                                    |  |
| FIN   | Financial Identification Number                    |  |
| FIT   | Feedback-Informed Treatment                        |  |

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|       |                                                             |  |
|-------|-------------------------------------------------------------|--|
| FORE  | Foundation for Opioid Response Efforts                      |  |
| FQHC  | Federally Qualified Health Center                           |  |
| FSN   | Family Support Network                                      |  |
| FSP   | Full-Service Partnerships                                   |  |
| FTE   | Full-Time Equivalent                                        |  |
| FWA   | Fraud, Waste and Abuse                                      |  |
| GAAP  | Generally Accepted Accounting Principles                    |  |
| GD    | Grave Disability                                            |  |
| GIRP  | Goal Intervention Response Plan                             |  |
| HCA   | Health Care Agency                                          |  |
| HCAI  | Department of Health Care Access and Information            |  |
| HCBS  | Home and Community-Based Services                           |  |
| HCPC  | Healthcare Common Procedure Code (Billing)                  |  |
| HCPCS | Healthcare Common Procedure Coding System                   |  |
| HHP   | Health Homes Program                                        |  |
| HHS   | Health and Human Services                                   |  |
| HIM   | Health Information Management                               |  |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |  |
| HMO   | Health Maintenance Organization                             |  |
| HOS   | Head of Service                                             |  |
| HSC   | Health and Safety Code                                      |  |
| HUT   | High Utilizer                                               |  |
| IA    | Intergovernmental Agreement                                 |  |
| IBNR  | Incurred But Not Reported                                   |  |
| IC    | Intake Coordinator                                          |  |
| ICC   | Intensive Care Coordination                                 |  |

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|        |                                                                |  |
|--------|----------------------------------------------------------------|--|
| ICD    | International Classification of Diseases (ICD-10)              |  |
| ICF    | Interim Care Facility                                          |  |
| ICF/DD | Intermediate Care Facility for the Developmentally Disabled    |  |
| ICP    | Interim Care Plan                                              |  |
| ICPC   | Interstate Compact for Placement of Children                   |  |
| IEP    | Individualized Educational Plan                                |  |
| IHBS   | Intensive Home-Based Services                                  |  |
| IHCP   | Indian Health Care Provider                                    |  |
| IHCS   | In-Home Crisis Stabilization                                   |  |
| ILP    | Independent Living Program                                     |  |
| IMCE   | Indian Managed Care Entities                                   |  |
| IMS    | Incidental Medical Services                                    |  |
| IOT    | Intensive Outpatient Treatment                                 |  |
| IP     | Implementation Plan                                            |  |
| IPS    | Inpatient Services                                             |  |
| IRIS   | Integrated Record Information System                           |  |
| IRT    | Interagency Review Team                                        |  |
| IS     | Intensive Services                                             |  |
| ISCA   | Information System Capacity Assessment                         |  |
| ISDEAA | Indian Self-Determination and Education Assistance Act of 1975 |  |
| ITFC   | Intensive Treatment Foster Care                                |  |
| ITP    | Individual Transition Plan                                     |  |
| JCWP   | Juvenile County Ward Program                                   |  |
| LAC    | Legal Action Center                                            |  |
| LCSW   | Licensed Clinical Social Worker                                |  |
| LD     | Learning Disability                                            |  |

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|       |                                              |  |
|-------|----------------------------------------------|--|
| LLOS  | Longer Length of Stay                        |  |
| LMFT  | Licensed Marriage and Family Therapist       |  |
| LMHP  | Licensed Mental Health Professional          |  |
| LOA   | Letter of Agreement (Residentials)           |  |
| LOC   | Level of Care                                |  |
| LOS   | Length of Stay                               |  |
| LOT   | Licensed Occupational Therapist              |  |
| LPCC  | Licensed Professional Clinical Counselor     |  |
| LPHA  | Licensed Practitioner of the Healing Arts    |  |
| LPS   | Lanterman-Petris-Short (LPS) Act             |  |
| LPT   | Licensed Psychiatric Technician              |  |
| LTC   | Long-Term Care                               |  |
| LTSS  | Long-Term Services and Supports              |  |
| LVN   | Licensed Vocational Nurse                    |  |
| MA    | Master Agreement OR Medical Assistant        |  |
| MAC   | Medicare Administrative Contractors          |  |
| MAT   | Medication Assisted Treatment                |  |
| MBU   | Medical Billing Unit                         |  |
| MC    | Medi-Cal                                     |  |
| MCBHD | Medi-Cal Behavioral Health Division          |  |
| MCHIP | Medicaid Children's Health Insurance Program |  |
| MCO   | Managed Care Organization                    |  |
| MCP   | Managed Care Plan                            |  |
| MCPAR | Managed Care Program Annual Report           |  |
| MCST  | Managed Care Support Team                    |  |
| MDPOR | Monthly Data and Performance Outcome Report  |  |
| MDT   | Multidisciplinary Team                       |  |

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|         |                                                               |  |
|---------|---------------------------------------------------------------|--|
| MHBG    | Community Mental Health Services Block Grant                  |  |
| MHP     | Mental Health Plan                                            |  |
| MHRC    | Mental Health Rehabilitation Center                           |  |
| MHRP    | Mental Health Recovery Plan                                   |  |
| MHRS    | Mental Health and Recovery Services                           |  |
| MHSA    | Mental Health Services Act                                    |  |
| MHSAOAR | Mental Health Services Act Outcomes and Accountability Review |  |
| MHSUD   | Mental Health and Substance Use Disorder (Dept. in DHCS)      |  |
| MOU     | Memorandum of Understanding                                   |  |
| MPF     | Master Provider File                                          |  |
| MRT     | Medi-Cal Review Team                                          |  |
| MSA     | Master Services Agreement                                     |  |
| MSE     | Mental Status Exam                                            |  |
| MSRF    | Medical Supervision Reporting Form                            |  |
| NACT    | Network Adequacy Certification Tool                           |  |
| NAR     | Notice of Appeal Resolution                                   |  |
| NARF    | New Applicant Request Form                                    |  |
| NCSACW  | National Center on Substance Abuse and Child Welfare          |  |
| NDP     | Naloxone Distribution Project                                 |  |
| NGR     | Notice of Grievance Resolution                                |  |
| NOABD   | Notice of Adverse Benefit Determination                       |  |
| NPI     | National Provider Identifier                                  |  |
| NPPES   | National Plan & Provider Enumeration System                   |  |
| NQTL    | Non-Quantitative Treatment Limitation                         |  |
| NTP     | Narcotics Treatment Program                                   |  |
| OA      | Open Access                                                   |  |

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|                   |                                                                |  |
|-------------------|----------------------------------------------------------------|--|
| OAHA              | Office of Administrative Hearings and Appeals                  |  |
| OAS PACT          | Older Adult Services Program for Assertive Community Treatment |  |
| OCBT              | Office Coordination Billing Team                               |  |
| OCC               | Office of Care Coordination                                    |  |
| OCDE              | Orange County Department of Education                          |  |
| OCEA              | Orange County Employee's Association                           |  |
| OCFC              | Orangewood Children and Family Center                          |  |
| ODF               | Outpatient Drug Free                                           |  |
| OHC               | Other Health Coverage                                          |  |
| OIG               | Office of Inspector General                                    |  |
| OMB               | Office of Management and Budget                                |  |
| OOC               | Office of Compliance                                           |  |
| OP                | Outpatient                                                     |  |
| OQP               | Other Qualified Provider                                       |  |
| ORP               | Ordering Referring Prescribing                                 |  |
| OSP               | Office of Suicide Prevention                                   |  |
| OTP (and non-OTP) | Opioid Treatment Program / non-Opioid Treatment Programs       |  |
| ODU               | Opioid Use Disorder                                            |  |
| P&P               | Policy and Procedure                                           |  |
| PACT              | Program for Assertive Community Treatment                      |  |
| PAHP              | Prepaid Ambulatory Health Plan                                 |  |
| PAN               | Personnel Action Notification                                  |  |
| PATH              | Providing Access and Transforming Health Initiative            |  |
| PAVE              | Provider Application and Validation for Enrollment             |  |
| PBM               | Pharmacy Benefit Management                                    |  |
| PCCM              | Primary Care Case Manager                                      |  |

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| PCCM Entity | Primary Care Case Management Entity                          |  |
|-------------|--------------------------------------------------------------|--|
| PCP         | Primary Care Physician                                       |  |
| PD          | Public Defender OR Police Department OR Probation Department |  |
| PECOS       | Provider Enrollment Chain and Ownership System (for PTANs)   |  |
| PED         | Provider Enrollment Division                                 |  |
| PERM        | Payment Error Rate Measurement                               |  |
| PG          | Practice Guidelines                                          |  |
| PHF         | Psychiatric Health Facility                                  |  |
| PHI         | Protected Health Information                                 |  |
| PI          | Paranoid Ideation                                            |  |
| PIHP        | Prepaid Inpatient Health Plan                                |  |
| PLW         | Professional Licensing Waiver                                |  |
| PMIS        | Provider Management Information System                       |  |
| POF         | Point of Focus                                               |  |
| POM         | Performance Outcome Measure                                  |  |
| PPC         | Provider Preventable Conditions                              |  |
| PPG         | Perinatal Practice Guidelines                                |  |
| PR          | Penetration Rate                                             |  |
| PRA         | Public Records Act                                           |  |
| PRAS        | Patients' Rights Advocacy Services                           |  |
| PSC         | Pediatric Symptom Checklist OR Personal Services Contractor  |  |
| PSPP        | Post-service Postpayment                                     |  |
| PTAN        | Provider Transaction Access Number (Medicare)                |  |
| PWB         | Pathways to Well Being                                       |  |
| PWD         | Persons With Disabilities                                    |  |
| QA/QI       | Quality Assurance & Quality Improvement                      |  |

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|        |                                                      |  |
|--------|------------------------------------------------------|--|
| QA/UR  | Quality Assurance and Utilization Review             |  |
| QAPI   | Quality Assessment and Performance Improvement       |  |
| QI     | Quality Improvement                                  |  |
| QM     | Quality Management                                   |  |
| QMS    | Quality Management Services                          |  |
| QRTips | Quality Review Tips                                  |  |
| QTL    | Quantitative Treatment Limitation                    |  |
| RAC    | Registered Addiction Counselor                       |  |
| RADT   | Registered Alcohol Drug Trainee                      |  |
| RCA    | Revenue Cycle Application                            |  |
| RCFE   | Residential Care Facilities for the Elderly          |  |
| RCOC   | Regional Center of Orange County                     |  |
| RFA    | Request for Application                              |  |
| RFI    | Request for Information                              |  |
| RFP    | Request for Proposal                                 |  |
| RGSi   | Registered Graduate Student Intern                   |  |
| RH     | Registered Hardship                                  |  |
| RHC    | Rural Health Clinic                                  |  |
| RI     | Recovery Incentives                                  |  |
| RN     | Registered Nurse                                     |  |
| ROP    | Regional Occupational Program                        |  |
| RS     | Recovery Services                                    |  |
| RTC    | Residential Treatment Center                         |  |
| RTF    | Recovery or Treatment Facilities                     |  |
| RTIS   | Responding to Internal Stimuli                       |  |
| SABG   | Substance Abuse Prevention and Treatment Block Grant |  |

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|        |                                                                        |  |
|--------|------------------------------------------------------------------------|--|
| SAMHSA | Substance Abuse and Mental Health Services Administration              |  |
| SAPT   | Substance Abuse Prevention and Treatment                               |  |
| SB     | Senate Bill                                                            |  |
| SBIRT  | Screening, Brief Intervention, and Referral to Treatment               |  |
| SDMC   | Short Doyle/Medi-Cal                                                   |  |
| SDOH   | Social Drivers of Health                                               |  |
| SED    | Severe Emotional Disturbance                                           |  |
| SIR    | Special Incident Report                                                |  |
| SMA    | State Medicaid Agency                                                  |  |
| SMART  | Specific Measurable Attainable Realistic Time-Bound                    |  |
| SME    | Subject Matter Expert                                                  |  |
| SMHS   | Specialty Mental Health Services                                       |  |
| SMI    | Serious Mental Illness                                                 |  |
| SNOMED | Systemized Nomenclature of Medicine                                    |  |
| SOAP   | Subjective, Objective, Assessment, Plan                                |  |
| SPA    | Service Provider Area                                                  |  |
| SPA    | State Plan Amendment                                                   |  |
| SPF    | Strategic Prevention Framework                                         |  |
| SPMI   | Serious Persistent Mental Illness                                      |  |
| SSA    | Social Security Administration, OR Social Services Agency              |  |
| SSI    | Supplemental Security Income                                           |  |
| STC    | Special Terms and Conditions                                           |  |
| StimUD | Stimulant Use Disorder                                                 |  |
| STRTP  | Short-Term Residential Therapeutic Programs                            |  |
| SUBG   | Substance Use Prevention, Treatment, and Recovery Services Block Grant |  |

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|        |                                                                  |  |
|--------|------------------------------------------------------------------|--|
| SUD    | Substance Use Disorder                                           |  |
| SUDCRS | Substance Use Disorder Cost Report System                        |  |
| SWOT   | Strengths, Weaknesses, Opportunities and Threats                 |  |
| TADT   | Timely Access Data Tool                                          |  |
| TAR    | Treatment Authorization Request                                  |  |
| TAT    | Turnaround Time                                                  |  |
| TAY    | Transitional Aged Youth                                          |  |
| TBS    | Therapeutic Behavioral Services                                  |  |
| TCM    | Targeted Case Management                                         |  |
| TFC    | Therapeutic Foster Care                                          |  |
| TGI    | Transgender, Gender Diverse, or Intersex                         |  |
| TIC    | Trauma-Informed Care                                             |  |
| TLS    | Transport Layer Security                                         |  |
| TPS    | Treatment Perception Survey                                      |  |
| TUD    | Tobacco Use Disorder                                             |  |
| UDT    | Urine Drug Test                                                  |  |
| UETA   | Uniform Electronic Transactions Act                              |  |
| UIO    | Urban Indian Organizations                                       |  |
| UM     | Utilization Management                                           |  |
| WCM    | Whole Child Model                                                |  |
| WET    | Workforce, Education, and Training                               |  |
| WIC    | Welfare & Institutions Code, <i>OR</i> Women and Infant Children |  |
| WLR    | Waiting List Record                                              |  |
| WM     | Withdrawal Management                                            |  |
| WPC    | Whole Person Care                                                |  |
| WRAP   | Wellness Recovery Action Plan                                    |  |

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|     |                            |  |
|-----|----------------------------|--|
| YTG | Youth Treatment Guidelines |  |
|-----|----------------------------|--|