SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

August 2026

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DMC-ODS Office Hours

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

Upcoming meeting: August 12, 2026 at 2pm

***CHANGE:** Beginning in August, Office Hours will only be offered once a month!

WHAT'S NEW?

3rd Party Suspected Abuse Disclosures

In line with the impending Health Information Exchange (HIE), where clients will have real-time access to the contents of their clinical record, it is important that we document disclosures for suspected abuse with the minimum necessary information to protect the anonymity of the reporter. For example, instead of documenting, "Client's mother Jane Smith disclosed…" we can simply indicate "a 3rd party disclosure was made."

Discharge planning

Prior to Payment Reform, general discharge planning or the development of the discharge plan was captured under the individual counseling service type. With the expansion of service billing codes, we should be more specific in how we code our services. Therefore, moving forward, general discharge planning should be claimed using the SUD Treatment Plan Development/Modification (70899-125) T1007 code. This will also help us to better align with the State's categorization of this code as a discharge service type. Of course, this does not mean that everything related to discharge will automatically be billable using this code. The general guidance still applies that the nature of the content of the session or service must be considered to determine the most appropriate service billing code:

Time spent with the client completing a discharge plan (which typically includes care coordination

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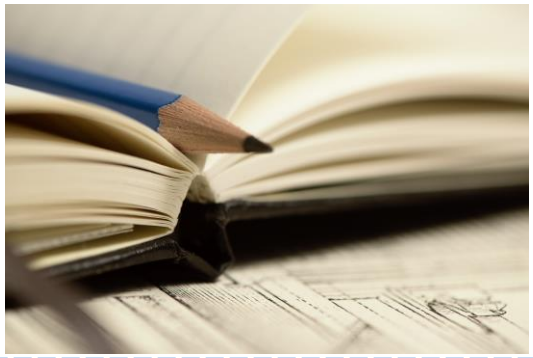


Training & Resources Access

Training Requests

TATS Training Request Form

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

Updated DMC-ODS Payment Reform 2026 - CPT Guide

Coding Quick Guides

By provider type at DMC-ODS Provider Website
See important info on page 2!

SUD Documentation Manual

MAT Documentation Manual

DMC-ODS Allowable Modifiers & Lockouts Reference Sheet

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

WHAT'S NEW?

…continued from page 1

elements, but is not solely care coordination and the primary focus is to facilitate a broad discussion of various aspects of the client's discharge) should be claimed using the SUD Treatment Plan Development/Modification (70899-125) T1007 code.

If time spent completing a discharge plan predominantly becomes a care coordination service (majority of the service time is on care coordination activities), it should be claimed using the Targeted Case Management, Each 15 Min (70899-120) T1017 code. The documentation needs to make clear that the primary focus of the service was on addressing the client's care coordination needs.

Likewise, if the session to complete a discharge plan becomes more heavily focused on providing individual counseling interventions (e.g., helping the client gain insight into SUD related experiences, skill-building for relapse prevention, etc.), then the service should be coded using the applicable individual counseling billing code. Again, the progress note documentation should make clear that the bulk of the time spent was on addressing the client's counseling-related needs.

As a reminder, a discharge plan is not required under the DMC-ODS. However, providers should be mindful of other regulations that their agency must abide by that may require a discharge plan.

Documentation FAQ

1. Is the Problem List required at Withdrawal Management?

Yes. The regulations do not indicate an exception for the Withdrawal Management level of care to complete a Problem List. Since a full assessment is not required and clients are often trying to stabilize physically, there may be limited information about the client's needs across the ASAM dimensions. Therefore, it makes clinical sense that the Problem List would not be as robust as it may be at other treatment levels of care. At minimum, the establishment of the client's SUD diagnosis by the LPHA should prompt the creation of a Problem List with the applicable diagnosis.

2. Does the LPHA need to document the justification for the client's SUD diagnosis in their required narrative/write-up (or Case Formulation)?

The State has made it clear that this is not required. The State's requirement is for the LPHA to document a narrative that explains their determination of the client's appropriateness for the level of care placement. However, the County's recommendation is for the LPHA to continue to include documentation of their justification for the client's SUD diagnosis. The reason is the access criteria requirement for DMC-ODS services that states that clients must meet criteria for an SUD diagnosis. If this is not clearly established, we put ourselves at risk of providing services perceived as potential fraud, waste, and/or abuse. Additionally, since the SUD diagnosis can only be established by an LPHA, their documentation helps to make clear that it was indeed the LPHA and not the non-LPHA making this determination. If it is not documented in a narrative by the LPHA, please make certain that the information to support the client's SUD diagnosis is captured elsewhere in the clinical record (such as in a progress note or in the other sections of the initial assessment).

Medicare Requirements

Medicare has a few specific documentation requirements. Please be sure that the clinical records for clients with Medicare or Medi-Medi (those with both Medicare and Medi-Cal) adhere to the following-

Individualized Written Plan of Care that includes:

- Problems to be addressed,
- What services will be provided to address these issues (e.g., care coordination, individual counseling, family therapy, etc.),
- Frequency (how often) of services to be provided (e.g., 1x/week, 3-5x/week, 1x/month, etc.),
- Duration (for how long) of services to be provided (e.g., for the next 6 months, for duration of treatment episode and as clinically appropriate, etc.), and
- LPHA's signature (does not have to be a physician).

Example: "To address the problems identified on the problem list, the following services will be provided by the treatment team between 1-4x/month or more as needed for the duration of this treatment episode and as long as is clinically appropriate…"

Progress note documentation includes (in addition to the State's requirements):

- Client's diagnosis
- Narrative to support the procedure code billed
- Signature of rendering Medicare-eligible* provider, along with credentials

*Physician, Physician Assistant, Nurse Practitioner, Licensed Clinical Social Worker, Clinical Psychologist, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor who have a Provider Transaction Access Number (PTAN)

Disclaimer: *The Quality Management Services (QMS) Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly SUD Newsletter to all DMC-ODS providers as a tool to assist with various QA/QI regulatory requirements. It is NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.*

REMINDERS

Timely Access Requirements

Remember that timely access requirements apply to all non-urgent appointments with a non-LPHA or non-medical LPHA. Appointments are required to be offered to a client within ten (10) business days. The timeframe is within fifteen (15) business days for MD appointments. Clients are not required to be seen at this frequency. However, we need to clearly document the clinical appropriateness for the frequency that clients are being seen. For NTPs, an appointment must be offered within three (3) business days of request for the initial appointment.

Diagnoses for Billing Prior to LPHA

At the outpatient levels of care, if the LPHA does not establish an SUD diagnosis on the date of admission, an SUD diagnosis should not be used to bill for the intake or any other services provided on that day. Remember that non-LPHA should be using the Z55-Z65 codes to bill for services until the LPHA establishes an SUD diagnosis. Z55-Z65 codes can also be used by LPHA/non-LPHA who may be conducting groups prior to the establishment of an SUD diagnosis.

Agency Protocol vs. Billable Services

Each service claimed must be medically necessary. An agency/program providing a particular service for every client as part of their workflow does not make it automatically billable. For example, if your agency/program has a practice of providing a "check-in" with every client at a certain point in the treatment episode, this is not automatically billable. It is only billable if the service is medically necessary for the particular client.

HEDIS POMs POD & OUD

FOOD FOR THOUGHT

DID YOU KNOW?

A 2025–26 Medicare study found that Black and Hispanic patients were about 3–4 percentage points less likely than White patients to receive buprenorphine or naltrexone after an opioid-related health event. In a separate 2024 review of more than 9 million buprenorphine prescriptions, 21 states showed longer treatment durations among White patients, and in 8 of those states, the disparity persisted even for long-term episodes (≥180 days). (CDUHR, 2025, JAMA, 2022)

These disparities matter for POD & OUD because they directly impact who gets diagnosed, who follows up, and who stays in treatment. Bridging those gaps requires culturally responsive outreach and intentional follow-up.

When it comes to HEDIS POD and CMS OUD they really are like two peas in a pod.

POD Pharmacotherapy for Opioid Use Disorder 2025-2026

CMS Centers for Medicare & Medicaid Services
OUD Use of Pharmacotherapy for Opioid Use Disorder 2025-2026

For more information on HEDIS and outcome measures reach out to the HEDIS POM Team via email at QISystems@ochca.com

Scan QR Code for full
POD OUD Training Module
You will be prompted to register your email in Articulate the first time only.

https://art-661759-3944.reach360.com/share/course/6ac75dd1-a700-4e3a-a0f0-7423f6d845b1





CHIYO MATSUBAYASHI | VERONICA DEFERNANDEZ | DIANE MARTIN | CECE MARTINEZ | SUSIE CHOI

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

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

REMINDERS, ANNOUNCEMENTS & UPDATES

PROVIDER DIRECTORY 274 USER INTERFACE

Monthly submissions for the Behavioral Health Plan Provider Directory have transitioned to the 274 User Interface (274 UI) **new cloud base upgrade** for all providers, effective 7/6/26. This platform aligns with key data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT), supporting improved data consistency and streamlined reporting for both the NACT and the Provider Directory.

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

Program administrators are to do first level approval for all providers listed under their assigned site(s) each month for accuracy. If there are no changes, select the "NO CHANGE" button for each provider's profile to confirm your review. This step allows the MCST to verify compliance and ensure administrators are confirming monthly reviews for all assigned providers.

IMPORTANT: If there are no activity of submission for two consecutive months, a Notice of Deficiency will be issued for non-compliance with DHCS BHIN-25-026 requirements.

ALL programs and providers should have access to the 274 UI.
If you still do **NOT** have access to the 274 UI portal, you are to contact BHPNetworkAdequacy@ochca.com immediately!

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST TRAININGS HAVE TRANSITIONED TO ONLINE MODULES FOR:

County Credentialing
NOABDs
Grievances, Appeals & State Fair Hearings
Supervision Reporting Forms
Access Logs
2nd Opinion/Change of Provider – Coming Soon
274 UI Provider Directory – Coming Soon

Link to the MCST Trainings:

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

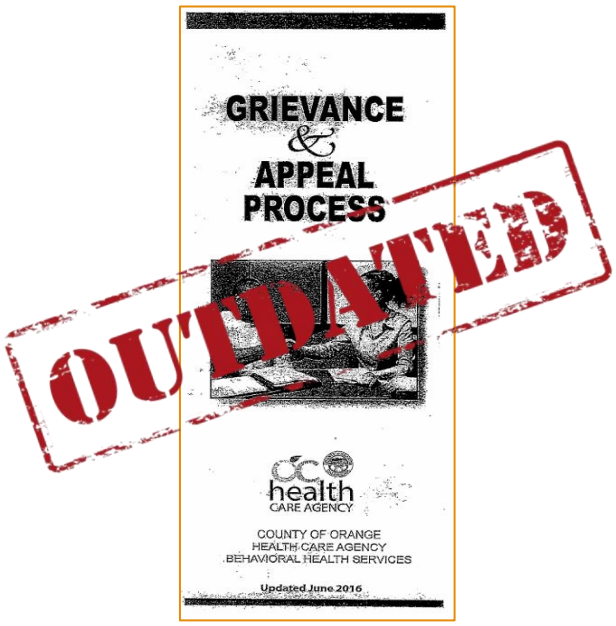
These trainings are now available on the QMS website for all new and existing providers. This transition is part of MCST's effort to streamline processes, increase efficiency, and ensure that essential training resources are easily accessible at any time—both for onboarding and for refresher purposes.

As part of MCST's role in tracking, monitoring and maintaining compliance with DHCS requirements the centralized trainings in an online format now allows MCST to verify participation, assess ongoing compliance, and ensure that all providers receive uniform guidance aligned with DHCS standards.

Each module is expected to take approximately 30–60 minutes to complete, depending on the trainee's pace and level of engagement with the interactive components designed to reinforce the understanding of DHCS mandates.

The MCST can offer a Microsoft Teams training session upon request. Please e-mail the MCST representative at BHPGrievanceNOABD@ochca.com with Subject Line: MCST Training Request for SMHS or DMC-ODS.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)



OUTDATED GRIEVANCE & APPEAL BROCHURE

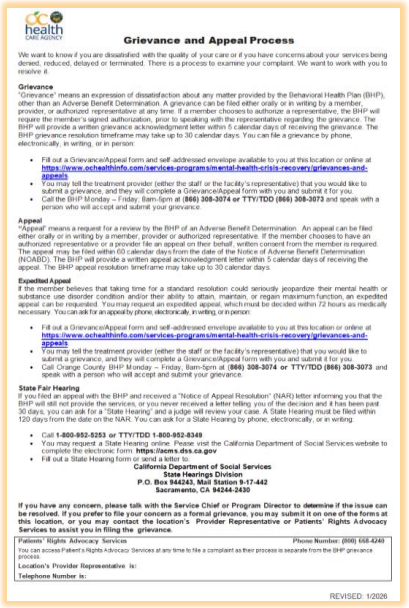
The MCST was recently informed that some county programs are still providing members with an outdated grievance and appeal brochure that are placed in initial intake and crisis assessment packets. Please discontinue the use of this brochure immediately. It should be discarded and replaced with the most current grievance and appeal poster, which can be printed on standard 8x11 paper. See the link below to access the poster.

GRIEVANCE & APPEAL POSTERS (REGULAR AND LARGE PRINT)

The grievance and appeal posters have been revised (1/2026) and available on the QMS website. DHCS issued BHIN 25-015 and BHIN 25-014 to provide updated guidance regarding the grievance and appeal process, including revised member notice templates and compliance with federal and state regulations.

KEY POINTS

- ✓ The Grievance and Appeal Poster must be prominently displayed in provider locations and printed on 8x14 legal size paper.
- ✓ Materials, including posters, must be available in alternate formats such as large print (11x17) and in all threshold languages to ensure accessibility.
- ✓ Providers are expected to make these materials available without requiring members to request them, supporting accessibility and compliance.



Grievance and Appeal Process

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

Grievance

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

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

Appeal

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

Expedited Appeal

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

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

State Fair Hearing

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

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

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

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

Patients' Rights Advocacy Services — Phone Number: (800) 668-4249

You can access Patient's Rights Advocacy Services at any time to file a complaint as their process is separate from the BHP grievance process.

Location's Provider Representative is:

Telephone Number is:

REVISED: 1/2026

Link to Access the SMHS Grievance & Appeal Posters:

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

Link to Access the DMC-ODS Grievance & Appeal Posters:

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

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER TRANSACTION ACCESS NUMBER (PTAN) – COUNTY CLINICS ONLY

A Provider Transaction Access Number (PTAN) is a Medicare-only identifier issued by Medicare Administrative Contractors (MACs) upon approval of provider enrollment. This identifier is used by Medicare to verify provider eligibility, ensure compliance, and facilitate claims processing. MACs issue an approval or notification letter with PTAN details once enrollment has been completed.

The MCST requires that eligible Medicare providers in Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) County Clinics obtain and maintain a valid PTAN to ensure that services delivered to Medicare members are reimbursable.

KEY POINTS

- ✓ The Medicare population within the Behavioral Health Plan is comparatively small; however, county clinics must still maintain a minimum number of PTAN-enrolled physicians and clinicians at each AOA and SUD County Clinic.
- ✓ When a Medicare member receives services, they must be assigned to a PTAN-enrolled provider immediately to prevent reimbursement loss.
- ✓ PTAN providers who do not submit claims for four consecutive quarters may have their PTAN deactivated by Medicare.
- ✓ PTAN providers must complete Medicare revalidation every five years to maintain active enrollment.
- ✓ Licensed Marriage and Family Therapists (LMFTs) must submit a post-graduate hours attestation form before they can be approved as PTAN providers.

If your county clinic has a provider who may need to obtain a PTAN, please contact BHPPTAN@ochca.com for screening and confirmation of eligibility.

Eligible Behavioral Health Provider Types:

- Physicians and Psychiatrist
- Clinical Psychologist
- Licensed Clinical Social Workers
- Nurse Practitioners
- Physician Assistants
- Licensed Marriage and Family Therapists
- Licensed Professional Clinical Counselors

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER

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

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

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

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER (CONTINUED)

Please be aware:

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

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

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING REQUIREMENTS

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

CREDENTIALING

PROVIDERS REQUIRED TO BE CREDENTIALED:

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

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

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/County Application
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if applicable)
- ✓ DHCS Waiver for Registered Psychological Associates

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

DMC-ODS CHECKLIST

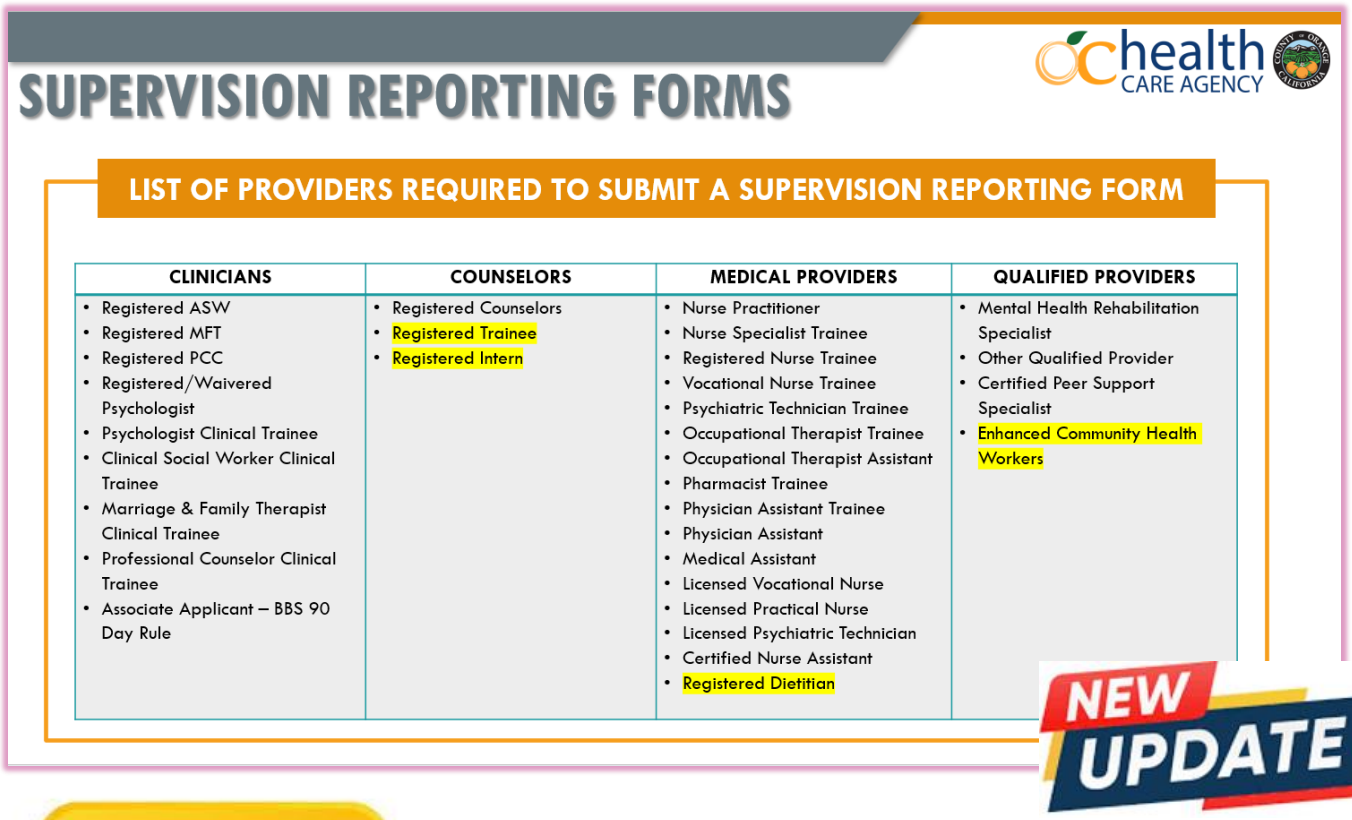
- ✓ Doe, John NARF
- ✓ Doe, John Resume/County Application
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Doe, John ASAM A
- ✓ Doe, John ASAM B
- ✓ 5 CEU/CME in Drug Addiction/Recovery (**ONLY** for MD, LCSW, LMFT, LPCC, Psychologist)
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if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

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORM REQUIREMENT

There are four types of supervision reporting forms the MCST oversees. We recently added some provider types on the forms and published it on the QMS website. Below is a grid listing all the provider types that must submit one of the required supervision reporting forms below:

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



NEW UPDATE

REMINDER

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

MANAGED CARE SUPPORT TEAM

ochealth CARE AGENCY

OUR TEAM

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II

Araceli Cueva
Staff Specialist

Boris Nieto
Staff Assistant

Jennifer Fernandez, LCSW
Behavioral Health Clinician II

Ashley Cortez, LCSW
Behavioral Health Clinician II

Liz Fraga
Staff Specialist

Vanessa Estrada
Office Specialist

Tanya Carbajal
Office Specialist

Joanne Pham
Office Specialist

Esmi Carroll, LCSW
Behavioral Health Clinician II

it's Summer time

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Leads: Esmi Carroll, LCSW & Jennifer Fernandez, LCSW

SUPERVISION REPORTING FORMS
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR SMHS
Leads: Araceli Cueva & Elizabeth "Liz" Fraga

CREDENTIALING AND PROVIDER DIRECTORY
Credentialing Lead: Ashley Cortez, LCSW
Cal Optima Credentialing Lead: Araceli Cueva & Elizabeth "Liz" Fraga
Provider Directory Leads: Joanne Pham

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)
Lead: Boris Nieto

COMPLIANCE INVESTIGATIONS
Lead: Catherine Shreenan, LMFT & Annette Tran, LCSW

CONTACT INFORMATION
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BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com
BHPPTAN@ochca.com

MCST ADMINISTRATORS
Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II

QMS MAILBOXES

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

BHPBillingSupport@ochca.com	IRIS Billing ● Office Support
BHPCertifications@ochca.com	SMHS Medi-Cal Certifications ● PAVE (SUD and JI) ● MPF/OOCR Updates
BHPDesignation@ochca.com	Inpatient Involuntary Hold Designation ● LPS Facility Designation ● Outpatient Involuntary Hold Designation
BHPGrievanceNOABD@ochca.com	Grievances & Investigations ● Appeals/Expedited Appeals ● State Fair Hearings ● NOABDs ● MCST Training Requests
BHPIDSS@ochca.com	General Questions Regarding Designation
BHPIRISFrontOfficeSupport@ochca.com	County Front Office Operational Support – Guidance on Front Office Procedures and Non-Technical EHR Workflow Inquiries
BHPManagedCare@ochca.com	Access Logs ● Access Log Entry Errors & Corrections ● Change of Provider/2nd Opinion ● County Credentialing ● Cal-Optima Credentialing (AOA County Clinics) ● Expired Licenses, Waivers, Registrations & Certifications ● PAVE (SMHS Only) ● Personnel Action Notification (PAN)
BHPNetworkAdequacy@ochca.com	Manage SMHS & DMC-ODS 274 Data ● Support of MHP County & Contract User Interface for 274 Submissions
BHPProviderDirectory@ochca.com	Provider Directory Notifications ● Provider Directory Submission for SMHS & DMC-ODS Programs
BHPPTAN@ochca.com	Assist in Maintaining PTAN Status of Eligible Clinicians & Doctors
BHPSUDSupport@ochca.com	DMC-ODS Clinical Chart Reviews ● Corrective Action Plan (CAP) Assistance ● Documentation & Coding Support ● Use of Downtime Forms ● Scope of Practice Guidance ● SUDsies Newsletter ● DMC-ODS Documentation Training Requests
BHPSupervisionForms@ochca.com	Submission of Supervision Reporting Forms for Clinicians, Counselors, Medical Professionals & Other Qualified Providers ● Submission of Updated Supervision Forms for Change of Supervisor, Separation, License/Registration Change ● Mental Health Professional Licensing Waivers
BHPUMCCC@ochca.com	Utilization Management of Out-of-Network (and In-Network) Complex Care Coordination Typically for ECT, TMS, Eating Disorders
BHSHIM@ochca.com	County-Operated SMHS & DMC-ODS Programs Use Related: Centralized Retention of Abuse Reports & Related Documents ● Centralized Processing of Client Record Requests and Clinical Documentation Review & Redaction ● Release of Information, ATDs, Restrictions & Revocations ● IRIS Scan Types, Scan Cover Sheets & Scan Types Crosswalks ● Record Quality Assurance & Correction Activity
BHSInpatient@ochca.com	Inpatient TARs ● Hospital Communications ● ASO/Carelon Communication
BHSIRISLiaison@ochca.com	EHR Support, Design & Maintenance ● Add/Delete/Modify Program Organizations ● Add/Delete/Maintain All County & Contract Rendering Provider and Front Office Staff Profiles in IRIS ● Manage SMHS & DMC-ODS 274 Requirements
BHSPandP@ochca.com	New BHS P&P needs ● BHS P&P updates
CalAIMSupport@ochca.com	Enhanced Care Management (ECM) ● Transitional Rent
QISystems@ochca.com	Quality Standards and Clinical Practice Team (QSCP) – EBPs, QAPI, BHA ● HEDIS/POM – CalOMS, CANS/PSC-35 ● BHP QI Support – QI Related Questions for SMHS and DMC-ODS Programs (Including DATAR, Medication Monitoring); QA/QI Meeting Invite Requests
QMSSpecialProjects@ochca.com	BHP Provider Manual ● Member Handbook ● Intake/Advisement Checklist ● Justice Involved SME
SMHSClinicalRecords@ochca.com	SMHS Clinical Chart reviews ● Corrective Action Plan (CAP) Assistance ● Documentation & Coding Support ● Use of Downtime Forms ● Scope of Practice Guidance ● QRTips Newsletter ● SMHS Documentation Training Requests