SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

August 2025

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CONTACT
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DMC-ODS Office Hours

A voluntary and informal space to ask questions and discuss documentation and coding issues. Occurs virtually on the second Wednesday of every month.

Next meeting: September 10, 2025

WHAT'S NEW?

NTP Requirements

The Department of Health Care Services (DHCS) has finalized changes to regulations for the NTPs to align with federal requirements. The new regulations are outlined in Behavioral Health Information Notice (BHIN) 25-008 and are effective October 1, 2025. The following is a brief overview of what is required:

- A screening evaluation by a physician or physician extender prior to admission (no more than 7 days prior)
- Minors under the age of 16 require consent of parent or legal guardian
- A full medical history and physical examination by a physician or physician extender within 14 calendar days of admission
- A behavioral health assessment
- An initial care plan based on a completed needs assessment within 14 calendar days of admission (must be reviewed and updated at least once every 3 months from the effective date of the initial care plan)
- In-person physical examination at least annually with review and evaluation of the care plan, response to treatment, etc.

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Training & Resources Access

DMC-ODS Payment Reform 2024 - CPT Guide (version 2):

DMC-ODS Payment Reform 2024 CPT Guide v2.pdf (ochealthinfo.com)

SUD Documentation Manual

DMC-ODS_CalAIM_Doc_Manual.pdf

MAT Documentation Manual

FINAL_CalAIM_MAT_Documentation_Manual_v3_11.6.24.pdf

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

WHAT'S NEW? (continued)

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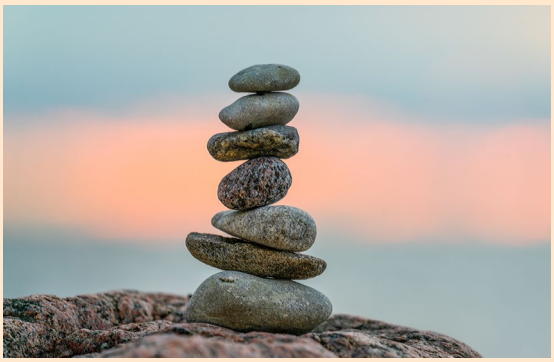
- 8 random tests or analyses for illicit drug use annually
- Minimum of 45 minutes of counseling services per calendar month with documentation completed within 14 calendar days of the session that includes:
    - Date of session, type of counseling (individual or group), session duration, session summary that addresses progress towards goal(s), response to drug testing, new issues, prenatal/postpartum support, or results of screenings/assessment
    - For groups, the documentation of the goal or purpose of the session, subjects discussed, and summary of the client's participation
- Documentation by the physician or physician extender regarding medical determination of medication and dosages with explanations for any deviations or changes in dosing schedule or frequency
- Additional requirements for pregnant clients

NTPs must submit an amended protocol based on the new regulations to DHCS no later than November 1, 2025.

Access the BHIN here: BHIN-25-008



CODING TIP

The **Skills Training and Development, Individual, per 15 Min (70899-113)** and **Skills Training and Development, Group, per 15 Min (70899-114) H2014** codes may now be used for more than just Patient Education. They can be used when services involve teaching life skills necessary to function independently in the community to support the client's recovery. It is intended to be a structured, goal-oriented teaching and demonstration of targeted skills, offering supervised practice to reinforce skills like social/interpersonal skills, problem-solving, self-care, etc. Remember: to use the billable code, it must be medically necessary so be sure to document how the teaching of the life skill is tied to the client's SUD.

Patient Education groups should continue to be claimed using this code.

These codes are not available for use at the residential or withdrawal management levels of care as it is part of the daily bundle of services to be provided and not separately billable.

Documentation FAQ

1. Do we still need documentation time on the progress note and in IRIS?

For Contracted Programs ONLY: No. Documentation time does not need to be indicated on the progress note. Previously, we were continuing to enter the documentation minutes into IRIS for tracking purposes. However, this is no longer required. The documentation and travel minutes field in IRIS can be left blank. County programs should continue to document any documentation and travel time.

2. If a client is transferring to a new primary counselor, does a new problem list need to be created?

No. There are times when a client may need to change primary counselors due to a counselor leaving the agency, client's preference or particular needs, etc. and there is no change in level of care or program. The problem list started by the client's former counselor may continue to be used. It is recommended that the new primary counselor review the problem list with the client to confirm that the items are still applicable and that there are no additional needs that should be included. If, based on the collaboration with the client, there is a new issue that needs to be addressed, the new primary counselor may add to the problem list, bearing in mind scope of practice.

3. Is letter writing for Prop 36 billable?

It is billable if the following is true:

A. The activity is medically necessary, and
B. The content is clinical information that can only be provided by the letter writer.

The letter simply being required for Prop 36 does not make it billable. The letter writing must be relevant to the client's SUD treatment. For example, if the letter is needed for court to make

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Documentation FAQ (continued)

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the case for client's continued stay in treatment, this needs to be made clear in the documentation of the progress note to justify billing for the time. Additionally, the information being provided must be clinical in nature that requires the expertise of the writer. In other words, it cannot be information that can be easily extracted from the client's chart by any staff (e.g., number of drug tests administered, attendance in individual and group counseling services, etc.). An example might be the writer needing to provide a clinical impression of the client's progress toward treatment goals and continued barriers that supports the writer's recommendation for the client to continue in treatment.

4. The program I work in is not a perinatal program. Do I still need to follow the Perinatal Guidelines for my pregnant client?

Yes. All pregnant and post-partum clients, regardless of whether they are enrolled in a perinatal-specific program, are required to receive services according to the Perinatal Guidelines. Access it here: Perinatal Practice Guidelines 2024

5. Can a Registered Nurse complete a MAT evaluation?

No. The evaluation to determine whether a client needs or is appropriate to receive medications for MAT can only be completed by a licensed physician, physician assistant, or nurse practitioner. An RN completing a MAT evaluation is acting out of scope of practice. Therefore, it is important that the documentation does not make it appear as though an RN is evaluating a client for MAT. The RN may gather information to support the MD's assessment of the client for MAT. The documentation for billing any time conducting assessment activities by an RN should make clear that it is for the purpose of obtaining information to be relayed to the MD.

Reminders

Transitions to Other Levels of Care

The State requires that providers transition clients from one level of care to another no later than 10 business days from the time of assessment or re-assessment. If this is not possible, be sure there is documentation to explain the reason for the delay.

Documenting Absences at Residential Programs

At the residential levels of care, if the client is unable to meet the requirement to participate in a minimum of 5 clinical programming hours per week, there needs to be documentation explaining the reason. Without this documentation, it is difficult to justify the claiming of treatment days. Also keep in mind that for each day that is claimed, there must be evidence of at least one qualifying service that was provided. This means there must be a progress note documenting that an assessment, individual or group counseling, family therapy, SUD crisis intervention, medication service, or patient education was provided on any given day.

Intake Documents across Levels of Care in the Same Program

The State regulations do not explicitly require new intake paperwork to be completed for the same program. However, they do require that client's rights be taken into consideration when providing services. We typically inform clients on treatment services and risks and benefits so that they may participate in decisions regarding their care through the review of intake documents. Therefore, it is good practice to review new intake documents at the time of each level of care change. If the same intake paperwork is going to be used across different levels of care within the same program, be sure that the documents are accessible in the client's chart for each episode of care.

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

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

REMINDERS, ANNOUNCEMENTS & UPDATES

PROVIDER DIRECTORY

Department of Health Care Services (DHCS) recently issued the BHIN 25-026 that supersedes BHIN 18-020, 25-015 (in part) and 22-068 (in part). It introduces new requirements that builds on existing policy by mandating that provider directories be searchable in electronic form, include whether each provider offers covered services via telehealth, etc.

In addition, DHCS also recognizes how the 274 Provider Network File aligns with the Provider Directory. In preparation to streamline the Orange County Provider Directory we will be integrating it into the 274 User Interface (UI). In July, a revised Provider Directory spreadsheet was disseminated containing additional fields to be completed to successfully help migrate some of the required data to the 274 UI. We kindly ask that program follow the submission guidelines using the most current Provider Directory spreadsheet, to maintain the accuracy of the information each month.

The MCST, Data Analytics & Evaluation (DAE) and HCAIT are working quickly to integrate the Provider Directory into the 274 UI. We are anticipating the launch of the Provider Directory 274 UI sometime soon! More information to come!

REMINDER: Provider Directory submissions are due on the 15th of every month to BHPProviderDirectory@ochca.com.

NEW

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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. Additionally, SB 923 requires DHCS to track, monitor, and report grievances, impose sanctions for violations of the law, and publicly report this data alongside other grievance data.

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.

The MCST is 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, **must 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 to close out the grievance.

Providers or staff at a program should note that any pattern of repeated TGI grievances that are substantiated against a provider(s) and/or staff at a program presumes that the provider(s) and/or staff at that program (BHP, 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 towards TGI members and requires further remediation, including, but not limited to staff training, staff discipline, and/or re-evaluation of the training curriculum.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER TRANACTION ACCESS NUMBER (PTAN)

The PTANs will be transitioned to the MCST, effective 7/1/25. Eligible providers are required to be registered with a PTAN in the SMHS and DMC-ODS Adult & Older Adult (AOA) outpatient county clinics for the county to be reimbursed for Medicare and Medi-Medi covered services.

If you are a county LPHA/LMHP provider, you may be eligible to obtain a PTAN. Please contact the PTAN Lead at BHPPTAN@ocha.com to initiate the process.

WHAT IS A PLW?

It is a Professional Licensing Waiver (PLW) for psychology candidates who has accumulated 48 semester units or 72 quarter units of graduate coursework or has graduated from a doctoral program and wants to deliver Medi-Cal covered services at a county clinic or contracted program.

PROFESSIONAL LICENSING WAIVERS (PLW)

Effective 7/1/25, the PLWs will be transitioned to the MCST. The MCST is required to complete the PLW application for County and County-contracted CYS and AOA providers. The PLW allows pre- and post-doctoral candidates to bill Medi-Cal for SMHS while acquiring supervised professional experience to obtain their license.

If you are a county or contracted provider needing to apply for a PLW please contact the Supervision Lead at BHPSupervisorForms@ocha.com with the subject line: PLW Request to initiate the process, effective 7/1/25.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

REVISED

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

DHCS REVISED THE NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) & ENCLOSURES

Department of Health Care Services (DHCS) recently issued the BHIN 25-014 and supersedes BHIN 18-010E. It provides updated clarification and guidance regarding the application of federal regulations and state law for processing grievances and appeals.

This BHIN also encloses several notice templates, including the Notice of Grievance Resolution (NGR), Notices of Adverse Benefit Determination (NOABD), Notices of Appeal Resolution (NAR), a "Your Rights" attachment, a member non-discrimination notice, and language assistance taglines. These notices provide members with required information about their rights under the Medi-Cal program.

BRIEF OVERVIEW OF THE REVISIONS

- Grievance and NOABD enclosures are renamed to:
  Your Rights => Your Rights Under Medi-Cal Managed Care
  Language Assistance => Notice of Availability
- The enclosure titled "Your Rights Under Medi-Cal Managed Care" include additional content about:
  - ✓ **Aid Paid Pending** (APP) – members have the right to keep receiving approved services while waiting for a final decision from an appeal or State hearing.
  - ✓ **Second Opinion** – members have the right to a second opinion from a network provider, or for the BHP to arrange for the member to obtain a second opinion outside of the network, at no cost to the member.
- The revised English NOABDs and enclosures are now available on the QMS website. The other threshold languages are currently being translated. See links below to access the forms:
  QMS SMHS Forms: Mental Health Plan and Provider Information | Orange County California - Health Care Agency (ochealthinfo.com)
  QMS DMC-ODS Forms: DMC-ODS For Providers | Orange County California - Health Care Agency (ochealthinfo.com)
- The revised NOABDs and enclosures are to go into effect, immediately.

NOABD DELIVERY SYSTEMS TO BE ISSUED TO SUD DMC-ODS MEMBERS

- SUD DMC-ODS outpatient programs are now required to use **NOABD Delivery System** instead of the NOABD Denial of Authorization for Requested Services.
- The **NOABD Delivery System** is used when it is determined that the member does not meet the criteria to be eligible for substance use disorder services and shall refer the member to the appropriate health care delivery system (i.e., Managed Care Plan, mental health, Medi-Cal Fee-for-Service), or other services.
- The **NOABD Denial of Authorization for Requested Services** is still available to use for denying the authorization of SUD residential service requests.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST GENERAL E-MAIL BOXES

QMS has renamed all the general e-mail addresses and created new ones to enhance the communication and efficiency with serving our providers and members. Please begin using the e-mail addresses listed below for questions and documents to be sent to the appropriate mailboxes. Please update our e-mail addresses, as some of the old e-mail addresses will expire August 2025.

	MCST MAILBOXES	OVERSEES
	BHPGrievanceNOABD@ochca.com	Grievances & Investigations; Appeals/Expedited Appeals; State Fair Hearings; NOABDs; MCST Training Requests
	BHPManagedCare@ochca.com	Access Logs, Access Log Entry Errors & Corrections; Change of Provider/2nd Opinion; County Credentialing; Cal-Optima Credentialing (AOA County Clinics); Expired Licenses, Waivers, Registrations & Certifications; PAVE (SMHS Only); Personnel Action Notification (PAN)
new	BHPProviderDirectory@ochca.com	Provider Directory Notifications; Provider Directory submission for SMHS and DMC-ODS programs by the 15th of every month.
new	BHPSupervisionForms@ochca.com	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
new	BHPPTAN@ochca.com	Provider Transaction Access Number (PTAN) enrollment and inquiries.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **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 to schedule the training at least a month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a full training about MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and the Service Chief II, Catherine Shreenan at cshreenan@ochca.com.

MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is offering open training sessions for new and existing providers. The 3-hour training is on NOABDs, Grievances, Appeals, State Fair Hearings, 2nd Opinion/Change of Provider, Supervision Reporting Forms and Access Logs.

Please e-mail BHPGrievanceNOABD@ochca.com with Subject Line: MCST Training for SMHS or DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

2nd Tuesdays of the Month @ 1 p.m. MCST Training (SMHS)
4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

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

SUPERVISION REPORTING FORMS
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR SMHS
Leads: Araceli Cueva & Elizabeth "Liz" Fraga (Staff Specialists)

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

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)
Lead: Boris Nieto, Staff Assistant

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

CONTACT INFORMATION
400 W. Civic Center Drive., 4th floor
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E-MAIL ADDRESSES
BHPGrievanceNOABD@ochca.com
BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com
BHPPTAN@ochca.com

MCST ADMINISTRATORS
Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
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