SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

July 2025

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Clarification

For the **Medication Training and Support – Individual per 15 Min (70899-110) H0034 code,** the CPT Guide and MAT Documentation Manual indicate it is for "providing psychoeducation, training, and/or support related to medication." For the residential and withdrawal management levels of care that also provide MAT services, this code is one of

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WHAT'S NEW?

Service Code Changes

The Department of Health Care Services (DHCS) has released an updated Service Table with changes to the available service billing codes for the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The most relevant changes to us are as follows:

1. **Telephone Evaluation & Management (E/M) Services code series (99441-99443)** have been removed.
    - As a replacement, for E/M services conducted via telephone or telehealth, the **Office Outpatient Visit of a New/Established Patient code series (99202-99205/99212-99215)** may be used.
2. **SUD Crisis Intervention (Outpatient) H0007** may now be used for services conducted via telehealth or telephone, with the appropriate modifiers.

Please note that both code changes apply to the outpatient levels of care.

The Service Table can be accessed here: MedCCC - Library

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

Clarification (continued)

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two codes available to claim MAT services. This means that the code can only be used for clients who are in the process of being assessed for MAT or whose medical necessity for MAT has been established. As a result, the psychoeducation, training, and/or support should be relevant to the specific MAT medications prescribed for the client in the MAT program. As a reminder, there is a distinction between MAT services and medication services that are part of the daily bundle of services at the residential and withdrawal management levels of care. Use of this code to bill for the medication services that are a component of the available services at these levels of care is considered duplicative billing and will result in disallowance.

Recovery Services

Recovery Services is a great way for our clients to stay engaged in services after completing treatment. It offers a "safety net" of monitoring, counseling/coaching, and care coordination that supports the client's independence and integration in the larger community while making treatment that may be needed in the future easily accessible. Ideally, clients arrive at Recovery Services as part of their move through the continuum of care through gradual step downs from higher levels of care. But in many cases, Recovery Services can be a beneficial alternative for our clients who are not interested in treatment. Whether you have a client who has been engaged in treatment for some time or has just presented to an intake appointment, Recovery Services may be an important part of the discussion in educating clients on available services in the DMC-ODS.

Remember that for clients who are discharging from a treatment level of care to receive Recovery Services, the treatment episode of care (EOC) should be closed and a new EOC opened for Recovery Services. A CalOMS is not required for Recovery Services.

Documentation FAQ

1. Why can't we bill for crisis at the residential or withdrawal management levels of care?

There is only one billing code that allows for billing the time spent addressing an SUD crisis, but this code is only able to be used at the outpatient levels of care. Thus, the SUD Crisis Intervention (Outpatient) (70899-107) H0007 code cannot be used at the residential or withdrawal management levels of care. Additionally, crisis intervention is considered part of the daily bundle of services. For the residential levels of care, the time spent de-escalating and stabilizing a client who is at risk of imminent relapse or has relapsed, is a qualifying service for billing the day rate. There must be documentation to evidence that the service was provided. It can also count towards the required five clinical hours for the week (again, it must be documented to support the time). Intervening in such crises as well as the engagement efforts needed to encourage a client to stay in treatment (e.g., client wishing to leave against clinical advice), also speaks to key factors like the client's level of motivation and ability to manage relapse triggers or urges to use, that should be highlighted in the re-assessments at residential programs as part of the consideration for continued stay.

2. The non-LPHA who completed the assessment has left the program before a consultation with the LPHA could be completed. Do we have to re-do the assessment?

No. The LPHA can meet with the client to review the information gathered by the non-LPHA to confirm that there is sufficient information for the LPHA to determine the appropriate level of care placement and SUD diagnosis. The LPHA should assess the client based on the combination of the non-LPHA's gathering of information and the LPHA's interaction with the client to complete the required narrative or write-up (or Case Formulation). The LPHA should document why meeting with the

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Documentation FAQ (continued)

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client was necessary, so it is clear why there is no documentation of a consultation between the non-LPHA and LPHA in this case.

3. Can we use ICD-10 Z codes that are outside of Z55-Z65?

Yes. The State specifically identified the Z55-Z65 codes as those that can be determined and utilized by a non-LPHA without the need for the involvement by the LPHA. This means that any Z codes that fall outside of Z55-Z65 would require the LPHA to establish. For example, some providers have been utilizing the Z86.59 "Personal history of other mental and behavioral disorders" code to indicate on the client's problem list that the client may have some mental health symptoms that do not meet the full criteria for a mental health diagnosis. This code falls outside of the Z55-Z65 codes and would require the LPHA to establish. The non-LPHA may add it to the problem list if it has been determined and documented by an LPHA.

4. A non-LPHA consults with the LPHA about the client's treatment plan/problem list. Is this billable as SUD Treatment Plan Development/Modification?

No. A medically necessary consultation between the non-LPHA and LPHA is billable using the Targeted Case Management, Each 15 Min (70899-120) T1017 code, even if the topic of the discussion is about the client's treatment plan or problem list. The SUD Treatment Plan Development/Modification (70899-125) T1007 code should only be used when the service is with the client to discuss the course of treatment, such as when developing the treatment plan or identifying problems to be included in the problem list, discussing how the client's progress or obstacles to progress may necessitate changes to the treatment plan/problem list, or strategizing on how new concerns that arise may be approached or addressed with particular services.

Reminders

Group Participant Lists

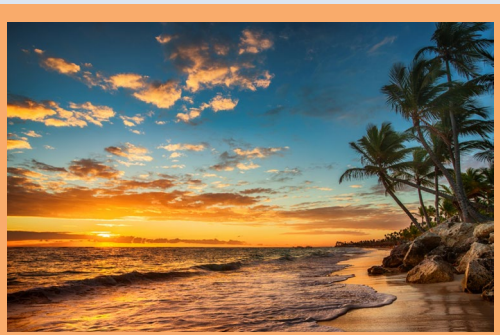
The group participant list cannot replace or be used in place of a progress note. Therefore, a group service claimed at the outpatient levels of care with only a participant list and no progress note, is a disallowance that will result in recoupment. For the residential levels of care, the group cannot count towards the required 5 clinical hours for the week without a corresponding progress note.

Case Formulation

The LPHA's narrative or write-up cannot be a "copy and paste" of the rationale sections of dimensions 1-6 of the ASAM. The LPHA is required to complete this documentation because the level of care determination can only be made by the LPHA. Therefore, the information in the LPHA's documentation must explain how the combination of the client's risk in the various ASAM dimensions points to their need for the intensity of services available at a particular level of care. Consider approaching the documentation from the angle of broadly identifying the client's treatment needs and tying the reasoning to the level of risk, clinical concerns, barriers, strengths, etc.

Medical Documentation

For perinatal programs, be sure to obtain medical documentation of the client's pregnancy as well as the last date of pregnancy (if applicable within the treatment episode) for the client's chart. The postpartum period is the 12-month period beginning on the last day of pregnancy. Use of the perinatal billing code is permitted until the last day of the calendar month in which the 365th day occurs.



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
- 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

BRAILLE GRIEVANCE MATERIALS READY FOR PICK-UP!

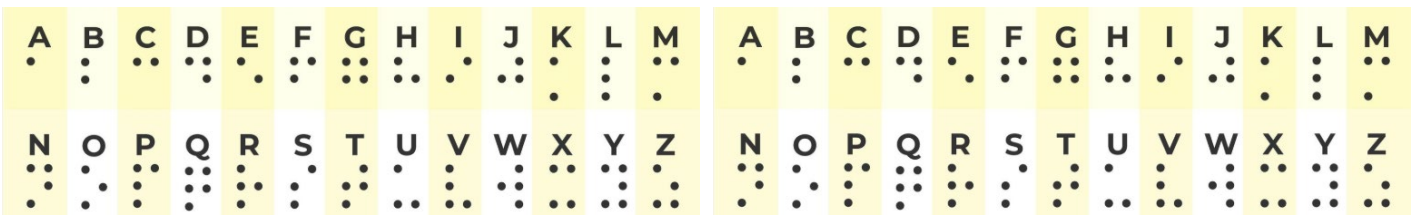
The Department of Health Care Services (DHCS) requires the Behavioral Health Plan (BHP) to accommodate the communication needs of all members and be prepared to facilitate alternative format request for Braille, audio format, large print, accessible electronic format, and other auxiliary aids and services that may be appropriate.

The County has received the Braille grievance informing materials to meet the requirement for the:

- Grievance & Appeal Form
- Grievance & Appeal Poster (SMHS)
- Grievance & Appeal Poster (DMC-ODS)

Information has been communicated to County and contracted programs to pick up the materials over the last month. If you have not picked up the materials for your program, please reach out to the MCST via e-mail at BHPProviderDirectory@ochca.com to coordinate a date and time to pick it up at the:

CAN Building
400 W. Civic Center Dr., 4th Floor
Santa Ana, CA 92701
(714) 834-5601



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.

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, **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. BHPs are also required to submit to DHCS verification of the completed refresher training quarterly.

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)

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 not 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 Systems** instead of the NOABD Denial of Authorization for Requested Services.
- The **NOABD Delivery Systems** 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. The old e-mail addresses will automatically be forwarded to the new ones for a short period of time. Please update our e-mail addresses, as some of the old e-mail addresses will expire August 2025.

MCST MAILBOXESV	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 for Psychology Candidates.
new BHPPTAN@ochca.com	Provider Transaction Access Number (PTAN) enrollment and inquiries.

PROVIDER DIRECTORY WILL BE INTEGRATED INTO THE 274 USER INTERFACE (UI)

The MCST has worked in collaboration with DAE and HCAIT to streamline and integrate the Provider Directory into the 274 UI. We are anticipating the launch of the Provider Directory 274 UI sometime in August/September 2025. More information to come!

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 Adult & Older Adult (AOA) and DMC-ODS Adult 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.

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

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

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

CONTACT INFORMATION

400 W. Civic Center Drive., 4th floor
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480-0755

E-MAIL ADDRESSES

BHPGrievanceNOABD@ochca.com
BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com
BHPPTAN@ochca.com

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II