October 2025

QRTips

Behavioral Health Services
Quality Management Services

New Training Request Form

The Technical Assistance and Training Support (TATS) Team is excited to announce that we now have a quick and easy way for providers to request training on documentation and service codes!

Once a request is submitted, a TATS Team member will begin the coordination process to determine how best to address the requested training needs/concerns.

If you are a direct service provider (e.g., counselor, clinician) interested in receiving more training, let your supervisor know. Only an administrator, such as a Service Chief, Program Director, QI Coordinator, etc. will be able to utilize this form.

Link to the TATS Training Request Form

TRAININGS & MEETINGS

Online Training:
BHP Annual Provider Training

SMHS QA/QI Coordinators' Meeting

Teams Meeting
11/13/25
10:00 AM - 11:30 AM

SMHS Documentation Office Hours

Teams Meeting
1st & 3rd Thursday
of the Month
10:00 AM - 10:50 AM
Email SMHS Clinical Records Review Team
for invitation

Helpful Links:

QMS Support Team
BHS EHR Blog Posts
Medi-Cal Certification

Progress Note Requirement: Brief description of how service addressed client's behavioral health need

When documenting the service provided, include *why* the service was provided and *how the service addressed the client's mental health symptoms*, behaviors, and/or problems.

Example 1:
Service: Referred client to a homeless shelter
Why: To increase client's sense of safety
Symptoms/behaviors/problems: To reduce client's anxiety and insomnia.

OQP referred client to a homeless shelter to increase client's sense of safety and to reduce client's anxiety and insomnia.

Example 2:
Service: Taught client squared breathing and practiced with client
Why: To increase calmness/decrease anxiety
Symptoms/behaviors/problems: anxiety, social phobia, going into public areas (as listed on Diagnosis/Problem List)

Due to client's anxiety when she is in public areas or in social settings, MHRS taught client the squared breathing technique to help client feel more calm and practiced the coping skill with client.

Please note: Justification for greater service time should be documented in the body of the progress note. This may include, but is not limited to, providing more than one intervention of the same service type, including barriers due to client's symptoms/ behaviors, modeling/practicing a learned skill.

Reminder to Service Chiefs & Supervisors: Please submit monthly program and provider updates / changes for the Provider Directory and send to: BHPProviderDirectory@ochca.com and BHSIRISLiaison@ochca.com. Review QRTips in staff meetings and include in your meeting minutes.

Disclaimer*: Quality Management Services (QMS) develops and distributes the monthly QRTips newsletter to all Specialty Mental Health Service (SMHS) providers as a tool to assist with various Quality Assurance (QA) and Quality Improvement (QI) regulatory requirements. The newsletter is NOT an all-encompassing document. Providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.*

Questions and Answers

Q: When can I bill for discharge?

A: If a medically necessary service is provided during discharge, the service can be billed under a service code for the type of service provided. Allowable services by provider type can be found in the Provider Type Quick Guides.

For example:

a) If it is medically necessary to consult with the treatment team to determine if the client is ready for discharge or to notify all involved parties that the client will be discharged, the provider(s) can bill the service under a plan development code.

b) If it is medically necessary to have a therapy session with the client upon discharge to process the discharge itself, the therapist can bill Individual Therapy.

Please note: Completing the discharge summary *form* is a non-billable service. It can be documented clearly as a non-billable service within the same progress note as the billable discharge service or documented separately.

Q: Can you bill for the formulation and synthesizing of domains 1 through 6 of the Comprehensive Assessment without the client present?

A: No. Documentation of the information gathered for domains 1 through 6 without the client present is a non-billable activity. According to DHCS, the reimbursement for this is already covered by the higher rates. Domain 7 is the only domain that can be billed without the client present for the formulation of the clinical summary and recommendations, diagnostic impression, medical necessity determination, level of care and access criteria.

Q: Is the Milestones of Recovery Scale (MORS) still being used?

A: The MORS tool is not a documentation requirement set by the Department of Health Care Services (DHCS); however, please consult with your supervisor if it is a programmatic requirement.

Q: If two practitioners are consulting with each other for 30 minutes, do they split the service minutes in their documentation?

A: If both practitioners are assigned treatment team members for that client, both are able to bill for the entire time of the consultation. Documentation of this service should include the purpose of the consultation, each practitioner's contribution, and the outcome of that consultation whether or not there is a change to treatment.

Q: How do we justify billing for providing a service that took longer than usual so the service time does not appear excessive?

A: To capture a greater service time for an intervention that may be completed in a shorter amount of time, the documentation should show justification (e.g. client's symptoms complicated the session, a referral packet was several pages long, multiple interventions of the same service type were provided, etc.).

Note: It is important to indicate which services in the body of the progress note are non-billable, if any, to notify the reader that the non-billable services are not included in the overall billable service time.

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 TRANSITION TO THE 274 USER INTERFACE

Beginning November 1, 2025, monthly submissions for the Behavioral Health Plan Provider Directory will transition to the 274 User Interface (274 UI) for all providers. This platform aligns with several data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT). This will help support improved data consistency and streamlined reporting for both the NACT and Provider Directory. The monthly Excel spreadsheet for the Provider Directory will no longer be required for submission starting **November 2025.**

This transition will have the program administrators from county and county-contracted programs, be responsible for entering and updating data through the 274 UI monthly. To support this change, training materials will be distributed in September/October 2025 to the Service Chiefs and Contract Monitors. Contract Monitors will be working closely with the county-contracted staff who currently access the county network with a token to publish a shortcut to the 274 UI site using the Citrix desktop to access and enter the data requirements for the NACT and Provider Directory.

All updates made in the 274 UI by program administrators will automatically reflect on the newly enhanced Provider Directory website.

https://bhproviderdirectory.ochca.com

This transition represents a significant advancement in streamlining and enhancing the efficiency of data collection for both providers and the MCST. To review the DHCS Provider Directory requirements, please refer to the BHIN 25-026.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

ANNUAL PROVIDER TRAINING CERTIFICATE OF COMPLETION

The Annual Provider Training (APT) deadline has been extended and can be completed by **10/16/25.** Any initial credential packets for new hires after 10/16/25 will require the 2025 APT certificate of completion. Any prior version of the APT certificate of completion submitted will be invalid.

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER

Effective November 1, 2025, QMS will implement 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.

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.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** programs are required to schedule comprehensive training to comply with the MCST oversight and DHCS requirements. It is recommended that Directors, Managers, Supervisors, and Clinical Staff participate in the training to ensure all requirements are met and implemented. Please contact the MCST to schedule the training at least one month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a comprehensive training on the MCST oversight, please email 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

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.

Group Mailbox	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)
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
BHPProviderDirectory@ochca.com	Provider Directory notifications ● Provider Directory submission for SMHS & DMC-ODS programs
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 document review & redaction ● Release of Information, ATDs, restrictions & revocations ● IRIS Scan Types, Scan Cover Sheets & Scan Types crosswalks ● Record quality assurance & correction activity
BHSIRISLiaison@ochca.com	EHR support, design & maintenance ● Add/delete/modify program organizations ● Add/delete/maintain all county & contract rendering provider profiles in IRIS ● Register eligible clinicians & doctors with CMS
BHPNetworkAdequacy@ochca.com	Manage MHP and DMC-ODS 274 data & requirements ● Support of MHP county & contract user interface for 274 submissions
BHPPTAN@ochca.com	Assist in maintaining PTAN status of eligible clinicians & doctors
SMHSClinicalRecords@ochca.com	Chart reviews ● Corrective Action Plan (CAP) assistance ● Documentation & coding support ● Use of downtime forms ● Scope of practice guidance ● QRTips newsletter
BHPSUDSupport@ochca.com	SUD documentation support ● CalOMS (clinical questions) & DATAR ● DMC-ODS reviews ● MPF updates ● PAVE (County SUD Clinics)
CalAIMSupport@ochca.com	Enhanced Care Management
BHPBillingSupport@ochca.com	IRIS billing ● Office support
BHPIDSS@ochca.com	General questions regarding designation
BHPDesignation@ochca.com	Inpatient involuntary hold designation ● LPS facility designation ● Outpatient involuntary hold designation
BHPCertifications@ochca.com	SMHS Medi-Cal certification
BHSInpatient@ochca.com	Inpatient TARs ● Hospital communications ● ASO / Carelon communication
BHPUMCCC@ochca.com	Utilization management of Out of Network (and in network) complex care coordination. Typically for ECT, TMS, eating disorders
QISystems@ochca.com	CANS/PSC-35 data entry issues ● QA/QI Meeting invite requests