SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

September/October 2025

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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 of every month.

NEW: We are adding another office hours on the **fourth Thursday @10:00am**

Upcoming meetings: October 8, 2025 & October 23, 2025

WHAT'S NEW?

AOD Counselor Education Requirements

The Department of Health Care Services (DHCS) has made changes to the education requirements for Alcohol and/or Drug counselors due to the passage of AB 2473, effective January 1, 2026. A summary of the Behavioral Health Information Notice (BHIN) 25-029 that outlines the changes is as follows:

- An individual who registers as a counselor for the first time on or after July 1, 2025, must complete a minimum of eighty (80) hours of education, including education in core competency education topics, within six (6) months of registration.
- Individuals who complete education hours prior to registration, using coursework approved by the certifying organizations, may count those hours towards the eighty (80) hours of education, including core competency education topic requirements.
- Within six (6) months of registration, first-year registered counselors must submit written documentation to the certifying organization

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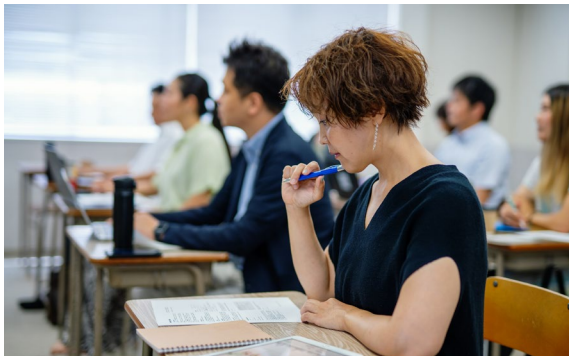

Training & Resources Access

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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demonstrating they completed the minimum education requirements.

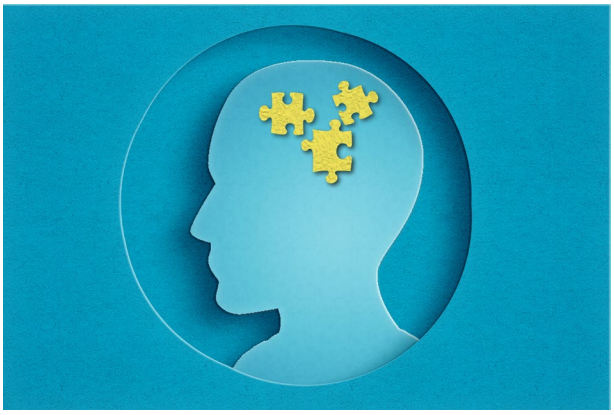
- First-year registered counselors must apply for registration renewal a minimum of one hundred twenty (120) calendar days prior to the expiration date specified on the current written registration.
- An individual who registered as a counselor prior to July 1, 2025, must provide written documentation to the certifying organization that they completed a minimum of 315 hours of AOD education including core competency education topics prior to initial certification.
- Registered counselors that have completed fewer than 315 hours of AOD education in total must provide written documentation to their certifying organization that they completed fifty (50) hours of AOD education to qualify for registration renewal.
- Registered counselors who have completed 315 hours of AOD education as required for initial certification shall submit twenty (20) hours of continuing education to qualify for registration renewal.

Access the BHIN here: BHIN 25-029

IMPORTANT
CARE COORDINATION UPDATE

In Behavioral Health Information Notice (BHIN) 24-001, the State indicates that a licensed provider is responsible for supervising care coordination. Registered/certified counselors may assist with aspects of this service. Therefore, going forward, please be sure it is clear in the documentation that the LPHA has determined that the client is appropriate for and necessitates care coordination. For example, this can be documented by the LPHA in the case formulation or narrative write-up where the level of care placement is established. The client's need for care coordination as one of the services to be provided can be included. Or the LPHA could document it in the progress note for the consultation with the non-LPHA where the ASAM-based assessment is reviewed, and treatment recommendations are discussed.

Refer to BHIN 24-001, Enclosure 5, for more information.



Documentation FAQ

1. A client did not attend the entire group session. Do I still need to complete a progress note?

Yes. The progress note documentation should explain that the client only partially attended the group (i.e., arrived late or left early). If the reason is known, this should also be included in the documentation. For example, "Client arrived 15 minutes late to the group due to delay in transportation" or "Client needed to leave the group early on this day (10 minutes) to attend appointment with PCP." For billing in these cases where the client is missing a small portion of the group service, it is permissible to claim the entire duration of the group.

2. I met with my client for individual counseling earlier today. Then I provided care coordination by telephone this afternoon. Is this one claim because it is on the same day?

No. For multiple encounters to be billed as one claim, all encounters must be of the same service type. In this situation, individual counseling and care coordination are two different service types and billing codes. Therefore, each must be claimed separately (i.e., a separate FIN for each). The rule is: same client, same provider, same date of service, and same service code.

3. Our site has ODF, IOT, and RS. If our clients transition across these levels of care in our program, do we have to obtain a new AOB/ATD each time?

No. Although it is recommended that a new AOB/ATD is obtained each time you are orienting the client to the new level of services, it is not required. Since it is the same entity, we can consider the client's transition across ODF, IOT, and RS as one overarching treatment episode for the purposes of the AOB/ATD. Obtaining a valid AOB/ATD upon the client's entry to services at your site

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Documentation FAQ (continued)

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would be sufficient. It is important to stress that the AOB/ATD document needs to be readily accessible in the client's chart. If your site utilizes separate charts for each episode of care, you must make sure that there is a copy of the valid AOB/ATD in each.

4. At the time of admission, our clients receive a brief screening with our intake coordinator before a session with their assigned counselor. How can this be billed?

If the only activity performed in the encounter is some type of screening, the SUD Screening (70899-105) H0049 or SUD Structured Assessment 5-14/15-30/30+ (70899-102/70899-100/70899-101) codes may be used. If the intake coordinator is also reviewing and obtaining signatures for the intake paperwork along with the brief screening, the SUD Screening (70899-105) H0049 code should be used. The progress note documentation for the encounter should make clear what was conducted and the purpose to justify the amount of time claimed.

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

Non-LPHAs can bill using Z55-65 codes

Until the LPHA determines an SUD diagnosis, the non-LPHA must use one of the Z55-65 codes to bill. This means that even beyond the intake service, all services provided until the LPHA has assigned an SUD diagnosis, would need to be claimed with one of the Z55-65 codes. The non-LPHA using an SUD diagnosis to bill *prior* to the LPHA establishing the diagnosis is out of scope of practice and will lead to a disallowance and recoupment.

Delays in completing ASAM-based assessment

Although there are no timelines for completing the assessment at the outpatient levels of care, the expectation is that they are completed as expeditiously as possible, based on the clinical needs of the client and generally accepted standards of practice. It is advised that any reason for the delay in completion be documented in the client's chart. For example, in documenting a no-show, the provider can add "Unable to continue with completion of assessment." For appointment rescheduling calls where you discussed the need for client to meet individually to complete the assessment, this can be included in the documentation. As a reminder, contact with the client to schedule appointments is not billable.

Group size limitation

All group counseling services claimed must have a minimum of 2 and a maximum of 12 clients (the only exception is Patient Education, where more than 12 clients is permissible). At the residential levels of care, clinical groups with more than 12 clients cannot count towards the required 5 clinical hours for the week. Group counseling services at the outpatient levels of care that do not adhere to these requirements will be disallowed and result in recoupment.

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-OCTOBER

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

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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
Service Chief II