SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

December 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 (2pm) & fourth Thursday* (10am) of every month.

Upcoming meetings: December 11, 2025 and January 14, 2026

**No Thursday Office Hours December*

WHAT'S NEW?

Substitute Codes Available

The Assessment Substitute (T2024) and Therapy Substitute (T2021) codes are now built in IRIS and available for use!

For County providers: Substitute codes are not yet available on the Powerforms. At this time, they may be used with the downtime forms only.

These substitute codes can only be used for the following assessment and therapy services:

- Psychiatric Diagnostic Evaluation 90791-1
- Psychiatric Diagnostic Evaluation with Medical Services 90792-1
- Psychiatric Evaluation of Hospital Record 90885-1
- Family Psychotherapy (without patient present) 90846-1
- Family Psychotherapy (with patient present) 90847-1
- Multiple-Family Group Psychotherapy 90849-1

Be sure to check the CPT Guide and the State's Service Table for the eligible providers who can use these codes. We have also created a cheat sheet for when the substitute codes may be utilized (see page 5).

Continued on page 2...

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!

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)

...continued from page 2

Prolonged Service Codes Available

The prolonged clinical staff service codes for the Evaluation and Management (E&M) codes are now built in IRIS and ready for use!

These prolonged codes can only be used when the service time exceeds the top of the range for the following E&M services:

- Office Outpatient Visit of New Patient, 60-74 Min (99205-1)
- Office Outpatient Visit of an Established Patient, 40-54 Min (99215-1)
- Home Visit of a New Patient, 75-89 Min (99345-1)
- Home Visit of an Established Patient, 60-74 Min (99350-1)

Be sure to check the CPT Guide and the State's Service Table for the eligible providers who can use these codes. There is also a reference sheet available for how to utilize these codes (see page 6).

Update: Withdrawal Management Treatment Day Billing

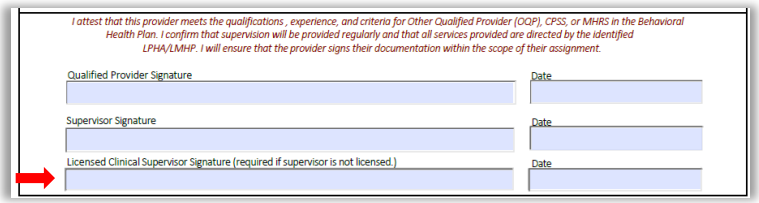
The State's recent billing manuals have indicated that the day rate at withdrawal management can be claimed when at least one of the following services is provided:

- Assessment
- Counseling (individual/group)
- Family therapy
- Patient education
- SUD crisis intervention

Note that observations are not included as a qualifying service to be able to claim the treatment day. We are in the process of following up with the State about this. However, at this time, all withdrawal management programs should be prepared to demonstrate that there is evidence of at least one of the above services on each day claimed. This includes the date of discharge. As such, it is crucial that there is adequate documentation to support the billing of each day at the withdrawal management programs.

Documentation FAQ

1. Is the County's Clinical Supervision Form sufficient for demonstrating that there is a valid LPHA providing direction for a Certified Peer Support Specialist?



I attest that this provider meets the qualifications, experience, and criteria for Other Qualified Provider (OQP), CPSS, or MHRS in the Behavioral Health Plan. I confirm that supervision will be provided regularly and that all services provided are directed by the identified LPHA/LMHP. I will ensure that the provider signs their documentation within the scope of their assignment.

Qualified Provider Signature — Date

Supervisor Signature — Date

Licensed Clinical Supervisor Signature (required if supervisor is not licensed.) — Date

Yes. If the clinical supervisor for a Certified Peer Support Specialist is not a qualifying Behavioral Health Professional (i.e., Physician, Nurse Practitioner, Registered Nurse, Licensed Clinical Psychologist, Licensed/Registered Clinical Social Worker, Licensed/Registered Professional Clinical Counselor, Licensed/Registered Marriage and Family Therapist, or Licensed Occupational Therapist), the requirement is for the Certified Peer Support Specialist to be "under the direction" of a qualified LPHA. The Clinical Supervision Form may be used as the providers' attestation of adherence to the requirement. As a reminder, the LPHA providing "direction" (i.e., acting as a clinical team leader, providing direct or functional supervision of service delivery), assumes ultimate responsibility for the Peer Support Services provided.

2. What happens if a qualifying service is not provided to bill a treatment day at the residential levels of care?

To claim the residential treatment day rate, there must be at least one qualifying service (assessment, individual/group counseling, family therapy, medication service, patient education, or SUD crisis intervention) provided. There must be documentation in the client's chart to evidence this. If none of these service components are provided on any given day, the treatment day cannot be claimed. In a County clinical chart review, this would result in a disallowance and recoupment. Note that structured activities are not included as a valid service to justify billing the treatment day.

Transitions from Residential level of care

For clients stepping down to the outpatient levels of care, it is important to remember that billing by both programs (except care coordination) is only permitted on the date of admission or discharge. Therefore, the outpatient program's intake or assessment service can only be claimed simultaneously with a residential treatment day if it is the date of discharge from the residential program. Bear in mind that once the outpatient program has determined through the assessment service that the client is appropriate for the outpatient level of care placement, the client no longer meets the criteria for the residential level of care. It is advised that outpatient programs coordinate closely with residential providers to ensure that outpatient admissions are taking place on or after the client's discharge date from the residential program whenever possible.

⚠ For Residential Providers: Please be advised that the State allows for **up to** 10 days to transition between levels of care. This means that we must demonstrate the need for each day of the transition once a client has been assessed or re-assessed as no longer needing the residential level of care. Treatment days claimed without supporting documentation will be disallowed and recouped. Transitions should happen quickly so that a 10-day transition is not the norm.

Clarification: Diagnosis for Billing (Withdrawal Management)

At the withdrawal management level of care, services claimed must be billed using a covered diagnosis, which requires an LPHA to establish. Z codes are not included in the State's covered diagnoses list. Claims for withdrawal management services with a diagnosis that is NOT from the covered list will be denied by the State. So, what does this mean for billing on the date of admission where the non-LPHA may conduct the Brief ASAM LOC Screening Tool but is not able to consult with the LPHA until the following day? This means that the only way to bill would be to hold the service (in other words, not enter it into IRIS) until after the LPHA has established a diagnosis. An example of this type of situation might be a client admitting on the 31st of the month where only the non-LPHA has an encounter with the client. The service for the date of admit on the 31st would need to be held. On the 1st or thereafter, once the LPHA has determined a diagnosis, the claim for the 31st can be entered using a covered SUD diagnosis.

REMINDERS

AOB/ATD

Don't forget that a valid AOB/ATD is necessary to bill DMC-ODS services to Medi-Cal. Most programs have been proactive in making sure this is a part of the intake process for all new admissions. It is advised that for programs with long-standing clients, providers double-check that a valid AOB/ATD is in the client's chart. Services claimed without the proper AOB/ATD will be disallowed and result in recoupment!

Repeating Information

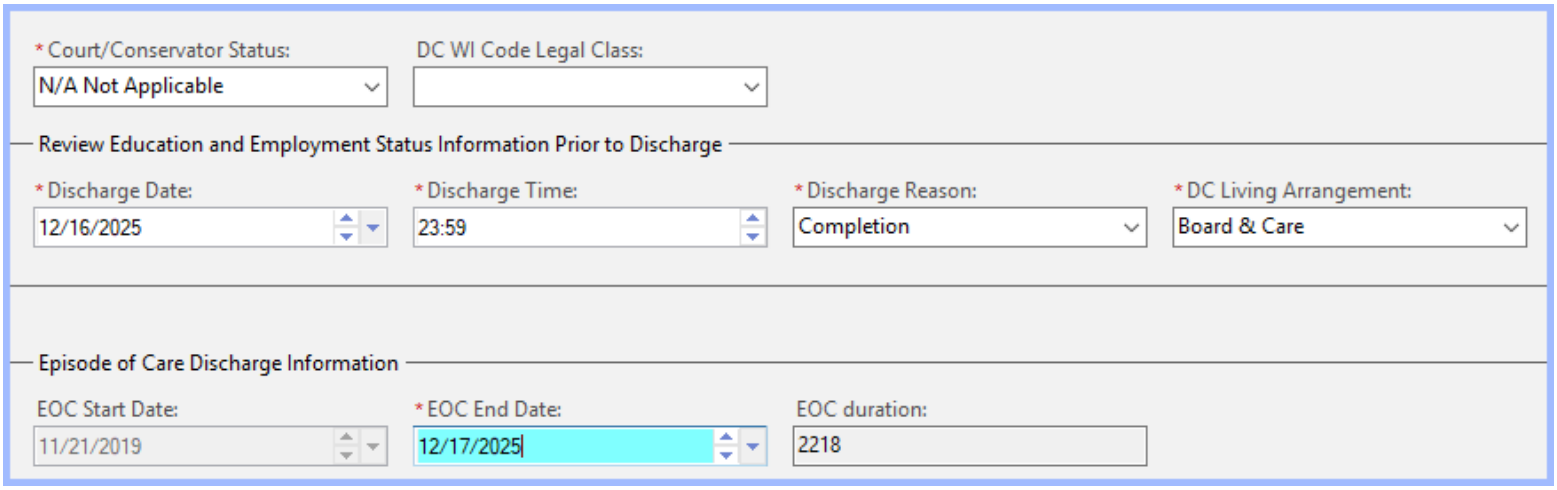
Remember that the State has made clear that information contained in one part of the client's clinical record does not need to be repeated elsewhere. For example, we should not "copy and paste" the LPHA's clinical summary or write-up (also known as the Case Formulation) into the progress note for the consultation between the LPHA and non-LPHA. Documentation in a consultation progress note must support the time that is claimed for the actual consultation. The necessary information is who was consulted, the main objective of the consultation (why it was necessary), and the result (what came out of the discussion that helps to justify the importance of the consult for the client's treatment and the amount of time spent).

Clinical Trainee Progress Notes

It is strongly advised that progress notes completed by Clinical Trainees be co-signed by the respective Clinical Supervisor. As a reminder, the Clinical Supervisor assumes ultimate responsibility for the Clinical Trainees under their supervision.

Discharges in IRIS

Good News! When doing a Discharge, contracted Fee For Service (FFS) providers no longer have to enter a Non-Billable note in IRIS. The Discharge Summary does not carry any billing, so it does not have to be attached to a FIN. You can simply complete the Discharge Summary in your own EHR and then end the EOC in IRIS. It is important to remember that the Discharge Date is the date that the client was actually discharged from the program. It is strongly recommended that the discharge paperwork be completed on the date of the client's last service so that the EOC End Date will be the same as the Discharge Date. However, if it occasionally takes one to two days to complete everything needed to close the chart, your EOC End Date may be later than your Discharge Date. Please make sure these dates are accurate. If your program requires you to write a discharge note in your own EHR, please continue to do so. Contractors that are not Fee For Service and have a different arrangement will need to check with their contract monitor to determine if they can follow this new process.



As we approach the end of the year, we would like to extend our gratitude for all of your hard work and dedication in providing quality substance use disorder services. We appreciate your collaborative spirit and look forward to working with you in the new year!

THANK YOU!

DMC-ODS Assessment and Therapy Substitute Codes

CDM	HCPC	Code Type	Service (Brief Definition)	Billing Unit of Svc	Minimum Time to Claim 1 Unit	When to Use
90846-7	T2021	Family Therapy	Family Psychotherapy (w/o Pt Present), 58+ Min 90846-7	1 unit = 15 minutes	58 minutes	Use when a family psychotherapy service (without the client) is 58 minutes or more. If service is 26-57 minutes, use 90846-1/90846-2.
90846-8	T2021	Family Therapy	Peri Family Psychotherapy (w/o Pt Present), 58+ Min 90846-8	1=15	58	
90847-7	T2021	Family Therapy	Family Psychotherapy (w/ Pt Present), 58+ Min 90847-7	1=15	58	Use when a family psychotherapy service (with the client) is 58 minutes or more. If service is 26-57 minutes, use 90847-1/90847-2.
90847-8	T2021	Family Therapy	Peri Family Psychotherapy (w/ Pt Present), 58+ Min 90847-8	1=15	58	
90849-7	T2021	Family Therapy	Multiple-Family Group Psychotherapy, 92+ Min 90849-7	1=15	92	Use when a multi-family group psychotherapy service is 92 minutes or more. If service is 43-91 minutes, use 90849-1/90849-2.
90849-8	T2021	Family Therapy	Peri Multiple-Family Group Psychotherapy, 92+ Min 90849-8	1=15	92	
90791-7	T2024	Assessment	Psychiatric Diagnostic Evaluation, 68+ Min 90791-7	1=15	68	Use when a psychiatric diagnostic eval service is 68 minutes or more. If service is 31-67 minutes, use 90791-1/90791-2.
90791-8	T2024	Assessment	Peri Psychiatric Diagnostic Evaluation, 68+ Min 90791-8	1=15	68	
90792-7	T2024	Assessment	Psychiatric Diagnostic Eval w/Med Services, 68+ Min 90792-7	1=15	68	Use when a psychiatric diagnostic eval with medical services is 68 minutes or more. If service is 31-67 minutes, use 90792-1/90792-2.
90792-8	T2024	Assessment	Peri Psychiatric Diagnostic Eval w/Med Services, 68+ Min 90792-8	1=15	68	
90885-7	T2024	Assessment	Psych Eval of Hospital Record, 68+ Min 90885-7	1=15	68	Use when a psychiatric eval of hospital record service is 68 minutes or more. If service is 31-67 minutes, use 90885-1/90885-2.
90885-8	T2024	Assessment	Peri Psych Eval of Hospital Record, 68+ Min 90885-8	1=15	68	

For questions, please reach out to the QMS SUD Technical Assistance Training Support (TATS) Team at BHPSUDSupport@ochca.com

New codes to prolong E&M services (for MDs and Physician extenders) have now been built in our IRIS system.

- **99415** Prolonged clinical staff service; first hour
    - For the first 60 minutes beyond the highest time in the range
    - Maximum of 1 unit per day
    - To use with 99205 (60-74 min) if duration is 104 min or more or 99215 (40-45 min); use once reach 84 min
- **99416** Prolonged clinical staff service; each additional 30 min
    - For each additional 30 min after the first 60 minutes beyond the highest time in the range
    - Maximum of 44 units per day
- Office E&M with New Patients:
    - 99205 (Office E&M new patient 60-74 min) to be used for services from 60-103 min
    - 99415 (prolonged 1st hour) from 10-4-148 min
    - 99416 (prolonged, each additional 30 min) 149 min+
- Office E&M with Established patients:
    - 99215 (Office E&M established patient (40-54 min) to be used for services from 40-83 min
    - 99415 (prolonged 1st hour) from 84-128 min
- 99416 (prolonged, each additional 30 min) 129 min+

- **99417** Prolonged outpatient E&M; each 15 min
    - To be used with 99345, 99350 (Home E&M codes, rarely used)

Cod	CDM*	Non-Alpha Charge Description*
99415	99415-1	Prolonged clinical staff service, First Hour
99415	99415-2	Peri Prolonged clinical staff service, First Hour
99416	99416-1	Prolonged clinical staff service; each additional 30 Min
99416	99416-2	Peri Prolonged clinical staff service; each additional 30 Min
99417	99417-1	Prolonged Outpatient Home E&M; each 15 Min
99417	99417-2	Peri Prolonged Outpatient Home E&M; each 15 Min

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.

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 have been distributed to the Service Chiefs and Contract Monitors. The Contract Monitors will soon provide the 274 UI Guide and work closely to train the county-contracted users once all tokens are issued to access the 274 UI through the county network. If a program and the Contract Monitor is unable to access the 274 UI during the transitional period, we recommend submitting the Excel spreadsheet for that month to follow the DHCS requirements.

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)

FAQ - SCREENING & TRANSITION OF CARE TOOLS (SMHS ONLY)

NOABD QUESTION: Is the Behavioral Health Plan (BHP) required to issue a Notice of Adverse Benefit Determination (NOABD) if an individual is referred to the other Medi-Cal mental health delivery system based on their screening score?

***NO**. The Screening Tools do not determine benefit or service eligibility but instead determine the appropriate mental health delivery system referral for an initial assessment for Medi-Cal members who are not currently receiving mental health services when they contact the Managed Care Plan (MCP)/BHP seeking mental health services. MCPs/BHPs should not issue an NOABD if an individual is referred to the other Medi-Cal mental health delivery system for assessment based on their screening score. For additional information on the Screening and Transition of Care Tools refer to APL 22-028 for the NOABD requirements, MCPs and BHPs may refer to BHIN 25-014, respectively.*

ACCESS LOG QUESTION: When the screening tool score results in the BHP routing to the MCP, does the BHP need to do an Access Log?

***NO**. The screening process is not considered an access request. There is no need to enter screenings into the Access Log, as no request for access in our system is being made if the member screens for the MCP. Similarly, there is no need to issue an NOABD at that point. All the Screening Tool does is route the member to the appropriate system of care to help them. The Screening Tool is not considered an "assessment" but a guide that assists in referring the member to the appropriate level of care.*

EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS

- Programs are strongly encouraged to ensure that their providers renew credentials with the appropriate certifying organization or licensing board at least 2–3 months before the expiration date. Providers should not continue delivering Medi-Cal covered services if their license, registration, waiver, or certification has lapsed or is pending renewal. Relying on the assumption that credentials will be retroactively renewed is not appropriate, as this is not guaranteed and may result in a disallowance.
- When the provider's credential has expired the MCST and IRIS takes action to deactivate the provider in the County system. The provider's reinstatement is **NOT** automatic. The provider must petition for their credentialing suspension to be lifted and e-mail proof of the license, certification and/or registration renewal to the MCST and IRIS to reinstate their privileges to begin delivering Medi-Cal covered services.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

Be sure to discard all outdated NOABDs and issue the most current NOABD templates to the members that were revised and made readily available back in June 2025. The NOABDs are located on the QMS website.

SMHS:

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

DMC-ODS:

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

AOD COUNSELORS IN SMHS

- Recent changes have now included the ability for AOD Counselors to deliver Medi-Cal covered services as a new provider type in Specialty Mental Health Services (SMHS).
- SMHS programs with AOD Counselors must now undergo the **County Credentialing** process with the MCST to provide services as this provider type.
- "Registered" AOD Counselors in SMHS must submit a **Counselor Supervision Reporting Form** to the MCST, as well.
- Documentation standards are different in the SMHS programs for AOD Counselors. Please consult with the Clinical Records Review Team for further information.

CHANGES TO THE OTHER QUALIFIED PROVIDERS (OQP)

- Previously, OQP Providers were differentiated into two levels: OQP I/II based on different experience requirements and allowed services for each category.
- The OQP provider type is now defined as one provider type with minimum qualifications required. While QMS recommends an additional 2 years or a BA degree for some allowed services, it's not required. It will be up to each program and supervisor to assess their staff and determine readiness.
- Programs that have previously submitted the Qualified Provider Supervision Form differentiating their staff between an OQP I/II do **NOT** have to resubmit an updated supervision form as MCST has internally combined the OQPs into one on the master tracking log.
- A revised Qualified Provider Supervision Reporting form is available on the QMS website. It combines the OQP I/II and includes the SUD matrix and a revised SMHS matrix.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MEDI-CAL CLAIMING DURING THE BBS 90-DAY RULE PRIOR TO BBS REGISTRATION NUMBER

(OPTIONAL COUNTY CONTRACTED PROGRAMS ONLY)

- The State Department of Health Care Services (DHCS) will honor the 90-day Board of Behavioral Sciences (BBS) rule and allow practitioners to provide services as if they are registered while they wait for their registration number after the completion of their Live Scan. DHCS has confirmed that Associates are considered "registered" during this 90-day period and can claim Medi-Cal for assessments and therapy services.
- The provider must submit the Clinical Supervision Report Form (CSRF) to MCST and follow the 90-day BBS rule guidelines below prior to delivering any Medi-Cal covered services:

CLINICAL SUPERVISION

COUNTY-CONTRACTED PROGRAM REQUIREMENT

- ✓ Post degree hours may only be counted as of the date recorded at the bottom of the Request for Live Scan Service form.
- ✓ CSRF Form, BBS Responsibility Form, Written Agreement (if applicable) and a completed **Live Scan Fingerprint Form** from the employer must be submitted to MCST.
- ✓ IRIS will **NOT** enter the provider into the system to bill for services if they do not have an Associate #.
- ✓ Once BBS issues an Associate #, the provider must submit updated clinical supervision forms to IRIS and MCST, along with the PAN.
- ✓ Without a PAN, IRIS will **NOT** activate the provider to begin billing for Medi-Cal covered services.
- ✓ County Employees do **NOT** qualify for the BBS "90-day rule" clause in the law. Human Resources requires an Associate # in order to hire a Behavioral Health Clinician I.

https://www.bbs.ca.gov/pdf/90day_rule.pdf

90-DAY RULE FOR GRADUATES

- County-Contracted programs **MUST** hold the claims until the registration number comes through (if it is issued retroactively). The Live Scan date on the Live Scan form is the date the BBS will use as the registration date for the Associates. This means, as soon as the provider receives their registration number from BBS the program administrator must immediately:
  1. Submit an updated CSRF with the newly assigned registration #.
  2. County Credential the provider and include a copy of the **Request for Live Scan Service form** for the credentialing approval letter to incorporate the date the Live Scan form was completed to deliver Medi-Cal covered services.
  3. Submit an updated PAN along with supporting documents to IRIS to add the provider into the system to begin entering and billing for services, retroactively.

DISCLAIMER:

The program will take the risk of any billed services being disallowed, if the provider separates from their employer prior to receiving their BBS registration # or if the BBS registration # is not granted.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

EXPEDITING CREDENTIALING APPROVALS EVEN SOONER

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.

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.**

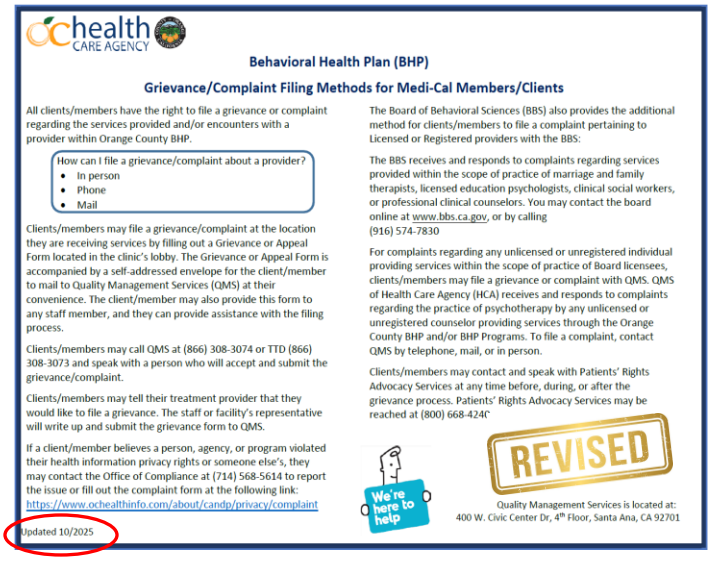
To avoid delays or compliance issues, it is critical that both the provider and the designated administrator remain vigilant in monitoring and responding promptly to all communications from VERGE/RLDatix and the MCST.

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.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

GRIEVANCE/COMPLAINT FILING METHODS FOR MEDI-CAL MEMBERS/CLIENTS



Behavioral Health Plan (BHP)

Grievance/Complaint Filing Methods for Medi-Cal Members/Clients

All clients/members have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within Orange County BHP.

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Clients/members may file a grievance/complaint at the location they are receiving services by filling out a Grievance or Appeal Form located in the clinic's lobby. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the client/member to mail to Quality Management Services (QMS) at their convenience. The client/member may also provide this form to any staff member, and they can provide assistance with the filing process.

Clients/members may call QMS at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint.

Clients/members may tell their treatment provider that they would like to file a grievance. The staff or facility's representative will write up and submit the grievance form to QMS.

If a client/member believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance at (714) 568-5614 to report the issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

Updated 10/2025

The Board of Behavioral Sciences (BBS) also provides the additional method for clients/members to file a complaint pertaining to Licensed or Registered providers with the BBS:

The BBS receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, clients/members may file a grievance or complaint with QMS. QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County BHP and/or BHP Programs. To file a complaint, contact QMS by telephone, mail, or in person.

Clients/members may contact and speak with Patients' Rights Advocacy Services at any time before, during, or after the grievance process. Patients' Rights Advocacy Services may be reached at (800) 668-4247

We're here to help

REVISED

Quality Management Services is located at: 400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

The **Grievance/Complaint Filing Methods for Medi-Cal Members/Clients Fact Sheet** for SMHS and DMC-ODS has been revised to reflect minor updates from DHCS and BBS. You may provide this handout upon the member's initial entry into services and when they are inquiring about the various methods for filing a grievance. The revised handout is currently available in English and will be available in all the threshold languages soon. To access the handouts, visit the hyperlinks below:

SMHS:

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

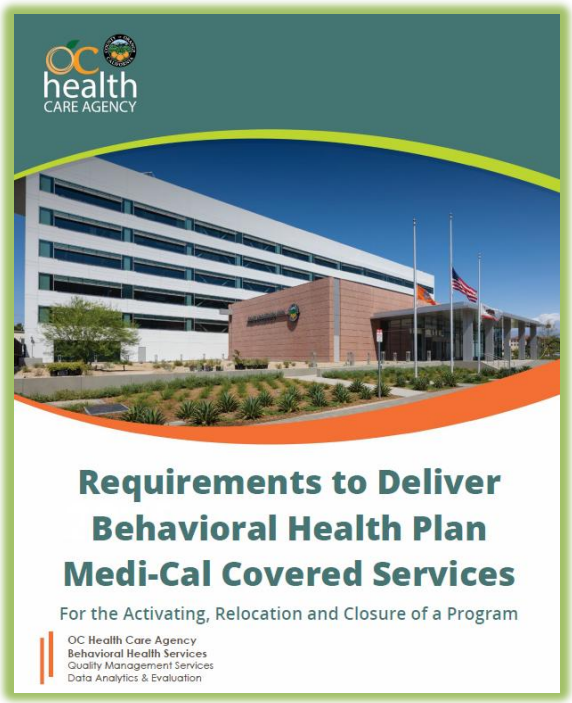
DMC-ODS:

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

NEW

This new manual provides comprehensive guidance to support both prospective and existing programs in meeting the requirements for delivering Medi-Cal covered services under the County Behavioral Health Plan during the processes of opening, relocating, or closing.

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



MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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: 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
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