SUD Support Newsletter

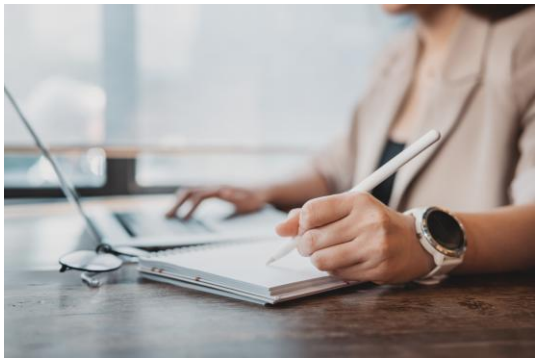
QUALITY MANAGEMENT SERVICES

January 2026

WHAT'S NEW?

There is a new substance use disorder (SUD) Clinical Records Review Team (CRRT) member! We would like to introduce Stephanie Bunyaputikul, who will be in the role of Quality Assurance (QA) Reviewer. She will be assigned to some of our County and County-contracted providers to support compliance with State and Federal regulations. You will likely see her on-site at your programs for the Clinical Records Reviews. A little bit about Stephanie:

"I'm a Licensed Marriage and Family Therapist with extensive experience across a variety of behavioral health settings. I've had the opportunity to serve as a clinician in several County-operated mental health clinics, providing care to individuals experiencing severe and persistent mental illness. My clinical background also includes facilitating group therapy in inpatient hospital settings, working in a level 12 residential group home for probation and foster youth, and delivering services in both private practice and Employee Assistance Programs. In addition to my clinical work, I've contributed to the Electronic Health Record (EHR) Compliance and Support Program, where I developed a strong interest in helping staff understand and implement compliance standards and program requirements while providing technical support. Outside of work, I'm a certified yoga instructor and enjoy spending time at the beach, rock climbing, practicing yoga, crafting, baking, stand-up paddling, and playing with my 10-year-old dog. I'm passionate about bridging clinical practice with operational excellence and take pride in bringing a thoughtful, collaborative approach to everything I do."



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

SUD Clinical Chart Review Team

April Jannise, LCSW
Yvonne Brack, LCSW
Ashlee Al Hawasli, LCSW
Caroline Roberts, LMFT
Ashlee Weisz, LMFT
Stephanie Bunyaputikul, LMFT
Faith Morrison, Staff Assistant

SUD Technical Assistance & Training Support Team

John Crump, LMFT
Crystal Swart, LMFT, LPCC
Laura Parsley, LCSW
Emi Tanaka, LCSW

CONTACT
BHPSUDSupport@ochca.com
(714) 834-5601

DMC-ODS Office Hours

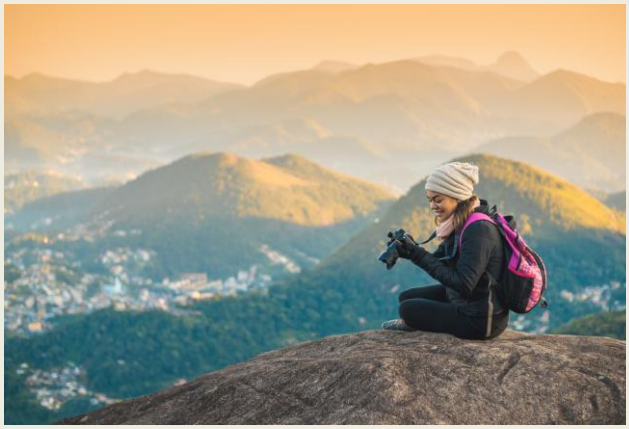
A voluntary and informal space to ask questions and discuss documentation requirements. Occurs virtually on the second Wednesday (2pm) & fourth Monday (11am) of every month.

Upcoming meetings: January 14, 2026 at 2pm & January 26, 2026 at 11am

Update

Service billing code: Environmental Intervention for Medical Management Purposes (90882-1)

This care coordination code is available for use at all levels of care. However, we have discovered that its intended purpose is quite narrow. The "coordinating with agencies, employers, or institutions on behalf of the client" is about working with external agencies/organizations on making necessary changes or accommodations to the client's physical environment to address the SUD. An example might be if a provider goes to the client's workplace to coordinate with the client's employer to address environmental factors or work conditions that affect the client's SUD (such as a specific trigger for the client in the workplace that the employer needs to be aware of and can modify the client's work space or the way in which their job duties are performed to support the client's ability to cope/manage). The other restriction for this code is that the maximum number of minutes that can be claimed is 23 minutes (because only 1 unit can be claimed). Please be sure that the activities provided and documented in the progress note are in accordance with the service code requirements when utilizing this code.



Clarification: Face-to-Face

A face-to-face service is primarily whenever the client is present with the rendering provider. Therefore, it does not apply to consultations with other providers where the client is not present. Some example scenarios:

- Telehealth session with the client = Face-to-Face
- Telephone call with the client = Non-Face-to-Face
- Telephone call with outside professional, but the client is in the office with you on call = Face-to-Face
- Meeting with family members in the office, without the client = Non-Face-to-Face

Documentation FAQ

1. For the Residential Treatment Services requirement to provide at least one qualifying service to claim the treatment day, what is the minimum time required?

The State does not make explicit the minimum amount of time required. Based on the billing rules for the equivalent outpatient codes, the minimum number of minutes to claim the code is typically 8 minutes. Therefore, until the State clarifies otherwise, the minimum number of service minutes of the qualifying service to claim a residential treatment day is 8 minutes. Keep in mind that the expectation remains for clients in the residential levels of care to receive the intensity and volume of clinical services to meet the higher acuity and severity of issues related to the SUD diagnosis. Hence, clients need to be receiving more clinical services than they would at the lower levels of care as part of demonstrating continued need for the residential level of care. As a reminder, only an assessment, individual/group counseling, family therapy, medication service, patient education, or SUD crisis intervention qualifies for claiming a treatment day. There must be documentation in the client's chart to evidence this.

2. Can the physician bill for follow-up services for pregnant clients at the NTP?

If a dosing service is provided on the same day, a physician's follow-up medical service with a pregnant client is not separately billable. The follow-up would be considered part of the bundle of services included in the reimbursement for dosing. If the follow-up encounter is predominantly for the purpose of care coordination (ensuring pre-natal care resources are accessible, assisting with referral/linkage, following up on warm hand-offs, etc.), the service may be claimed using the Targeted Case Management, Each 15 Min (70899-120) T1017 or Prenatal Care, At Risk Assessment (70899-119) H1000.

3. Can a client's residential stay be extended due to severity of mental health symptoms?

The client's functioning based on mental health alone is not

Continued on page 3…

Documentation FAQ (continued)

…continued from page 2

sufficient. Remember that the client must first and foremost exhibit medical necessity, which means that the primary diagnosis and impairments in functioning are due to the SUD. If the client's SUD is stable enough for a step-down, we should take steps to ensure that the client's ongoing mental health needs can be addressed at the lower level of care. This typically means that the client needs extensive care coordination so there is no lapse in mental health treatment.

Mental health symptoms can certainly exacerbate the client's ability to maintain stability with their SUD diagnosis. In such cases, the documentation needs to make clear where the client's ability to manage their SUD is negatively impacted by the mental health. Additionally, the documentation should show that the extent (severity, risk, etc.) of impairments related to SUD is such that it warrants continued stay at the residential level of care.

4. Does the administration of the evidence-based MAT assessment at the outpatient programs need to be billed separately?

Not necessarily. It depends on whether or not there were any other screening or assessment services provided on the same day by that provider. If it was administered as part of the intake service (e.g., where intake paperwork was reviewed/signed), the time can be included in the service and claimed using the SUD Screening (70899-105) H0049 code. If the evidence-based MAT assessment is provided in an assessment service where the bulk of the time is spent gathering other information relevant to completing the ASAM-based assessment or the evidence-based MAT assessment is part of the ASAM assessment, the total time can be claimed using the SUD Assessment (70899-103) H0001 code. If there were no other assessment services and you would like to claim the time spent for *only* administering the evidence-based MAT assessment (that is not part of the ASAM-based Assessment), the SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 code series may be used. Remember that this code series has lockouts that we need to be mindful of. Refer to the CPT Guide and the State's Service Table to prevent claims from being denied.

Re-Assessments at Residential

We continue to come across re-assessment documents at the residential levels of care that are exact templates. Such duplications mean that the re-assessment is not valid and places the services provided based on those re-assessments at risk of being disallowed and recouped. If the client's condition is not changing, it is advised that providers make sure to document what will be done differently with the client's treatment to promote change (i.e., change in the types of services, frequency, modality/approach, etc.).

Problem List at Next Level of Care

For programs that have multiple levels of care that clients transition between, be sure that the relevant assessments and problem lists are readily accessible in the client's chart for each level of care. Problem lists can be carried over from one level of care to another as long as it remains up-to-date and relevant to the client's treatment needs. There should be documentation of a service with the client to discuss treatment planning and any necessary changes to the problem list or treatment plan upon the client's move to the new level of care.

Receiving Assessments from Other Programs

If a client is entering your program with a completed screening or assessment from another program, it is permissible to utilize the information. If the assessment received is going to be used to substantiate a diagnosis or level of care placement determination, there should be documentation by an LPHA at the receiving program to attest that the information is accurate and applicable for the current program and placement.

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 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 adhere to 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)

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. BHIN 24-023, allows the implementation of the BBS 90-day rule to be implemented for dates of services on or after July 1, 2023.

REMINDERS:

The BBS and DHCS have allowed providers to provide and bill for Medi-Cal covered services who have completed their master's program but have not received their associate registration number yet, if:

- ✓ They apply for their BBS associate registration number within 90 days after their graduation date.
- ✓ They are in the position of a clinician at your program.
- ✓ The MCST receives both Clinical Supervision Reporting Forms - as a clinician without an associate registration number indicating that the provider is a "90 Day Applicant" and when your clinician receives their associate registration number indicate that they are now an associate, social worker, marriage family therapist or professional counselor.
- ✓ You submit their employer's live scan form (not the BBS live scan form).

Delivering Medi-Cal covered services can begin on:

- ✓ The date written on their employer live scan form (not their BBS application live scan form) **IF** the live scan form is completed after their graduation date.
  Example: The applicant, graduated on 6/1/2025, their employer live scan form is dated 6/15/2025 then billing can begin on 6/15/2025.
- ✓ The day after their graduation date, **IF** their employer live scan date was before their graduation date.
  Example: The applicant's, employer live scan form date is 5/15/2025, provider graduated on 6/1/2025, billing can begin on 6/2/2025.
- ✓ Be sure to confirm the billing date with the MCST prior to your provider billing for Medi-Cal services under the BBS 90 Day Rule to ensure it is correct and to prevent potential recoupment.

In general, new providers meeting the BBS 90-Day rule criteria must submit the CSRF indicating they are an "Associate Applicant – BBS 90 Day Rule" in the Registration Type drop-down and provide the Employer Live Scan Form to MCST. In addition, the new provider must obtain the county credentialing approval letter before delivering any Medi-Cal covered services.

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)

COUNTY CREDENTIALNG REQUIRED PRIOR TO DELIVERING MEDI-CAL SERVICES

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.

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)

MANAGED CARE SUPPORT TEAM

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

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BHPSupervisionForms@ochca.com
BHPPTAN@ochca.com

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II