SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

February 2026

SUD Clinical Chart Review Team

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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 Monday (11am) of every month.

Upcoming meetings: February 11, 2026 at 2pm & February 23, 2026 at 11am

WHAT'S NEW?

Alcohol or Drug (AOD) Counselor Education Frequently Asked Questions (FAQ)

Last month, the State released an FAQ on the changes to the education requirements for AOD Counselors. The new requirements went into effect on January 1, 2026.

As a reminder, first-year registered counselors who registered between July 1, 2025, and December 31, 2025, must submit proof of eighty (80) hours of education and core competency education topics by July 1, 2026.

Remember that failure to complete the education requirements needed for renewal will lead to the expiration of credentials, which means that the counselor will not be eligible to provide services until their credential is renewed.

DMC-ODS services claimed for any period during which there is an expiration or lapse will result in recoupment and disallowance as these services may be considered fraud, waste, and/or abuse.

The changes do not affect counselors certified before January 1, 2026.

Be sure to check out the FAQ!

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

Clarification:
Drug Testing

Drug testing is billable at the outpatient levels of care using the **SUD Drug Testing Point of Care Tests (70899-104) H0048** code. However, only the following providers are eligible to claim for drug testing in the DMC-ODS:

- Licensed Physician or Medical Student in Clerkship
- Physician Assistant or Physician Assistant Clinical Trainee
- Nurse Practitioner or Nurse Practitioner Clinical Trainee
- Registered Nurse or Registered Nurse Clinical Trainee
- Licensed Vocational Nurse or Vocational Nurse Clinical Trainee
- Licensed Psychiatric Technician or Psychiatric Technician Clinical Trainee
- Pharmacist or Pharmacist Clinical Trainee
- Medical Assistant

To claim for drug testing, the minimum number of service minutes required is 8 minutes. A corresponding progress note must be completed and supporting documentation of the medical necessity for the drug testing must be evident in the chart. **If drug testing is not billed to Medi-Cal,** a progress note for each encounter and documentation of medical necessity is not required. It is advised that a record is kept of drug tests provided, but how this is done is up to the discretion of each provider.

Additional reminders about drug testing -

- Drug testing is included in the daily rate at the residential and withdrawal management levels of care and not separately billable.
- Drug testing is part of the dosing service at the NTPs and not separately billable.

For this and all service billing codes, please be sure to refer to the CPT Guide and the State's Service Table!

Documentation FAQ

1. For withdrawal management clients who are too physically ill to engage in a treatment service, what should we do?

It is always best practice to document any attempts to engage the client in a treatment service where the client declines. If the reason is due to the client being physically unwell, it is also important to document the client's experience of signs and symptoms of withdrawal (may also be captured in the observation documentation). Since the main objective of the withdrawal management level of care is to stabilize the client so they can be safely transitioned to the next treatment level, documentation of the client's inability to participate due to withdrawal symptoms helps to demonstrate the client's continued need for the withdrawal management level of care.

If several attempts are made on the same day by the same provider (e.g., an AOD Counselor trying to offer the client an individual counseling service in the morning and in the afternoon), the encounters can be documented together. This may be especially helpful for those cases where you may have briefly tried to utilize motivational interviewing to elicit behavior change that did not meet the 8-minute minimum in one instance, however, the combined total minutes from the multiple encounters does. Whether the State will accept documentation of a client's decline to engage as justification to meet the requirement for providing at least one treatment service to claim the day rate is unknown. However, it does help us make the case to the State for allowing the treatment day to still be claimed.

2. If a doctor provides psychiatric care (i.e., medication management for mental health) at the residential levels of care, is this separately billable?

No. Medication management for a client's mental health needs at the residential levels of care would fall under the "medication services" component that is part of the daily bundle. It is not separately billable on top of the treatment day. However, it is

Continued on page 3…

Documentation FAQ (continued)

…continued from page 2

important to note that a medication service is one of the services that justifies the billing of the treatment day, if there is proper documentation. If the residential client is also simultaneously receiving MAT services at the same program, the physician also addressing the client's mental health could be considered incidental and part of the MAT service. In this case, the service encounter may be claimed using one of the two MAT service codes available for the residential and withdrawal management levels of care – Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033 or Medication Training and Support – Individual per 15 Min (70899-110) H0034.

3. If a client's only substance use is Cannabis, do we still need to conduct the evidence-based MAT assessment?

Yes. The State does not make any exceptions based on the client's drug of choice or SUD diagnosis. Therefore, it is expected that every client entering any licensed and/or certified SUD recovery or treatment facility receive an evidence-based MAT assessment within 24 hours of admission in accordance with your program's MAT policy. If a client declines to engage in an evidence-based MAT assessment, please be sure to document this clearly in the client's chart.

Care Coordination Example

Scenario

If the nurse meets with the client to review the Health Questionnaire for potential medical linkages (e.g., connecting to the PCP), how can this be billed?

Documentation

If the service time was at least 8 minutes, this encounter can be claimed using the Targeted Case Management, Each 15 Min (70899-120) T1017 code. The documentation should make clear how the nurse's exploration of the client's specific responses to the Health Questionnaire was for the purpose of determining what additional physical health care resources the client may need to support their SUD treatment. If actual referrals/linkages were part of the service, be sure to document what was provided or how you assisted the client with this.

Problem List Updates

Don't forget that the problem list needs to be updated regularly. This means that we need to periodically discuss treatment progress with the client to ensure that the problem list remains relevant to the client's needs. If no updates are needed, then documenting this conversation with the client helps to explain why the problem list has not been changed. Items on the problem list need to be "resolved" if achieved and new issues added as they are identified throughout the course of treatment.

Observations at Withdrawal Management

The requirement is that during the first 72 hours after admission, clients must receive close observation and face-to-face physical checks at least every 30 minutes and monitoring of vital signs at least every 6 hours. *This must be documented and signed by the appropriately trained staff.* Changes in frequency after the first 24 hours must be documented.

Registered AOD Counselors to Clinical Trainees

Providers previously functioning as registered AOD Counselors who are now eligible to provide services as a Clinical Trainee and will switch to providing services as a Clinical Trainee, need to make sure that the Clinical Supervision Reporting Form is submitted to the Managed Care Support Team and a Provider Access Number (PAN) form submitted to IRIS to change the provider's taxonomy/NPI and credentials prior to billing any services.

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

On November 1, 2025, monthly submissions for the Behavioral Health Plan Provider Directory 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.

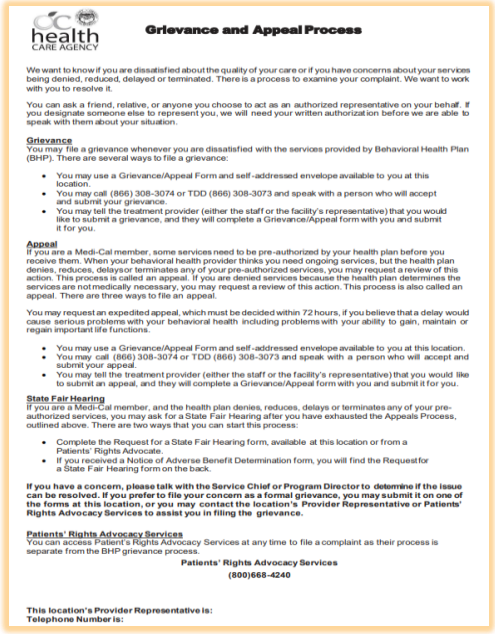
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

REVISED: GRIEVANCE & APPEAL POSTERS (REGULAR AND LARGE PRINT)

The grievance and appeal posters have been revised and are readily available on the QMS website. DHCS issued BHIN 25-015 to provide updated guidance regarding the grievance and appeal process, including revised member notice templates and compliance with federal and state regulations.

KEY POINTS

- ✓ The Grievance and Appeal Poster must be prominently displayed in provider locations.
- ✓ Materials, including posters, must be available in alternate formats such as large print and in all threshold languages to ensure accessibility.
- ✓ Providers are expected to make these materials available without requiring members to request them, supporting accessibility and compliance.



ochealth CARE AGENCY

Grievance and Appeal Process

We want to know if you are dissatisfied about the quality of your care or if you have concerns about your services being denied, reduced, delayed or terminated. There is a process to examine your complaint. We want to work with you to resolve it.

You can ask a friend, relative, or anyone you choose to act as an authorized representative on your behalf. If you designate someone else to represent you, we will need your written authorization before we are able to speak with them about your situation.

Grievance
You may file a grievance whenever you are dissatisfied with the services provided by Behavioral Health Plan (BHP). There are several ways to file a grievance:

- You may use a Grievance/Appeal Form and self-addressed envelope available to you at this location.
- You may call (866) 308-3074 or TDD (866) 308-3073 and speak with a person who will accept and submit your grievance.
- You may tell the treatment provider (either the staff or the facility's representative) that you would like to submit a grievance, and they will complete a Grievance/Appeal form with you and submit it for you.

Appeal
If you are a Medi-Cal member, some services need to be pre-authorized by your health plan before you receive them. When your behavioral health provider thinks you need ongoing services, but the health plan denies, reduces, delays or terminates any of your pre-authorized services, you may request a review of this action. This process is called an appeal. If you are denied services because the health plan determines the services are not medically necessary, you may request a review of this action. This process is also called an appeal. There are three ways to file an appeal.

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions.

- You may use a Grievance/Appeal Form and self-addressed envelope available to you at this location.
- You may call (866) 308-3074 or TDD (866) 308-3073 and speak with a person who will accept and submit your appeal.
- You may tell the treatment provider (either the staff or the facility's representative) that you would like to submit an appeal, and they will complete a Grievance/Appeal form with you and submit it for you.

State Fair Hearing
If you are a Medi-Cal member, and the health plan denies, reduces, delays or terminates any of your pre-authorized services, you may ask for a State Fair Hearing after you have exhausted the Appeals Process, outlined above. There are two ways that you can start this process:

- Complete the Request for a State Fair Hearing form, available at this location or from a Patients' Rights Advocate.
- If you received a Notice of Adverse Benefit Determination form, you will find the Request for a State Fair Hearing form on the back.

If you have a concern, please talk with the Service Chief or Program Director to determine if the issue can be resolved. If you prefer to file your concern as a formal grievance, you may submit it on one of the forms at this location, or you may contact the location's Provider Representative or Patients' Rights Advocacy Services to assist you in filing the grievance.

Patients' Rights Advocacy Services
You can access Patient's Rights Advocacy Services at any time to file a complaint as their process is separate from the BHP grievance process.

Patients' Rights Advocacy Services
(800)668-4240

This location's Provider Representative is:
Telephone Number is:

Link to Access the SMHS Grievance & Appeal Posters:
Behavioral Health Plan and Provider Information | Orange County California - Health Care Agency

Link to Access the DMC-ODS Grievance & Appeal Posters:
DMC-ODS For Providers | Orange County California - Health Care Agency

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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)

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING REQUIREMENTS

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.

COUNTY CREDENTIALING

PROVIDERS REQUIRED TO BE COUNTY CREDENTIALED:

NOTE: Any provider who works in a job classification that requires a license, waiver, certification and/or registration and delivers Medi-Cal covered services must be credentialed by the County. This list is not exhaustive, please inquire with the MCST for further guidance.

- ✓ Licensed Vocational Nurse
- ✓ Licensed Psychiatric Technician
- ✓ Certified Nurse Assistant
- ✓ Certified Medical Assistant
- ✓ Certified/Registered AOD Counselor
- ✓ BBS Licensed (LMFT, LPCC, LCSW)
- ✓ BBS Associate (AMFT, APCC, ACSW)
- ✓ BOP Registered/DHCS Waivered
- ✓ Physician Assistant
- ✓ Psychiatrist
- ✓ Physician
- ✓ Nurse Practitioner
- ✓ Registered Nurse
- ✓ Occupational Therapist
- ✓ Psychologist
- ✓ Pharmacist
- ✓ Certified Peer Support Specialist

COUNTY CREDENTIALING

SUBMISSION CHECKLIST

A complete packet should contain the following documents listed below and be labeled Last Name, First Name. The document names can be abbreviated. For example, New Applicant Request Form (NARF), Annual Provider Training (APT), Cultural Competency (CC), etc. The e-mail subject line must be titled Credentialing – Program Name.

SMHS CHECKLIST

- ✓ Doe, John NARF
- ✓ Doe, John Resume
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if applicable)

NOTE: The APT and CC Training must be the most current training that was completed in the last year.

DMC-ODS CHECKLIST

- ✓ Doe, John NARF
- ✓ Doe, John Resume
- ✓ Doe, John APT
- ✓ Doe, John CC
- ✓ Doe, John ASAM A
- ✓ Doe, John ASAM B
- ✓ 5 CEU/CME in Drug Addiction/Recovery (**ONLY** for MD, LCSW, LMFT, LPCC, Psychologist)
- ✓ Provider Insurance Verification Form
- ✓ Supervision Reporting Form (if applicable)

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORM REQUIREMENT

There are four types of supervision reporting forms the MCST oversees. Below is a grid listing all the provider types that must submit one of the required supervision reporting forms below:

- ✓ Clinician Supervision Reporting Form
- ✓ Counselor Supervision Reporting Form
- ✓ Medical Supervision Reporting Form
- ✓ Qualified Provider Supervision Form

SUPERVISION REPORTING FORMS

LIST OF PROVIDERS REQUIRED TO SUBMIT A SUPERVISION REPORTING FORM

CLINICIANS	COUNSELORS	MEDICAL PROVIDERS	QUALIFIED PROVIDERS
• Registered ASW • Registered MFT • Registered PCC • Registered/Waivered Psychologist • Psychologist Clinical Trainee • Clinical Social Worker Clinical Trainee • Marriage & Family Therapist Clinical Trainee • Professional Counselor Clinical Trainee • Associate Applicant – BBS 90 Day Rule	• Registered Counselors	• Nurse Practitioner • Nurse Specialist Trainee • Registered Nurse Trainee • Vocational Nurse Trainee • Psychiatric Technician Trainee • Occupational Therapist Trainee • Occupational Therapist Assistant • Pharmacist Trainee • Physician Assistant Trainee • Physician Assistant • Medical Assistant • Licensed Vocational Nurse • Licensed Practical Nurse • Licensed Psychiatric Technician • Certified Nurse Assistant	• Mental Health Rehabilitation Specialist • Other Qualified Provider • Certified Peer Support Specialist

REMINDER

- All required providers must submit the supervision form to the MCST upon commencement (e.g., new hire).
- Any status change requires an updated form to be submitted to the MCST (e.g., separation, change in supervisor, etc.).
- Supervision must be provided regularly.
- Provider's that require supervision are **prohibited** from delivering any Medi-Cal covered services if they have **NOT** submitted their supervision reporting form.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

AOD COUNSELORS IN SMHS (EFFECTIVE 1/1/26)

NEW

- 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 guidance.

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
Cal Optima Credentialing Lead: Araceli Cueva & Elizabeth "Liz" Fraga
Provider Directory Leads: 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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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 ● Transitional rent
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	**Quality Standards and Clinical Practice Team** (QSCP) – EBPs, QAPI, BHA ● **HEDIS/POM** – CalOMS, CANS/PSC-35 ● **BHP QI Support** – QI related questions for SMHS and DMC-ODS programs (including DATAR, med monitoring)