March 2026
QRTips

Behavioral Health Services
Quality Management Services

Telehealth Reminders

Consent for services should be obtained prior to initiating telehealth services. Consent may be documented by obtaining the client's signature on the combined Informed Consent for Services and Telehealth Consent form or a standalone consent form for telehealth services.

Each progress note should indicate the following:

- Service was provided through telehealth
- Service is medically necessary and clinically appropriate to be delivered via telehealth
- Service was provided to client located in California and provider verified client's location

References: BHIN 23-018, OCHCA BHS P&P 01.03.04

Care Plan Timelines

Monitoring and follow-up activities that are necessary to ensure that the care plan is effectively implemented and adequately addresses the client's needs may be done with the client and/or support person(s) and conducted as frequently as necessary, but at least annually, to help determine whether the following conditions are met:

- Services are provided in accordance with the client's care plan.
- Services in the care plan are adequate.
- There are changes in the needs. Monitoring and follow-up activities including making necessary adjustments in the care plan and service arrangements.

References: 42 C.F.R. § 440.169(d)

TRAININGS & MEETINGS

Online Training:
BHP Annual Provider Training

SMHS QA/QI Coordinators' Meeting

Teams Meeting
3/12/2026
10:00 AM – 12:00 PM

SMHS Documentation Office Hours

Teams Meeting
1st Thursday
at 10:00 AM – 10:50 AM
&
3rd Wednesday
at 3:00 PM – 3:50 PM
of every month

Email
SMHSClinicalRecords@ochca.com
for invitation

Helpful Links:

QMS Support Team
TATS Training Request Form
BHS EHR Blog Posts
Medi-Cal Certification

Targeted Case Management (TCM)

Recently, OQPs and MHRSes received a training on TCM services. For those who could not attend, and to share the information with all providers who bill TCM, here are some highlights.

Common but not exhaustive list of billable TCM activities

(if minimum service time is met)

Coordinating care with an external psychiatrist to ensure medication management aligns with client's needs/goals	Referring client to a housing program, providing information on how to access and navigate the services	Coordinating medical services with a primary care physician to address physical health needs affecting mental health stability	Verifying attendance at scheduled outpatient counseling sessions and addressing barriers preventing their attendance
Referring/linking to transportation to assure member can access community resources and scheduled appointment	Verifying attendance with school counselors, discussing path to increasing attendance with member	Identifying service delivery gaps (why client is not yet linked) and addressing them with client	Monitoring the client's progress in accessing needed services
Evaluating successful linkages and instituting routines to encourage continued effectiveness	Proactively monitoring client with a history of crises and linking client to crisis services if needed	Discussing barriers to successful placement with the client and identifying strategies to address them	Conducting follow-ups post-placement to ensure that needs are being met, identifying additional needs

When is TCM billable?

Qualifying Activity

To bill for TCM, you must complete at least one of the following activities:

- Coordination of care/services with primary care, MH, other providers
- Discharge/placement planning
- Referral/linkage to medical providers, MH providers, other community services

The service must be **medically necessary and clinically appropriate**

You may do several of these activities for a member in one day

- Document all TCM activities for one client for the day in one progress note—even if the activities happened at different times

Billable Duration for TCM

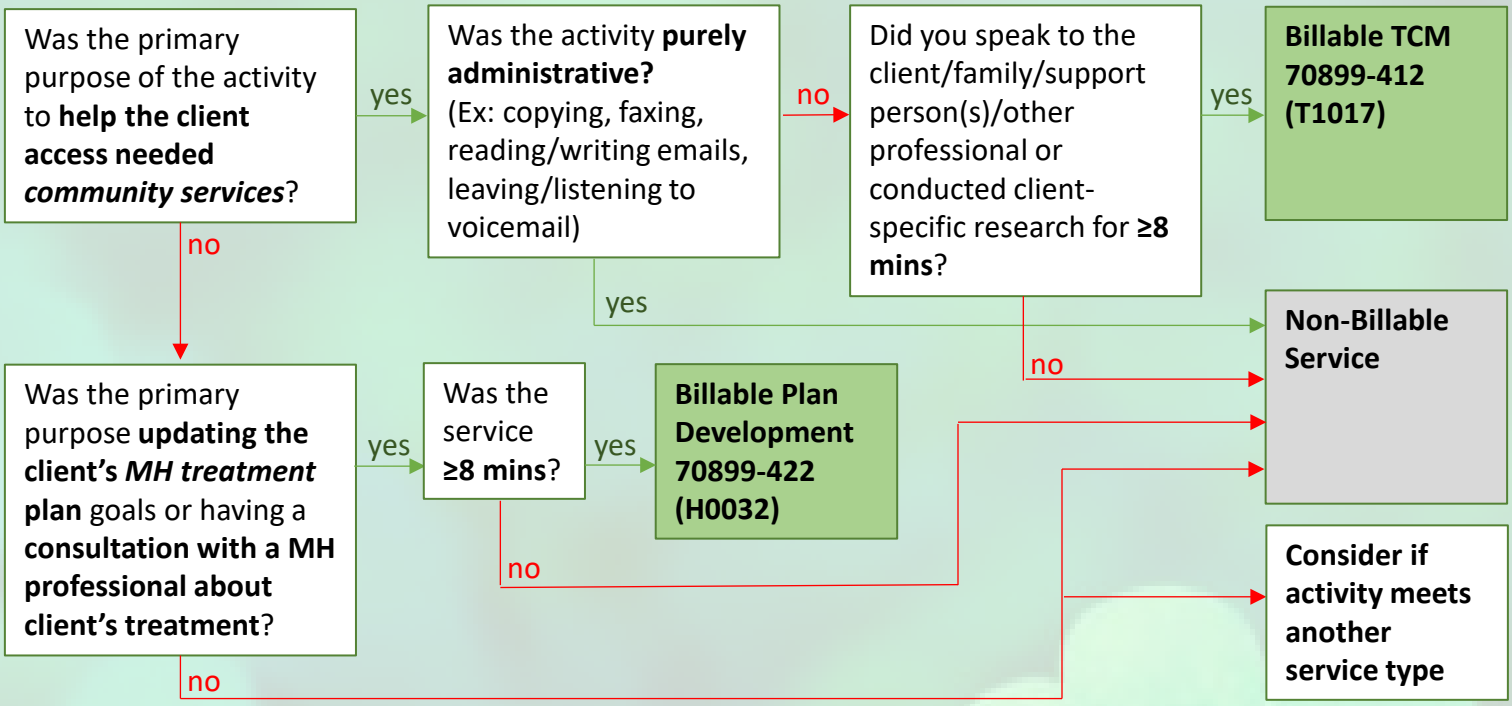
At least 8 minutes of qualifying activity

Don't count time spent on non-billable tasks (e.g., leaving a voicemail with no other contact)

- When mentioning non-billable tasks in the progress note, write "not included in duration of service" or "non-billable" to clearly indicate the time was not included in the overall billable service time

Targeted Case Management (TCM) Continued

Decision Tree



How to shift your approach to deliver a more clinically valuable TCM service

What you did for client	*What you could do to make this TCM*
Provided a client with a list of phone numbers to community resources	Provide list of phone numbers and coach client on which agencies to contact based on eligibility and location. Client identified two programs to call today.
Explained how to use benefits	Inform client about Medi-Cal transportation benefit and guide client through process to arrange first ride to clinic
Scheduled an appointment / filled out a form for a client	Assist client with making an appointment / filling out forms if they are unable to do it independently due to a BH problem
Gave client a bus pass	Link client to OCTA, help them open the app and find the bus line they should use to get to their next appointment

Always

- Connect intervention to client's BH needs & problem list
- Explain why professional support was needed

Reminders

What are the requirements for the disclosure of HIV-related information?

We must abide by the California Health & Safety Code requirements, which states that for Protected Health Information (PHI) related to HIV/AIDS, any disclosure requires specific, written consent from the client for each release. Authorizations to Disclose (ATDs) for treatment, payment, and healthcare operations (TPO), is not an exception for HIV/AIDS PHI.

Please contact the Office of Compliance if you have questions regarding PHI

Problem Lists

The problem list may include symptoms conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters, and is developed by the provider.

A problem list is required for every member receiving Medi-Cal behavioral health services.

Care Plans

Care plans, which are also called client plans, treatment plans, or service plans, are developed in collaboration with the client to define goals. Care planning is an ongoing, interactive component of service delivery an dis not a one-time event.

A care plan is only required for specific services, facility types, funding sources, and/or program types. Problem list cannot substitute for a care plan when one is required.

BHS • QMS • Billing Team Newsletter

DHCS Medi-Cal Claim Submission Timely Filing Limits

State Requirements:

- **Initial Claim:** Must be submitted within 12 months from the month of service, which is critical.
- **Replacement Claim:** Must be submitted within 15 months from the month of service (only if the initial claim was submitted within one year of the service date).

County-to-State Claim Submission Schedule:

- **Medi-Cal ADP Claim Submissions:** Occur every Tuesday. All charges should be entered or corrected by the end of day Monday.
- **Medi-Cal Short Doyle Claim Submissions:** Occur every Wednesday. All charges should be entered or corrected by the end of day Tuesday.

Submitting Clean Claims to Medi-Cal

Submitting clean, accurate, and timely claims helps reduce denials, speeds up reimbursement, and ensures compliance with Medi-Cal and County requirements. Below are key steps and reminders to support successful claim submission.

1. Verify Eligibility & Enrollment
Confirm eligibility **before service**.
Ensure your organization and rendering providers are properly enrolled with Medi-Cal (NPI, taxonomy, and specialty).

2. Complete All Required Fields
Accurate patient information (name, DOB, Medi-Cal ID, etc.).
Enter correct **ICD-10 diagnosis** and **CDM (CPT/HCPCS) codes**.

3. Maintain Required Documentation
Assignment of Benefits/Authorization to Disclose (AOB/ATD)
Consent forms
Medical necessity documentation

4. Submit Timely & Monitor Queues
Follow Medi-Cal timely filing rules.
Check internal queues for claims needing correction or completion.

5. Keep Records & Stay Audit Ready
Retain EOBs, RAs and all supporting documentation.
Maintain readiness for audits, or compliance reviews.

6. Stay Informed & Updated
Review **DHCS updates** and **Billing Manuals**.
Provide regular staff training on new requirements.

BHS • QMS • Billing Team Newsletter Continued

Helpful Resources

- Aid Code Chart – MedCCC – Library
- BHS Contract Provider Web Portal – BHS Contract Provider Claims/Billing Resources | Orange County California - Health Care Agency
- Medi-Cal Eligibility Verification – DHCS - Provider Portal
- Medi-Cal Service Table – MedCCC – Library
- Medicare Advantage Plans – Medicare Advantage Plans
- Medicare COB Requirements –Short Doyle: Specialty Mental Health Services Billing Manual SFY 2025-26, ADP: DMC-ODS Billing Manual SFY 2025-26
- Share of Cost Spend Down Guide – Share of Cost (SOC) (share)

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

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

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

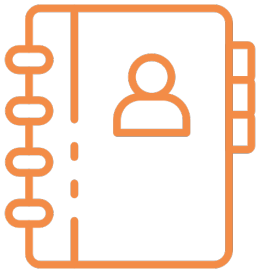
PROVIDER DIRECTORY 274 USER INTERFACE

Monthly submissions for the Behavioral Health Plan Provider Directory have transitioned to the 274 User Interface (274 UI) for all providers. This platform aligns with key data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT), supporting improved data consistency and streamlined reporting for both the NACT and the Provider Directory.

With this transition, program administrators from county and county-contracted programs are now be responsible for entering and updating provider data in the 274 UI monthly. Providers will receive automated email notifications on the 1st of each month, prompting them to submit updates. If a submission is not completed by the 15th, another reminder email will be sent.

Remember to review each provider listed under your assigned sites every month. Submit updates as needed. If no changes are required, select the "NO CHANGE" button on each provider's profile to confirm your review. This step allows the MCST to verify compliance and ensure administrators are completing monthly reviews for all assigned providers.

IMPORTANT: If no activity is recorded for your program and provider reviews for three consecutive months, a Notice of Deficiency may be issued for non-compliance with DHCS BHIN-25-026 requirements.



For questions, you may e-mail:

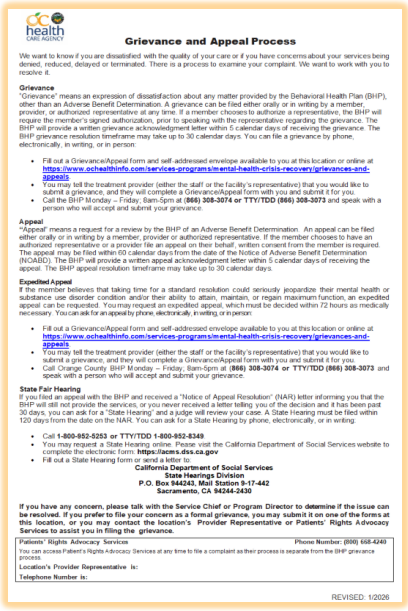
- Provider Directory: BHPProviderDirectory@ochca.com
- NACT: BHPNetworkAdequacy@ochca.com

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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

The grievance and appeal posters have been revised (1/2026) 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.

- ✓ 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.



Grievance and Appeal Process

We want to know if you are dissatisfied with 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.

Grievance

"Grievance" means an expression of dissatisfaction about any matter provided by the Behavioral Health Plan (BHP), other than an Adverse Benefit Determination. A grievance can be filed either orally or in writing by a member, provider, or authorized representative at any time. If a member chooses to authorize a representative, the BHP will require the member's signed authorization, prior to speaking with the representative regarding the grievance. The BHP will provide a written grievance acknowledgment letter within 5 calendar days of receiving the grievance. The BHP grievance resolution timeframe may take up to 30 calendar days. You can file a grievance by phone, electronically, in writing, or in person:

- Fill out a Grievance/Appeal form and self-addressed envelope available to you at this location or online at https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/grievances-and-appeals
- 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.
- Call the BHP Monday – Friday, 8am-5pm at **(866) 308-3074 or TTY/TDD (866) 308-3073** and speak with a person who will accept and submit your grievance.

Appeal

"Appeal" means a request for a review by the BHP of an Adverse Benefit Determination. An appeal can be filed either orally or in writing by a member, provider or authorized representative. If the member chooses to have an authorized representative or a provider file an appeal on their behalf, written consent from the member is required. The appeal may be filed within 60 calendar days from the date of the Notice of Adverse Benefit Determination (NOABD). The BHP will provide a written appeal acknowledgment letter within 5 calendar days of receiving the appeal. The BHP appeal resolution timeframe may take up to 30 calendar days.

Expedited Appeal

If the member believes that taking time for a standard resolution could seriously jeopardize their mental health or substance use disorder condition and/or their ability to attain, maintain, or regain maximum function, an expedited appeal can be requested. You may request an expedited appeal, which must be decided within 72 hours as medically necessary. You can ask for an appeal by phone, electronically, in writing, or in person:

- Fill out a Grievance/Appeal form and self-addressed envelope available to you at this location or online at https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/grievances-and-appeals
- 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.
- Call Orange County BHP Monday – Friday, 8am-5pm at **(866) 308-3074 or TTY/TDD (866) 308-3073** and speak with a person who will accept and submit your grievance.

State Fair Hearing

If you filed an appeal with the BHP and received a "Notice of Appeal Resolution" (NAR) letter informing you that the BHP will still not provide the services, or you never received a letter telling you of the decision and it has been past 30 days, you can ask for a "State Hearing" and a judge will review your case. A State Hearing must be filed within 120 days from the date on the NAR. You can ask for a State Hearing by phone, electronically, or in writing:

- Call **1-800-952-5253 or TTY/TDD 1-800-952-8349**
- You may request a State Hearing online. Please visit the California Department of Social Services website to complete the electronic form: **https://acms.dss.ca.gov**
- Fill out a State Hearing form or send a letter to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-442
Sacramento, CA 94244-2430

If you have any 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	Phone Number: (800) 668-4240
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.	
Location's Provider Representative is:	
Telephone Number is:	

REVISED: 1/2026

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

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

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

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)