

SUD

Support Newsletter

QUALITY MANAGEMENT SERVICES

April 2026

WHAT'S NEW?

SUD Clinical Chart Review Team

April Jannise, LCSW
Yvonne Brack, LCSW
Ashlee Al Hawasli, LCSW
Caroline Roberts, LMFT
Ashlee Weisz, LMFT
Stephanie Bunyaputikul, LMFT
Jaime Bueno, Office Specialist

SUD Technical Assistance & Training Support Team

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: April 8, 2026 at 2pm & April 27, 2026 at 11am

It's coming...Health Information Exchange (HIE)

A HIE is the secure, bi-directional sharing of the minimum necessary client data in "real time" with others that are also part of the HIE like contracted providers and other Medi-Cal partners to support service delivery, care coordination, referrals, and transitions. As we move towards demonstrating compliance with state and federal regulations for this, what this will mean for our clients is that they too will have "real time" access to information contained in their clinical record (e.g., assessments, problem lists/treatment plans, progress notes, labs/test results, etc.).

Here is how you can begin preparing for the implementation of the HIE:

- Ensure documentation is completed in a timely manner
- Document the minimum necessary
- Use person-centered language (e.g., "Client with a SUD" instead of "addict," "Having a positive drug test" instead of "testing dirty," or "Return to use" instead of "relapse")
- Document in a concise, objective, and purposeful manner using easily understandable language (limit clinical jargon)
- Avoid making speculations or judgments



A good question to ask is whether YOU would be OK with what you have written if that is what your provider wrote about YOU!



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!

Coming Soon... Updated DMC-ODS Payment Reform 2026 - CPT Guide

Please refer to the State's [Service Table](#) for the most accurate information on billing codes.

SUD Documentation Manual

[DMC-ODS CaAIM Doc Manual.pdf](#)

MAT Documentation Manual

[FINAL CaAIM 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

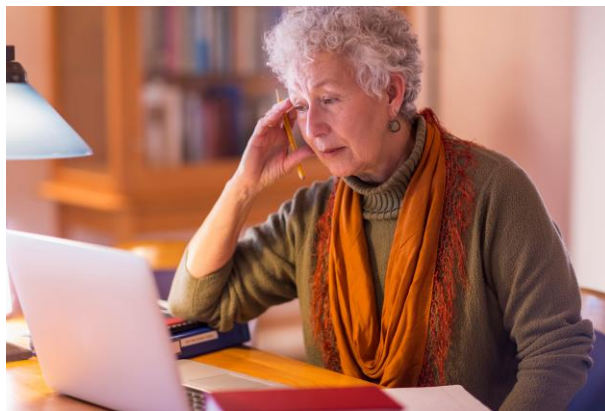
Continued on page 2...

WHAT'S NEW?

...continued from page 1

Consider Collaborative Documentation –

This is when the provider completes the service progress note documentation with the client in the session. Working together on the documentation allows for full transparency while also empowering clients to give feedback on what information is being captured in their clinical record. It can also be a great way to reinforce or review what was discussed in the session. The time spent working on the documentation with the client in session is considered billable service time.



Documentation

FAQ

UPDATE!

Telehealth Services

There has been a change in our guidance around the requirements for documentation for DMC-ODS services provided via telehealth, which includes telephone. There must be documentation of the confirmation of the client's specific location (i.e., address) in California at the time of the service. Previously, it was sufficient to simply note confirmation of the client being in California. However, to align with the California Code of Regulations on the standards of practice for telehealth, we need to “verbally obtain from the client and document the client's full name and address of present location, at the beginning of each telehealth session.” If the client's home address is in the client's chart, it is sufficient for you to indicate that client confirmed they were at home.



1. Is discharge planning billed as Targeted Case Management?

This depends on what the primary focus of the discharge planning session was. If most of the service was spent discussing resources, linkages, and referrals that the client may need post-discharge, then the service is primarily about care coordination and the Targeted Case Management (70899-120) T1017 code is most appropriate. If the service with the client primarily involved discussing preparations for how they can maintain the gains they have achieved in staying sober and preventing relapse in their home environment or where they may encounter triggers for potential return to use, then the interventions provided are more skill-based and the service is more appropriate to be coded as an individual counseling service.

2. Are only Z Codes and diagnoses allowed on the problem list?

No. There is no requirement for all items on the problem list to be associated with a Z Code or a DSM-5 diagnosis. For example, there may be a specific issue that clients would like to address that is unable to be accurately captured with a Z Code. If your program's problem list allows for a free-text entry or annotation, it can be captured there. Be sure to include who (along with their credentials) identified the issue and the date it was identified.

3. Do we have to complete an assessment (or re-assessment) to document a change to the client's SUD diagnosis?

No. There is no specific requirement that an assessment must be completed for a change in the client's diagnosis. However, remember that an assessment is required if the client's condition changes. So, if the change in diagnosis also involves changes in the client's presentation or functioning across the ASAM dimensions that could potentially indicate the need for a different level of care, an assessment should be completed. If, for example, there is more information you have acquired about



Telephone Encounters

“Telephone” should be selected or entered as the encounter type in IRIS only for telephone contact with the client directly. All other telephone contact (e.g., calling the pharmacy, speaking to a family member via telephone, consultations with other providers by telephone, etc.) should be entered as a “clinic” encounter type. Please be sure that going forward, the correct selection or entry is made.

Continued on page 3...

Documentation FAQ (continued)

...continued from page 2

the client and a diagnosis needs to be added to their existing diagnosis, it is sufficient to document the reason for the change in a progress note where the information pertaining to the change was discussed. Some agencies utilize a document specifically to explain a client's diagnosis and this would suffice. It is important to remember that only a qualified LPHA may establish a diagnosis. Therefore, the documentation to explain the change would need to be completed by the LPHA who determined the diagnosis.

4. What should I do if I can't remember how much service time was spent for a billable service?

The encounter should be documented in a progress note and coded as a non-billable service. The amount of service time should be "1" (so that it can be entered into IRIS). In a situation like this, even though it was a billable service, it is not appropriate to simply "guess" or "make up a number" for the amount of time that was spent.



Outpatient Non-Overridable Lockout Example

For clients who are receiving Recovery Incentives as well as the outpatient level of care (i.e., ODF, IOT), it is important to know that **Recovery Incentives (70899-118) H0050** and **SUD Structured Assessment, 15-30/30+ Min (70899-100/70899-101) G0396/G0397** are **locked out from each other.**

If Provider A conducts a Recovery Incentives service for the same client on the same day as Provider B who conducted a brief screening using SUD Structured Assessment, 30+ Min (70899-101) G0397, one of the claims will be denied by the State!

TIP: Consider whether the SUD Screening (70899-105) H0049 code may be used instead of the SUD Structured Assessment, 30+ Min (70899-101) G0397.

Please see the "DMC-ODS Allowable Modifiers & Lockouts" reference sheet for all non-overridable/overridable codes!

Disclaimer: The Quality Management Services (QMS) Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly SUD Newsletter to all DMC-ODS providers as a tool to assist with various QA/QI regulatory requirements. It is NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.

REMINDERS



Cannabis Use

Be sure to consider what impairments in functioning are directly associated with a client's Cannabis use. Remember that *use alone is not enough to justify the diagnosis* of a Cannabis Use Disorder. We must also take into consideration of the fact that medicinal Cannabis use is legal in California. So be sure to explore a bit further with clients who report Cannabis use!

Physical Exam Status

Dimension 2 of your ASAM-based assessment is a great place to document whether the client has had a physical exam in the 12 months prior to admission. Keep in mind that "seeing a doctor" is not the same thing! The client may have seen a doctor for any number of reasons but not completed a physical exam. It is best to confirm with the client that they have seen a doctor for a physical exam.

Evidence-Based MAT Assessment

If your program's practice is to have your doctor complete a MAT evaluation for all clients admitted instead of completing the evidence-based MAT assessment (to determine whether a referral to MAT services is appropriate), be sure the doctor is completing it within 24 hours of admission. This is to so the requirement for every client to receive an evidence-based MAT assessment can be bypassed.

Signing with Your Credentials

It is best practice for providers to include their credentials with every signature on all documents in a client's chart. This helps ensure that there is no ambiguity in terms of who rendered the service and the appropriateness of the services provided.

BHS QMS Billing Team

DHCS Medi-Cal Claim Submission Timely Filing Limits

- **Initial Claim:** Must be submitted within 12 months from the month of service.
- **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 (837 File) 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.

DHCS Billing Corner: Understanding M80 Denials & PCCN Requirements

M80 Lockout Denials

An M80 denial occurs when DHCS identifies a pair of procedure codes that **cannot be billed together** for the same member on the same day.

How to Prevent M80 Denials

- Reference the Service Table on MEDCCC Library
- Apply correct overridable modifiers (such as 59, XE, XP, XU) for distinct services
- Clearly document when services are separate and independent
- Review M80 denials promptly and submit corrections

PCCN Reminder

When submitting a **replacement** or **void** claim, the **Payer Claim Control Number (PCCN)** must be included from a previously processed claim.

Why It Matters

- Ensures DHCS can link your correction to the previously processed claim
- Reduces preventable rejections and speeds up payment
- Supports accurate record-keeping and auditing

Bottom Line:

Avoiding M80 denials and including the PCCN on all corrected claims are simple but crucial steps to ensuring clean claims and timely DHCS

Important Update

The DHCS FY 25-26 Service Tables have been updated as of March 2026.

- The Medicare COB requirement has been removed from procedure codes T2021 and T2024. **However, if you are substituting another code that *does* require Medicare COB, you must bill Medicare first, following the guidance provided in the “Medicare COB Required?” column.**

Helpful Resources

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

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/RE-CREDENTIALING**
- 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.

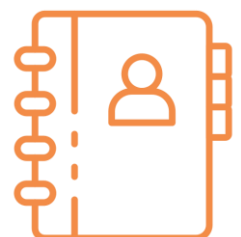
With this transition, providers and program administrators from county and county-contracted programs are responsible for entering and updating provider data in the 274 UI monthly. Providers will receive automated email notifications on the 1st of each month, prompting them to submit updates. If a submission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

Program administrators are to review each provider listed under their assigned site(s) 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



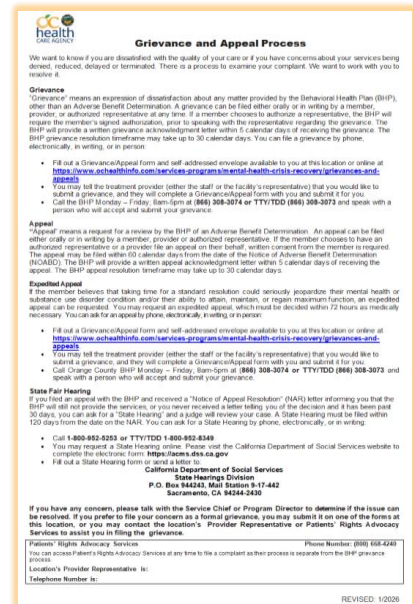
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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.

KEY POINTS

- ✓ The Grievance and Appeal Poster must be prominently displayed in provider locations and printed on 8x14 legal size paper.
- ✓ Materials, including posters, must be available in alternate formats such as large print (11x17) 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 1 calendar day 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-stills-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) 368-3074 or TTY/TDD (866) 368-3073 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 (NABCD). 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 must 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-stills-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 Change County BHP Monday – Friday, 8am-5pm at (866) 368-3074 or TTY/TDD (866) 368-3073 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 1-800-852-0233 or TTY/TDD 1-800-852-0349
- You may request a State Hearing online. Please visit the California Department of Social Services website to complete the electronic form: <https://casms.dss.ca.gov>
- Fill out a State Hearing form or send a letter to:
 California Department of Social Services
 State Hearing Division
 P.O. Box 944262, Mail Station 9-7-442
 Sacramento, CA 95844-2620

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 concerns 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 Patient Rights Advocacy Services to assist you in filing the grievance.

Phone Number: (866) 662-4263
 You can access Patient Rights Advocacy Services at any time to file a complaint or 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](#)



AVAILABLE
NOW

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 CREDENTIALIED:



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
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Registered Counselors 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.

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.

BHPBillingSupport@ochca.com	IRIS Billing • Office Support
BHPCertifications@ochca.com	SMHS Medi-Cal Certifications • PAVE (SUD and JI) • MPF/OOCR Updates
BHPDesignation@ochca.com	Inpatient Involuntary Hold Designation • LPS Facility Designation • Outpatient Involuntary Hold Designation
BHPGrievanceNOABD@ochca.com	Grievances & Investigations • Appeals/Expedited Appeals • State Fair Hearings • NOABDs • MCST Training Requests
BHPIDSS@ochca.com	General Questions Regarding Designation
BHPIRISFrontOfficeSupport@ochca.com	County Front Office Operational Support – Guidance on Front Office Procedures and Non-Technical EHR Workflow Inquiries
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)
BHPNetworkAdequacy@ochca.com	Manage SMHS & DMC-ODS 274 Data • Support of MHP County & Contract User Interface for 274 Submissions
BHPProviderDirectory@ochca.com	Provider Directory Notifications • Provider Directory Submission for SMHS & DMC-ODS Programs
BHPPTAN@ochca.com	Assist in Maintaining PTAN Status of Eligible Clinicians & Doctors
BHPSUDSupport@ochca.com	DMC-ODS Clinical Chart Reviews • Corrective Action Plan (CAP) Assistance • Documentation & Coding Support • Use of Downtime Forms • Scope of Practice Guidance • SUDsies Newsletter • DMC-ODS Documentation Training Requests
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
BHPUMCCC@ochca.com	Utilization Management of Out-of-Network (and In-Network) Complex Care Coordination Typically for ECT, TMS, Eating Disorders
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 Documentation Review & Redaction • Release of Information, ATDs, Restrictions & Revocations • IRIS Scan Types, Scan Cover Sheets & Scan Types Crosswalks • Record Quality Assurance & Correction Activity
BHSInpatient@ochca.com	Inpatient TARs • Hospital Communications • ASO/Carelton Communication
BHSIRISLiaison@ochca.com	EHR Support, Design & Maintenance • Add/Delete/Modify Program Organizations • Add/Delete/Maintain All County & Contract Rendering Provider and Front Office Staff Profiles in IRIS • Manage SMHS & DMC-ODS 274 Requirements
BHSPandP@ochca.com	New BHS P&P needs • BHS P&P updates
CalAIMSupport@ochca.com	Enhanced Care Management (ECM) • Transitional Rent
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, Medication Monitoring); QA/QI Meeting Invite Requests
QMSSpecialProjects@ochca.com	BHP Provider Manual • Member Handbook • Intake/Advisement Checklist • Justice Involved SME
SMHSClinicalRecords@ochca.com	SMHS Clinical Chart reviews • Corrective Action Plan (CAP) Assistance • Documentation & Coding Support • Use of Downtime Forms • Scope of Practice Guidance • QRTips Newsletter • SMHS Documentation Training Requests