

SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

May 2026

SUD Clinical Records Review Team

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UPDATED!

DMC-ODS Office Hours

A voluntary and informal space to ask questions and discuss documentation requirements. Occurs virtually on the second Wednesday (2pm) & **fourth Tuesday (10am)** of every month.

Upcoming meetings: May, 13, 2026 at 2pm & May 26, 2026 at 10am

WHAT'S NEW?

Registered Psychological Associates

We have received clarification from the State that Registered Psychological Associates are NOT eligible provider types in the DMC-ODS. They do not fall under the category of Clinical Psychologists (licensed or registered) or Psychologist Clinical Trainee. Unfortunately, there are no existing state laws that authorizes Registered Psychological Associates to provide Medi-Cal services for SUD and statutory changes would be necessary before the Department of Health Care Services (DHCS) is able to allow for this provider type.

If your program utilizes or intends to utilize Registered Psychological Associates, they will need to register as an AOD Counselor or serve in the role of Other Qualified Provider (OQP) to provide and bill for services in the ODS. It is important to keep in mind that this would mean that they would be limited to functioning within the scope of a registered AOD Counselor or OQP.

For questions, please reach out to your assigned Quality Assurance Reviewer or send an email to BHPSUDSupport@ochca.com.



Continued on page 2...



Training & Resources Access

☀️ Training Requests ☀️

[TATS Training Request Form](#)

To be utilized by administrators (i.e., Service Chief, Program Director, QI Coordinator, etc.) to request a training on documentation and service codes!

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

WHAT'S NEW?

...continued from page 1

MAT at Withdrawal Management

Recent updates to DHCS' Service Table of allowable service billing codes came with a new requirement for the use of the Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033 code at the Withdrawal Management level of care. This code is one of two codes available for MAT services at the Withdrawal Management programs. The Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033 code cannot be claimed with a 3.2 Withdrawal Management treatment day (90899-779) H0012 unless there is a National Drug Code (NDC) on the claim. Please be advised that failure to include the NDC will result in one of the two claims being denied.

This lockout is only applicable for the 3.2 Withdrawal Management level of care and does not impact MAT services at the Residential 3.1 and 3.5 levels of care.

The State's NDC list can be accessed at [MedCCC-Library](#)



Documentation

FAQ

1. For Contracted providers, which forms/documents should contain the County logo?

For Contracted providers, the County logo should remain on the Medi-Cal AOB/ATD and the Notice of Privacy Practices forms. Note: when removing the County logo from the Intake Advisement Checklist, be sure to also remove references to "BHP staff" and "Health Care Agency/Behavioral Health Plan (BHP)."

2. Can I provide a telehealth service while the client is out of state?

No. If the provider is not licensed/registered in the state that the client is physically located in, then services cannot be provided by that provider. If you must address an SUD crisis or care coordination unexpectedly while the client is out of state, the encounter should be documented in a *non-billable* progress note because the nature of the interaction is clinically relevant to the client's overall course of treatment. Even though it is not billable, be sure the documentation makes clear why you needed to address the issue (i.e., why it could not wait until the client's return).

3. What is the difference between the SUD Screening (70899-105) H0049 and SUD Assessment (70899-103) H0001 code?

The SUD Assessment (70899-103) H0001 code will be the most commonly used assessment code as it should be used when the majority of the service involves working on the ASAM-based assessment (e.g., meeting with the client to gather information for ASAM dimensions, formulating the rationales and determining the risk ratings, etc.). For the SUD Screening (70899-105) H0049 code, as the name suggests, it should be used when there is a "screening." Typically, a "screening" is quick and involves acquiring minimal information to make some preliminary decisions (e.g., using the SUD Brief LOC Screening Tool to determine the level of care or program to direct an individual to). Oftentimes, an intake appointment at the outpatient programs



Medical Necessity REMINDER

The State recently confirmed the requirement for medical necessity to be evident in each, standalone progress note. The progress note documentation to support the client's need for the service must tie back to their SUD. Before you sign your progress note, double check that you've made it clear to an outside reader how the interventions and activities you provided in the session are relevant to the client's SUD treatment.

If it's not documented, it didn't happen!

Don't forget that for each service that is claimed, there must be a corresponding progress note.

Continued on page 3...

Documentation FAQ (continued)

...continued from page 2

focuses primarily on reviewing intake legal paperwork with the client to admit the client and open their case. In these appointments, minimal information may be obtained about the client's substance use or needs to make the preliminary decision that the client is likely appropriate for the program. The evidence-based MAT assessment is also often administered at intake to fulfill the 24-hour timeframe requirement. Due to this limited information or "screening," the SUD Screening (70899-105) H0049 code should be used to claim for the intake service. These codes are not separately billable at the residential and withdrawal management levels of care on top of the treatment day.

4. Are there documentation timeline requirement differences for adolescents?

No. The requirements are the same for adolescents and adults. Progress note documentation is due within 3 business days of the date of service (date of service counts as day zero). Crisis intervention progress notes are due within 24 hours of the date of service. There are no hard timelines for the assessment or problem list at the outpatient levels of care but should be completed within a clinically reasonable amount of time, according to generally accepted standards of care.



Outpatient Overridable Lockout Scenario

The **Psychiatric Diagnostic Evaluation, 60 Min (90791-1)** and **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)** provided on the same day to the same client is a lockout situation that requires a modifier to be used to be able to bill both services.

Where might this happen? For example, if the client is receiving an assessment service by an LPHA on the same day that the client also sees the MD for a MAT medication service at an outpatient program. To bill for both services in this situation with the above codes, the MD will need to use the appropriate modifier on their evaluation and management claim to override the lockout.

Be sure to check out the [Allowable Modifiers & Lockouts handout](#) for all non-overridable and overridable lockouts!

24-Hour Service Lockouts: Residential to Outpatient Transitions

We continue to see claim denials from the State due to the lockout rules not being adhered to.

Residential and Withdrawal Management treatment days CANNOT be claimed with an outpatient service (such as an intake/assessment) EXCEPT on the dates of admission or discharge.

Some steps to ensure that claims are not denied:

1. Residential and Outpatient providers coordinate so the client's outpatient admission takes place *on or after* the residential discharge date.
2. Residential provider shares with the Outpatient provider their Re-Assessment document that indicates that the client is appropriate for the outpatient level of care.
3. Outpatient provider uses the Residential provider's Re-Assessment document as the initial assessment (verified by an LPHA).
4. Outpatient provider confirms with the referring Residential provider that the client's discharge date from the residential program coincides with the intake/assessment appointment date.

Important Reminders:

Residential providers have up to 10 days to transition the client once they no longer demonstrate medical necessity for the residential level of care. Documentation must support the need for each day. Clients should not be returning to the residential program for additional treatment days once they complete an assessment service with the outpatient provider that confirms the client's appropriateness for the outpatient level of care.





FOR COUNTY PROVIDERS ONLY: SUSPECTED ABUSE REPORTING

Since April 2022, County Clinic staff no longer scan Adult Protective Services (APS) or Child Protective Services (CPS) Abuse Reports or APS/CPS response letters into IRIS. For County Clinics, the QMS Health Information Management (HIM) Team is responsible for the centralized retention of all APS/CPS Abuse Reports completed by County Clinic/Program Clinicians, as well as any response letters received.

Procedure:

Due to the sensitive nature of APS/CPS documents, Reporting Clinicians (mandated reporters) are responsible for submitting all APS/CPS Abuse Report documents directly to HIM. Office Support staff should not participate in this process. This approach supports a trauma-informed workplace and minimizes staff exposure to potentially distressing content. If a mandated reporter is unavailable, their Service Chief or the Service Chief's clinical designee should complete the submission process.

After completing an APS/CPS Abuse Report, the Reporting Clinician will:

1. Complete a PHI Accounting of Disclosure PowerForm when applicable.
2. Complete one HIM APS & CPS Documents Routing Slip per document (do not alter the PDF format).
3. Scan and email the routing slip and the corresponding APS/CPS report to BHSHIM@ochca.com
4. After receiving confirmation from HIM that the submission has been processed, shred the original documents. (Hard copies should not be retained at the clinic.)
5. If an APS/CPS response letter is received for a previously submitted report, follow steps 2 through 4 above.

The **HIM APS/CPS Documents Procedure** and **HIM APS/CPS Documents Routing Slip** can be found in the EHR Blogs under: Quick Guides > Health Information Management.

If there are any questions regarding the APS/CPS Document Procedure, please contact QMS HIM at BHSHIM@ochca.com or 714-834-8608. HIM staff will respond as soon as possible.

Care Coordination

The State's requirement regarding care coordination: ***“Registered or certified counselors may assist with some aspects of this service, however, a licensed provider is responsible for supervising this service component.”***

The State has not specified how providers should evidence this. In the past we have provided guidance that LPHAs can indicate in their narrative or Case Formulation section of the ASAM-based assessment about their recommendations for care coordination to demonstrate compliance with the requirement. Oftentimes, clients will need care coordination services as soon as they are admitted and prior to the LPHA's completion of their narrative or Case Formulation at the outpatient levels of care. To account for these cases, it is up to the discretion of each program on what protocols will be in place to ensure compliance with the State's requirement.

For example, some agencies have instituted policies and procedures that make clear the role of the licensed professional's supervisory responsibilities as it relates to the care coordination services provided by non-LPHA. Other programs may elect to have an LPHA document in the client's chart at the time of the client's admission as attestation to their oversight of the provision of care coordination services needed to address the client's specific needs.

Reference: [BHIN 24-001](#)



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.

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.

Technical Denials

Increase in Technical Denials

Increase in Technical Denials related to Taxonomy and alias codes, including:

- N54
- N95
- N288

Action Required

Please *do not* work these denials at this time. The Billing Team is aware of the issue and is actively working to resolve it.

MA43 = Unsatisfactory Immigration Status (UIS)

State Update

- MA43 technical denials are now eligible for resubmission
- We will begin releasing these denied claims from your queues
- Claims will be resubmitted automatically


Please Note: Not all resubmissions may qualify for reimbursement, and we still cannot determine a member's UIS status via Eligibility Portals

Important: Do **NOT** adjust Technical Denials with **MA43** for DOS 07/01/2024 to current.


New AOB Queue

A new billing queue has been added to the RCA app. The *new* queue, **AOB Signature Required**, now *replaces* the former **AOB Signature Required Transition** queue.

NEW

 AOB Signature Required

OLD

 AOB Signature Required Transition

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

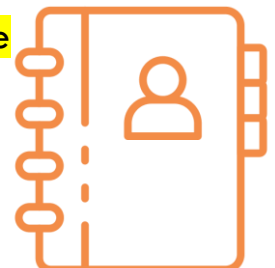
Monthly submissions for the Behavioral Health Plan Provider Directory have transitioned to the 274 User Interface (274 UI) for all providers, effective 11/1/25. This platform aligns with key data elements required by the Department of Health Care Services (DHCS) Network Adequacy Certification Tool (NACT), 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 notification will be sent.

Program administrators are to review each provider listed under their assigned site(s) each month for accuracy. If there are no changes, select the "NO CHANGE" button for each provider's profile to confirm your review. This step allows the MCST to verify compliance and ensure administrators are confirming monthly reviews for all assigned providers.

IMPORTANT: If there are no activity of submission for two consecutive months, a Notice of Deficiency may be issued for non-compliance with [DHCS BHIN-25-026](#) requirements.

ALL programs should have access to the 274 UI. If you still do NOT have access to the 274 UI portal, you are to contact BHPNetworkAdequacy@ochca.com immediately! Tokens were issued to all county contracted programs over the last several months to designees to begin entering the required data on the 274 UI.



REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

ACCESS LOG REMINDERS

- ✓ DHCS requires tracking both the offer date and render date for initial appointments. Therefore, ALL **new** recipients requesting **initial access** to SMHS and/or DMC-ODS—whether by phone, walk-in, or any other method—must have an Access Log completed at every **access point**.
- ✓ To meet DHCS time and distance standards, an appointment must be offered to the member with the provider closest to their place of residence. If a member declines the appointment offered within the required timeframe and instead request an appointment outside of that timeframe, the provider has still met the Access Log requirement.
- ✓ If the provider completes a warm hand-off to the 24/7 Member Access Line, an Access Log is not required, as the 24/7 Member Access Line staff will complete it.
- ✓ Programs that operate on weekends must include weekend business days when calculating the 10 business-day window for offering a “routine” appointment.
- ✓ A timely access NOABD is issued only when the BHP has exhausted all options and is unable to secure an appointment with any provider in the network to meet the timeframe requirement for an initial appointment. If you believe the BHP has been unable to meet this requirement, you must consult with the NOABD Lead before issuing a timely access NOABD. Contact the NOABD Lead at (714) 834-5601 or e-mail BHPGrievanceNOABD@ochca.com.

ACCESS LOG REPORT

ACCESS LOG REPORTS & ERROR FINDINGS

- Service Chiefs/Program Directors are to run and review Access Log reports **weekly** to fix timely access errors and ensure Access Log entries are entered **daily** by the staff (e.g. Intake Counselor).
- MCST runs an IRIS Access Log report monthly for SUD and SMHS to monitor and reconcile for errors.
- Any errors found by MCST must be corrected and re-submitted by the program within **3 business days**. The MCST Access Log Leads are required to reach out to the program to correct the errors and confirm it has been corrected on the Access Log.
- MCST may conduct random audit to verify that programs are generating Access Log encounters. Programs that are not in compliance may be issued a Notice of Deficiency.

COMMON

ERRORS



- ✓ There is **NO** Access Log Entry.
- ✓ There is a **LATE** Access Log Entry.
- ✓ Data Entry Errors: Dates, misspelling, etc.
- ✓ Duplicate Entries
- ✓ An appointment was made outside the required timeframe and an NOABD – Timely Access was not issued.

For questions regarding the Access Log requirements, please contact the Access Log Lead at (714) 834-5601 or e-mail at BHPManagedCare@ochca.com and include “Access Log” in the subject line.

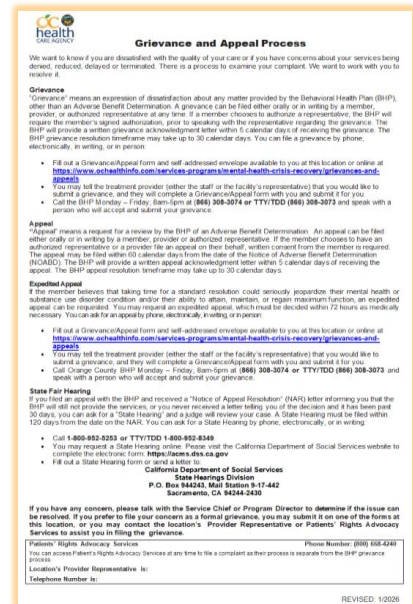
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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.



[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)

SUPERVISION REPORTING FORM REQUIREMENT

There are four types of supervision reporting forms the MCST oversees. We recently added some provider types on the forms and published it on the QMS website. 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 - **REVISED**
- ✓ Medical Supervision Reporting Form - **REVISED**
- ✓ Qualified Provider Supervision Form - **REVISED**

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 • Registered Trainee • Registered Intern 	<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 • Registered Dietitian 	<ul style="list-style-type: none"> • Mental Health Rehabilitation Specialist • Other Qualified Provider • Certified Peer Support Specialist • Enhanced Community Health Workers



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.**

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)**





OUR TEAM



Annette Tran, LCSW
Health Services Administrator



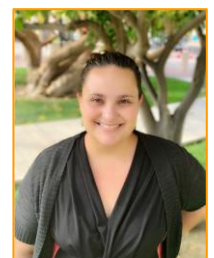
Catherine Shreenan, LMFT
Service Chief II



Araceli Cueva
Staff Specialist



Boris Nieto
Staff Assistant



Jennifer Fernandez, LCSW
Behavioral Health
Clinician II



Ashley Cortez, LCSW
Behavioral Health
Clinician II



Liz Fraga
Staff Specialist



Vanessa Estrada
Office Specialist



Tanya Carbajal
Office Specialist



Joanne Pham
Office Specialist



Esmi Carroll, LCSW
Behavioral Health
Clinician II

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

CREDENTIALING AND PROVIDER DIRECTORY

Credentialing Lead: Ashley Cortez, LCSW

Cal Optima Credentialing Lead: Araceli Cueva & Elizabeth "Liz" Fraga

Provider Directory Leads: Joanne Pham

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)

Lead: Boris Nieto

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/Carelon 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