# Notice of Adverse Benefit Determination (NOABD) Notices

For Medi-Cal Beneficiaries

An Adverse Benefit Determination is defined to mean any of the following actions taken by The Plan: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) The reduction, suspension, or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary's request to dispute financial liability. Beneficiaries must receive a written NOABD when The Plan takes any actions described above. The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

| NOABD | Who Receives Notice? | Criteria for Beneficiary Notice |
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| **Denial of Authorization Notice** | Client or parent/legal guardian | The Plan denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Use this notice for denied residential services requests (both MH and SUD). The Plan must mail the notice within two (2) business days of the decision. |
| **Delivery System Notice** | Client or parent/legal guardian | The Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health or other services. The Plan must mail the notice to the beneficiary within two (2) business days of the decision. |
| **Modification Notice** | Client or parent/legal guardian | The Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services. The Plan must mail the notice to the beneficiary within two (2) business days of the decision. |
| **Termination Notice** | Client or parent/legal guardian | The Plan terminates, reduces or suspends a previously authorized service. The Plan must mail the notice to the beneficiary within ten (10) days before the date of the action. |
| **Timely Access Notice** | Client or parent/legal guardian | When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. The Plan must issue this notice if access to services is extended beyond 60 days from the initial request for services. The Plan must mail the notice to the beneficiary at the time of any action regarding the delay. |
| **Authorization Delay Notice** | Client or parent/legal guardian | When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When The Plan extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest. The Plan must mail the notice to the beneficiary within two (2) business days of the decision. |
| **Financial Liability Notice** | Client or parent/legal guardian | The Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. The Plan must mail the notice to the beneficiary at the time of any action regarding the dispute. |
| **Payment Denial Notice** | Client or parent/legal guardian | The Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary. The Plan must mail the notice to the beneficiary at the time of any action denying the provider's claim. |

**NOTE:** Services that are reduced, modified, or terminated by outpatient providers that are not subject to prior authorization and are the result of a treatment Team/Clinician decision based on the individual's clinical condition and/or progress in treatment is not subject to an adverse benefit determination notification. The client may appeal the decision with the appropriate advocacy agency.