

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-33
POLICY:	Next Review Date: May, 18, 2023
<u>NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) TO MEDI- CAL BENEFICIARIES</u> SUPERSEDES – 214-07, PP 205-04	Date Reviewed/Approved: May 18, 2020
	By:  Jer Africa, PsyD Director of Behavioral Health and Recovery Services

**POLICY: NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) TO
MEDI-CAL BENEFICIARIES**

I. PURPOSE:

The purpose of this policy is to define an adverse benefit determination, to ensure that the rights of Medi-Cal beneficiaries are protected, and to describe the situations that warrant a Notice of Adverse Benefit Determination (NOABD) and the process through which a NOABD is issued.

II. REFERENCES:

MHSUDS IN No. 19-026; 18-010E
 Title 42, CFR, Part 431, Subpart E;
 Title 42, CFR, Part 438, Subparts A and F

III. POLICY:

Marin Behavioral Health and Recovery Services (BHRS) is required to issue a Notice of Adverse Benefit Determination to eligible Marin Medi-Cal beneficiaries when BHRS, or a provider on behalf of BHRS, takes any action defined as an adverse benefit determination in regard to a beneficiary's SMHS or DMC-ODS services. Adverse benefit determination means any of the following actions taken by BHRS:

- 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;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of BHRS to act within the required timeframes for standard resolution of grievances and appeals; or
- The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities.

A beneficiary who receives a Notice of Adverse Benefit Determination

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(NOABD) has a right to appeal this decision within 60 calendar days from the date on the NOABD. Should the beneficiary decide to request an appeal, the Quality Improvement Coordinator will review the adverse benefit determination to either uphold or overturn BHRS' decision. If BHRS determines that taking time for a standard appeal resolution could jeopardize the beneficiary's health or functioning, beneficiaries can file an expedited appeal. Beneficiaries are informed of their right to a State Hearing by the Notice of Adverse Benefit Determination and the Notice of Appeal Resolution, if the decision is to uphold the adverse benefit determination. Beneficiaries must exhaust the BHRS appeal process prior to requesting a State Hearing. In the event that BHRS fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted BHRS' appeal process and may initiate a State Hearing. Beneficiaries can also request a second opinion on the determination of not meeting medical necessity

IV. AUTHORITY/RESPONSIBILITY:

Quality Improvement Coordinator
Program Manager/Supervisors
BHRS Service Providers
BHRS Administrative Staff

V. DEFINITION OF TERMS:

Appeal and Expedited Appeal – The standard appeal and expedited appeal procedure provides an avenue for a Medi-Cal beneficiary to request a review when BHRS takes any action defined as an adverse benefit determination.

Beneficiary – Individuals enrolled in Medi-Cal who are eligible for SMHS or DMC-ODS services. Only Medi-Cal beneficiaries may receive a Notice of Adverse Benefit Determination, request an appeal or expedited appeal, or request a State Hearing.

Continuation of Benefits (Aid Paid Pending) -Beneficiaries who have filed a timely request can have their existing services (i.e., benefits) continue while an appeal or State Hearing are pending. *Timely* means that the beneficiary requested an appeal within 10 calendar days from the date of the NOABD or before the intended effective date of BHRS' proposed adverse benefit determination. BHRS must continue the beneficiary's services if all of the following occur: the beneficiary files a timely request for an appeal; the appeal involves the termination, suspension, or reduction of an existing service authorization, which has not lapsed; and the beneficiary timely files for continuation of services. If, at the beneficiary's request, BHRS continues or reinstates the beneficiary's

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existing services, the services must be continued until one of the following occurs: the beneficiary withdraws the appeal or request for a State Hearing; the beneficiary fails to request a State Hearing and continuation of services within 10 calendar days after BHRS sends the Notice of Appeal Resolution upholding the adverse benefit determination; or the State Hearing office issues a hearing decision adverse to the beneficiary. Beneficiaries shall be informed that they may be held liable for the cost of those services if the State Hearing upholds the BHRS adverse benefit determination.

Medical Necessity -The criteria used to determine a beneficiary's eligibility for SMHS or DMC-ODS services. State guidelines list the included diagnoses and define impairment and intervention-related criteria by which medical necessity is determined.

Specialty Mental Health Services (SMHS) - Meeting medical necessity criteria for SMHS includes the following:

The beneficiary age 21 and over must have-

- an included DSM 5 diagnosis in accordance with the MHP contract; AND at least one of the following problems as a result of the included diagnosis: significant impairment in an important area of life functioning OR a probability of significant deterioration in an important area of life functioning; AND
- the expectation that the proposed treatment to address the included diagnosis will do at least one of the following: significantly diminish the impairment OR prevent significant deterioration in an important area of life functioning; AND
- the condition would not be responsive to physical health care based treatment.

The beneficiary under age 21 must have-

- an included DSM 5 diagnosis in accordance with the MHP contract; AND
- except as provided in CCR §1830.210, a reasonable probability that the beneficiary will not progress developmentally as individually appropriate as a result of the included diagnosis; AND
- except as provided in CCR §1830.210, the expectation that the proposed treatment to address the included diagnosis will allow the beneficiary to progress developmentally as individually appropriate; AND
- the condition would not be responsive to physical health care based treatment.

Drug Medi-Cal Organized Delivery System (DMC-ODS) - Meeting medical necessity criteria for DMS-ODS includes the following:

The beneficiary age 21 and over must have-

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- a DSM 5 diagnosis for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; AND
- the beneficiary shall meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria.

The beneficiary *under age 21* must be-

- assessed to be at-risk for developing a Substance Use Disorder (SUD); AND
- the beneficiary shall meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria.

Notice of Adverse Benefit Determination (NOABD) - A Notice of Adverse Benefit Determination informs a beneficiary of a denial or change to their SMHS or DMC-ODS services, and the beneficiary's right to request an appeal if the beneficiary does not agree with BHRS' decision. The NOABD also informs the beneficiary of delays in resolving grievances or appeals, providing services in a timely manner, delays in authorization, or to dispute financial liability.

State Hearing -A State Hearing is provided to beneficiaries pursuant to Title 42, CFR, Part 431, Subpart E. It is an independent review conducted by the California Department of Social Services to ensure that beneficiaries receive SMHS or DMC-ODS services entitled under the Medi-Cal program. A beneficiary does not have access to the State Hearing process until the BHRS appeal process has been exhausted and the adverse benefit determination is upheld.

Written NOABD Requirements: BHRS, or a provider on behalf of BHRS, must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, which must explain all of the following:

- The adverse benefit determination that BHRS has made or intends to make;
- A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. BHRS shall explicitly state why the beneficiary's condition does not meet SMHS and/or DMC-ODS medical necessity criteria;
- A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such

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determinations;

- The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Timing of the NOABD: BHRS, or a provider on behalf of BHRS, must hand deliver or mail the NOABD to the beneficiary within the following timeframes:

- For termination, suspension, or reduction of a previously authorized SMHS and/or DMC-ODS service, at least 10 days before the date of the action;
- For denial of payment, at the time of any action denying the provider's claim; or
- For decisions resulting in denial, delay, or modification of all or part of the requested SMHS and/or DMC-ODS services, within 2 business days of the decision.
- For an extension, BHRS must provide the beneficiary written notice for reason of extension within two (2) days. BHRS shall resolve the appeal as expeditiously as the appellant's health condition requires and no later than the date the extension expires.
- BHRS must also communicate the decision to the affected provider within 24 hours of making the decision. Decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, BHRS must also include the name and direct telephone number or extension (or other effective means for contact) of the decision-maker.

Written NOABD Templates: In accordance with the federal requirements, BHRS must use the Department of Health Care Services' (DHCS) uniform notice templates when providing beneficiaries with a written NOABD. The notice templates include both the NOABD and the *NOABD Your Rights* documents to notify beneficiaries of their rights in compliance with the federal regulations. BHRS, or providers on behalf of BHRS, shall not make any changes to the NOABD templates or the *NOABD Your Rights* attachment without prior review and approval from DHCS, except to insert information specific to beneficiaries as required.

Types of NOABD:

NOABD -Denial (formerly *NOA-A*). Denial of authorization for requested services. Use this template when BHRS, or a provider on behalf of BHRS, denies a request for a service. Denials include determinations based on type or level of service, requirements for medical

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necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS, also use this template for denied residential service requests.

NOABD -Payment Denial (formerly NOA-C). Denial of payment for a service rendered by provider. Use this template when BHRS 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. This notice reads "this is not a bill" so that the beneficiary knows that one is not responsible for the cost of the service rendered, but that the service request has been retrospectively denied.

NOABD -Delivery System. Use this template when BHRS has determined that the beneficiary does not meet the criteria to be eligible for SMHS through BHRS. The beneficiary will be referred to Beacon, or other appropriate systems, for non-specialty mental health or other services.

NOABD -Modification. Modification of requested services. Use this template when BHRS 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.

NOABD -Termination. Termination of a previously authorized service. Use this template when BHRS terminates, reduces, or suspends a previously authorized service.

NOABD -Authorization Delay. Delay in processing authorization of services. Use this template when there is a delay in processing a provider's request for authorization of SMHS or DMC-ODS services.

When BHRS extends the timeframe 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.

NOABD - Timely Access (formerly NOA-E). Failure to provide timely access to services. Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

NOABD -Financial Liability. Dispute of financial liability. Use this template when BHRS denies a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

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NOABD - Grievance/Appeal Resolution (formerly NOA-D). Failure to timely resolve grievances and appeals. Use this template when BHRS does not meet required time frames for resolution of grievances, standard appeals, or expedited appeals. This notice will be issued by the Quality Improvement Coordinator.

NOABD "YOUR RIGHTS" Attachment. This document must be sent to beneficiaries with each NOABD. The NOABD "Your Rights" attachment provides beneficiaries the following required information pertaining to NOABD:

- The beneficiary's or provider's right to request an appeal with BHRS within 60 calendar days from the date on the NOABD;
- The beneficiary's right to request a State Hearing only after filing an appeal with BHRS and receiving a notice that the adverse benefit determination has been upheld;
- The beneficiary's right to request a State Hearing if BHRS fails to send a resolution notice in response to the appeal within the required timeframe;
- Procedures for exercising the beneficiary's rights to request an appeal;
- Circumstances under which an expedited review is available and how to request it;
- The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits.

VI. **PROCEDURE:**

Issuing NOABD and Required Enclosures:

- A *Provider Decision Grid* has been developed to assist providers in deciding if, when, and which NOABD type needs to be issued to the beneficiary. See Attached Grid.
- The NOABD must be issued according to the required time frame as defined above.
- Each NOABD must be issued with the required enclosures which include the *NOABD Your Rights* attachment, the *Language Assistance* taglines, and the beneficiary *Nondiscrimination Notice*.
- Notices of Adverse Benefit Determination and the required enclosures are to be provided to the beneficiary in one's primary language when indicated.
- Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS in an inpatient hospital to beneficiaries shall be communicated to the beneficiary's treating providers, including both the

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hospital and the treating physician, in writing, within 24 hours of the decision. If BHRS denies or modifies the request for inpatient authorization, BHRS must notify the beneficiary, in writing, of the adverse benefit determination. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of BHRS' decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. In cases where BHRS determines it will terminate, modify, or reduce inpatient SMHS services, BHRS must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

- BHRS requires 3 copies of the issued Notice of Adverse Benefit Determination which are distributed as follows: 1) one copy is given or sent to the beneficiary (or parent/legal guardian if not a minor consent case, or authorized representative); 2) the second copy is given to the affected provider where applicable and/or retained by the authorizer and a hard copy placed in the beneficiary's physical medical record; and 3) the third copy is given to the Quality Improvement Coordinator to log and maintain a file on all NOABDs.
- Upon issuing a Notice of Adverse Benefit Determination, there begins the 60 day period that a beneficiary may file an appeal; however, beneficiaries may request State Hearings in circumstances when no NOABD was generated and it has been past 30 days, or when the appeal process has been completed and the decision is to uphold the adverse benefit determination.
- Beneficiaries who are in on-going services must file a request for an appeal within 10 days of the date of issue to be eligible for services to continue while the appeal is pending.
- Programs/authorizers must document the pertinent background and criteria of the decisions resulting in issuing a Notice of Adverse Benefit Determination and maintain this documentation in the beneficiary's medical record. In the event of a State Hearing, this documentation is critical to defending BHRS' adverse benefit determination.

Obtaining NOABD Templates and Required Enclosures: These notices are available in our county threshold languages in English and Spanish. The Notice of Adverse Benefit Determination templates, the *NOABD Your Rights* attachment, *Language Assistance* taglines and the beneficiary *Nondiscrimination Notice*, can be accessed here:

<https://www.marinhhs.org/mental-health-services-contractor-resources>

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Attachments:

BHRS 33 NOABD GRID

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
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 within two business days.
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.

