1.Use appropriate letter of action

Type of Notice ↗ "Termination"
Leave this here!

Santa Cruz County Behavioral Health

2.Letter Instructions. Do not change the formatting of the letter.

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date: The date the letter was handed to client or put in the mail

Beneficiary Name = person with Medi-Cal coverage
Adult Client = Adult Client Name & Address
Minor Client = To the parents or guardians of:
"Medi-Cal beneficiary" + Address

Treating Provider = County or Contractor
Program where service is provided & Address
EX: ACCESS Team & Address
JANUS RESIDENTIAL & Address

RE: Service Requested = service you are not offering, are terminating, reducing or modifying, or did not offer within required timeline (EX: therapy, case management, medication support, residential treatment)

Name of Requestor = Either: Beneficiary / Client ("You") (applies to: Timely Access / Denial) or Provider making request (applies to: Modification / Timely Access / Denial)

Service to be terminated (for Termination NOABD) = same as service requested

Termination Date (NOABD Term only) = No less than 10 days *after* date letter was provided, unless you have an explanation in the chart and in the letter as to why the beneficiary was not given 10 days' notice

Check Box for Plan that *does* apply: ☐Drug Medi-Cal Plan (DMC) or ☐Mental Health Plan (MHP)

- Check the box of the Plan under which the beneficiary is receiving services (Plan you work for)
- Check box is in Paragraph 1 of the letter for: Delivery System, Timely Access, Denial, Modification
- Check box is in Paragraph 3 of the letter for: Termination

Explanation: Why is Plan/Provider terminating, denying or reducing services or why the Plan found that the beneficiary does not meet medical necessity criteria for services = see sample language on pages 2-4

Signature Block = name of staff person who completed the letter is preferred/must use Tx Provider name

Additional Enclosures: Be *sure* to include **ALL** necessary enclosures with the letter (double-sided printing is ok). Enclosures for all NOABD types discussed here include:

- NOABD Your Rights
- Language Assistance Taglines
- Beneficiary Non-Discrimination Notice

3.Saving the Letter: How to name the completed letter & deliver to County BH QI

1. Save on desktop so you can email to QI
2. Email a copy of every NOABD to:
askQI@santacruzcounty.us
3. Name the file when saving in this format:

Client Initials_type of NOABD letter_provider_program name_date of letter [use underscores]
(Date = same as on the letter / date handed or mailed to client)
Examples: SR_NOABD Delivery System_Co_ACCESS_12.18.19
CL_NOABD Timely Access_Co_CBH_CSS_12.18.19
CM_NOABD Termination_Encompass_SSP_1.3.20

4.General guidance for letter content as indicated based on letter type

Listed in Order of Most Common Letters

Delivery System NOABD: [Use: medical necessity criteria for services not met]
Used by MHP Access/Children Gates & all DMC-ODS Provider Access Gates

Mental Health Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- Your mental health diagnosis as identified by the assessment is not covered by the Plan,
- Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan,
- The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition,
- Your condition has been determined to be of mild to moderate severity, and therefore you have been referred to Beacon Health Options at (855) 765-9700. Beacon Health Options is the provider for individuals with mild to moderate conditions such as yours,
- Your mental health condition would be responsive to treatment by a physical health care provider.

DMC-ODS Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- The Brief ASAM assessment determined that you have no active substance use disorder, nor do you have a history of substance use behaviors that qualify for SUD treatment services (tobacco disorders are excluded),
- You are not a current resident of Santa Cruz County and your Medi-Cal is connected to another county. You are recommended to contact __ (Name) County to either request services or initiate a transfer of Medi-Cal coverage to Santa Cruz County.

Timely Access NOABD:
Used by MHP and DMC-ODS providers who have not provided the beneficiary with services within timeliness guidelines. [Number of working days / Timeliness guidelines:]

- Urgent service appointment – 48 hours (2 calendar days) if service doesn't require a prior-authorization & 96 hours (4 calendar days) if service requires a prior authorization
- Routine service appointment – 10 working days from date of initial request for service
- Psychiatric service appointment – 15 working days from date of initial request for service
- For NTP/OTP (Opioid Treatment) service (Janus Methadone Clinics) – 3 working days from date of initial request for service

➢ Use of the Service Request and Disposition Log (SRDL) tracks timeliness of services. No NOABD letter is needed if MHP/DMC-ODS provider documents in SRDL that a timely appointment was offered and beneficiary declined the offered timely appointment and selected a later date.

Shared Mental Health and DMC-ODS Sample Language for Paragraphs 1 & 2:

- Beneficiary Name or Provider has asked the Plan (check appropriate box) to obtain or approve Service Requested. The MHP or DMC-ODS has not provided services within (use working days guidelines from above). Our records show you requested services on X Date (date they requested the service).
  In Paragraph 2 enter service requested again.

Termination NOABD:

Used by MHP and DMC-ODS providers when the Plan (provider) terminates, reduces or suspends a previously authorized service.

[County will accept Modification NOABD if provider mistakenly used for reducing service frequency or duration.] *New DHCS Clarification regarding use of TERM letter*

Mental Health Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- Your condition has improved, and you no longer require the service. As a follow-up to our discussion, this letter is to inform you that we have discontinued your therapy services. This change will go into effect on MMDDYYYY, 10 calendar days from the date of this letter.
- Your condition has improved, and you no longer require the amount and frequency of the service. As we discussed, this letter is informing you that we have reduced your service being received from 3x week to 1x week. This change will go into effect on MMDDYYYY, 10 calendar days from the date of this letter.
- Services are no longer appropriate for the condition (ongoing authorization for alternative treatment (such as ECT) is ending). This change will go into effect on MMDDYYYY, 10 calendar days from the date of this letter.

DMC-ODS Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- Your condition has improved, and you no longer require residential treatment services as you continue to wait for your SLE housing. The Plan is aware that you have declined the recommended discharge plan to intensive outpatient services due to not having SLE housing.
- Current services being provided (state specific service being received) are no longer appropriate for your current condition (not meeting ASAM LOC criteria)

SHARED Plan Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- We have attempted to contact you after you did not attend session on date X, date, X and date X. You have not responded to our phone calls and letter, thus we have determined, based on your lack of response, that you are no longer interested in receiving services. We will discontinue your treatment services on MMDDYYYY, 10 calendar days from the date of this letter, unless we hear from you. Please call XXX-XXX-XXXX if you are interested in continued services.
- Due to your behavior which resulted in an unsafe environment for yourself and/or others, your services are being terminated immediately to prevent endangerment to others.
- You left the program against staff advice on X date and did not return. Based on this behavior we have determined that you are no longer interested in receiving substance use disorder services.

Denial NOABD

Used by MHP and DMC-ODS when the Plan denies a request for a service for a client who is already receiving Specialty Mental Health services or DMC-ODS services.

Denials may be based on:

- type or level of service (EX: MH: denial of residential eating disorder treatment when outpatient would suffice, TBS, ICC or IHBS when lower level of care would suffice; DMC-ODS: denial of residential SUDS treatment that could have been treated at a lower level of care)
- setting (EX: denial of request for Intranasal Esketamine treatment as we are not a Certified Healthcare Facility that can prescribe / administer Esketamine or denial of STRTP placement if not a good match with other youth currently at the facility),
- medical necessity (EX: denial of ECT for depression when all prior options have not been tried),
- not a covered Medi-Cal benefit (EX: TMS / Transcranial Magnetic Stimulation or Equine Therapy),
- appropriateness, or effectiveness of a covered benefit

Mental Health Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- We have reviewed your request for service requested (EX: ECT or TBS) and determined that all options have not been tried at a lower level of care. The treatment team has an initial goal for you to: insert lower level that hasn't been tried yet (EX: try additional anti-depressant medications or work with your treatment team on current behavior management goals). The treatment team feels that this is a necessary first step.
- We have reviewed your request for service requested (EX: equine therapy) and determined we are unable to provide such services based on Medi-Cal managed care guidelines as service requested is not an approved Medi-Cal service.

DMC-ODS Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- We have reviewed your request for services and determined we are unable to provide such services based on Medi-Cal managed care guidelines and ASAM assessment criteria due to (choose most appropriate):
- Type or level of services (including denied residential service requests if not 3.1-3.5 ALOC)
- Lack of medical necessity for services (not ASAM LOC appropriate)
- Services not appropriate for the condition (non-perinatal client wanting continued perinatal residential services)
- Setting not appropriate (readmission request after completing the 2 residential maximum)

RARE - Modification NOABD – Will be utilized by County Staff for prior authorizations or re-authorizations of services.
Used by MHP and DMC-ODS County Authorizing Staff when the Plan modifies or limits a Provider's request for a service, including reduction in frequency and/or duration of services and Plan approves alternative treatment and services.

Mental Health Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- We cannot approve this treatment as requested (EX: Inpatient care while receiving ECT). This is because we need to ensure that your services are appropriate in amount, duration and scope. The Plan has determined that your needs can be met receiving ECT while living at home with family support.
  We will instead approve service approved (EX: ECT therapy on an outpatient basis).

DMC-ODS Sample Language to describe criteria, guidelines and clinical reasons for the decision:

- We cannot approve this treatment as requested (EX: Additional 60 days of residential treatment). This is because State regulations only allow the Plan to authorize an additional 30 days of services.
  We will instead approve service approved (EX: an additional 30 service days).

- We cannot approve this treatment as requested (EX: Intensive Outpatient Therapy). This is because we need to ensure that your services appropriately match what is medically necessary. The Plan has determined, due to your ASAM assessment which indicated that you qualify for Outpatient Therapy services, that your needs can be met receiving Outpatient Therapy Services.
  We will instead approve service approved (EX: Outpatient Therapy Services).