

**SANTA CRUZ COUNTY
Behavioral Health Services**

POLICIES AND PROCEDURE MANUAL

**Subject: MHP and DMC-ODS Notice of
Adverse Benefit Determination**

Policy Number: 3223

Date Effective: 5/1/2023

Pages: 6

Prior Version: 11/16/2020

**Responsible for Updating:
Quality Improvement**

Approval: DocuSigned by:
Karen Kern
8196F709E3274C2
Deputy Director on behalf of the
Behavioral Health Director

5/8/2023
Date

BACKGROUND:

Santa Cruz County Behavioral Health Services (BHS), which includes Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) network providers, is committed to the protection of beneficiary rights and strengthened access to mental health and substance use disorder services for beneficiaries. BHS and network entities shall comply with state and federal managed care requirements for processing beneficiary service requests, grievances and appeals, including giving beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR 438.10 and DHCS Information Notice 18-010E.

SCOPE:

Providers in the MHP and DMC-ODS networks will adhere to this policy and issue Notices of Adverse Benefit Determination (NOABDs) as appropriate to ensure beneficiaries understand their rights to appeal when a benefit determination is made.

PURPOSE:

This policy provides network providers guidance regarding types of adverse actions requiring a written notice, and the associated uniformed notice template requirements. For this policy MHP & DMC-ODS will be referred to as “the Plan”.

POLICY:

A written Notice of Adverse Benefit Determination (NOABD) shall be issued to a beneficiary when an authorized representative of the Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan determines that one of the regulatory criteria requiring a notice exists, as described below.

DEFINITIONS:

- 1. DMC-ODS:** Drug Medi-Cal Organized Delivery System refers to a network of Santa Cruz County Substance Use Disorder (SUD) treatment service entities, County and Contractor, who are certified by DHCS as Drug Medi-Cal authorized providers and its representatives.

2. **MHP:** The Mental Health Plan refers to a network of Santa Cruz County Mental Health (MH) service DHCS certified entities, County and Contractor, and its authorized representatives.
3. **NOABD – Delivery System / Assessment:** Provided when a beneficiary does not meet medical necessity and access criteria for specialty mental health services.
4. **NOABD – Modification:** Modification or limitation of a Provider’s request for a service, including reduction in frequency and/or duration of services, and approval of alternative treatments and services.
5. **NOABD – Termination:** Termination of a previously authorized service. A termination, reduction, or suspension of a previously authorized service, including loss of contact with the beneficiary.
6. **NOABD - Payment Denial Service Received:** Denial of payment, in whole or in part, for a service that has already been delivered to the beneficiary, including inpatient psychiatric hospital days(s).
7. **NOABD – Denial of Service Authorization Requested:** Provided when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity and access criteria, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS, this template is also used for denied residential service requests.
8. **NOABD – Timely Response Grievance / Appeal:** Provided when the Plan does not resolve a grievance or appeal within the required timeframes.
9. **NOABD - Lack of Timely Access:** Provided when there is a delay in providing the beneficiary with a requested service in a timely manner as required by the timely access standards applicable to the delayed service. The date the services were requested to date of first offered appointment determines timeliness.
10. **NOABD - Financial Liability:** Provided when the Plan denies the beneficiary’s request to dispute financial liability.
11. **NOABD – Authorization Delay:** Provided when the Plan does not make an authorization decision within the required timeframe and is in delay in processing a Provider’s request for authorization of prior-authorization Specialty MH Services or DMC-ODS Residential services within required timeframes. This includes when the Plan processes 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.
12. **TAR:** Treatment Authorization Request – a form for hospitals to request payment for inpatient psychiatric hospitalization of Medi-Cal beneficiaries.

PROCEDURES:

1. Notice of Adverse Benefit Determination Criteria

A Notice of Adverse Benefit Determination must be sent to a beneficiary when an authorized representative of the Plan does one of the following:

- a. Finds that a beneficiary does not meet medical necessity and access criteria for specialty mental health or DMC-ODS services.

- b. Denies or modifies a request for services, terminates or reduces previously authorized services or there is a delay by the Plan in processing an authorization of services (the Plan did not respond in specified timeframe).
- c. Denies a partial or entire payment of a service that has already been delivered to a beneficiary, including inpatient psychiatric day(s), or denies payment of a service that has been requested but not yet delivered.
- d. Does not respond to a beneficiary's grievance or appeal within the designated timeframes without written notice requesting an extension.
- e. Does not provide covered services in a timely manner as required by the timely access standards applicable to the delayed service.
- f. Denies a beneficiary's request to dispute financial liability.
- g. Does not respond to a request for authorization of services within required timeframes.

2. NOABD Provision to Beneficiary

Notices of Adverse Benefit Determination will:

- a. Be written in the templates provided by DHCS, and templates will not be modified by network providers;
- b. Explain the adverse benefit determination the Plan has made or intends to make;
- c. Provide a clear, concise explanation of the reason(s) for the decision;
- d. Provide a description of the criteria used;
- e. Explain 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;
- f. Explain the beneficiary's right to file an appeal, and provide information regarding how to file an appeal;
- g. Be sent with required enclosures:
 - Language Taglines (including Santa Cruz County threshold language, Spanish)
 - NOABD Your Rights Attachment
 - Beneficiary Non-Discrimination Notice
- h. Be available in Large Print
- i. Be sent in client's preferred language and as needed, oral interpretation for ease of understanding the notice is available.

3. NOABD-Delivery System / Assessment

- a. When there is a determination that a Medi-Cal beneficiary does not meet medical necessity and access criteria for specialty mental health services, a NOABD, "Delivery System" must be given to the beneficiary (or authorized representative) on the day of the decision or mailed within 2 business days of the decision. The Plan will explicitly state why the beneficiary's condition does not meet medical necessity and access criteria for specialty mental health services. In addition, options for obtaining care outside the Plan will be explained, as appropriate.
- b. The NOABD "Delivery System" informs the beneficiary of their right to request a second opinion. If requested by the beneficiary, the Plan shall provide for a second opinion by a licensed mental health professional when the Plan or its providers determine that medical necessity and access criteria has not been met. (See policy 3226 BHS Second Opinion).

4. NOABD- Modification

- a. When the Plan modifies, reduces, or limits a provider's request for services a NOABD, "Modification" must be provided to the beneficiary (or authorized representative) within 2 business days of the decision.
 - i) The Plan must process the service request requiring prior authorization within the appropriate timeframe (see Policies 3424 Medi-Cal Adult & Crisis Residential Services (Prior & Concurrent) Authorization and 3425 Outpatient SMHS Prior Authorization).
 - ii) The Plan will communicate the authorization decision to the provider within 24 hours of the decision by telephone or facsimile and also in writing. Written notification to the provide will include the name and direct phone number or extension of the decision-maker.
 - iii) The Plan will include, in the Modification NOABD, the reduction in frequency and/or duration of services, and the approval of alternative treatments and services if applicable.
 - iv) Modification to change the level of care or frequency for services in the DMC-ODS network does not require "modification" NOABD.

5. NOABD- Termination

- a. When a previously authorized service is terminated, reduced, or suspended a NOABD "Termination" must be mailed to the beneficiary (or authorized representative) at least 10 calendar days before the date of action. The "date of action" refers to the future date in which the termination, reduction or suspension will come into effect. This includes loss of contact with the beneficiary (examples: Absent Without Official Leave (AWOL), leaving services Against Staff and/or Medical Advice (ASA / AMA)).
- b. Termination of services prior to the required 10 calendar days before the date of action is only allowable under these circumstances:
 - i) Confirmed death of beneficiary;
 - ii) Beneficiary provided written statement declining further services;
 - iii) Ineligibility for further services (such as loss of Medi-Cal or violation of program safety rules endangering the health and/or safety of the beneficiary or others;
 - iv) For DMC-ODS services, a change in the level of medical care is prescribed by the beneficiary's physician and/or facility Medical Director;
 - v) Probable cause indicates, and is verified through secondary sources, that fraud by the beneficiary has occurred.
 - vi) The beneficiary is non-compliant with treatment program guidelines / rules such that they are jeopardizing their own, or other beneficiary's success in treatment.
- c. Continuation of Services during an Appeal: The beneficiary has the right to request a continuation of mental health or DMC-ODS services, and the Plan will provide and/or pay for those services during an appeal, from filing to resolution.
- d. Beneficiary in Agreement with Termination: A NOABD "Termination" is not required if the beneficiary is in full agreement with the planned discharge and/or change in level of care.
- e. Documentation by staff in the medical record must include the reason for discharge and whether or not a Termination NOABD was issued to the beneficiary.

6. NOABD-Payment Denial Service Received

- a. The Plan is required to send a NOABD “Payment Denial” when a provider’s request for payment is denied, in whole or in part, for services that have already been delivered or when payment is denied for all or a portion of a service. For example, any portion of psychiatric inpatient stay that is denied (on a TAR).
 - i) The NOABD “Payment Denial” will be sent at the time of the action.
 - ii) The NOABD “Payment Denial” will inform the beneficiary regarding his/her rights and also indicate that the notice is not a bill.

7. NOABD- Denial of Authorization of Service Requested

- a. The Plan is required to send a NOABD “Denial” (for Service Requested) to the beneficiary when the Plan denies a request for services within 2 business days of the decision.
- b. The Plan must process the service request requiring prior authorization within the appropriate timeframe (see Policies 3424 Medi-Cal Adult & Crisis Residential Services (Prior & Concurrent) Authorization and 3425 Outpatient SMHS Prior Authorization).
- c. The Plan will communicate the authorization decision to the provider within 24 hours of the decision by telephone or facsimile and also in writing. Written notification to the provider will include the name and direct phone number or extension of the decision-maker.
- d. Denials include determinations based on type of level of service, requirements for medical necessity or access criteria, appropriateness, setting, or effectiveness of a covered benefit.

8. NOABD-Timely Response Grievance / Appeal

- a. If the Plan does not resolve a grievance (30 days), a Standard Appeal (30 days), or an Expedited Appeal (72 hours) within the designated timeframes, a NOABD “Timely Response Grievance / Appeal” will be sent to the beneficiary notifying them of the delay. This notice will be mailed on the date that the applicable timeframe expires.
- b. The timeframe to process a Standard Grievance and/or Appeal may be extended ONE TIME by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests the extension or MHP or the DMC-ODS Plan determines there is need for additional information and the delay is in the beneficiary’s interest). If the timeframe is extended:
 - i) The Plan will demonstrate effort to provide prompt oral notification to the beneficiary of the extension;
 - ii) The Plan will provide written notice of the extension to the beneficiary within 2 calendar days of the decision. The notice will state that the beneficiary may file a grievance if they disagree with the extension.

9. NOABD- Lack of Timely Access

- a. If the Plan fails to provide specialty mental health or DMC-ODS services covered by the Plan within the timely access standards applicable to the delayed service, a NOABD “Timely Access” will be sent to the beneficiary within 2 business of the decision. The date the services were requested to date of first offered appointment determines timeliness. The Timely Access NOABD will notify the beneficiary that they have the right to file an appeal.

10. NOABD – Financial Liability

- a. If the Plan denies the beneficiary’s request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities, a NOABD “Financial Liability” will be sent

to the beneficiary at the time of the action notifying them that they have the right to file an appeal.

11. NOABD – Authorization Delay

- a. If the Plan does not respond to a request for authorization of services within required timeframes, 14 calendar days for a standard decision request or 72 hours for an expedited decision request, a NOABD “Authorization Delay” will be sent to the beneficiary notifying them that they have the right to file an appeal. This notice will be mailed on the date that the applicable timeframe expires.

12. Exceptions to NOABD Requirements:

- a. Provision of Information: A NOABD is not required if the Plan is asked for and provides information regarding services available outside the Plan.
- b. Shorter Period of Service: A NOABD is not required if a shorter period of service is authorized than requested. The provider can submit another request at the end of the time authorized. However, the beneficiary may file an Appeal.
- c. A NOABD “Termination” is not required if the beneficiary is in full agreement with the planned discharge and/or change in level of care.

PRIOR VERSIONS: November 16, 2020, March 25, 2018, March 12, 2018, February 26, 2018, October 27, 2017, July 1, 2017, September 28, 2016, April 17, 2015 and July 13, 2004

REFERENCES: 42 CFR, 438 Subpart F; 438.400; 438.402; 438.406; 438.408; 438.404; 438.210; 438.10; 438.420; 438.416; 438.424; 431.211; 431.244; CCR, Title 28, Section ; CCR Title 22, Section 53858; 45 CFR Section 92.8, 1300.68

FORMS: NOABD’s, NOABD Your Rights, Notices of Appeal Rights, Language Assistance, Beneficiary Non-Discrimination