Notice of Adverse Benefit Determination Training

Santa Cruz County Behavioral Health

Quality Improvement

Mental Health Plan / Drug Medi-Cal Plan

From here-out to be referred to as Plans

05/1/18

Training Goals & Objectives

NOABDs are only sent to Medi-Cal Beneficiaries

(including as their primary & secondary insurance)

Goal

- To improve your understanding of NOABD requirements and utilization of associated letters

Objectives

- ✓ You will learn Federal and state reasons for uniform letters for MHP & DMC-ODS services
- ✓ You will be able to identify timeframes for providing each notice letter
- ✓ You will have an understanding of each letter, and appropriate letter specific language

Effective 2/14/18, per DHCS Info Notice 18-010 & 18-010E (Department of Health Care Services)

- The purpose of the notice is to provide the Plans with clarification and guidance regarding the application of revised federal regulations for processing appeals; NOABD letters provide information to beneficiaries about their appeal rights and other beneficiary rights under the Medi-Cal program.

- Uniform notice templates were provided with this notice and are now required to be used.

- A NOABD supports beneficiary protection by advising beneficiaries of their rights in writing.

ABDs – Adverse Benefit Determinations

- The term “Action” has been replaced with “Adverse Benefit Determination” (ABD).
- A NOABD letter is sent to a beneficiary when any of the following actions are taken by the Plan:

1. Beneficiary does not meet medical necessity criteria for MHP or DMC-ODS Plan services
2. Denial or limited authorization of a requested service
3. Reduction, suspension or termination of a previously authorized service (when beneficiary disagrees)
4. Modification or limit of a provider’s request for a service and approval of alternative services
5. Denial, in whole or in part, of payment for a service
6. Failure to provide services in a timely manner
7. Failure to process authorization decision in a timely manner
8. Failure to act within the required timeframes for grievance and appeals resolutions
9. Denial of a beneficiaries' request to dispute financial liability

NOABD - Timing of the Notice

- The Plan must mail the notice to the beneficiary within the following timeframes:

Type of NOABD	When are you required to send the letter?
Termination	At least 10 days before the date of Action
Delivery System	Within 2 business days of the decision
Modification	Within 2 business days of the decision
Timely Access	Within 2 business days of the decision
Timely Response to Grievance / Appeal	Within 2 business days of the decision
Denial	Within 2 business days of the decision
Authorization Delay	At the time of the action
Payment Denial	At the time of the action
Financial Liability	At the time of the action

BH Policy and Procedure – 3223 NOABD

Shared MHP and DMC-ODS policy located on county intranet, under Quality in Beneficiary Protection 3200 section

3200	Beneficiary Protection (Patient Rights)	
Number	Title of Policy	Effective Date
3210	Confidentiality	
3211	Confidentiality of Mental Health Medical Records	5/24/2017(Rev.)
3212	Client Access to Med. Record Information	11/24/16(Rev)
3213	Release of Conf. Info Pursuant to Subpoena	12/03/04
3214	Mandatory Reporting Requirements	9/26/16
3220	Beneficiary Rights	
3221	Consent for Services	10/13/16(Rev)
3222	Beneficiary Choice of Providers	10/13/16(Rev)
3223	Notice of Adverse Benefit Determination	3/12/18(Rev.)
3224	Beneficiary Grievance & Appeal Process	2/8/18(Rev.)
3225	Advance Medical Directives	9/26/16(Rev.)
3226	Right to a Second Opinion	7/1/17(Rev.)
3227	Beneficiary Rights	9/27/16(Rev.)

Required Formatting – Please do not change

- Each available letter and required attachment has been customized for Santa Cruz County users and translated into Spanish.
  - The type of letter name is located: 1) Word File name, 2) on upper right corner and 3) letter footer.
- Each available letter is FINAL VERSION and shall not be modified; Citations shall remain in the letter.
- Letter author shall only insert clear, simple and concise wording into identified areas.
- Author shall print out letter and the three (3) attachments using both sides of paper when possible to minimize volume. **Please do not change any font sizing or special characterization.**
- Author shall send a secure electronic copy of all completed letters to Quality Improvement via askQI email for filing and storage.

There are Required Citations in each of the NOABD letters, please do not remove the citations

There are 3 Required Attachments for all NOABD letters:

1. NOABD “Your Rights” Attachment
2. Nondiscrimination Notice
3. Language Taglines

Delivery system – Not meeting eligibility criteria for services

- **Who would use the Delivery System NOABD**: ACCESS, Children Gates

MHP

- Does not meet the eligibility criteria for specialty mental health services
- Referral to Beacon Health Options or Primary Care Setting or County DMC-ODS Plan

Delivery system – suggested content

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - County staff use Santa Cruz County Behavioral Health & your Program of Service
   - Contractor staff use Contractor's name & your Program of Service
3. "Service requested" = Type of service requested
   - (therapy, medication management, case management coordination)
4. Check which Plan that applies – Mental Health Plan

Delivery system – suggested narrative

5. Narrative box: "*Our assessment is based on Medi-Cal managed care guidelines and state regulations which staff utilized to determine if medical necessity criteria are met. Your request for services is denied because…"* (author inserts best choice of below):

- your mental health diagnosis as identified by the assessment is not covered by the mental health 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 Medi-Cal 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.

Timely Access – Failure to provide service within 10 working days of date of service request

- **Who would use the Timely Access NOABD**: ACCESS, Children's Gates

MHP

- Gate/Access did not offer an Intake Assessment Appointment within 10 working days

Timely Access – suggested content

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - County staff use Santa Cruz County Behavioral Health & your Program of Service
   - Contractor staff use Contractor's name & Your Program of Service
3. "Service requested" = Type of service requested
   - MHP = medication support
   - DMC-ODS = methadone/NTP, withdrawal management/detox, residential
4. Check which Plan that applies – Drug Medi-Cal Plan **or** Mental Health Plan
5. The number of days to insert = 10 working days
6. "date requested" = Enter the date of the initial request for services

Denial - of authorization for requested services

Denials include determinations based on:

- **type or level of service,**
- **requirements for medical necessity,**
- **appropriateness,**
- **setting or**
- **effectiveness of a covered benefit**

Who would use Denial NOABD: ACCESS, FQHC Therapist

MHP

- Denial of County Coordination request based on adequate level of functioning
- Denial of FQHC Therapy request because client cannot benefit from service (service is not appropriate)

Denial letter – suggested content

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - County staff use Santa Cruz County Behavioral Health & Your Program of Service
   - Contractor staff use Contractor's name & Your Program of Service
3. "Service requested" = Type of service requested
   - (therapy, case management, medication management)
4. "Name of requester" = Beneficiary or County program name or Contracted provider name
5. Check which Plan that applies – Mental Health Plan

6. Narrative: **The reason for the denial is** *the Plan has reviewed your Provider's request for services and determined we are unable to provide such services based on state Medi-Cal managed care guidelines due to* (choose most appropriate):

- Type or level of services
- Lack of medical necessity for services
- Services not appropriate for the condition
- Service will not be beneficial to you

Modification – When the Plan modifies or limits a PROVIDER's request for a service (and the client disagrees)

The Plan may:

- Reduce or limit a service frequency and/or duration,
- Approve alternative treatments and services

- **Who would use the Modification NOABD:** Supervisors, Managers, (Chief of Psychiatry or designé)

MHP

- Eating Disorder (approval of alternative treatment)
- Decrease in therapy frequency from panel provider

Modification – suggested content

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - County staff use Santa Cruz County Behavioral Health & Your Program Name
   - Contractor staff use Contractor's name & Your Program Name
3. "Service requested" = Type of service requested (therapy, medication support, case management)
4. "Name of Requestor" = Provider Name

Modification – suggested content (continued)

5. Check which Plan that applies – Mental Health Plan

6. Narrative: **We cannot approve this treatment as requested. This is because** *the Plan has reviewed your Provider's request for services and has changed the services based on* (choose most appropriate):

- Your condition has improved and you require the service less often
- Services are no longer appropriate for the condition (alternative treatments / services)

However we will instead approve the following treatment: Example: individual therapy twice per month.

Termination – of a previously authorized service (and the client disagrees)
* notification at least 10 days before action, except as permitted under 42 CFR 431.213 and 431.214

Who would use the Terminate NOABD: Supervisors, Managers, (Chief of Psychiatry or designé), Therapists

MHP

- Client no longer meets medical necessity for County Mental Health services
- No longer meet criteria for a service type (case management, county coordination, therapy)

Termination – suggested content

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - County staff use Santa Cruz County Behavioral Health & Your Program Name
   - Contractor staff use Contractor's name & Your Program Name
3. "RE: Service requested" = Service currently authorized that is being terminated
   - (therapy, medication support, case management)
4. "Service to be terminated": Same as #3, service requested
5. "Termination date" = at least 10 days after letter is sent

Termination – suggested content (continued)

6. Narrative: "*The Plan has determined, based on a review of state Medi-Cal managed care guidelines, that…..*"

- Your condition has improved and you no longer require the service
- Services are no longer appropriate for the condition (ongoing authorization for alternative treatment)

7. Check which Plan that applies – Mental Health Plan

Delay in processing authorization of services- when the plan does not respond to a request for authorization of services with required timeframes

- **Who would use the Delay of Authorization NOABD**: MH Managed Care Senior Manager, Children's MH Management or Designée

MHP

- Decision Timeframes:
  - Standard decision requests: 14 calendar days
  - Expedited decision requests: 72 hours after receipt of the request
- Decision Examples of County pre-authorizations:
  - SAR - Service Authorization Request
  - Neuropsych testing
  - Eating Disorder
  - Obsessive Compulsive Disorder

Dispute of Financial Liability – County Only

When the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities

Questions?

Thank You