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 with updates 7/1/19, 10/5/20, 9/13/2021

Training Goals & Objectives

NOABDs are only sent to Medi-Cal Beneficiaries (both as their primary and secondary insurance)

Goal

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

Objectives

✓To learn Federal and state **reasons** for uniform letters for MHP & DMC-ODS services

✓To be able to identify **timeframes** for providing each notice letter

✓You will have an **understanding** of each letter, and appropriate letter specific language

Info Notice 18-010 & 18-010E from the Department of Health Care Services **(2/14/18)** provided information to all Plans serving Medi-Cal beneficiaries

- The purpose of the notice is to provide Plans with clarification and **guidance** regarding helping a client process an appeals; **NOABD letters** provide information to beneficiaries about their appeal rights.
- Uniform **notice templates** were provided with this notice and are now required to be used.
- A **NOABD** advises beneficiaries of their **rights** in writing and is required for providers serving **Medi-Cal** beneficiaries.

*County Behavioral Health **Policy & Procedure 3223**, MHP & DMC-ODS Notice of Adverse Benefit Determination provides additional detailed information*

Adverse Benefit Determination Letter Types

A NOABD letter is sent when an **action** is taken by the Plan that effects the beneficiaries service(s):

Actions Commonly Taken by **Providers** / NOABDs **Providers** will likely issue:

1. **Medical necessity** criteria for MHP or DMC-ODS Plan services are not met (**Delivery System** NOABD)
2. Failure to provide **services** in a **timely** manner (**Timely Access** NOABD)
3. **Denial** or limited authorization of a requested service (**Denial** NOABD)
4. Reduction, suspension or **Termination** of a previously authorized service (**Termination** NOABD)

Adverse Benefit Determination Letter Types

Actions that **Quality Improvement / County Behavioral Health leadership** more commonly take / NOABDs (providers are ***less likely*** to issue):

1. **Modification** or limit of a provider's request for a service and approval of alternative services (**Modification** NOABD)
2. Failure to process **authorization decision** in a timely manner (**Authorization Delay** NOABD)
3. Failure to act within the **required timeframes** for **grievance** and **appeals** resolutions (**Timely Access Grievance/Appeal** NOABD)
4. Denial of a beneficiaries' request to dispute financial liability (**Financial Liability** NOABD)
5. **Denial**, in whole or in part, of **payment** for a service (**Payment Denial** NOABD)

NOABD - Timing of the Notice

The Plan must mail or provide 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

NOABD Letters

Required Formatting

Each NOABD letter and required attachments have been customized for Santa Cruz County users and translated into Spanish.

☑ Each letter template is a **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.

Letters must be mailed with required attachments listed after the Signature Block

Required Attachments:

√ NOABD "Your Rights" Attachment

√ Nondiscrimination Notice

√ Language Taglines

Signature Block

Enclosed: "Your Rights (NOABD)"
Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

NOABD Letter Types

Delivery System

Beneficiary does not meet **medical necessity** criteria for services

Who: ACCESS (intake) providers, Child / Youth Services Gates, DMC-ODS Gates for Youth / Adult

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

DMC-ODS

√ Does not meet the eligibility criteria for any DMC-ODS services

√ Referral to other health care provider (primary care MD), mental health services (Beacon or County Behavioral Health)

Delivery System NOABD: Mental Health Plan

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health

  Contractor staff = Contractor Agency Name

- "Service requested" = Type of service requested

  Therapy, Medication management, Case Management Coordination

- Check the correct Plan = Mental Health Plan

Delivery System – Mental Health suggested language in Narrative Box

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 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.

Delivery System NOABD: DMC-ODS

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health & Program of Service

  Contractor staff = Contractor Agency Name & Program of Service

- "Service requested" = Type of service requested

  Assessment, Methadone / NTP, Withdrawal Management, Detox, Residential, Outpatient / Intensive Outpatient

- Check the correct Plan = Drug Medi-Cal Plan

Delivery System – DMC-ODS suggested language in Narrative Box

1. Narrative box: "*Our decision is based on Medi-Cal managed care and American Society of Addition Medicine (ASAM) guidelines to determine medical necessity of requested services. Your request for services is denied because…*" (author inserts best choice of below):

   √ The Brief ASAM assessment determined that you have no active SUD 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

Failure to provide service(s) within 10 working days of date of request

Who: ACCESS (intake) providers, Child / Youth Services Gates, DMC-ODS Gates for Youth / Adult

MHP

√ Gate/Access not offering a Psychosocial Assessment within 10 working days or a Medication Support Appointment within 15 working days.

DMC-ODS

√ Provider not able to provide an initial treatment service within 10 working days of initial request date.

√ Beneficiary Request Brief ASAM Referral Initial treatment service (within 10 working days)

√ Collaboration between the Gate (Brief ASAM) and treatment provider (referral) to ensure timely services.

Timely Access NOABD: Mental Health Plan & DMC-ODS Language

- Beneficiary's Name:
  - Adult / Youth = Adult / Youth name
  - Child =To the parent or guardian of Child Name
- Treating Provider's Name:
  - County staff = Santa Cruz County Behavioral Health & Program of Service
  - Contractor staff = Contractor Agency Name & Program of Service
- "Service requested" = Type of service requested
  - MHP = Therapy, Medication management, etc.
  - DMC-ODS = methadone/NTP, WM/detox, residential, OP/IOS, etc.
- Check the correct Plan = Mental Health Plan or Drug Medi-Cal Plan
- "Plan or Name of requesting provider" = Treating Provider's Name
- Number of Days to Insert = 10 working days
- "Date Requested" = Date of Initial Request for Services

Denial

Deny the authorization for requested services

Denials include determinations based on:

√ Type or level of service
√ Appropriateness of service;
√ Effectiveness of a Covered Benefit
√ Requirements for medical necessity;
√ Treatment Setting;

Who: ACCESS (intake) providers, FQHC Therapist (MHP), Medication Support Providers, DMC-ODS Providers

MHP

√ Client requested FQHC therapy but cannot benefit from this treatment

√ Client requested ECT but all anti-depressant medication treatments have not yet been tried

√ Client requested service that is not a covered by the MHP (ex: equestrian therapy)

√ Client requested a service not determined to be medically necessary by MD

DMC-ODS

√ Denial of requested LOC treatment services when beneficiary does NOT meet ASAM LOC criteria (service request is not appropriate)

√ Denial Letter provided when beneficiary is not interested in utilizing the appropriate LOC service (ASAM scores as 2.1 but individual only wants residential services)

Denial NOABD: Mental Health Plan Language

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health

  Contractor staff = Contractor Agency Name

- "Service requested" = Type of service requested

  MHP = Therapy, Medication management, ECT, etc.

- "Name of Requestor" = Beneficiary / Client OR County or Contract Provider making the request

- Check the Correct Plan = Mental Health Plan

- 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
  - All lower level of care options have not been exhausted

Denial NOABD: DMC-ODS Language

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health

  Contractor staff = Contractor Agency Name

- "Service requested" = Type of service requested

  Residential Treatment, OP/IOS, WM/Detox, Methadone/NTP, etc.

- "Name of Requestor" = Beneficiary / Client OR County or Contract Provider making the request

- Check the Correct Plan = Drug Medi-Cal Plan

- Narrative: **The reason for the denial is** *the Plan has 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 services)
  - Setting not appropriate (readmission request after completing the 2 residential maximum)

Termination

Termination a **Previously Authorized Service** before authorization expiration

Termination Notice must occur **10 days before the termination action**, except as permitted by 42 CFR section 431.213 and 431.214

Who: Service Providers and Supervisors and Managers from all Programs, both MHP & DMC-ODS

MHP

√ Client no longer meets medical necessity for services.

√ Client no longer to receive a service type (case management, therapy, med support)

√ Loss of contact with client

√ Telos/EDC ending treatment due to violation of program safety rules

√ Client met goals / discharge from treatment prior to treatment plan expiration

DMC-ODS

√ ASAM criteria indicated a client meets criteria for a higher or lower level of service and client disagrees with transition of services

√ Ending a beneficiary's residential treatment service, due to violation of program safety rules (unsafe behaviors to self and/or others, bringing drugs to program, violence and causing risk to other beneficiaries).

Termination NOABD

Client Must be Notified 10 days before the Termination Action Occurs

UNLESS the Following **Exceptions** Apply:

CFR Section 431.213 Exceptions:

- Confirmed death of individual
- Individual provided a written statement declining further services
- In-eligibility for further services (such as, loss of Medi-Cal, could include violation of program safety rules or not meeting medical necessity for services)
- A change in the level of medical care is prescribed by the beneficiary's **physician** (facility Medical Director); a change in care level based on ASAM level of need and medical necessity determination

CFR Section 431.214 Exceptions:

- Advance notice may be shortened to **5 days** before the date of action if:

  Agency has facts indicating that action should be taken because of probable fraud by the individual; Such facts have been verified, if possible, through secondary sources.

Services may be terminated Immediately if:

Failure to discharge would endanger the health or safety of the other individuals in the facility. The facility must document the danger that failure to discharge would pose.

The facility may not transfer or discharge an individual while an appeal is pending, when an individual exercises his or her right for continued services during appeal of a termination notice.

Termination NOABD: Mental Health Plan Language

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health

  Contractor staff = Contractor Agency Name

- "Service requested" = Service currently authorized that is being terminated

  MHP = Therapy, Medication Support, Case management, etc.

- "Service to be Terminated" = Same as "Service Requested"

- "Termination Date" = at least 10 days after letter is sent or provided to beneficiary (unless previously mentioned exceptions apply).

- 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)
  - Your left treatment against staff advice and have not responded to our attempts to reconnect with you.

- Check the Correct Plan = Mental Health Plan

Termination NOABD: DMC-ODS Language

- Beneficiary's Name:

  Adult / Youth = Adult / Youth name

  Child =To the parent or guardian of Child Name

- Treating Provider's Name:

  County staff = Santa Cruz County Behavioral Health

  Contractor staff = Contractor Agency Name

- "Service requested" = Service currently authorized that is being terminated

  DMC-ODS = Residential Treatment, Methadone / NTP Treatment, OP Treatment, etc.

- "Service to be Terminated" = Same as "Service Requested"

- "Termination Date" = at least 10 days after letter is sent or provided to beneficiary (unless previously mentioned exceptions apply).

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

  - Your condition has improved, and you no longer require residential treatment services as you continue to wait for SLE housing. You have declined the recommended discharge plan to intensive outpatient services.
  - Services are no longer appropriate for the condition (not meeting ASAM LOC criteria)
  - Your left treatment against staff advice and have not responded to our attempts to reconnect with you.
  - Your behavior resulted in an unsafe environment for yourself and/or others; services are being terminated immediately to prevent endangerment to others.

- Check the Correct Plan = Mental Health Plan

Adverse Benefit Determination Letters Provider will not typically utilize:

1. **Modification** or limit of a provider's (not client / beneficiary) request for a service and approval of alternative services (**Modification** NOABD)
2. Failure to process **authorization decision** in a timely manner (**Authorization Delay** NOABD)
3. Failure to act within the **required timeframes** for **grievance** and **appeals** resolutions (**Timely Access Grievance/Appeal** NOABD)
4. Denial of a beneficiaries' request to dispute financial liability (**Financial Liability** NOABD)
5. **Denial**, in whole or in part, of **payment** for a service (**Payment Denial** NOABD)

*Just know these exist, review the policy and Information Notice & seek support from askQI@santacruzcounty.us if you think one of these letters may apply to your program

For All NOABDs
Email a copy to:
askQI@santacruzcounty.us

Body of Email must include:
Client Date of Birth & Avatar Number

File must be named correctly!!

Client Initials_type of NOABD letter_provider_program name_date of letter

JR_Termination NOABD_Janus_NTP_9.13.2021
SX_Delivery System NOABD_CBH_Access_7.1.2021

Questions?

Thank You !

askQI@santacruzcounty.us