County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-02-01**
	Effective Date	**02-28-2018**
	Revision Date	**03-01-2020**
Title: **Notice of Adverse Benefit Determination**	Functional Area: **Authorization**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Quality Management		

BACKGROUND/CONTEXT:

Notice of Adverse Benefit Determinations (NOABD), formerly known as Notice of Action (NOA), are written notifications required by the State Department of Health Care Services (DHCS) and the California Code of Regulations (CCR) Title 9 § 1850.210, Title 22§ 51014.1 and Code of Regulations (CFR) Title 42, Part 438, Subpart F. The notifications advise Medi-Cal beneficiaries (hereafter referred to as Member) of their rights and provides guidance regarding due process.

DEFINITIONS:

A Notice of Adverse Benefit Determination occurs when the Sacramento County Division of Behavioral Health (BHS), which includes the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Prevention and Treatment Services (SUPT), takes one of the following actions:

1. **NOABD-Authorization Delay**: This template is used when BHS fails to process a provider's request for authorization of specialty mental health or substance use disorder residential services. When BHS 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 member or the provider, and/or those granted when there is a need for additional information from the member or provider, when the decision is in the member's interest.

2. **NOABD-Denial**: This template is used when BHS denies a member a requested service for reasons that may include: determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. For Continuity of Care Requests, this notice must also include the availability of in-network specialty mental health (SMHS) or DMC-ODS services, how and where to access SMHS or DMC-ODS services, and provide the appropriate

beneficiary handbook and provider directory. For SUPT, this notice will also be used for denied residential service requests.

3. **NOABD-Delivery System**: This template is used when BHS has determined that the member does not meet the requirements for medical necessity for specialty mental health or substance use prevention and treatment services. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

4. **NOABD-Modification of Provider Requested Services:** This template is given when BHS modifies or limits a provider's request for a previously authorized service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

5. **NOABD-Payment Denial for Services Rendered by a Provider:** This template is given when BHS denies for any reason, in whole or in part, a payment for a service already received by the member.

6. **NOABD-Delay of Timely Access Notice**: This template is to be used when there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service.

7. **NOABD-Financial Liability**: This template is used when BHS denies a dispute of a member's financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities of members.

8. **NOABD-Termination**: This template is given when BHS terminates, reduces, or suspends a previously authorized service.

9. **NOABD-Grievance and Appeal Timely Resolution Notice**: This notice is used when BHS fails to act within the required timeframes for standard resolution of grievances and appeals, or within the required timeframe for the resolution of an expedited appeal.

NOTICES THAT MUST BE GIVEN FOR GRIEVANCE AND APPEAL RESOLUTION

10. **Acknowledgement of Receipt:** BHS shall send the member an Acknowledgement of Receipt letter, postmarked within (5) calendar days of receipt of a grievance or appeal, to include the date of receipt, and the BHS representative's contact information to include: name, address, and phone number.

11. **Notice of Grievance Resolution (NGR):** This template is used to notify members of the results of the grievance. This notice shall contain a clear and concise explanation of BHS's decision.

12. **Notice of Appeal Resolution (NAR-Overturned):** This template is given following a member's appeal of a NOABD. It stipulates that BHS has decided to overturn the original decision and the date it was completed.

13. **Notice of Appeal Resolution (NAR-Upheld):** This template is given following a member's appeal of a NOABD. It stipulates that BHS has decided to uphold the original decision and the date it was completed.

ATTACHMENTS THAT MUST BE GIVEN ALONG WITH NOABD, NGR, OR NAR

14. **NOABD-Your Rights Under Medi-Cal:** Contains information regarding a member's right to a State Fair Hearing and to request and receive a continuation of services pending the hearing decision. **It is to be given along with every NOABD.**

15. **NAR-Your Rights Under Medi-Cal:** Contains information regarding a member's right to a State Fair Hear and to request and receive a continuation of services pending the hearing decision. **It is to be given along with every NAR.**

16. **Non-Discrimination Notice:** Explains that discrimination is against the law and offers language assistance and aids to communicate in alternative formats. **It is to be given with every NOABD, NAR, grievance and appeal acknowledgement letter, and grievance resolution letter.**

17. **Language Assistance Taglines:** Explains to members that they are entitled to language assistance, free of charge. **It is to be sent in conjunction with written materials that are critical to obtaining services** including, at a minimum, appeal and grievance notices, and denial and termination notices, which must be available to members in threshold languages and alternative formats.

18. **Beneficiary Handbook**: This document must be given, in addition to the other attachments, when a beneficiary is issued a Continuity of Care denial. It contains general information about the MHP or SUPT, including how and where beneficiaries may access specialty mental health or DMC-ODS services and how to file a grievance or an appeal based on an adverse benefit determination.

19. **Provider Directory**: This document must be given, in addition to the other attachments, when a beneficiary is issued a Continuity of Care denial. It contains a list of available in-network specialty mental health or DMC-ODS providers within the MHP or SUPT.

20. **Sacramento County Medi-Cal Behavioral Health Quick Guide**: This document must be given, in addition to the other attachments, when a beneficiary is issued a Delivery System denial. It contains a list of Medi-Cal Managed Care Plans and information about how to access mental health and DMC-ODS services.

PURPOSE:

The purpose of this policy and procedure is to ensure that the Sacramento County Division of Behavioral Health is in compliance with the Notice of Adverse Benefit Determination documents required by the State Department of Health Care Services (DHCS).

DETAILS:

Procedure:

BHS must give members timely and adequate notice of an adverse benefit determination (NOABD), in writing, indicating the date it was completed. The written notice must explain all of the following:

1. The adverse benefit determination BHS has made or intends to make;
2. 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. BHS shall explicitly state why the beneficiary's condition does not meet specialty mental health or substance use prevention and treatment medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
4. 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.

Notification of an Adverse Benefit Determination

BHS must adhere to the following guidelines and timeframes regarding the issuance of an adverse benefit determination in accordance with DHCS Information notice 18-010E:

1. BHS must issue the appropriate written NOABD template to members when an adverse benefit determination occurs. The template shall not be modified, except as permitted by Quality Management. **Do not change any font size or formatting**.
2. Each notice sent to members must include the appropriate "Your Rights" document to notify members of their right to appeal the decision and State Fair Hearing rights. There are two (2) types of "Your Rights" attachments:
    a. Notice of Adverse Benefit Determination (NOABD) "Your Rights Under Medi-Cal" attachment.
    b. Notice of Appeal Resolution (NAR) "Your Rights Under Medi-Cal" attachment.
3. All affected providers must be notified of the issuance of a NOABD by BHS within (24) hours of the decision being made by BHS, initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively, when applicable.
4. Each notice sent to members must include both a Notice of Nondiscrimination and Language Assistance taglines. These documents must be sent with each NOABD, NAR, grievance acknowledgement letter, appeal acknowledgement letter, grievance resolution letter.

5. When the Delivery System NOABD is issued, the most current Sacramento County Medi-Cal Behavioral Health Quick Guide must be attached, in addition to the above attachments. This can be found on the County website at dhs.saccounty.net/BHS/Documents/GI-MediCal-Behavioral-Health-Quick-Guide.pdf
6. NOABDs must be signed by the decision maker. When the decision is based upon medical necessity criteria, the signer must be the licensed clinician responsible for the assessment.
7. Translated versions of these informing materials are also available on the website and upon request.

NOABD Timeframes are as follows:

1. **Authorization Delay** (County Staff Only)**: Issue at time of the action.** Providers responsible for the issuance of this NOABD include:
    a. MHP Access Team
    b. SUPT System of Care

2. **Delivery System: Issue within (2) business days of the decision**. Providers responsible for the issuance of this NOABD include:
    a. All providers that conduct assessments. When medical necessity is not met, the member is referred, as appropriate.

3. **Denial of Authorization for Requested Services: Issue within (2) business days of the decision** (This in not necessarily a denial of all services). Providers responsible for the issuance of this NOABD include:
    a. MHP and SUPT Points of Entry
    b. Outpatient providers who provide assessments to determine medical necessity for the type or level of service, appropriateness, setting or effectiveness of a service
    c. MHP or SUPT Program Monitors or Intensive Placement Team when an assessment is performed to determine medical necessity for the type or level of service, appropriateness, setting or effectiveness of a service
    d. SUPT Residential programs

4. **Financial Liability Denial: Issue at the time of the action** (County Staff Only). Providers responsible for the issuance of this NOABD include:
    a. Quality Management
    b. Fiscal Services

5. **Grievance and Appeal Delays** (County Staff Only): **Issue within (2) business days of the decision.** Providers responsible for the issuance of this NOABD include:
    a. Quality Management

6. **Modification Denial** (County Staff Only): Issue within (2) business days of the decision. .
    a. MHP Access Team
    b. Contract Monitors

    c. SUPT System of Care
7. **Payment Denial** (County Staff Only): **Issue at the time of the action**. Providers responsible for the issuance of this NOABD include:
    a. Quality Management

8. **Timely Access Delay: Issue within (2) business days of the decision.** Providers responsible for the issuance of this NOABD include:
    a. MHP and SUPT Points of Entry
    b. Outpatient providers

9. **Termination Notice: Issue at least (10) calendar days before the date of the action.** Providers responsible for the issuance of this NOABD include:
    a. MHP and SUPT Outpatient providers who provide on-going specialty mental health or substance use disorder services

Storage Requirements

Providers are responsible to report to Member Services the type and number of each NOABD given to members on an annual basis, by September 1st of each year for the preceding fiscal year. NOABDs are to be stored as follows:

- MHP and SUPT providers are to retain (scan) a copy of the NOABD in Avatar in the "Court/Legal category. Non-Avatar user must retain a copy of the NOABD in a central file.
- Quality Management, and fiscal services**,** will retain a copy of the NOABD in a central file.

Appeals:

BHS shall inform the Member or Member representative of the right to file an appeal using the BHS Problem Resolution Process (see P & P Problem Resolution 03-01). A Member has (60) calendar days from the date on the Notice of Adverse Benefit Determination to file an appeal to BHS Member Services **or** (10) days to file an appeal, if they would like services to continue pending the resolution of the appeal (see Aid Paid Pending below).

State Fair Hearings:

The member may request a State Fair Hearing if dissatisfied with the appeal resolution. (see P&P Problem Resolution 03-01). Failure of BHS to adhere to the notice and timing requirements will deem the appeal process exhausted and the member may file a State Fair Hearing. A member may request a State Fair Hearing, regardless of whether a Notice of Adverse Benefit Determination was received, if the member exhausted the appeals process. Assistance in completing the State Fair Hearing form shall be provided, when needed. Whenever possible, the Member will be informed verbally, in their primary language, of the contents of the written notice.

A. Members must request a State Fair Hearing no later than 120 calendar days from the date of the notice of appeal resolution.

B. Members requesting a hearing within 10 calendar days of notification or before the effective date of the change, whichever is later, may, under certain circumstances, continue receiving services while the hearing is pending.

C. Detailed instructions for filing a State Fair hearing are located on the NAR-Your Rights attachment and the NOABD-Your Rights attachment.

Aid Paid Pending:

Aid Paid Pending means that a member has the right to continue receiving mental health or substance use disorder services pending the outcome of a grievance, appeal, or State Fair Hearing, under certain circumstances. BHS Member Services will notify the affected provider when a member files a grievance, appeal, or State Fair Hearing. Providers are to continue providing services to active members who file a grievance to allow Member Services the opportunity to resolve the grievance issue, when appropriate. The grievance process should not impact a member's provision of services.

Members who file an appeal as a result of receiving a NOABD, which reduces or terminates an existing authorization, and wish to continue receiving services, must file the appeal with Member Services within (10) calendar days of receiving the NOABD **or** before the date the NOABD says services will stop. Providers are to continue providing services pending the resolution by Member Services, in some circumstances. The member will receive a written decision in a Notice of Appeal Resolution (NAR) letter, with a copy to the affected provider. Otherwise, a member has (60) days to file an appeal after the receipt of a NOABD.

When a member receives an adverse decision to an appeal, members who wish to appeal the decision must ask for a State Fair Hearing within (120) of receiving the NAR, or if the NAR was not received within (30) days of filing an appeal. Members who wish to continue receiving services pending the outcome of the State Fair Hearing must ask to continue services within (10) calendar days of receiving the NAR or before the effective date of the change, whichever is later. There is no cost to members to file a State Fair Hearing. BHS may request a representative from the involved provider site to participate in the hearing process.

The State Hearing Office may take up to (90) calendar days to render a decision. Members may ask for an expedited hearing and get an answer within 72 hours, following a written request detailing how waiting for (90) days will seriously harm his/her life, health, or ability to attain, maintain, or regain maximum function. Should the Administrative Law Judge overseeing the State Fair Hearing overturn BHS's decision, BHS must authorize or provide the disputed service(s) no later than 72 hours from the date the reversal decision is rendered.

REFERENCE(S)/ATTACHMENTS:

- CCR Title 9, §1850.210 - 215

- CCR Title 22, 51014.1
- CFR Title 42, Part 438, Subpart F
- DHCS All Plan Letter (APL) 17-006
- MHSUD Information Notice 18-010E
- SUPT Practice Guidelines Provider Procedure Manual

RELATED POLICIES:

- No. 03-01 Problem Resolution
- No. 02-03 Continuity of Care
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DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	**X**	Mental Health Treatment Center
X	Adult Contract Providers	**X**	Specific grant/specialty resource
X	Children's Contract Providers		
X	Substance Use Prevention and TreatmentServices		

CONTACT INFORMATION:

- Quality Management Unit
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