

# Notice of Adverse Benefit Determination DMC-ODS Specific Training

Sonoma County Behavioral Health

## **Quality Assurance**

Mental Health Plan / Drug Medi-Cal Plan

From here-out to be referred to as Plans

8/14/2024

# Training Goals & Objectives

## 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 understand each letter, and appropriate letter specific language

Note: NOABDS are only sent to Medi-Cal Beneficiaries

---

# NOABDs

---

# NOABDS

## **What is a NOABD?**

- A NOABD is a Notice of Adverse Benefit Determination.
- A NOABD is issued when a Medi-Cal beneficiary's services have been denied, terminated, and/or significantly altered.

## **Why is a NOABD Issued?**

- NOABD letters provide information to beneficiaries about their appeal rights and other beneficiary rights under the Medi-Cal program.
- A NOABD supports beneficiary protection by advising beneficiaries of their rights in writing.

# ABDs – Adverse Benefit Determinations

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. Failure to provide services in a timely manner
3. Denial or limited authorization of a requested service
4. Reduction, suspension or termination of a previously authorized service (when beneficiary disagrees)
5. Modification or limit of a provider's request for a service and approval of alternative services
6. Failure to process authorization decision in a timely manner
7. Denial, in whole or in part, of payment for a service
8. Failure to act within the required timeframes for grievance and appeals resolutions
9. Denial of a beneficiaries' request to dispute financial liability

# Timing of the Notice

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

*\*Note: Those in bold are NOABDs the DMC-ODS Plan would use.*

Type of NOABD	When are you required to send the letter?
<b>Termination</b>	<b>At least 10 days before the date of Action</b>
<b>Denial</b>	<b>Within 2 business days of the decision</b>
<b>Timely Access</b>	<b>Within 2 business days of the decision</b>
<b>Modification</b>	<b>Within 2 business days of the decision</b>
Delivery System	Within 2 business days of the decision
Timely Response to Grievance / Appeal	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

# Required Formatting

- Each available letter and required enclosures have been customized for Sonoma County users and translated into Spanish versions.
- The type of letter name is located:
  - 1) On the Word File name
  - 2) At the top of the NOABD letter
  - 3) On the letter footer
- Each available letter 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.
- Quarterly a copy of all completed NOABDs will be securely sent electronically to Quality Assurance via the BHQA email for filing and reporting purposes -  
BHQA@sonoma-county.org

# Required Enclosures

- There are 3 Required Enclosures for all NOABD letters:
  1. NOABD “Your Rights” Attachment
  2. Nondiscrimination Notice
  3. Language Taglines
- The Author shall print out the NOABD with the three (3) enclosures using both sides of paper, when possible, to minimize volume. **Please do not change any font sizing or special characterization.**



# Required Enclosures

**The enclosures provide information to Medi-Cal beneficiaries regarding the following rights:**

- Their right to file an appeal and how a beneficiary can file an appeal.
- Their right to ask for a State Fair Hearing and how to ask for a State Fair Hearing by phone, electronically, or in writing.
- Their right to have an authorized representative speak on their behalf to advocate for them.
- Their right to free legal help and the contact number for the local Legal Aid Program that they can contact for assistance.
- Their right to file a grievance if the BHS has failed to provide services in a timely manner or if they feel discriminated against. Medi-Cal beneficiaries have a right to file a grievance for any reason such as access to care, quality of care received, etc.
- Their right to file a civil rights complaint with the U.S. Department of Health and Human Services by phone, electronically, or in writing.

# Fillable Areas of the NOABD

## **The following areas are to be completed when issuing a NOABD:**

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
  - County staff = Sonoma County Behavioral Health & Your Program of Service
  - Contractor staff = Contractor's name & Your Program of Service
3. "Service requested" = Type of service requested
  - (ex. Assessment, methadone/NTP, withdrawal management/detox, residential, OP)
4. Some types of NOABDs will have a narrative section

# Example: Denial Notice NOABD

## NOTICE OF ADVERSE BENEFIT DETERMINATION - DENIAL NOTICE

[Date]

[Member's Name]  
[Address]  
[City, State Zip]

[Treating Provider's Name]  
[Address]  
[City, State Zip]

RE:      [Service requested]

[Name of requestor] has asked Sonoma County Behavioral Health Division (BHD), "The Plan," to approve [Service requested]. This request is denied. The reason for the denial is **[Using plain language, insert a clear and concise explanation of the reason(s) for the decision and the clinical reason(s) for the decision regarding medical necessity.]**

Per the Code of Federal Regulations, Title 42, Section 438.400(b)(3), Sonoma County BHD may approve in whole, or in part, a member's request for service(s) in this case (all items selected below apply):

- A) The member does not meet medical necessity criteria.
  - B) The requested service(s) is excluded from reimbursement.
  - C) The person for which the service(s) is being requested is ineligible for said service(s).
  - D) The Plan requested additional information from your provider that The Plan needs to approve payment of the proposed service(s). To date, the information has not been received.
-

— NOABD Forms issued by DMC-ODS —

# Common NOABD Types

**Below are common NOABD types that you may issue as DMC-ODS providers:**

- **Timely Access** = Services were not provided in a timely manner
- **Service Denial** = When there is a denial of authorization for requested services
- **Modification** = When there is a modification of a requested service
- **Termination** = When the plan terminates a previously authorized service

# NOABD: Timely Access

## A Timely Access NOABD:

- Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. *(include dates in letter)*

**Note:** For an Opioid Treatment Program, use when services are NOT provided within 3 business days

# NOABD: Timely Access

- Narrative Box
  - **[You or your provider (Name of requesting provider)]** has asked Sonoma County's Behavioral Health Division (BHD), "the Plan" to obtain or approve **[Service requested]**. The **[Plan or Name of requesting provider]** has not provided services within **[number of] working days**. Our records show that you requested service(s), or service(s) were requested on your behalf on **[date requested]**.
  - We apologize for the delay in providing timely services. We are working on your request and will provide you with **[Service requested]** soon.

# NOABD: **Service Denial Notice**

## **Service Denial NOABD is Used when:**

- There is a denial of authorization for requested services.
- Denials include the following:
  - Determinations based on type or level of service
  - Requirements for access criteria or medical necessity
  - Appropriateness
  - Setting
  - Effectiveness of a covered benefit

## **Example:**

- Denial of requested LOC treatment services when a beneficiary does NOT meet ASAM LOC criteria (service request is not appropriate)
- A Denial Letter is provided when the beneficiary is not interested in utilizing the appropriate LOC service. (ASAM scores as 2.1 but individual only wants residential services)



# NOABD: Service Denial Notice

## Narrative Box:

- **[Name of requestor]** has asked Sonoma County Behavioral Health Division (BHD), “The Plan,” to approve **[Service requested]**. This request is denied. The reason for the denial is **[Using plain language, insert a clear and concise explanation of the reason(s) for the decision and the clinical reason(s) for the decision regarding medical necessity.]**
- Per the Code of Federal Regulations, Title 42, Section 438.400(b)(3), Sonoma County BHD may approve in whole, or in part, a member’s request for service(s) in this case (all items selected below apply):
  - A) The member does not meet medical necessity criteria.
  - B) The requested service(s) is excluded from reimbursement.
  - C) The person for which the service(s) is being requested is ineligible for said service(s).
  - D) The Plan requested additional information from your provider that The Plan needs to approve payment of the proposed service(s). To date, the information has not been received.
  - E) The provider did not agree to/satisfy The Plan contractual agreements, or Medi-Cal reporting/documentation requirements.

# NOABD: Modification

## **Modification NOABD is Used when:**

- "The Plan" modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

# NOABD: Modification

**Narrative Box Requirements** (*The below statement must be included*):

**[Name of requestor]** has asked Sonoma County Behavioral Health Division (BHD), “The Plan” to approve **[Service requested]**. We cannot approve this treatment as requested. This is because **[Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]**.

Per the Code of Federal Regulations, Title 42, Section 438.400(b)(3), Sonoma County BHD may approve in whole, or in part, a member’s request for service(s) in this case (all items selected below apply):

- A) The member does not meet medical necessity criteria.
- B) The requested service(s) is excluded from reimbursement.
- C) The person for which the service(s) is being requested is ineligible for said service(s).
- D) The Plan requested additional information from your provider that The Plan needs to approve payment of the proposed service(s). To date, the information has not been received.
- E) The provider did not agree to/satisfy The Plan contractual agreements, or Medi-Cal reporting/documentation requirements.

We will instead approve the following treatment: **[Service or service length approved]**.

# NOABD: Termination

## Used when:

- DHS-BHD terminates, reduces, or suspends a previously authorized service and the client disagrees with the decision.
- **Note:** The facility may not transfer or discharge an individual during the following:
  - When an individual exercises his or her right for continued services during appeal of a termination notice.
    - Unless the failure to discharge would endanger the health or safety of the other individuals in the facility, which must be documented.

## Timeline:

- Termination NOABDS must be issued at least 10 days before action, except as permitted under **42 CFR 431.213 & 431.214**

Let's review the exceptions!

# NOABD: Termination

## 431.213 Exceptions:

1. Confirmed death of individual
2. Individual provided a written statement declining further services
3. Ineligibility for further services (such as, loss of Medi-Cal, could include violation of program safety rules or not meeting medical necessity for services)
4. A change in the level of medical care is prescribed by the beneficiary's physician (facility Medical Director)
  - ❖ **#4 related to a change to care based on ASAM level of need and medical necessity determination**
5. The beneficiary's whereabouts are unknown with no known address and failed outreach efforts.

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

1. The Plan has facts indicating that action should be taken because of probable fraud by the individual.
  - a. Such facts have been verified, if possible, through secondary sources

# NOABD: Termination

## Narrative Box:

You are currently receiving [**Service to be terminated**]. Beginning on [**termination date**] we will no longer approve this treatment. This is because [**Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity**].

Per the Code of Federal Regulations, Title 42, Section 438.400(b)(3), Sonoma County Behavioral Health Division (BHD) may approve in whole, or in part, a member's request for service(s) in this case (all items selected below apply):

- A) The member does not meet medical necessity criteria.
- B) The requested service(s) is excluded from reimbursement.
- C) The person for which the service(s) is being requested is ineligible for said service(s).
- D) The provider did not agree to/satisfy The Plan contractual agreements, or Medi-Cal reporting/documentation requirements.

# NOABDs Issued by the County

# **NOABDS: Issued by County Staff**

## **Delay of processing authorizations**

### **Used when:**

- The plan does not respond to a request for authorization of services within required timeframes.
- Delay in processing a PROVIDER's request for DMC-ODS services, including extensions due to a need for additional information from the beneficiary or provider
- Delay Letter is issued in addition to any other required NOABD letters (Denial, Modify, etc.)

## **Delivery System (SMHS Only)**

### **Used when:**

- The plan has determined that the client's mental health condition does not meet medical necessity criteria for SMHS services.



# **NOABDS: Issued by County Staff**

## **Dispute of Financial Liability**

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

## **Timely Response to Grievances & Appeals**

- Used when BHP 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.

## **Payment Denial**

- 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.

All NOABD forms can be found here:

[County of Sonoma Forms and Materials page](#) *(Confirmation will be provided when forms are made available)*

Please reach out if you have any questions regarding NOABDs

Katie Gustafson: [Katie.Gustafson@sonoma-county.org](mailto:Katie.Gustafson@sonoma-county.org)

Trisha Sheldon: [Trisha.Sheldon@sonoma-county.org](mailto:Trisha.Sheldon@sonoma-county.org)