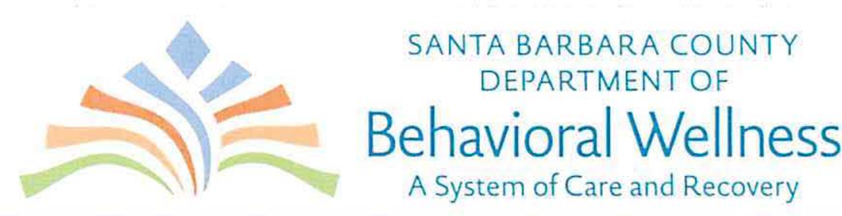

Departmental Policy and Procedure

Section	Quality Care Management	**Effective:**	4/01/1998
Sub-section	General		
Policy	Notice of Adverse Benefit Determination	**Last Revised:**	6/13/2018
Policy #	4.010		
Director's Approval	Alice Gleghorn, PhD	**Date**	6/26/18
Chief Quality Care/ Strategy Officer	Suzanne Grimmesey, MFT	**Date**	6/29/18
Supersedes:	4.010 – Notice of Action (NOA), rev. 12/22/16	**Audit Date:**	6/13/2021

1. BACKGROUND

1.1. Notice of Adverse Benefit Determinations are written notifications advising Medi-Cal beneficiaries of an Adverse Benefit Determination and are required by the State Department of Health Care Services (DHCS); the California Code of Regulations (CCR), Title 9, Section 1850.210 and Title 22, Section 50179; and the Code of Federal Regulations (CFR), Title 42, Part 438, Subpart F, Section 438.404.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Adverse Benefit Determination** – any of the following actions taken by the Department:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

2.2. **Notice of Adverse Benefit Determination** – a formal letter informing a Medi-Cal beneficiary of an Adverse Benefit Determination.

3. POLICY

3.1. It is the policy of the Santa Barbara County Department of Behavioral Wellness (hereafter "the Department") to inform Medi-Cal beneficiaries of an Adverse Benefit Determination and provide a Notice of Adverse Benefit Determination in accordance with all relevant state and federal laws and regulations.

3.2. Notice of Adverse Benefit Determinations will be issued in a timely manner and the beneficiary advised of his/her right to request a second opinion, file a verbal or written action appeal, file a verbal or written expedited action appeal, and/or request a State Hearing in response to a Notice of Adverse Benefit Determination.

3.3. This policy applies to County-operated and contracted provider programs.

4. TYPES OF ADVERSE BENEFIT DETERMINATION

4.1. **Denial** – a denial of authorization for requested services; required when the Department denies a request for a service. This includes determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit, and denial of residential service requests. These determinations must be based on an assessment consisting of a face-to-face clinical interview completed by Department or contracted provider employees acting within their scope of practice. (See *Attachment A*.)

4.2. **Payment denial** – a denial of payment for a service rendered by the provider; required when the Department denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary. Denials include, but are not limited to denials based on documentation standards. (See *Attachment B*.)

4.3. **Delivery system** – required when the Department has determined that the beneficiary does not meet criteria to be eligible for specialty mental health or substance use disorder services through the Department. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services. (See *Attachment C*.)

4.4. **Modification** – a modification of requested services; required when the Department 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. (See *Attachment D*.)

4.5. **Termination** – the termination of previously authorized service; required when the Department terminates, reduces, or suspends a previously authorized service. (See *Attachment E*.)

4.6. **Authorization Delay** – a delay in processing authorization of services; required when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the Department 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 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. (See *Attachment F.*)

4.7. **Timely Access** – a failure to provide timely access to services; required when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. (See *Attachment G.*)

4.8. **Financial Liability** – a dispute of financial liability; required when the Department denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. (See *Attachment H.*)

4.9. **Grievance/Appeal Resolution** – required when the Plan does not meet required timeframes for the standard resolution of grievances and appeals.[1] (See *Attachment I.*)

5. GENERAL REQUIREMENTS AND STANDARDS

5.1. The primary clinician who works with the beneficiary, or a designee by that clinician's supervisor, will be responsible for delivering the Notice of Adverse Benefit Determination.

1. The primary clinician or designee must first submit the Notice of Adverse Benefit Determination to their supervisor for approval.
2. Upon supervisor approval, the primary clinician or designee will be responsible for delivering the Notice of Adverse Benefit Determination to the beneficiary and to QCM for logging.

5.2. Whenever a decision is made to issue an Notice of Adverse Benefit Determination, a copy will be hand-delivered or mailed to the beneficiary and faxed or mailed to the program (when indicated).

5.3. The Notice of Adverse Benefit Determination issued must be hand-delivered or deposited with the United States Postal Service in time for pick-up no later than:

1. For decisions resulting in denial, delay or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.
2. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of the action.

5.4. Staff are under no obligation to search for and locate individuals who are indigent or who did not provide staff with the most current contact information. It is the beneficiary's obligation to inform providers of a change in address. The Notice of

[1] Please refer to the Department's "Client Problem Resolution Process" policy for further details.

Adverse Benefit Determination will be mailed to the last known address on file, including an address for a shelter or board and care facility.

5.5. Quality Care Management (QCM) will maintain copies of all Notice of Adverse Benefit Determinations for a minimum of seven (7) years.

5.6. A Notice of Adverse Benefit Determination is not required when a provider determines that a beneficiary does not qualify for a specific service covered. This includes, but is not limited to, the following: crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service (SMHS) to treat a beneficiary's urgent condition, provided that the determination does not apply to any other SMHS covered by the provider.

6. BENEFICIARY RIGHTS

6.1. All Notice of Adverse Benefit Determinations forms, regardless of type, must include an attachment with information on the beneficiary's right to appeals, expedited appeals and expedited State Fair Hearings (i.e., "Notice of Adverse Benefit Determination Your Rights" information notice, *Attachment J*).

6.2. All Notice of Adverse Benefit Determinations forms, regardless of type, must include an attachment with information on how to access the form and other information in a different language or alternative format (i.e., "Language Assistance Taglines", *Attachment K*).

6.3. All Notice of Adverse Benefit Determinations forms, regardless of type, must include an attachment with information on the Department's policy of non-discrimination and free language services (i.e., "Beneficiary Non-Discrimination", *Attachment L*).

6.4. In response to a Notice of Adverse Benefit Determination, the beneficiary has the right to respond in the following ways:

1. **Request documents and records** – The beneficiary may request, free of charge, copies of all documents and records relevant to the Notice of Adverse Benefit Determination, including criteria or guidelines used.
2. **Request for a second opinion**[2] – The beneficiary may make a request for a second opinion upon receipt of a Notice of Adverse Benefit Determination (Denial, Delivery System, Modification, Termination) for review and re-determination of medical necessity.
3. **File a verbal or written action appeal**[3] – The beneficiary may file an action appeal verbally or in writing pertaining to a Notice of Adverse Benefit Determination.
4. **Request a State Hearing** – The beneficiary may request a State Hearing by calling or writing directly to the State Hearing Office (1) upon exhausting the Department's appeal process and receiving notice that the Adverse Benefit Determination has

[2] Please refer to the Department's policy, "Second Opinion", for further details.
[3] Please refer to the Department's policy, "Client Problem Resolution Process", for further details.

been upheld, or (2) if the Department fails to send a resolution notice in response to the appeal within the required timeframe. Beneficiaries must request a state fair hearing within 120 calendar days from the date of the notice of appeal resolution (NAR).

ASSISTANCE

Suzanne Grimmesey, MFT, Quality Care and Strategy Management Officer

Jamie Huthsing, LMFT, Quality Care Management

Susan Soderman, LMFT, Quality Care Management

REFERENCE

Federal Register
Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule
Volume 81, Page 27497

Department of Health Care Services (DHCS)
Federal Grievance And Appeal System Requirements With Revised Beneficiary Notice Templates
Information Letter 18-010E, March 27, 2018

Department of Health Care Services (DHCS)
All Plan Letter 17-006, May 9, 2017

Department of Health Care Services (DHCS)
Medi-Cal General Notice of Action (NOA) Policy
Information Letter 13-13, May 14, 2013

Department of Health Care Services (DHCS)
Information Letter 05-03, June 2, 2005

Department of Health Care Services (DHCS) – Mental Health Plan
Exhibit A, Attachment 1, Sections 15.F.1, 15.I, 15.J, 15.K

Code of Federal Regulations – Public Health
Title 42, Chapter 4, Part 438, Subpart F, Sections 438.10(c), 438.206(b)(3), 438.400(b), 438.404(c)(2)

California Code of Regulations – Rehabilitative and Developmental Services
Title 9, Chapter 11, Sections 1810.405(e), 1830.205(a),(b)(1),(2),(3), 1850.210(a)-(j), 1850.212

ATTACHMENTS

Attachment A – Denial

Attachment B – Payment Denial

Attachment C – Delivery System

Attachment D – Modification

Attachment E – Termination

Attachment F – Authorization Delay

Attachment G – Timely Access

Attachment H – Financial Liability

Attachment I – Grievance and Appeal Timely Resolution

Attachment J – Your Rights

Attachment K – Language Assistance Taglines

Attachment L – Beneficiary Non-Discrimination

RELATED POLICIES

Client Problem Resolution Process

Service Triage: Routine Conditions

Client Problem Resolution Process

Second Opinion

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
12/17/16	2.0	• Substantive revisions made to reflect current standards of training and operations.
6/14/17	2.1	• Updated policy to comply with Managed Care Final Rule
6/13/2018	2.2	• Updated the policy to reflect "Adverse Benefit Determination" language throughout • Removed information on Appeals for consolidation in separate policy • Added new attachments as per DHCS requirements

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).