

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

POLICY NO. :	POLICY TITLE:	EFFECTIVE DATE:
0704.500	NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)	04/11/ 2007
PROGRAM:	ALL BEHAVIORAL HEALTH PROGRAMS; ORGANIZATIONAL PROVIDERS	REVISION DATES: 09/01/08, 5/16/17, 2/1/18, 1/28/19
AFFECTS:	DHHS BEHAVIORAL HEALTH STAFF; BENEFICIARIES; CONTRACT PROVIDERS	REVIEW DATES: 07/26/10, 03/01/11, 9/23/13; 02/06/14

POLICY Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH) complies with the state and federal requirements to provide a Notice of Adverse Benefit Determination (NOABD) to Medi-Cal beneficiaries when required. Best judgment should be used regarding the requirements for issuing NOABDs, but should resolve doubts in favor of providing a NOABD.

DEFINITION(S) Mental Health Plan (MHP): is a county Behavioral Health department under contract with the State Department of Health Care Services (DHCS) which provides specialty mental health services (SMHS) to Medi-Cal beneficiaries, under a waiver with the federal government.

Adverse Benefit Determination: An “Adverse Benefit Determination” occurs when the DHHS-BH, while acting as the MHP for the County, takes any of the following actions:

1. The denial or limited authorization of requested services, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit ([1045 – Denial](#), [1045 – Delivery System](#));
2. The reduction, suspension, or termination of a previously authorized service ([1045 – Modification](#), [1045 – Termination](#));
3. The denial, in whole or in part, of payment for a service ([1045 – Payment Denial](#));
4. The failure to provide services in a timely manner ([1045 – Timely Access](#), [1045 – Authorization Delay](#));
5. The failure to act within the required timeframes for standard resolution of grievances and appeals ([1045 – Grievance/Appeal Resolution](#)); or
6. The denial of a beneficiary’s request to dispute financial liability ([1045 – Financial Liability](#)).

Notice of Adverse Benefit Determination (NOABD): is a letter given to a Medi-Cal beneficiary when the MHP takes any of the actions described above. The purpose of the NOABD is to advise the beneficiary of the Adverse Benefit Determination and to provide information about the beneficiary’s right to appeal the decision.

- PROCEDURE**
1. It is the policy of DHHS-BH to utilize the most current State approved NOABD forms.
 - 1.1. For any NOABD, there is a coinciding letter form template that is filled in and sent to the beneficiary. These form letters are all labeled 1045, along with the title that describes its use. See 2 – 11 below for detailed instructions.
 2. MHP will send a [1045 – Denial](#) to the beneficiary in the following circumstance:
 - 2.1. Inappropriate type or level of care, does not meet medical necessity, inappropriate setting or ineffectiveness of a covered benefit. Medical necessity refers to the following:
 - 2.1.1. The beneficiary has been assessed and a determination has been made that
 - 2.1.1.1. The beneficiary does not have a covered diagnosis (as specified by Department of Health Care Services (DHCS)) **or**

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- 2.1.1.2. A beneficiary 21 years old or older has a covered diagnosis, but there is no covered intervention that will correct or ameliorate the condition,
or
 - 2.1.1.3. A beneficiary younger than 21 years old has a covered diagnosis, but does not have a significant impairment, **or**
 - 2.1.1.4. The beneficiary has a covered diagnosis, but the condition would be responsive to physical health care based treatment.
 - 2.2. For example, when a beneficiary is assessed and does not meet criteria for medical necessity and it is decided that they will not receive SMHS, then a **1045 – Denial** is sent.
 - 2.3. The **1045 – Denial** will be sent to the beneficiary within 2 business days of decision and the provider shall be notified within 24 hours of the decision.
 3. The MHP will send a **1045 – Delivery System** to the beneficiary in the following circumstances:
 - 3.1. When MHP determines that the beneficiary does not meet the criteria to be eligible for SMHS or substance use disorder (SUD) services through the plan and are referred for a lower level of care. In these instances the beneficiary will be referred to a Managed Care Plan, or other appropriate services.
 - 3.1.1. For example, when a beneficiary meets criteria for a lower level of care (Level 2 or 3) and is referred to Beacon for behavioral health services, a **1045 – Delivery System** is sent.
 - 3.2. The **1045 – Delivery System** will be sent to the beneficiary at least 10 days before the date of decision and the provider shall be notified within 24 hours of the decision.
 4. The MHP will send a **1045 – Termination** to the beneficiary in the following circumstances:
 - 4.1. When MHP terminates, reduces, or suspends a previously authorized service.
 - 4.1.1. For example, when a beneficiary has met treatment goals and no longer meets medical necessity but wants to continue with treatment, a **1045 – Termination** is sent.
 - 4.2. The **1045 – Termination** will be sent to the beneficiary at least 10 days before the date of termination and the provider shall be notified within 24 hours of the decision.
 5. The MHP will send a **1045 – Modification** to the beneficiary in the following circumstances:
 - 5.1. When MHP modifies or limits a provider’s request for a service, including reductions or increases in frequency and/or duration of services, and approval of alternative treatments and services.
 - 5.1.1. For example, when an organizational provider is authorized to provide one therapy session weekly by the MHP and there is a change in circumstances requiring more services MHP modifies by increasing to twice weekly, a **1045 – Modification** is sent.
 - 5.2. The **1045 – Modification** will be sent to the beneficiary within 2 business days of the decision and the provider shall be notified within 24 hours of the decision.
 6. The MHP will send a **1045 – Payment Denial** to the beneficiary in the following circumstances:
 - 6.1. When MHP denies, in whole or in part, a provider’s request for payment for a service that has already been delivered to a beneficiary.
 - 6.1.1. For example, when a Utilization Review (UR) Nurse reviews a chart of a beneficiary that stayed on Sempervirens (SV) for 7 days and decides to deny 3 days due to not meeting medical necessity, a **1045 – Payment Denial** is sent.
 - 6.1.2. For example, if an Out of County Treatment Authorization Request (TAR) includes denied days, a **1045 – Payment Denial Notice** will be mailed to the last known address of the beneficiary.
 - 6.2. The **1045 – Payment Denial** will be sent to the beneficiary at the time of the action and the provider shall be notified within 24 hours of the decision.
 7. The MHP will send a **1045 – Timely Access** to the beneficiary in the following circumstances:
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- 7.1. When the MHP fails to provide services in a timely manner (10 business days from the initial request for services).
 - 7.1.1. For example, the program staff offering a first appointment to the beneficiary offers an appointment 12 business days from receiving the referral, a [1045 – Timely Access](#) is sent.
 - 7.2. The [1045 – Timely Access](#) will be sent to the beneficiary and the provider shall be notified within 24 hours of the decision.
 8. The MHP will send a [1045 – Authorization Delay](#) to the beneficiary in the following circumstances:
 - 8.1. When there is a delay in processing a provider's request for authorization of SMHS or SUD services. This includes when the extension granted is at the request of the beneficiary or provider.
 - 8.1.1. For example, when the Access Clinician receives an authorization request from an organizational provider ([1216 Managed Care Authorization](#) (MCA) or Service Authorization Request (SAR)) and is unable to provide an authorization decision within 14 days for a SAR or 5 days for MCA, a [1045 – Authorization Delay](#) is sent.
 - 8.2. The [1045 – Authorization Delay](#) will be sent to the beneficiary and the provider shall be notified within 24 hours of the decision.
 9. The MHP will send a [1045 – Grievance/Appeal Resolution](#) to the beneficiary when the MHP fails to act within the timeframes for disposition for Grievances, resolution of Standard Appeals, or resolution of Expedited Appeals. This means:
 - 9.1. A beneficiary registers a Grievance or Appeal and the MHP fails to notify the beneficiary and affected parties of the decision or resolution:
 - 9.1.1. For a Grievance, within 60 calendar days of the MHP receipt of the Grievance.
 - 9.1.2. For a Standard Appeal, within 45 calendar days of the MHP receipt of the Appeal.
 - 9.1.3. For an Expedited Appeal, within 3 working days of the MHP receipt of the Expedited Appeal.
 - 9.2. Staff assigned to Grievance/Appeal resolution is responsible for sending the [1045 – Grievance/Appeal Resolution](#).
 10. The MHP will send a [1045 – Financial Liability](#) to the beneficiary in the following circumstances:
 - 10.1. When the MHP denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
 - 10.1.1. For example, CDM will send a [1045 – Financial Liability](#) to the beneficiary when a decision is upheld regarding the beneficiary's responsibility for payment, after the beneficiary has disputed.
 - 10.2. The [1045 – Financial Liability](#) is sent to the beneficiary at the time of the decision and the provider shall be notified within 24 hours of the decision.
 11. Along with the aforementioned NOABD forms (1045 Forms), the beneficiary is to receive the [QI-108 NOABD "Your Rights"](#) attachment, [QI-109 Nondiscrimination Notice](#), and [QI-110 Language Assistance Tag Lines](#).
 12. The Quality Improvement Unit of DHHS-BH maintains copies of all NOABDs issued to clients. Clinical staff who issue NOABDs to clients will copy and send to the QI unit:
 - 12.1. A copy of the NOABD letter.
 - 12.2. A copy of the authorization paperwork (Forms 1038/1039, 1216 MCA, Service Authorization Request (SAR)) for [1045 – Denials](#), [1045 – Terminations](#) and for [1045 – Payment Denials](#).
 - 12.3. Copy of above information should be sent to Medical Records by staff completing NOABD for inclusion in client medical records.
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13. NOABD Appeal Process: Once any of the aforementioned 1045 letters are sent to a beneficiary, the beneficiary has the right to appeal the adverse benefit determination within 60 calendar days from when the NOABD was sent.
- 13.1. A beneficiary, or a provider and/or authorized representative, may request an appeal either orally or in writing.
- 13.2. An oral appeal (excluding expedited appeals) shall be followed by a written appeal signed by the beneficiary. The date of the oral appeal establishes the filing date of the appeal. QI is responsible for requesting the follow-up written appeal, when appeal is provided orally. The beneficiary is to fill out a [QI-85 Problem Resolution Request](#) form (Pink form) in order to submit appeal in writing.
- 13.2.1. QI is responsible for assisting the beneficiary in completing forms and taking other procedural steps to file an appeal. The MHP shall provide guidance to beneficiary in finding the form on the website or providing them with the form upon request.
- 13.2.2. QI must assist the beneficiary in requesting continuation of benefits during a NOABD appeal process. Although Authorized Representatives may file a grievance, request an appeal, or request a State hearing on behalf of the beneficiary; only the beneficiary may request continuation of benefits.
- 13.3. Standard Resolution of Appeals
- 13.3.1. QI shall provide the beneficiary with written acknowledgement of receipt of the appeal within 5 calendar days of receipt.
- 13.3.1.1. The acknowledgement shall include the date of receipt, as well as the name, telephone number, and address of the MHP representative who the beneficiary may contact about the appeal.
- 13.3.2. QI must resolve a NOABD appeal within 30 calendar days of receipt.
- 13.3.3. QI may extend the resolution timeframes for NOABD appeals by up to 14 calendar days if either of the following conditions apply:
- 13.3.3.1. The beneficiary requests the extension **or** QI demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.
- 13.3.3.2. For any extension not requested by the beneficiary:
- 13.3.3.2.1. QI is required to provide the beneficiary with written notice of the reason for delay.
- 13.3.3.2.2. QI shall make a reasonable effort to provide the beneficiary with prompt oral notice of extension.
- 13.3.3.2.3. QI shall provide written notice of extension within 2 calendar days of decision to extend and beneficiary shall also be notified of right to file a grievance if they disagree with the extension.
- 13.3.3.2.4. QI shall resolve the extended appeal within a maximum of 14 calendar days.
- 13.3.3.2.5. If QI fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate State hearing.
- 13.4. Expedited Resolution of Appeals
- 13.4.1. If it is established that taking time for a standard resolution could seriously jeopardize the beneficiary's behavioral health or SUD condition and/or the beneficiary's ability to attain, maintain, or regain maximum function; then the plan must follow established expedited appeal resolution procedure.
- 13.4.2. QI must resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, no longer than 72 hours after QI receives the expedited appeal request.
- 13.4.2.1. If QI denies a request for expedited resolution, it must transfer the appeal to the timeframe for standard resolution. In addition, QI must complete all of the following actions:
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- 13.4.2.1.1. QI shall make reasonable efforts to provide the beneficiary with prompt oral notice of decision to transfer to standard appeal;
 - 13.4.2.1.2. QI shall provide written notice of the decision to transfer to standard appeal within 2 calendar days and notify the beneficiary of their right to file a grievance if they disagree with the extension; and
 - 13.4.2.1.3. QI shall resolve the appeals as expeditiously as the beneficiary's health condition requires and no longer than 30 days of receipt of the appeal.
- 13.5. Notice of Appeal Resolution (NAR)
- 13.5.1. A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.
 - 13.5.1.1. For appeals not resolved wholly in favor of the beneficiary, a [QI-114 Notice of Appeal Resolution Upheld](#) is provided to the beneficiary, along with a copy of [QI-112 NAR "Your Rights"](#) attachment.
 - 13.5.1.2. For appeals resolved wholly in favor of the beneficiary, a [QI-113 Notice of Appeal Resolution Overturned](#) is provided to the beneficiary, along with a copy of [QI-112 NAR "Your Rights"](#) attachment.
 - 13.5.1.3. Notice of Appeal Resolution, whether upheld or overturned, shall include the following:
 - 13.5.1.3.1. Results of the resolution and the date it was completed;
 - 13.5.1.3.2. The reasons for the determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
 - 13.5.1.3.3. For appeals not resolved wholly in the favor of beneficiary; the right to request a State hearing and how to request it and the right to request and receive benefits while the hearing is pending and how to request it; and
 - 13.5.1.3.4. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds QI's adverse benefit determination.
 - 13.5.1.4. If it the decision is overturned during the appeal process, the beneficiary must be notified and authorized or provided services, within 72 hours of the overturned decision.
- 13.6. State Hearing
 - 13.6.1. Beneficiaries must exhaust QI's appeal process prior to requesting a State hearing and may only be requested by beneficiary after QI has upheld an adverse determination.
 - 13.6.2. The appeals process is deemed exhausted if QI fails to adhere to the notice and timing requirements.
 - 13.6.3. Beneficiaries may request a State hearing within 120 calendar days from the date of the [QI-114 Notice of Appeal Resolution Upheld](#) was sent.
 - 13.6.3.1. For standard hearing, QI shall notify beneficiaries that the State must reach its decision on the hearing with 90 calendar days of the date of the request for the hearing.
 - 13.6.3.2. For expedited hearing, QI shall notify beneficiaries that the State must reach its decision on the hearing within 3 working days of the date of the request for the hearing.
 - 13.6.4. QI shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives the notice reversing the MHP's adverse benefits determination.

FORM(S)/
ATTACHMENTS

- [1045 – Denial](#)
- [1045 – Delivery System](#)
- [1045 – Termination](#)
- [1045 – Modification](#)
- [1045 – Payment Denial](#)
- [1045 – Timely Access](#)
- [1045 – Authorization Delay](#)
- [1045 – Grievance/Appeal Resolution](#)

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[1045 – Financial Liability](#)
[QI-113 Notice of Appeal Resolution Overturned](#)
[QI-114 Notice of Appeal Resolution Upheld](#)
[QI-108 NOABD “Your Rights”](#)
[QI-109 Nondiscrimination Notice](#)
[QI-110 Language Assistance Tag Lines](#)
[QI-85 Problem Resolution Request](#)
[QI-112 NAR “Your Rights”](#)
[1216 Managed Care Authorization](#)

REFERENCE

[DMH Letter 05-03, Medi-Cal Requirements for Aid Paid Pending](#)
[42 CFR Section 438.404 c \(2\)](#)
[CCR Title 9, Div. 1, Chapter 11, Subchapter 3, Art. 2, Section 1830.205 \(a\), \(b\)\(1\),\(2\),\(3\)](#)
[CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 2, Section 1850.210 \(a\)-\(g\)](#)
[CCR Title 28, Div. 1, Chapter 2, Art. 8, Section 1300.70](#)
[State Management Advisory and Response Team NOABD FAQs](#)
