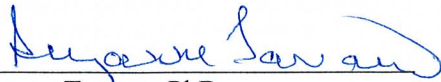


Contra Costa County Health Services Department Behavioral Health Services Division Mental Health Services Alcohol and Other Drugs Services	POLICY NO. 815
	Date Reviewed/Revised: January 13, 2020 Date Initially Approved: March 2000 Next Review Date: January 13, 2023
POLICY: <u>NOTICE OF ADVERSE BENEFIT DETERMINATION</u>	By:  Suzanne Tavano, PhD Behavioral Health Director

POLICY: NOTICE OF ADVERSE BENEFIT DETERMINATION

I. PURPOSE:

The purpose of this policy is to identify the procedures to be followed by Behavioral Health Services Division (BHSD) in informing a Medi-Cal beneficiary when a decision has been made to deny, modify, terminate, reduce or defer a requested mental health or substance abuse service or when BHSD fails to adhere to timely access to services standards or fails to adhere to required time frames to process appeals, expedited appeals or grievances.

II. REFERENCES:

- 42 CFR, Part 438
- CCR, Title 9, § 1850.210
- CCR, Title 22, § 51014.1
- County of Contra Costa, ODS Contract # 16-93243
- DHCS, MHSUDS Information Notice 18-010

III. POLICY:

It is the policy of BHSD that all Medi-Cal beneficiaries and/or their authorized representatives will be informed in writing by the issuance of a Notice of Adverse Benefit Determination (NOABD), previously known as Notice of Action (NOA), of any of the following:

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 a payment for a service.
4. The failure to provide services in a timely manner.

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5. The failure of BHSD to act within the required timeframes for standard resolution of grievances, appeals, and expedited appeals.
6. The denial of a beneficiary's request to dispute financial liability.

IV. AUTHORITY/RESPONSIBILITY:

Mental Health Program Managers/Supervisors
 Alcohol and Other Drugs Services Program Managers/Supervisors
 Care Management Unit Manager/Supervisors
 Utilization Review Manager/Coordinators
 Quality Improvement Coordinator (QIC)

V. PROCEDURE:

- A. All BHSD and contracted providers issuing NOABD notices must mail the NOABD to the beneficiary within the following timeframes:
 1. For termination, suspension or reduction of a previously authorized specialty mental health service, at least ten (10) business days before the date of action, except as permitted under 42 CFR 431.213 and 431.214.
 2. For denial of payment, at the time of any action denying the provider's claim.
 3. For decisions resulting in denial, delay or modification of all or part of the requested specialty mental health or substance use services within two (2) business days of the decision.
 4. For notifications resulting from the failure to provide access to services within standards or failure to adhere to required timeframes for appeals (thirty [30] calendar days), expedited appeals (seventy-two [72] hours) or grievances (ninety [90] calendar days) on or before the last date of compliance.
- B. BHSD must communicate the NOABD decision to the impacted provider(s) within twenty-four (24) hours of making the decision. Decisions shall be communicated initially by facsimile or telephone, and then in writing, except decisions that are made retrospectively.
- C. All NOABD notices must explain the adverse benefit determination that BHSD or contracted providers issuing the NOABD notice has made or intends to make,

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including a clear, concise explanation of the decision. For decisions made based on medical necessity, the following shall be stated:

1. Why the beneficiary's condition does not meet medical necessity criteria.
 2. A description of the medical necessity criteria used including any processes, strategies, or evidentiary standards used in making such determinations.
 3. 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.
- D. All BHSD and contracted providers issuing NOABDs shall use DHCS approved templates or the electronic equivalent generated from the Electronic Health Record. This includes all NOABD notices and attachments. The following outlines all of the NOABD types and their purpose:
1. NOABD - Delivery System Notice: This notice shall be used when BHSD or a contracted provider has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services or substance use disorder services through BHSD. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, mental health services, substance use disorder services or other services.
 2. NOABD - Denial Notice: This notice shall be used when BHSD makes the decision to deny authorization of a requested service based on, but not limited to, determinations on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Template shall also be used for denied residential service requests.
 3. NOABD - Payment Denial Notice: This notice shall be used when BHSD denies, in whole or in part, for any reason payment authorization to the provider for a service already delivered to a beneficiary. Reasons for denials include, but are not limited to, denials based on documentation standards.
 4. NOABD - Modification Notice: This notice shall be used when BHSD modifies or limits the requested service, including reductions in frequency and/or duration of service, and approves alternate treatments or services.
 5. NOABD - Authorization Delay Notice: This notice shall be used when there is a delay in processing a provider's request for authorization of specialty mental health services or substance abuse disorder residential services. When BHSD extends the timeframe to make an authorization

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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 best interest.

6. NOABD - Termination Notice: This notice shall be used when BHSD or contracted provider terminates, reduces, or suspends a previously authorized service.
 7. NOABD - Timely Access Notice: This notice shall be used in the event that BHSD or the contracted provider does not provide services in a timely manner according to BHSD standards for timely services.
 8. NOABD - Financial Liability Notice: This notice shall be used when BHSD denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary liabilities.
 9. NOABD - Grievance/Appeal Resolution Notice: This notice shall be used in the event that BHSD does not meet required timeframes for the standard resolution of grievances, appeals, and expedited appeals.
- E. The Language Assistance Taglines attachment must be sent with all NOABD mailings regardless of the primary language specified on the Medi-Cal Eligibility Data System to ensure that limited-English-proficient individuals are aware of the translation services for which they are entitled.
 - F. The Beneficiary Non-Discrimination Notice shall be sent with all NOABD mailings. This notice informs beneficiaries of their right to services free of discrimination and to services and aids provided by BHSD for beneficiaries with disabilities to help them communicate better.
 - G. The NOABD Your Rights attachment must be included with all NOABD mailings. This attachment informs beneficiaries of their rights to file an appeal if they do not agree with the NOABD and request a State Fair Hearing after the appeal decision if they do not agree with the decision of the appeal.
 - H. Beneficiaries will be assisted in preparing for the adverse benefit determination, including, but not limited to, identifying alternate resources and/or support, such as self-help groups and free community services.
 - I. BHSD and contracted providers assessing beneficiaries who do not meet medical necessity; and providers denying, modifying, or terminating services; shall maintain a log. The log and copies of all NOABD notices must be forwarded to Behavioral Health Administration by the tenth (10th) of each month.

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- J. The QIC shall maintain a log and retain all notices pertaining to grievances and appeals that are resolved outside the required timeframes.
- K. All Mental Health Program Managers/Supervisors and contracted providers issuing NOABD timeliness notices shall maintain a log. The log and copies of all NOABD forms must be forwarded to Behavioral Health Administration by the tenth (10th) of each month.
- L. BHSD shall:
 - 1. Keep a file of all Notices.
 - 2. Analyze denials.
 - 3. Report significant findings regarding denials to the Utilization Review Committee.
 - 4. Report summary information to DHCS annually as required.

VI. ATTACHMENTS:

- DHCS *Language Assistance* attachment
- DHCS *Your Rights Under MediCal* attachment for NOABDs
- DHCS *Non-discrimination Notice* attachment

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 888-678-7277 (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 888-678-7277 (TTY: 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-678-7277 (TTY: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-678-7277 (TTY: 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-678-7277 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

888-678-7277 (TTY: 711) 번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-678-7277

(TTY: 711)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 888-678-7277 (TTY: 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-678-7277 (TTY: 711).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (888-678-7277 (TTY: 711 تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-678-7277 (TTY: 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 888-678-7277 (TTY: 711).

ਪੰਜਾਬੀ (Punjabi)

ਪਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-678-7277 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-678-7277 (رقم

هاتف الصم والبكم: 711

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [888-678-7277 (TTY: 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 888-678-7277 (TTY: 711).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ រសើនជាអ្នកនិយាយភាសាខ្មែរ, រសវាជំនួយមននកភាសា រាយមិនគិតច្បួន
គឺអាចមានសំរាប់អុើនក។ ចូរស្តាប់ 888-678-7277 (TTY: 711)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 888-678-7277 (TTY: 711).

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Contra Costa Behavioral Health Services by calling *telephone number*.

IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.

HOW TO FILE AN APPEAL

You have **60 days** from the date of this “Notice of Adverse Benefit Determination” letter to file an appeal. **If you are currently getting treatment and you want to keep getting treatment, you must ask for an appeal within 10 days** from the date on this letter OR before the date your Plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- **To appeal by phone:** Contact Contra Costa Behavioral Health Services, Quality Improvement Coordinator between 8AM and 5PM, Monday through Friday, excluding holiday’s by calling 925-957-5131. Or, if you have trouble hearing or speaking, please call 711.
- **To appeal in writing:** Fill out an appeal form or write a letter to your plan and send it to:

Contra Costa Behavioral Health Services
Attn: Quality Improvement Coordinator
1340 Arnold Drive, Suite, 200
Martinez, CA 94553

Your provider will have appeal forms available. Contra Costa Behavioral Health Services can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an “authorized representative.” You can send in any type of information you want your Plan to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Plan has 30 days to give you an answer. At that time, you will get a “Notice of Appeal Resolution” letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan’s decision within 30 days, you can ask for a “State Hearing” and a judge will review your case.** Please read the section below for instructions on how to ask for a State Hearing.

EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an **“expedited appeal.”**

STATE HEARING

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your Plan will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days**, you can ask for a “State Hearing” and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the “Notice of Appeal Resolution” letter. You can ask for a State Hearing by phone, electronically, or in writing:

- **By phone:** Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- **Electronically:** You may request a State Hearing online. Please visit the California Department of Social Services’ website to complete the electronic form: <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>
- **In writing:** Fill out a State Hearing form or send a letter to:

**California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430**

Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail

how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an “**expedited hearing**” and provide the letter with your request for a hearing.

Authorized Representative

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

LEGAL HELP

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.

NONDISCRIMINATION NOTICE

Discrimination is against the law. Contra Costa Behavioral Health Services (CCBHS) follows Federal civil rights laws. CCBHS does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CCBHS provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact CCBHS 24 hours a day, 7 days a week by calling 888-678-7277. Or, if you cannot hear or speak well, please call 711.

HOW TO FILE A GRIEVANCE

If you believe that CCBHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CCBHS. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CCBHS between 9AM and 5 PM Monday through Friday, excluding holidays by calling 925-957-5131. Or, if you cannot hear or speak well, please call 711.
- In writing: Fill out a grievance form, or write a letter and send it to:

Contra Costa Behavioral Health Administration
Attn: Quality Improvement Coordinator
1340 Arnold Drive
Martinez, CA 94553

- In person: Visit your provider's office or CCBHS administration and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.