Timely Access & Notice of Adverse Benefit Determination (NOABD)

Medi-Cal Clients' Rights & Benefits

Presented by San Mateo BHRS Quality Management

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

V3.23.2021

Timely Access & Notice of Adverse Benefit Determination (NOABD)

Federal law (CFR 42 §438) and California law (CCR 9 §1810)

Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System: BHRS POLICY: 19-01

https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf

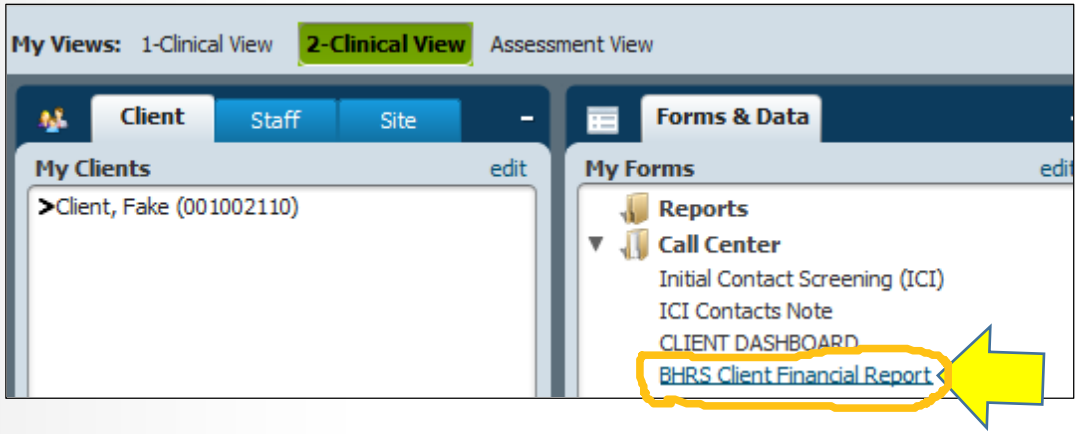
DEFINITIONS

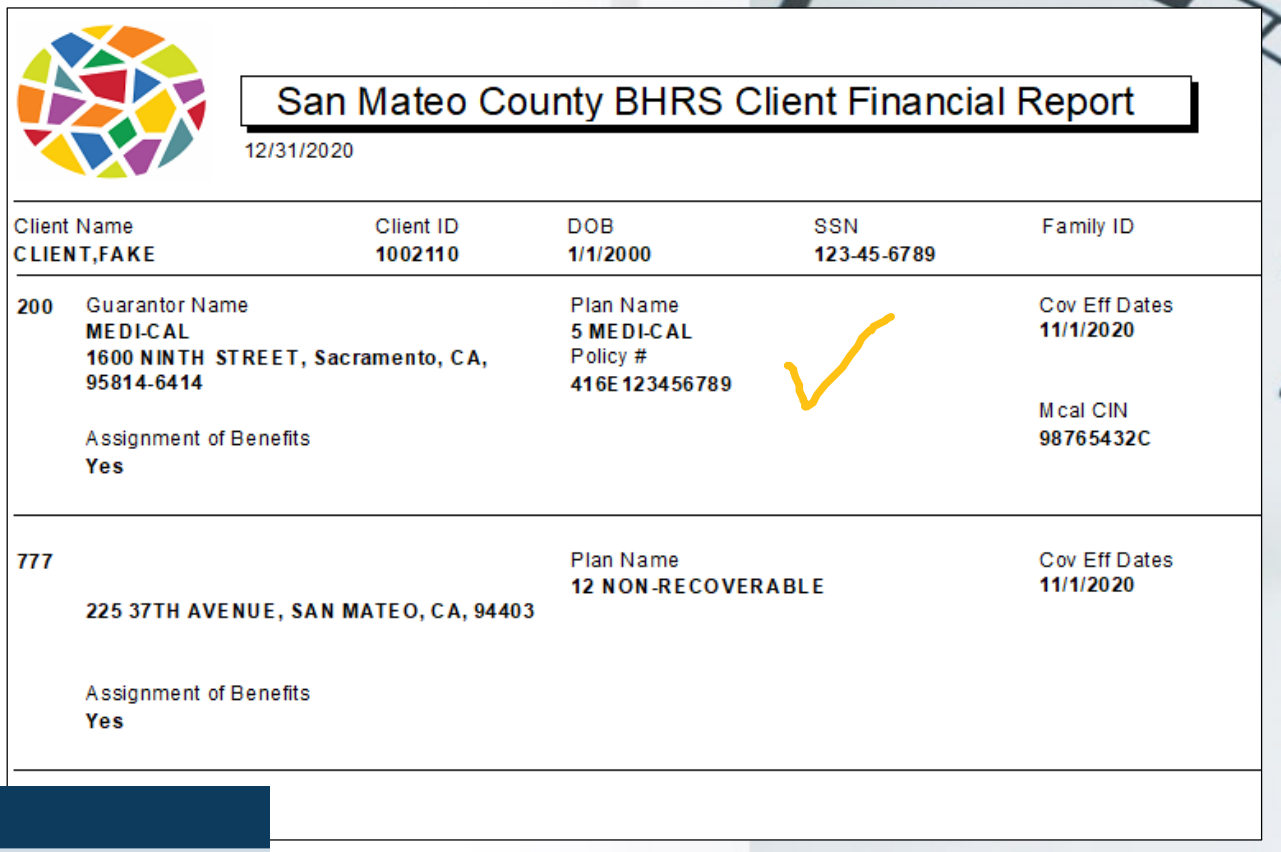
<u>Adverse Benefit Determination (ABD):</u> Any decision made by BHRS or its contractors that **denies, reduces, or terminates mental health services** to a beneficiary in-whole or in-part, including **denial of payment** and **failure to meet timeliness standards**, as outlined by the State.

<u>Beneficiary/Legal Representative:</u> An individual with **Medi-Cal coverage** or that individual's legal representative (parent of minor, conservator, court/lawyer/social worker of minor removed from home). A legal representative is someone authorized to consent for the individual's treatment.

<u>Expedited Request or Appeal</u>: An expedited request for services or appeal of **<u>Adverse Benefit Determination (ABD)</u>**: When **BHRS determines**, or provider indicates, that t**aking the time for a standard decision or resolution could seriously jeopardize** the beneficiary's **life, physical or mental health**, or ability to attain, maintain or regain optimal functioning.

Another Way to Check Insurance in Avatar





San Mateo County BHRS Client Financial Report

12/31/2020

Client Name	Client ID	DOB	SSN	Family ID
CLIENT,FAKE	1002110	1/1/2000	123-45-6789	

200 Guarantor Name
MEDI-CAL
1600 NINTH STREET, Sacramento, CA, 95814-6414

Plan Name
5 MEDI-CAL
Policy #
416E123456789

Cov Eff Dates
11/1/2020

Mcal CIN
98765432C

Assignment of Benefits
Yes

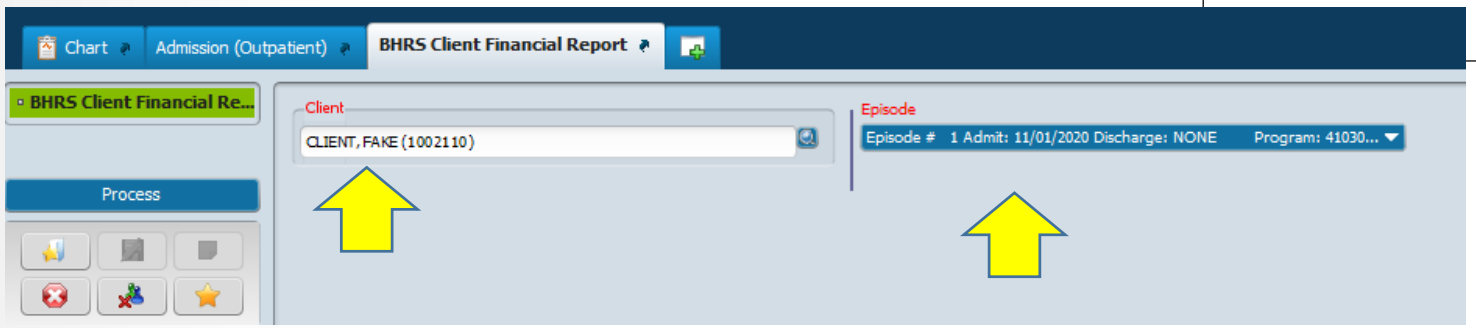
777

225 37TH AVENUE, SAN MATEO, CA, 94403

Plan Name
12 NON-RECOVERABLE

Cov Eff Dates
11/1/2020

Assignment of Benefits
Yes



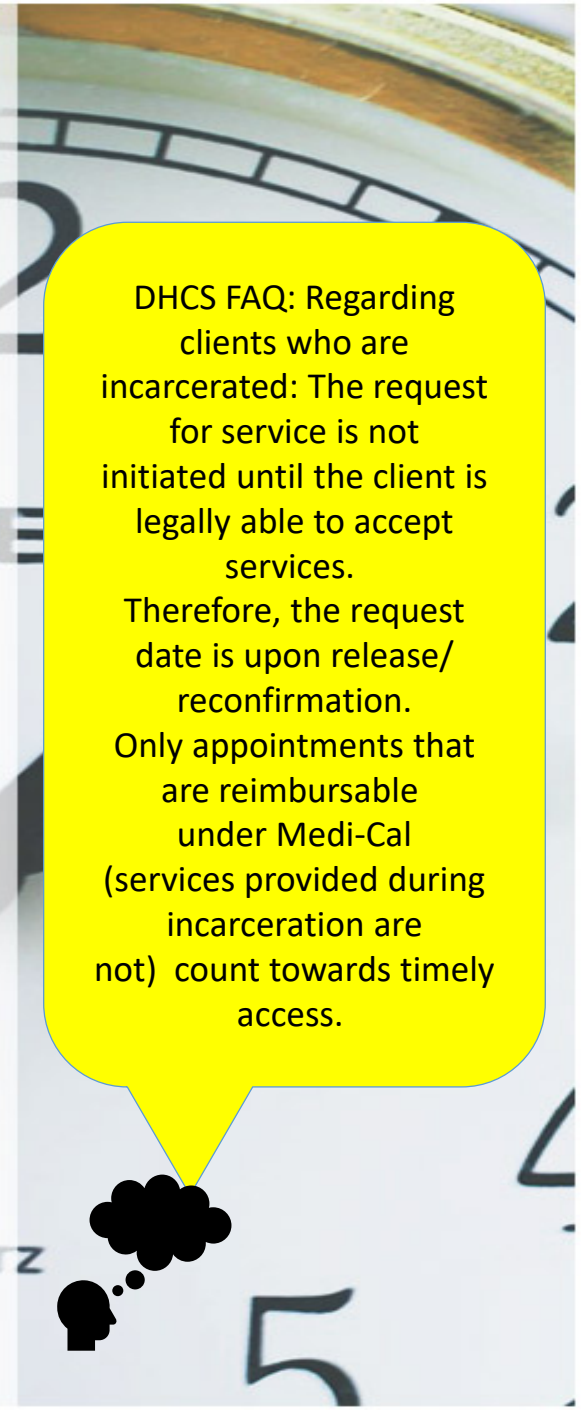
DEFINITIONS

Request for Services - when a **Medi-Cal beneficiary asks for covered service:**
This may be a new client or returning client. Most of the time this requirement is for a new client; occasionally it is for a client asking for a different level of care. A new client is someone currently not open to any BHRS Medi-Cal program (includes CBOs).

The timeline starts the moment the client or representative requests services (for which they are legally able to authorize and accept services).

A request for services is made in the following ways:

1. A beneficiary/legal representative calls Call Center or other 24/7 ACCESS line.
2. A beneficiary/legal representative calls or walks into a clinic or provider site to request services.
3. A written request for services for a beneficiary is submitted via email, fax, letter, referral form, or authorization request. The timeline starts when the written request is received.
4. A client requests additional services from a current provider.
5. A provider requests services for a beneficiary/legal representative *after their approval/agreement to make a referral.*



All Requests for Services Should be Considered in a Timely Fashion

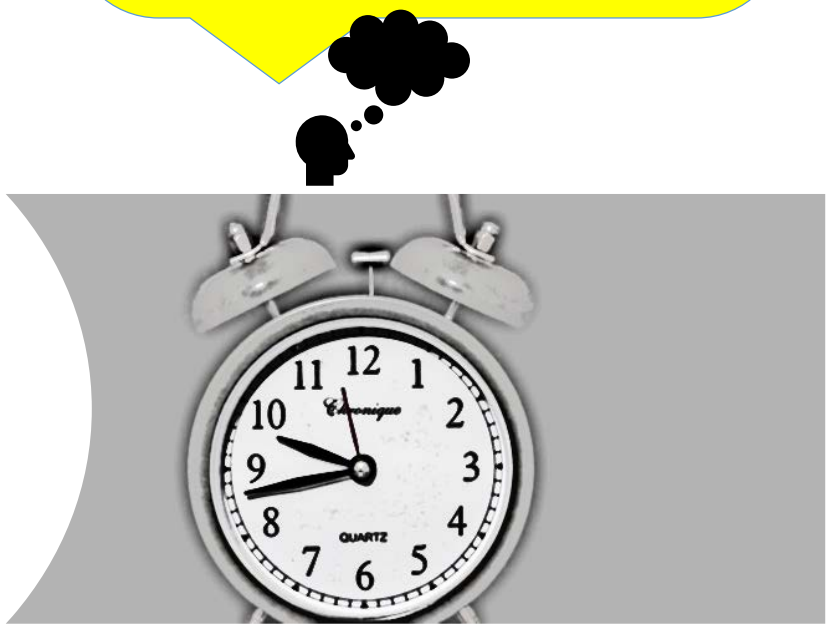
All requests for assessment and/or services must be considered, and a **decision must be made within 14 calendar days**. (**Expedited** decisions are made within **72 hours**). The decision may be to assess.

Services that require prior authorization must be reviewed and a decision must be made as expeditiously as the beneficiary's mental health condition requires. **This decision is not to exceed five (5) business days from the request and receipt of the information**—that is reasonably necessary and requested by BHRS—to make the determination.

We may extend this process by 14 days if the client requests an extension or if we are waiting for information to make a decision.

Prior authorization for MHP referral is required for the following services:

- Therapeutic Behavioral Services
- Therapeutic Foster Care
- Intensive Home-Based Services (IHBS)
- Adult Residential
- Crisis Residential



The Medical Record

There must be diligent, complete and timely documentation of **every request for services** and **all steps to consider requests.**

Always scan referral forms and emails with referrals into Avatar.

Poll Answer

Do only the clinical staff assigned to the client need to document the client's request for services?

No

No, all staff need to document requests for services in the client's medical record (call log) and/or efforts to contact the client (in progress notes).

Poll Answer

Do we **only** open medical records for beneficiaries/clients after they consent for treatment and are assigned clinical staff?

No

No, we open the medical record (not an ICI episode) as **soon as we get a request from a beneficiary/client, a person that can consent** for the client's care, or a provider if the provider indicates that the client is aware of and wants the referral. We don't wait for signed consent and/or assignment of staff. If you receive a request for services from another provider and **you are not sure if the client was aware of the request/referral, do not open a billing episode**. Instead, you should document attempts to contact the client (to confirm their interest in services) in the ICI episode.

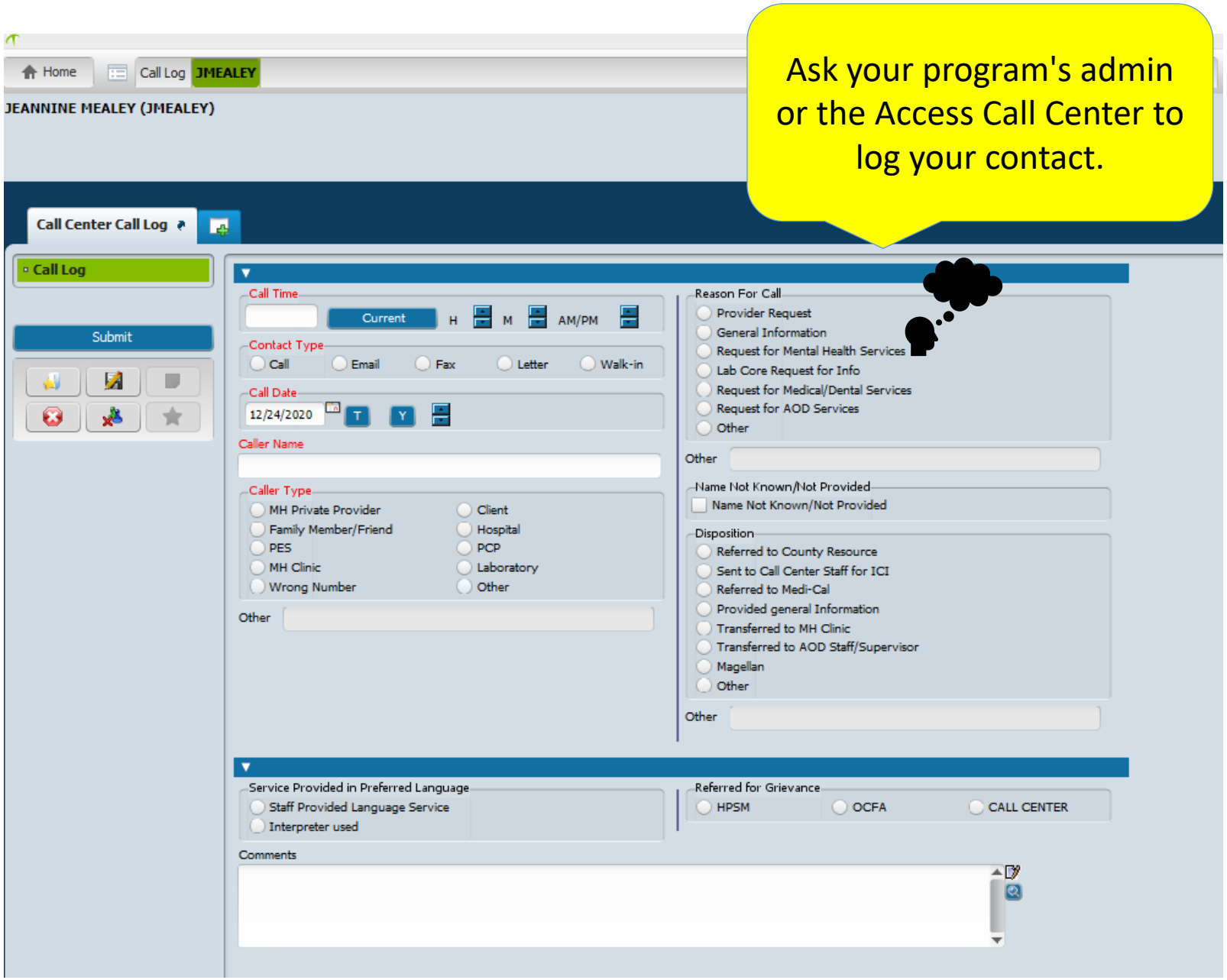
8 poll results from slide 1

Documenting Requests for Services

Requests for services are documented in the Call Center Call Log and in Progress Notes.

<u>Call Center Call Log</u>
This is how we log requests for services.

Note: some teams use the initial contact information form. *Ask your supervisor which form your team uses.* A new CSI form will be coming soon.



DOCUMENT OUR EFFORTS TO ASSESS AND PROVIDE CARE

- Reason for referral, who referred client, date of initial request for service
- Assessment appointment dates offered (3), and which offered appointments were accepted by the client
- Efforts to reach the client
- Whether or not the client meets Medical Necessity and will proceed to treatment
- Offered treatment date(s)
- Reason for closure of case or reason clinician could not follow up with client (e.g., “client is homeless and phone was disconnected”…etc.)

TIMELY ACCESS STANDARDS (DHCS)

We Must Conduct Timely ASSESSMENT & TREATMENT

Timely access standards for requested services:

- Non-urgent, non-psychiatry outpatient mental health/SUDS appointments - within 10 business days from request
- Non-urgent psychiatry appointments - within 15 business days from request
- Opioid treatment - within 3 business days from request

Expedited/Urgent Services:

- 48 hours for services not requiring preauthorization
- 96 hours for services that do require preauthorization

The assessment appointment counts as a first appointment. YES

If we offer AT LEAST 3 appointment(s) within the timeframe but the client does not accept the appointment(s), we are still in compliance. YES

If you complete the assessment, the client meets medical necessity, and you then put the client on a wait list, you need to issue a NOABD. YES

Treatment Decisions are Based on CLINICAL ASSESSMENT

01

ASSESSMENT OR ASSESSMENT REVIEW WITHIN THE FIRST 3 SESSIONS (WHEN POSSIBLE)

02

DETERMINE IF CLIENT MEETS MEDICAL NECESSITY (MN)

03

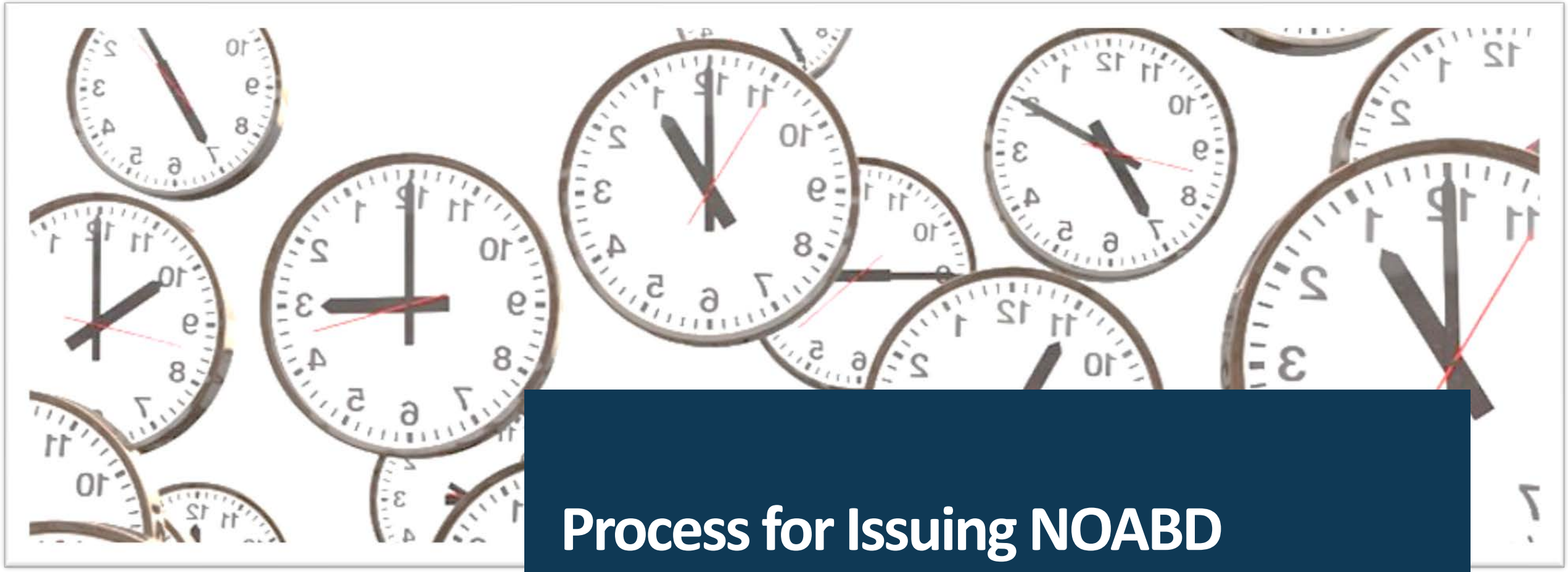
IF NO MEDICAL NECESSITY, ISSUE NOABD

04

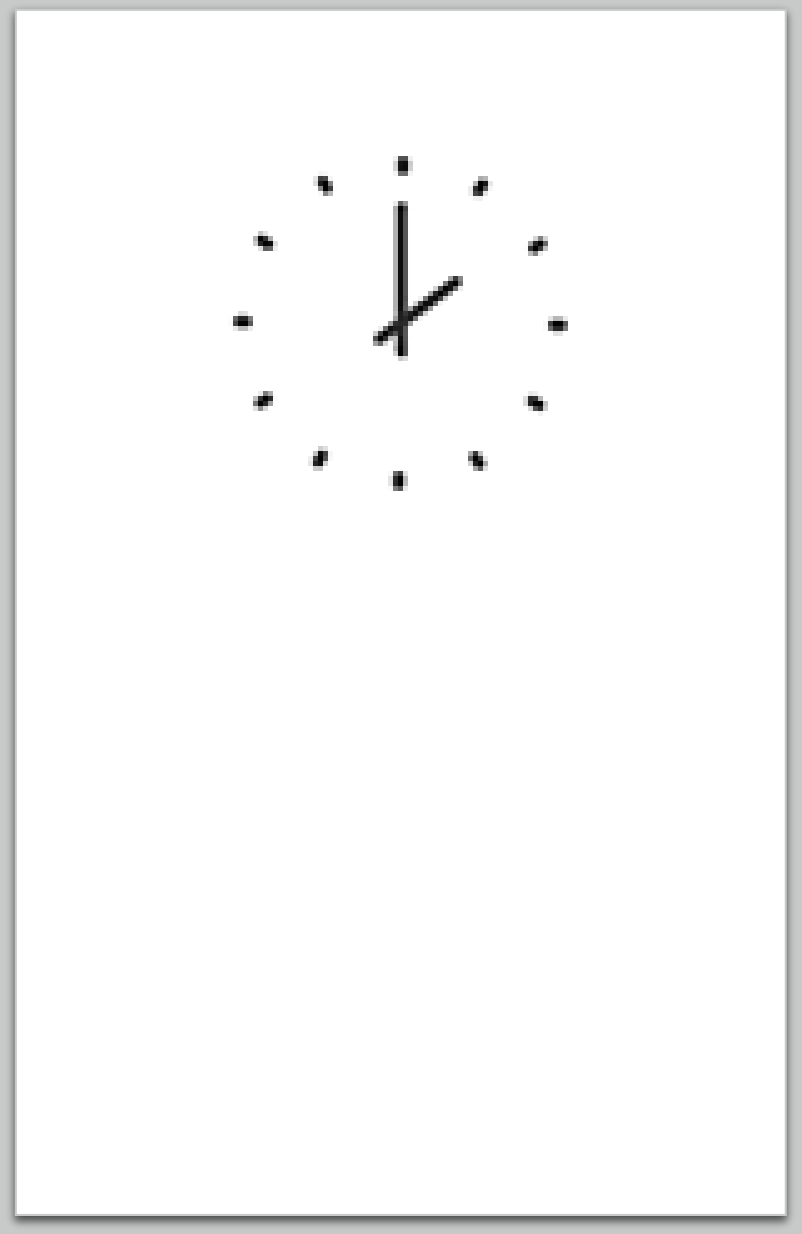
IF CLIENT MEETS MN, DEVELOP TREATMENT PLAN WITH THE CLIENT (APPROVE SERVICES)

05

THEN, YOU MAY PROVIDE PLANNED SERVICES WITHIN TIMELY ACCESS MANDATES



Process for Issuing NOABD



Purpose of the NOABD

Informing the Medi-Cal beneficiary and provider:

- What we did (or if we did it on time)
- Exactly why we did it
- What they can do about it
- What their rights are and how we protect their rights

When possible, decisions should be communicated first by telephone or in person, then in writing (except for decisions rendered retrospectively).

Reminder - ABD Definition

An Adverse Benefit Determination is defined to mean any of the following actions taken by BHRS (including CBOs):

1. The *denial* or limited authorization of a requested service
   (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 previously authorized service.
3. The *denial,* in whole or in part, of payment for a service.
4. The *failure* to provide timely services.
5. The *failure* to act within required timelines for resolution of grievances/appeals.
6. The *denial* of a beneficiary's request to dispute financial liability.

Timing of Notice

Timing of Notification

Client - 2 Business Days
Provider - 24 Hours

For a Change - at Least
10 Days Before Action

C. Timing of the Notice

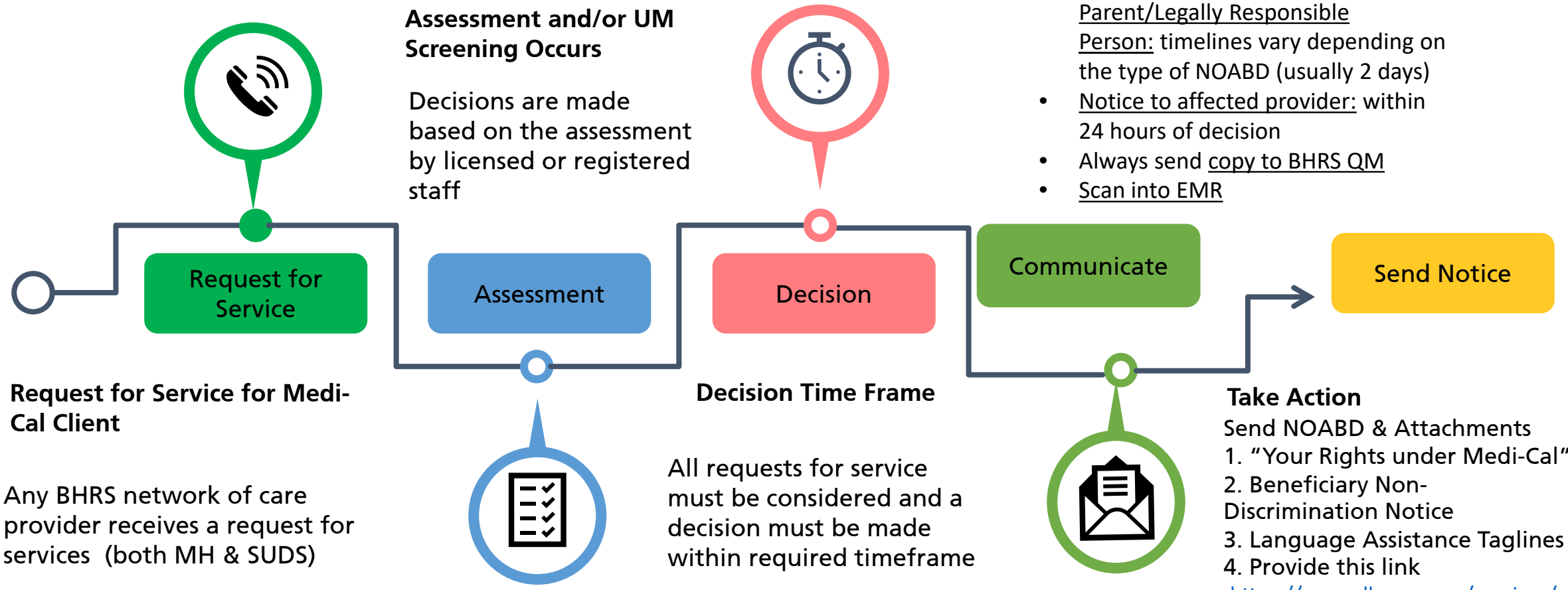
The Plan must mail the notice to the beneficiary within the following timeframes:[10]

1. 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 action,[11] 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; or,
3. 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.

The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

10 Title 42, CFR, Section 438.404(c) 11 Title 42, CFR, Section 431.211

Informing a Beneficiary about an Adverse Benefit Determination by BHRS (including CBOs)



Request for Service for Medi-Cal Client

Any BHRS network of care provider receives a request for services (both MH & SUDS)

Assessment and/or UM Screening Occurs

Decisions are made based on the assessment by licensed or registered staff

Decision Time Frame

All requests for service must be considered and a decision must be made within required timeframe

Communicate ABD

- Notice to Beneficiary, Parent/Legally Responsible Person: timelines vary depending on the type of NOABD (usually 2 days)
- Notice to affected provider: within 24 hours of decision
- Always send copy to BHRS QM
- Scan into EMR

Take Action

Send NOABD & Attachments
1. "Your Rights under Medi-Cal"
2. Beneficiary Non-Discrimination Notice
3. Language Assistance Taglines
4. Provide this link https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

Timelines for Mailing NOABDs to Beneficiary

For decisions that result in:	Mail to Beneficiary/legally responsible person:
Termination, suspension, or reduction of previously authorized SMHS/DMC-ODS service	At least 10 days before the date of action
Denial, delay, or modification of all or part of the requested SMHS/DMC-ODS service	Within 2 business days of decision
Denial of payment	At the time of any action denying the provider's claim

FAQ

Request for Service FAQ:

A Medi-Cal beneficiary calls a BHRS clinic and requests primary care services for a health issue. We refer the client to primary care and inform her that we do not provide primary care services for physical health.

Do we issue a Denial NOABD?
What do you think? Yes or No

Answer: No
Explanation:
We **do not need to issue a NOABD** for request for **non-covered** mental health or SUD services.

Just help the beneficiary connect with the needed services. Ask your admin to log this request in the Call Center Call Log.

Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

NOABD	Responsible Staff	Criteria for Beneficiary Notice
Denial 	-Access Call Center -UM Teams (Adult/Youth) -Clinician/Supervisor at Program -CBO Conducting Assessment -DMC-ODS Authorizer	• Beneficiary requests covered MH or SUDS service: BHRS denies/does not approve services after completing assessment • Denial-Based: Assessment determines no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective for diagnosis

Scenario

Request for Service Scenario:

A beneficiary is assessed for specialty mental health services and does not meet criteria for medical necessity due to the diagnosis of Relational Problems, and it is decided that they will not receive specialty mental health services.

Do we issue a Denial NOABD?
What do you think? Yes or No

Answer: YES
Explanation:
We **DO issue a NOABD Denial** due to the beneficiary not meeting medical necessity.

Provide the beneficiary three community referrals if possible.

Scenario

Request for Service Scenario:

The clinical team assessed the beneficiary for medical necessity. The beneficiary meets the medical necessity requirement.

The team offers to provide outpatient specialty mental health services including rehab groups, case management, and medication support, but the client requested therapy. We do not offer therapy.

Do we issue a Denial NOABD?
What do you think? Yes or No

Answer: NO.
Explanation: We **do not need to issue a NOABD.** However, the beneficiary should participate in the development of the client plan. We should ensure that services, to the extent possible, are client-directed. A client who believes that additional services are necessary has the right to challenge our decision through the beneficiary appeal and State Fair Hearing processes.

Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

NOABD	Responsible Staff	Criteria for Beneficiary Notice
Denial	Access Call Center UM Teams (Adult/Youth) Clinician/Supervisor at Program CBO Conducting Assessment DMC-ODS Authorizer	• Beneficiary requests covered MH or SUDS service: BHRS denies/does not approve services after completing assessment • Denial Based: Assessment determines no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective for diagnosis
Delivery System 	Access Call Center SDA Clinician/Supervisor SDA CBO	**Beneficiary does not meet criteria for specialty mental health services or SUDS** but <u>does</u> meet criteria for other mental health/SUDS systems of care: • Mild to Moderate - referred to Health Plan of San Mateo (HPSM) • SED - referred to school district for mental health.

Scenario

Delivery System Scenario:

The client is screened at Same Day Assistance and it is determined that the beneficiary does not meet criteria to be eligible for specialty mental health services or substance use disorder (SUD) services through BHRS.

The client appears to have a more mild condition and we referred the beneficiary to HPSM for Mild to Moderate Services.

Do we issue a Delivery System NOABD?

What do you think? Yes or No

Answer: YES

Explanation:

We **DO** issue a NOABD for Delivery System and connect the client with HPSM.

Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

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Denial	Access Call Center UM Teams (Adult/Youth) Clinician/Supervisor at Program CBO Conducting Assessment DMC-ODS Authorizer	• Beneficiary requests covered MH or SUDS service: BHRS denies/does not approve services after completing assessment • Denial-Based: Assessment determines no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective for diagnosis.
Delivery System	Access Call Center SDA Clinician/Supervisor SDA CBO	**Beneficiary does not meet the criteria for specialty mental health services or SUDS** but does meet criteria for other mental health/SUDS systems of care: • Mild to Moderate - referred to Health Plan of San Mateo (HPSM) • SED - referred to school district for mental health
Modification	Access Call Center UM Team/Coordinator (Adult/Youth) CBO Conducting Assessment	Beneficiary is already authorized for mental health treatment by BHRS Call Center or UM Teams (Adult/Youth) • Reduced frequency and/or duration of authorized services

Treatment Plans Approve Services

Planned services are approved by adding them to the client's treatment plan.

APPROVED SERVICES

VS.

AUTHORIZED SERVICES

Authorizations Authorize Services

Services requiring Authorizations require NOABDs if terminated, modified, or reduced during the authorized time block (once authorized).

Approved Services **NOT** Subject to NOABD

If the service type does **not require an authorization,** a **NOABD is not required** when 1) client has **approved Planned Services** on the current treatment plan and 2) the Provider/Clinician decides to make changes because:

Changes are to the benefit of the client based on the client's clinical condition and/or progress in treatment.

Example of changes NOT subject to NOABD:

The client will continue to receive services approved on the treatment plan with modifications (some changes will be made).

This applies to services like rehab, therapy, and groups:

- reduced in frequency (e.g., changed to monthly instead of weekly)
- modified service type (e.g., group is changed to rehab instead of therapy)
- or service is stopped/terminated (group or therapy is stopped)

If the client is unhappy, they may file a grievance or appeal the decision.

Authorized Services **ARE** Subject to NOABD

If an authorization is required for services and the authorization is granted:

Any reduction, suspension, or termination of a previously authorized service, while in the authorization timeframe, requires a NOABD.

Scenario

Modification Scenario:

The client is approved for rehab group on the treatment plan.

However, the client disrupts the group weekly and upsets the other clients.

The group leader informs the client that she will no longer be able to participate in the group.

The client's other services are continued as normal and approved.

Do we issue Modification NOABD?
What do you think? Yes or No

Answer: NO
Explanation:
We do NOT need to issue a NOABD for modifying services (approved on the treatment plan) that are in the best interests of the client.
However, this is a clinical issue that should be addressed to help the client develop the skills to possibly rejoin the group at a later date.
Document this in a progress note.

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Delivery System	Access Call Center SDA Clinician/Supervisor SDA CBO	**Beneficiary does not meet the criteria for specialty mental health services or SUDS** but does meet criteria for other mental health/SUDS systems of care: • Mild to Moderate - referred to Health Plan of San Mateo (HPSM) • SED - referred to school district for mental health
Modification	Access Call Center UM Team/Coordinator (Adult/Youth) CBO Conducting Assessment	Beneficiary is already authorized for mental health treatment by BHRS call center or UM Teams (Adult/Youth) • Reduced frequency and/or duration of authorized services
Termination	Access Call Center UM Teams (Adult/Youth) DMC-ODS Authorizer	BHRS terminates or suspends a currently authorized service (or ends treatment that a client still wants)

Scenario

Termination Scenario 1:

The client successfully completes services as planned, in that either the treatment plan or authorization period ends as planned.

Do we issue a Termination NOABD?
What do you think? Yes or No

Answer: NO
Explanation:
If the client successfully completes treatment and is not wanting additional services, we **do not need to issue a NOABD**.

Document your client's care and discharge in a progress note.

Scenario

Termination Scenario 2:

The client is lost to follow-up; you try but can't get the client to respond to your outreach efforts. This is unplanned but the client seems to have withdrawn or given up on treatment.

The treatment plan and/or authorization is now expired.

Do we issue a Termination NOABD?
What do you think? Yes or No

Answer: NO
Explanation:
If you do not discharge the client prior to the treatment plan and/or authorization ending, you **do not need to issue a NOABD** but you should document outreach calls and send call/close letter.

If you discharge the client prior to the end date of the treatment plan and/or authorization, **issue a NOABD Termination**.

Scenario

Termination Scenario 3:

The client meets medical necessity, is participating in services, and wants services.

The client does not follow the clinic/program's rules and the clinic terminates all services and discharges the client due to the client's behavior.

The client still wants services.

Do we issue a Termination NOABD?
What do you think? Yes or No

Answer: YES
Explanation:
If you discharge a client that meets medical necessity and still wants services, **issue a NOABD Termination**. Make sure that you make all efforts to help the client be successful.
If you move the client's treatment location or transfer the client to another clinic and the client does not want that, **issue either a NOABD Termination or Modification**.

Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

NOABD	Responsible Staff	Criteria for B
Denial	Access Call Center UM Teams (Adult/Youth) Clinician/Supervisor at Program CBO Conducting Assessment DMC-ODS Authorizer	• Beneficiary request covered MH or SUDS service: BHR • Denial-Based: Assessment determining no medical ne appropriate, or service not effective for diagnosis.
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If we are adding another program at the same level of care, and continuing the old program until the transition or addition, and it takes longer than the required timeframe, we don't need to issue a NOABD.

Example: the client is open to South Adult; we add Total Wellness.

Scenario

Timely Access Scenario:

A beneficiary is referred to a mental health clinic. The beneficiary **has Medi-Cal, wants services, and has been diagnosed in the recent past with a covered diagnosis**. The clinical staff are currently maxed out on case assignments and a few staff are on leave.

The program supervisor opens the beneficiary in their ICI episode (clinic's informal waitlist) to stop the documentation timeline.

Do we issue a Timely Access NOABD?

What do you think? Yes or No

Answer: YES

Explanation:

We **do need to issue a NOABD Timely Access** if we are unable to offer assessment or treatment within the required timeframes.

Also, just opening an ICI episode or waiting to open the chart does not stop the documentation timelines.

Scenario

Timely Access Scenario:

A beneficiary is referred to a mental health clinic SDA by a primary care provider.

It is unknown if the individual wants mental health treatment, but the PCP thinks that it is a good idea.

The clinic team tries to contact the beneficiary many times with no luck.

Do we issue a Timely Access NOABD?

What do you think? Yes or No

Answer: NO

Explanation:

We **do NOT need to issue a NOABD Timely Access** because we don't really know if we have a beneficiary who wants services.

All efforts should be made to contact the individual. Document this in a progress note and in the Call Center Call Log.

Scenario

Timely Access Scenario:

A beneficiary requests medication support services. The program staff offer a first appointment to the beneficiary 30 business days from receiving the referral.

Do we issue a Timely Access NOABD?

What do you think? Yes or No

Answer: YES

Explanation:

We **do need to issue a NOABD Timely Access** because we did not meet the required timeframe for that level of care.

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Authorization Delay	Access Call Center UM Team/Coordinator (Adult/Youth) Clinician/supervisor at Program CBO Agency	If Authorization decision is not made on time: • Updates on this to come. Contact Ask QM if you have any questions about issuing this NOABD.

Scenario

Request for Authorization Delay:

UM staff receives an authorization request from an organizational provider but is unable to provide an authorization decision within 14 days.

Do we issue an Authorization Delay **NOABD?**

What do you think? Yes or No

Answer: YES

Explanation:

We **do need to issue a NOABD** if we are unable to meet the authorization timeframes.

What Happens if the Client is not Happy?

The client/beneficiary can talk with Supervisor or Manager

The client/beneficiary can appeal Adverse Benefit Determination (ABD)

The client/beneficiary can file a grievance or get help

The client/beneficiary can contact Office of Consumer and Family Affairs (OCFA) 1-800-388-5189

The client/beneficiary can file a State Fair Hearing

Related Resources

Included Diagnosis SMN

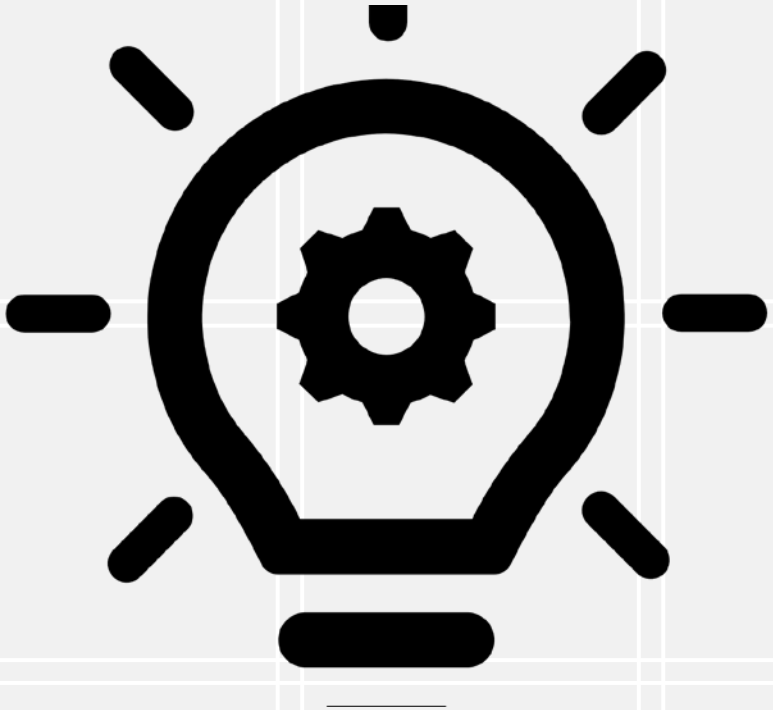
https://www.smchealth.org/sites/main/files/file-attachments/billabledx-enclosures_2_in_18-053_icd-10.pdf?1597249807

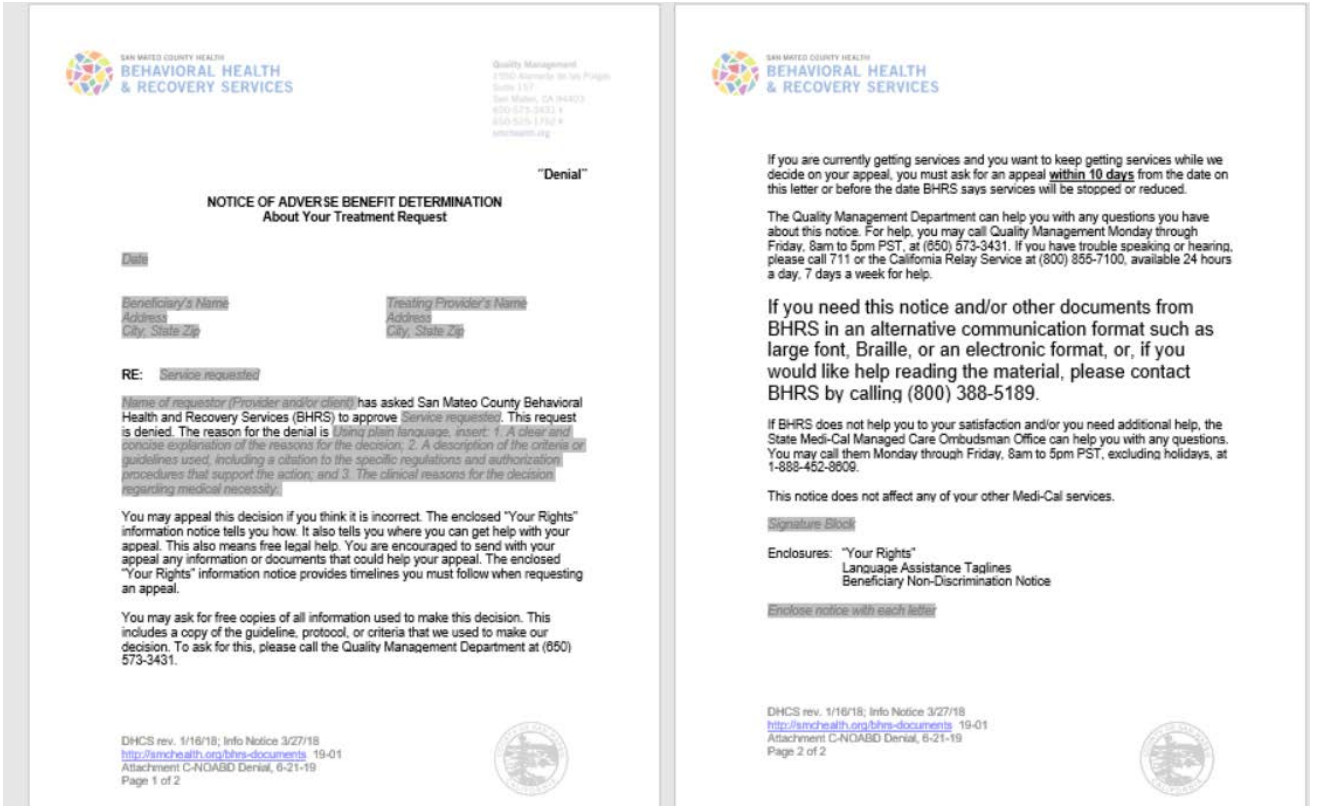
Medical Necessity Policy SMN

https://www.smchealth.org/bhrs-policies/medical-necessity-criteria-specialty-mental-health-services-19-05

SUDS Policies

https://www.smchealth.org/bhrs/aod/policy





SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

"Denial"

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Name of requestor (Provider and/or client) has asked San Mateo County Behavioral Health and Recovery Services (BHRS) to approve *Service requested*. This request is denied. The reason for the denial is *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 authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.*

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the Quality Management Department at (650) 573-3431.

DHCS rev. 1/16/18; Info Notice 3/27/18
http://smchealth.org/bhrs-documents 19-01
Attachment C-NOABD Denial, 6-21-19
Page 1 of 2

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal **within 10 days** from the date on this letter or before the date BHRS says services will be stopped or reduced.

The Quality Management Department can help you with any questions you have about this notice. For help, you may call Quality Management Monday through Friday, 8am to 5pm PST, at (650) 573-3431. If you have trouble speaking or hearing, please call 711 or the California Relay Service at (800) 855-7100, available 24 hours a day, 7 days a week for help.

If you need this notice and/or other documents from BHRS 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 BHRS by calling (800) 388-5189.

If BHRS does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

Signature Block

Enclosures: "Your Rights"
Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

DHCS rev. 1/16/18; Info Notice 3/27/18
http://smchealth.org/bhrs-documents 19-01
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Page 2 of 2

Fillable forms are located at https://www.smchealth.org/bhrs-policies/consumer-problem-resolution-noa-19-01

SAN MATEO COUNTY HEALTH
All together better.

COVID-19 HEALTH CARE SERVICES LIVE HEALTHY FOI

CONSUMER PROBLEM RESOLUTION & NOA: 19-01

Client Rights

Consumer Problem Resolution & NOA: 19-01 Policy 19-01

SUPERSEDES: 04-10 Notice of Action, 03-03 Consumer Problem Resolution System

New Policy June 2019, Technical edits and Translated attachments added, October 10, 2019;
Technical Revision January 9, 2020
Attachment A: Amended January 9, 2020

ATTACHMENTS:

A. Consumer Problem Resolution (Grievance) and Notice of Adverse Benefits Determination (NOABD) User Manual Manual

B. Grievance and Appeals System Usage Matrix How To Guide

C. NOABD Denial Notice English Spanish Tagalog Cantonese Mandarin

D. NOABD Modification Notice English Spanish Tagalog Cantonese Mandarin

E. NOABD Termination Notice English Spanish Tagalog Cantonese Mandarin

F. NOABD Delivery System Notice English Spanish Tagalog Cantonese Mandarin

G. NOABD Authorization Delay English Spanish Tagalog Cantonese Mandarin

H. NOABD Timely Access Notice English Spanish Tagalog Cantonese Mandarin

I. NOABD Financial Liability Notice English Spanish Tagalog Cantonese Mandarin

J. NOABD Payment Denial Notice English Spanish Tagalog Cantonese Mandarin

K. NOABD Grievance and Appeal Timely Resolution Notice English Spanish Tagalog Cantonese | Mandarin

L. NAR (Notice of Appeals Resolution) NOABD Overturned Notice OCFA: English Spanish Tagalog Cantonese Mandarin QM: English Spanish Tagalog Mandarin Cantonese

M. NAR (Notice of Appeals Resolution) NOABD Upheld OCFA English Spanish Tagalog Cantonese Mandarin QM English Spanish Tagalog Cantonese Mandarin

N. Notice of Grievance Resolution OCFA English Spanish Tagalog Cantonese Mandarin QM English Spanish Tagalog Cantonese Mandarin

O. NOABD Your Rights English Spanish Tagalog Cantonese Mandarin

P. NAR (Notice of Appeals Resolution) Your Rights English Spanish Tagalog Cantonese Mandarin

Q. Language Assistance Taglines

R. Beneficiary Non-Discrimination Notice English Spanish Tagalog Cantonese Mandarin

S. Grievance and Appeals Resolution Poster English Spanish Chinese Tagalog Russian

T. Grievance and Appeals Resolution Brochure English Spanish Chinese Tagalog

Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

NOABD	Responsible Staff	Criteria for Beneficiary Notice
Financial Liability Notice	MIS	BHRS MIS/Billing denies a client's request to dispute financial liability for services provided.
Payment Denial Notice	MIS/UM	When BHRS Billing Dept. Denies—in whole or in part for any reason—a request for payment for services already delivered to the beneficiary because: • Condition as described by provider did not meet medical necessity criteria for DMC-ODS, psychiatric inpatient hospital services, or specialty MH services. • Services provided are not covered by BHRS. • BHRS MIS/QM requested but has not received additional information from the provider needed to approve payment. • Provider did not meet documentation standards.
Grievance/Appeal Delay	OCFA	The Plan does not meet required timeframes for the standard resolution of grievances and appeals.

Payment Decisions are Based on POLICY

01

02

DETERMINE IF PAYMENT IS REQUIRED

03

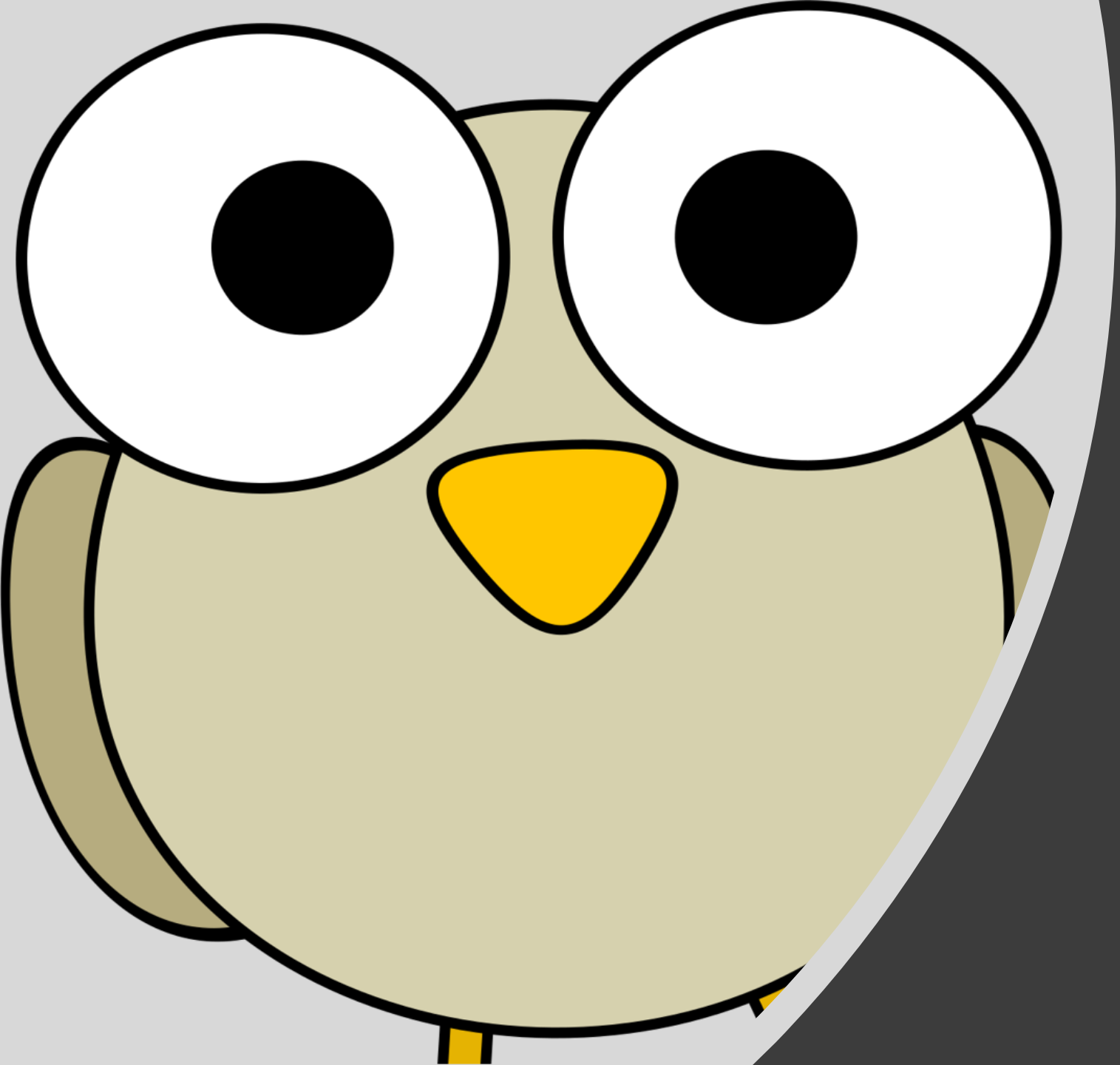
IF NO MEDICAL NECESSITY**, ISSUE NOABD TO CLIENT** WITHIN REQUIRED TIMELINE AND TO **PROVIDER WITHIN 24 HOURS**

04

SEND COPY OF NOABD **TO QM**

Alert: COMING SOON to Avatar

A new form is being built in Avatar for creating NOA and grievance letters



If you want to consult about YOUR program's requirements, let us know.

Thank you!

EMAIL YOUR QUESTION OR REQUEST FOR CONSULTATION TO HS_BHRS_ASK_QM@SMCGOV.ORG