Guide to Using the AVATAR NOABD / NAR Form

Notice of Adverse Benefit Determination Notices (NOABDs) are issued to Medi-Cal beneficiaries when the person has Medi-Cal and one of these take place:

- You **deny services** (decision to not start treatment at any BHRS program or CBO) or limit authorization, based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit (issue notice within 2 business days of the decision).
- You **reduce, suspend, or stop** a **previously authorized service** (issue notice a minimum of 10 days before action).
- You **discharge a client that wants service** with an active treatment plan (issue notice a minimum of 10 days before action).
- You **do not or cannot offer to provide** the **first assessment** or **first treatment service** in a timely manner (issue notice within 2 business days of the decision).
- You **do not pay**, in whole or in part, **for a service** that the **client has already received** (issue notice within 24 hours.)
- You **deny** the beneficiary's **request to dispute financial liability** (issue notice within 24 hours).
- You are **late providing** a standard **resolution of a grievance or appeal** (issue notice within 2 business days of the decision).

RESOURCES

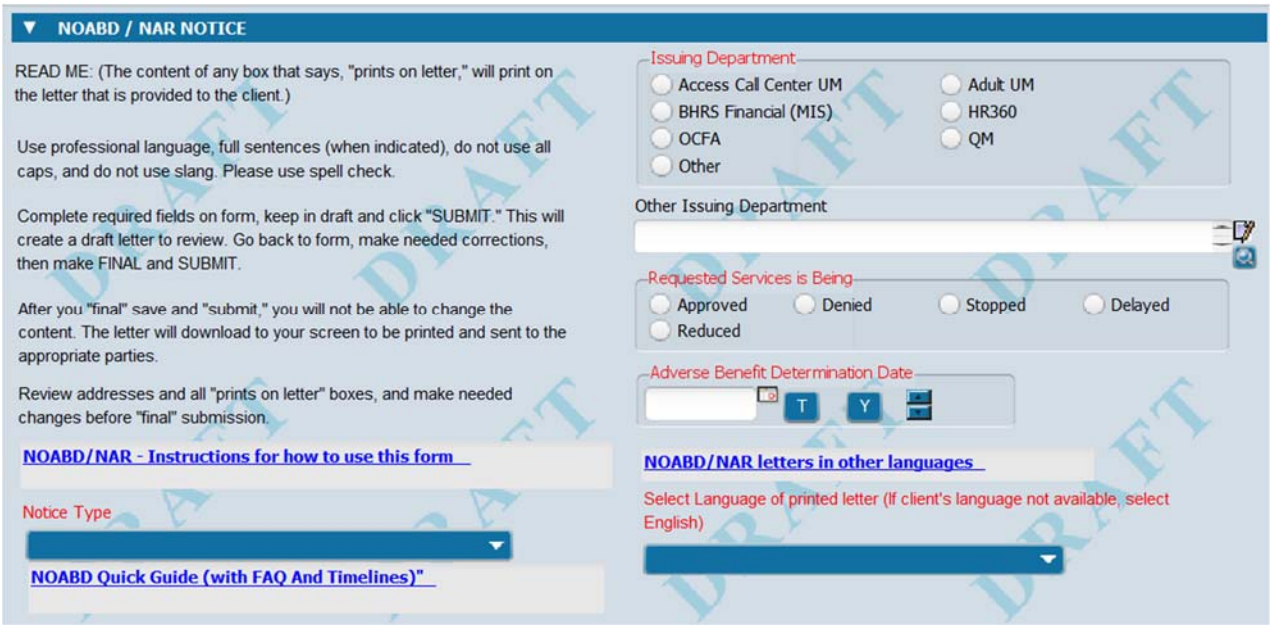
Quick Guide to figure out when and what type of NOABD to complete
How to determine what type NOABD
Guide to completing the Avatar NOABD / NAR Form
https://www.smchealth.org/sites/main/files/file-attachments/noabdavatarform.pdf
Templates to help you complete the reason for issuing the NOABD /NAR
https://www.smchealth.org/sites/main/files/file-attachments/noabdreasons.pdf
Policy and Word Versions of NOABD / NAR in threshold languages
https://www.smchealth.org/bhrs-policies/consumer-problem-resolution-noa-19-01

NOABD / NAR NOTICE FORM IN AVATAR

To find the form in Avatar

For all NOTICE TYPES complete all fields in the NOABD / NAR NOTICE section

NOTICE TYPE



ISSUING DEPARTMENT

Authorization Delay NOABD	When there is a DELAY in processing a provider's request for specialty mental health services or substance use disorder residential services that REQUIRES AN AUTHORIZATION.
Delivery System NOABD	Mild to Moderate referred Health Plan of San Mateo (HPSM). SED referred to School District for mental health
Denial NOABD	Use when NO SERVICES WILL BE PROVIDED due to assessment determining no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective for diagnosis.
Financial Liability NOABD	A client disputes financial liability, including cost sharing and/or beneficiary's other financial liabilities.
Modification NOABD	Beneficiary is **already authorized** for a service; then, frequency and/or duration of authorized services is REDUCED.
Timely Access NOABD	Timely access standards not met: FIRST ASSESSMENT or FIRST TREATMENT APPOINTMENT NOT OFFERED within required timeframe, or client placed on WAITLIST.
Payment Denial NOABD	When BHRS DENIES—in whole or in part for any reason—a request for payment for services already delivered.
Termination NOABD	BHRS terminates or suspends a currently authorized service (or ends treatment that a client still wants).
Overturned Appeal Resolution (NAR)	Use this when a client appeals a Notice of Adverse Benefit Determination and **BHRS overturns the original decision, in the client's favor.**
Upheld Appeal Resolution (NAR)	Use this when a client appeals a Notice of Adverse Benefit Determination and **BHRS upholds the original decision, NOT in the client's favor.**
Grievance-Appeal Timely Resolution	BHRS does not meet required timeframes for the standard resolution of grievances and appeals.

Choose your department or enter your agency/department in the other box.

REQUESTED SERVICE IS BEING – your notice is for a service/request that is:

Approved	Usually used when you overturn an appeal.
Denied	When you deny a request for payment, services, or refer to another delivery system.
Stopped	You terminate services.
Delayed	You are late in providing services, making an authorization , grievance, or appeal decision.
Reduced	You modify an already authorized service to reduce the frequency or duration.

ADVERSE BENEFIT DETERMINATION DATE

This is the date that you are filling out the NOABD/NAR form.

SELECTED LANGUAGE OF PRINTED LETTER

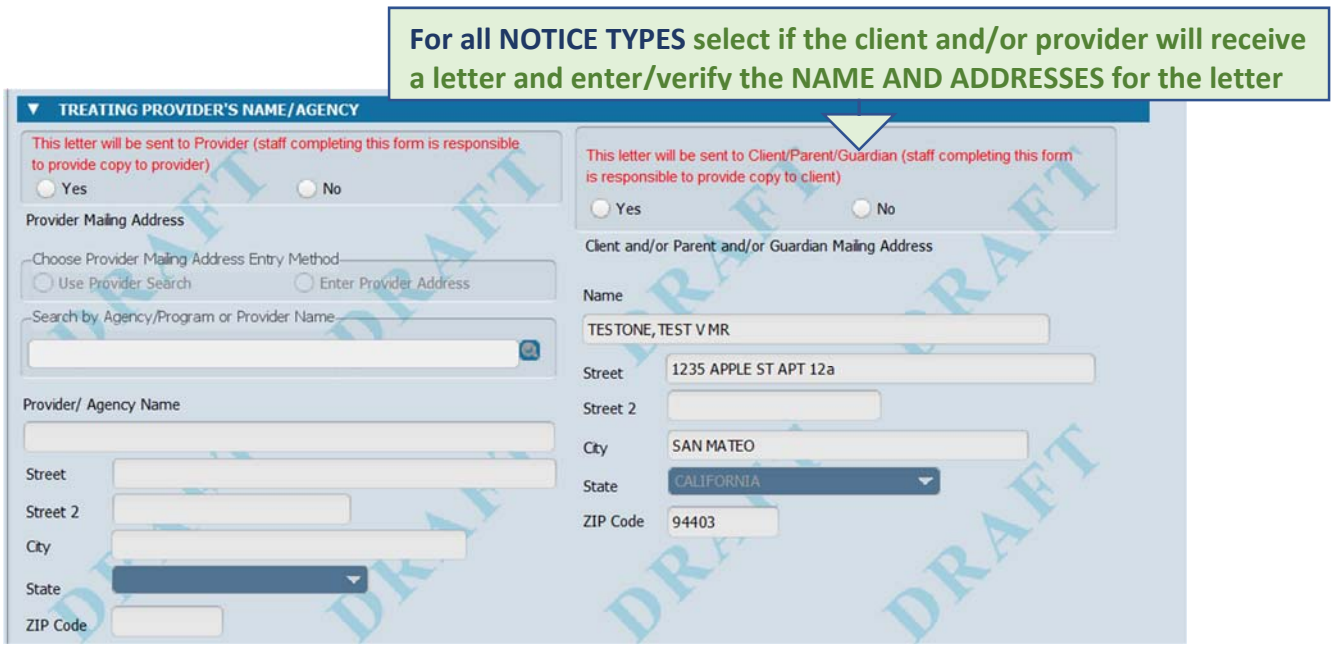
This determines if the client's letter will be printed in English or Spanish.

- The provider letter always prints in **English**
- If you select **Spanish**, the client's letter will print in Spanish

If the client's language is not English or Spanish, select English. You may still use this form and attach the word version in the client's language:
https://www.smchealth.org/bhrs-policies/consumer-problem-resolution-noa-19-01

- **These languages are only available in the word versions:**
  Tagalog Cantonese Mandarin

TREATING PROVIDER AND CLIENT INFORMATION

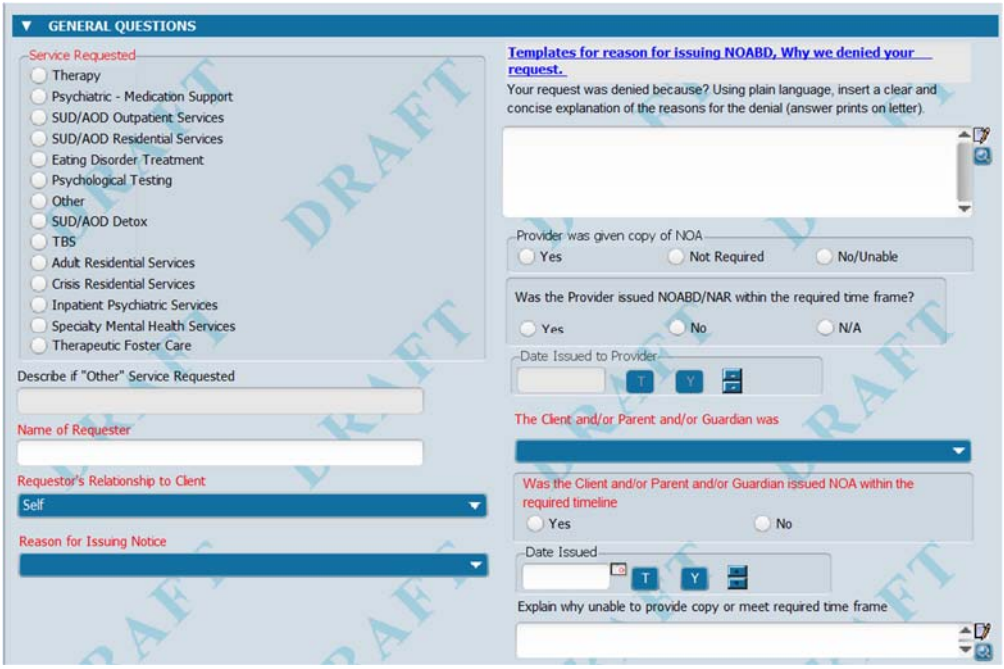


Indicate if THIS LETTER WILL BE SENT TO PROVIDER and/or CLIENT/PARENT/GUARDIAN

Answer Yes or No

- <u>You may search for a provider's address</u> by selecting **USE PROVIDER SEARCH,** then type in an agency name or provider name to search and select the address
- Many addresses in the system are not current or correct; please verify address
- <u>You may type in the address</u> by selecting **ENTER PROVIDER ADDRESS** and entering the information
- The client's name and address on file will appear on the form and **<u>THIS WILL PRINT ON THE LETTER</u>**
- **YOU MAY CHANGE THE CLIENT'S NAME AND/OR ADDRESS**

GENERAL QUESTIONS



For all NOTICE TYPES answer questions to indicate the requested service, name of requestor, why we are issuing a notice and determine if our notice was within the required timelines.

Service Requested (this prints on letter)
Select the service requested that is related to the issue of this notice.

Name of Requester
Enter name.

Requestor's Relationship to Client
Select from drop down. ("Self" automatically populates.)

Reason for Issuing Notice:

- Authorization Delay Notice
- Delivery System Notice - Referral Notice
- Financial Liability Denial Notice
- Late Grievance and Appeal Resolution
- Modification of Service Notice
- Notice of Appeals Resolution
- Payment Denial Notice
- Service Denial
- Termination of Service Notice
- Timely Access Notice

The Client and/or Parent and/or Guardian was:

- given a copy in person
- sent a copy by mail
- offered a copy but refused to accept
- not given a copy

Was the Client and/or Parent and/or Guardian issued a NOA within the required timeline?
Yes or No
Date issued (in date field).

Explain why unable to provide copy or meet required time frame.
Please indicate any issues that caused you to be late in issuing the notice or not being able to issue the notice. Also, indicate here if a copy of NOABD or ABD was sent in language other than English or Spanish. You can still use this form for the provider and attach the word version in the client's language.

Provider was given copy of NOA:
Yes or Not Required; or No, Unable
Date issued to provider (date).

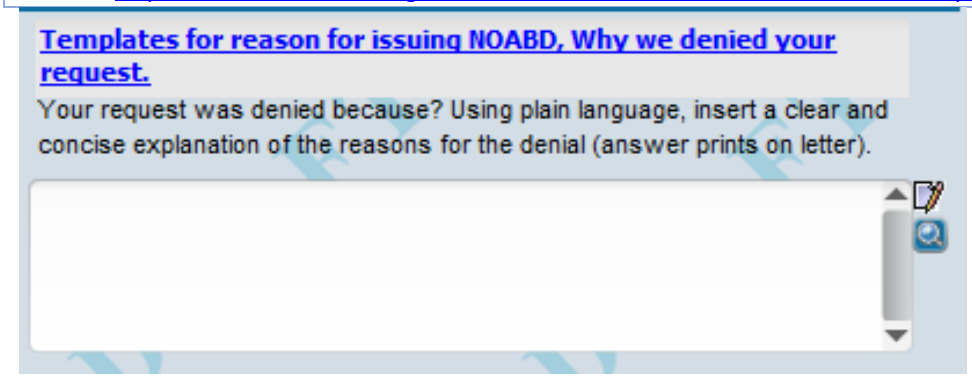
Was the Provider issued NOABD/NAR within the required time frame?
Yes, No, N/A

Timing of the Notice: BHRS must mail the notice to the beneficiary within the following timeframes:

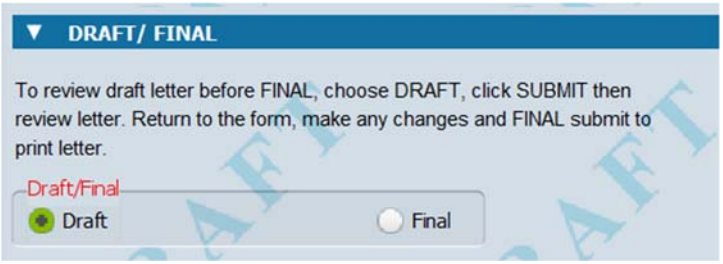
- **Termination, suspension, or reduction** of a previously authorized/approved service - **at least 10 days before the date of action**, except as permitted under 42 CFR §§ 431.213 and 431.214
- **Denial of payment**, **at the time of any action** denying the provider's claim; or,
- Decisions resulting in **denial, delay, or modification** services - within **two business days of the decision**

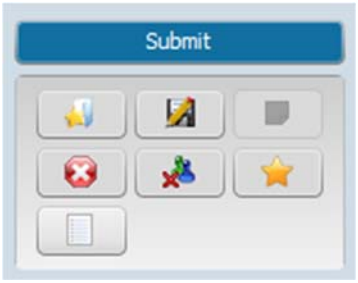
Your request was denied because...

Templates to help you complete the reason for issuing the NOABD /NAR
https://www.smchealth.org/sites/main/files/file-attachments/noabdreasons.pdf



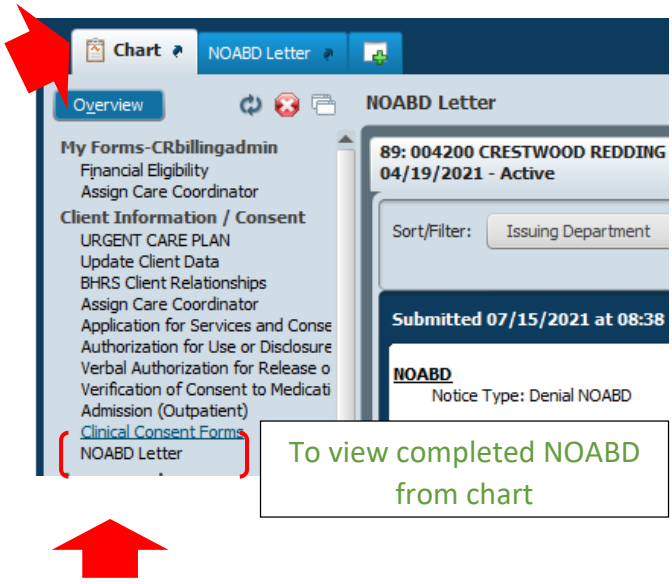
REVIEWING DRAFT AND FINALIZING LETTERS





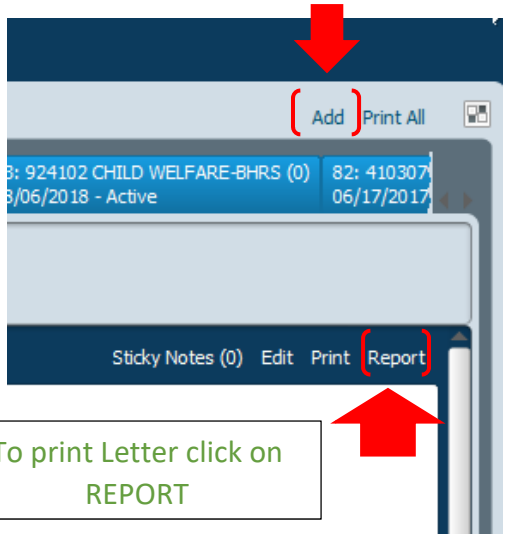
Complete required fields on form, keep in DRAFT and click SUBMIT. This will create a draft letter to review. This will also create a TO DO item to remind you to FINAL SUBMIT when done.

Go back to form, make needed corrections, then make FINAL and SUBMIT.

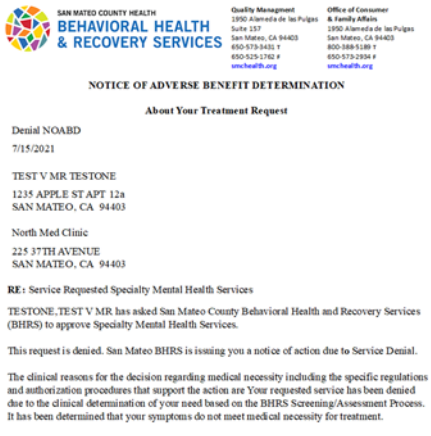


To view completed NOABD from chart

To complete a new NOABD click ADD



To print Letter click on REPORT



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

NOTICE OF ADVERSE BENEFIT DETERMINATION

About Your Treatment Request

Denial NOABD
7/15/2021

TEST V MR TESTONE
1235 APPLE ST APT 12a
SAN MATEO, CA 94403

North Med Clinic
225 37TH AVENUE
SAN MATEO, CA 94403

RE: Service Requested Specialty Mental Health Services

TESTONE,TEST V MR has asked San Mateo County Behavioral Health and Recovery Services (BHRS) to approve Specialty Mental Health Services.

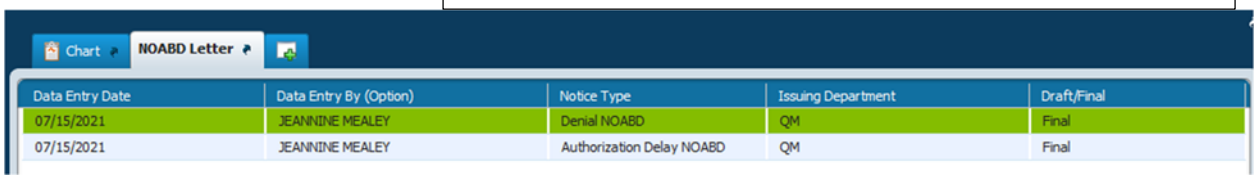
This request is denied. San Mateo BHRS is issuing you a notice of action due to Service Denial.

The clinical reasons for the decision regarding medical necessity including the specific regulations and authorization procedures that support the action are Your requested service has been denied due to the clinical determination of your need based on the BHRS Screening/Assessment Process. It has been determined that your symptoms do not meet medical necessity for treatment.

The Letter will print to your screen (PDF) upon clicking submit.

You may also print from the client's chart, by selecting NOABD letter, finding the letter you want to print, then click REPORT.

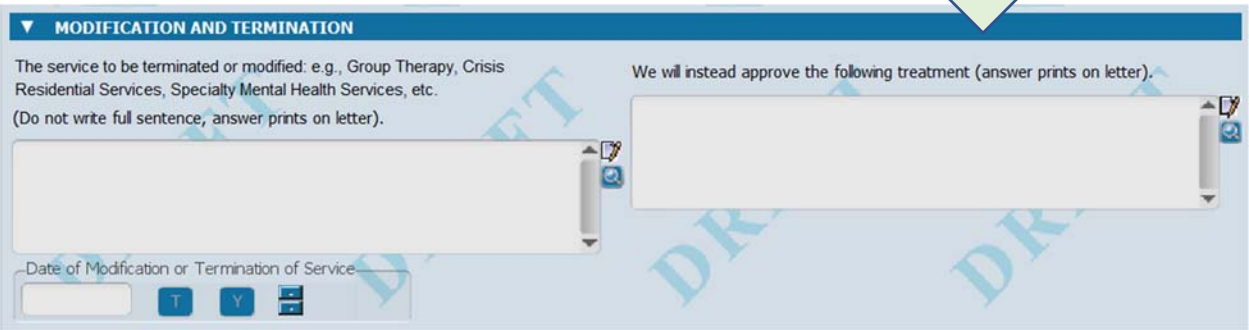
Display window to see letters in DRAFT or FINAL



SPECIFIC NOABD / NAR QUESTIONS

For these types of NOABD / NARS there are additional required questions.

MODIFICATION AND TERMINATION

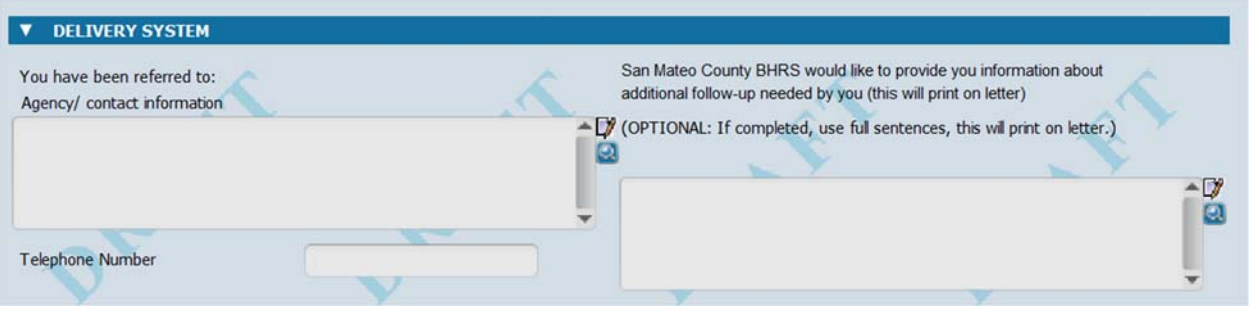


The service to be terminated or modified:
State the service type being terminated or modified. Example: Group Therapy, Crisis Residential Services, Specialty Mental Health Services...etc.
(Do not write full sentence; answer prints on letter.)

We will instead approve the following services:
Type in the service or service length approved.
(Do not need full sentence; answer prints on letter.)

Date of Modification or Termination of Service:
Enter date that service will be terminated or modified.
(This prints on letter.)

DELIVERY SYSTEM



You have been referred to:
Agency/contact information (in text box).
Telephone number (enter phone number).

San Mateo County BHRS would like to inform you that we have taken the following action to coordinate your care and/or we would like to provide you information about additional follow-up needed by you.
This field is OPTIONAL.
(If completed, use full sentences; this will print on letter.)

FINANCIAL LIABILITY

Description of the disputed financial liability:
E.g., cost-sharing, co-insurance, other liabilities.
(Answer prints on letter.)

AUTHORIZATION DELAY/TIMELY ACCESS

Date of Original Request (*date*)
The date the client, or person legally able to consent for client, requested services or assessment.

TIMELY ACCESS STANDARDS

All requests for service must be considered and a decision must be made within 14 days, (expedited decisions are within 72 hours), or we must issue a notice.

Timely access standards not met for FIRST ASSESSMENT APPOINTMENT, and/or NOT OFFERED TREATMENT APPOINTMENT, or placed client on WAIT LIST:

- MH/SUDS OP - within 10 business days from request.
- MED SUPPORT - within 15 business days from request
- Opioid treatment - within 3 business days

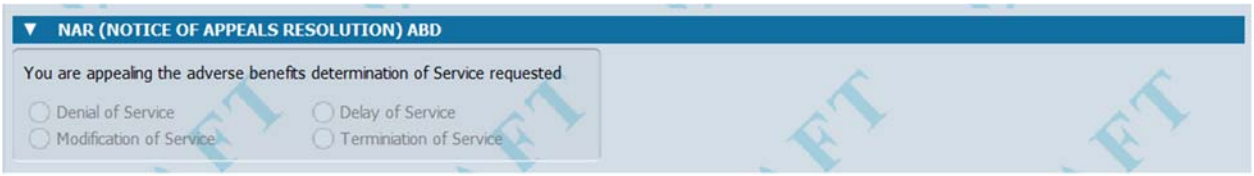
Urgent Services: if not OFFERED APPOINTMENT WITHIN

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

GRIEVANCE/APPEAL RESOLUTION LATE

This request is a Grievance or Appeal
Name of Provider/Program grievance or appeal filed against/with.
Date grievance/appeal originally filed (date).

NAR (Notice of Appeals Resolution) ABD



You are appealing the adverse benefits determination of service requested:

- ❑ Denial of Service
- ❑ Delay of Service
- ❑ Modification of Service
- ❑ Termination of Service