Notice of Adverse Benefit Determination (NOABD)

Los Angeles County Dept. of Public Health
Substance Abuse Prevention and Control

Webinar Housekeeping Items

- Please make sure your computer or line is muted, this will reduce background noise and disruptions during the meeting.
- Submit all questions via the Skype Chat function anytime during the Webinar.
- Questions will be answered at the conclusion of each section.

Learning Objectives

- Learn Federal and State reasons for uniform letters for MHP & DMC-ODS services.
- Identify which NOABDs apply to your agency.
- Understand the appeal process.

What are NOABDs and Why do I need to use them

Department of Health Care Services released MHSUDS Information Notice 18-010E on 3/27/18

This notice provides the Plan clarification and guidance regarding the application of revised federal regulations for processing appeals.

NOABD letters provide information to Medi-Cal beneficiaries about their appeal rights and other beneficiary rights under the Medi-Cal program.

Types of NOABD

- Denial Notice (NOABD)
- Payment Denial Notice (NOABD)
- Delivery System Notice (NOABD)
- Modification Notice (NOABD)
- Termination Notice (NOABD)
- Timely Access Notice (NOABD)
- Financial Liability Notice (NOABD)
- Authorization Delay Notice
- NOABD Grievance and Appeal Timely Resolution Notice
- Notice of Grievance Resolution (NGR)

Plus 3 additional required per NOABD

NOABD Your Rights Attachment

Beneficiary Non-Discrimination Notice

Language Assistance Taglines

Required Formatting

- NOABD letters and required attachments are on State provided templates that have been customized for L.A. County users.
- The type of letter name is located:
  - Document File name
  - Top of the Notice
  - Letter footer
- Each available letter is a FINAL VERSION and shall not be modified except as permitted by the Plan

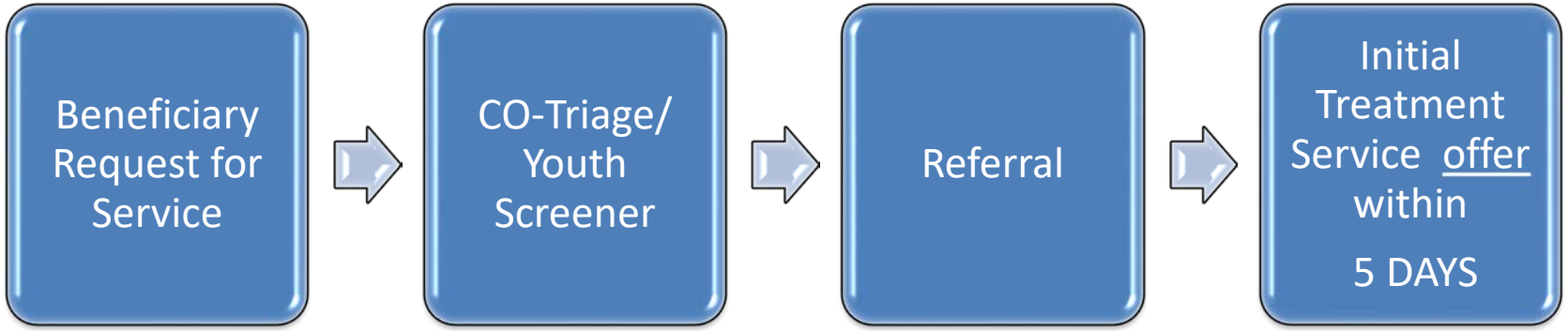
Do not change any font sizing or formatting

Timely Access: All Providers

Failure to offer services within designated timeframes from the initial request for service

- Opioid Treatment Programs: 5 business days
- Outpatient: 5 business days
- Residential: 5 business days

Request for Service may only be initiated by the beneficiary or their legal representative (parent, conservator, court designee for wards/juvenile dependents)



Timely Access NOABD Letter: provided by treatment provider **within two (2) business days** if unable to admit

Timely Access: Letter Layout

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

For adult, adult's name.
For minor, "To the parent or guardian of…"

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested.*

Name of requesting provider has not provided services within *number* working days from the initial request.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

Your agency name and site (if applicable)

RE: *Service reque*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested.*

Name of requesting provider has not provided services within *number* working days from the initial request.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Type of service requested (1.0 Outpatient; 3.3 Residential; 3.7 Withdrawal Management; etc.)

You or your provider *[Name of requesting* ngeles County Substance Abuse Prevention and approve *Service requested*. Our records s ce(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Your Agency's name

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested.*

Name of requesting provider has not provided services within *number* working days from the initial request.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

Enter the date of the initial request for services

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested.*

Name of requesting provider has not provided services within *number* working days from the initial request.

Your/Referred Agency name

Enter the number of days since request of services

Timely Access: NOABD Letter Language

1. Beneficiary's Name: for adult, adult's name; for child, "To the parent or guardian of"
2. Treating Provider's Name
   - Agency name & Site (if applicable)
3. "Service requested" = Type of service requested: ex 1.0 outpatient, 3.3 residential, 3.7 withdrawal management, etc.
4. "Name of requesting provider" = Treating provider's name
5. "date requested" = Enter the date of the initial request for services
6. "number"= Enter the number of days since request of services
7. "Signature Block"= Enter the information of the letter's author

Termination: Pre-Authorized Services ONLY

NOABD is required if the patient **disagrees** with the termination

- Notification is required *at least* 10 days prior to the date of action. Examples:
  - Patient wants to remain in the residential setting but no longer meets medical necessity for that LOC
  - Patient is not participating/engaging in treatment
  - Patient non adherence to program rules.

- A facility may not transfer or discharge an individual while an appeal is pending for a termination notice, unless the failure to discharge would endanger the health or safety of the other individuals in the facility.

Termination: Exceptions to the 10 day notification are allowed under 42 CFR 431.213

431.213 Exceptions:

1. Confirmed death of individual
2. Individual provided a written statement declining further services
3. Ineligibility for further services (such as, loss of Medi-Cal, could include violation of program safety rules or not meeting medical necessity for services)
4. A change in the level of medical care is prescribed by the beneficiary's physician (facility Medical Director)
5. The beneficiary's whereabouts are unknown with no known address and failed outreach efforts.

Code of Federal Regulations https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/xml/CFR-2017-title42-vol4-part431.xml#seqnum431.214

Termination: Exceptions to the 10 day notification are allowed under 42 CFR 431.214

Advance notice may be shortened to 5 days before the date of action if –

a) Agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

b) The facts have been verified, if possible, through secondary sources.

Termination: Reasons for Termination in the Letter

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service Type*

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because *delete the reasons that do not apply* :

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

For adult, adult's name.
For minor, "To the parent or guardian of…"

Treating Provider's Name
Address
City, State Zip

Your agency name and site (if applicable)

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because *delete the reasons that do not apply* :

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

Type of service
Terminated: 3.3
Residential

Date services will be terminated

RE: *Service Type*

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because *delete the reasons that do not apply* :

Termination: Reasons for Termination in the Letter

- you have violated *Treating Provider's Name* safety rules, as stated in your admission agreement, endangering your safety and the safety of individuals in the facility by engaging in:
  - ☐ unsafe behaviors to self and/or others
  - ☐ bringing drugs to program
  - ☐ violence
- you are no longer enrolled or eligible for Medi-Cal, My Health LA (MHLA), or other qualified Los Angeles County benefits (DMC-ODS Special Terms and Conditions (STC) 132(d)).
- you do not reside in Los Angeles County (DMC-ODS Special Terms and Conditions (STC) 132(d)).
- your substance use condition has improved, and the service is no longer appropriate;
  - ☐ your diagnosis no longer meets the criteria for Diagnostic and Statistical Manual of Mental Disorders (Title 22 CCR § 51341.1(h)(1)(A)(v)).
  - ☐ [If under 21 years old] you are no longer assessed as 'at-risk' for developing a substance use disorder.
- you left the program without formal notification and attempts to reach you have been unsuccessful.

Termination: The Letter

The following must be included in the NOABD termination letter

- Beneficiary's Name
- Treating Provider's Name and address
- Service Type patient is receiving at your agency
- Service to be Terminated
- Termination Date: at least 10 days after letter is sent unless it meets an exception as described in 42 CFR 431.213 or 431.214
- Reason for termination from the provided check box options.
- Signature Block

I Completed a NOABD, Now What?

- Complete Distribution Log provided by SAPC.
  - Provide copy of the Log and Notice to your CPA.
  - Due to SAPC quarterly (Fiscal Quarters)
    - Send Securely to sapcmonitoring@ph.lacounty.gov

NOTICE OF ADVERSE BENEFIT DETERMINATION

Distribution Log

Patient Information			Timely Access		Termination		Attachments Included (Y/N)	Additional Action/Comments
Last Name	*First Name*	*Tracking Number*	*Issue/Sent Date*	*Offered Service Date*	*Issue/Sent Date*	*Termination Date*		
			Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.	Choose an item.	

- Tracking number is composed of your agency initials as well as a six (6) digit number

When The Patient Disagrees with a NOABD

It is their right to file an appeal

Beneficiary or Provider may request an internal appeal within 60 calendar days from the date on the NOABD.

- Providers submitting appeals require written consent from the beneficiary
- Verbal appeals by the beneficiary require follow up with a written appeal signed by the beneficiary, but the oral appeal is the official appeal filing date.

Appeal Process

- Within five (5) calendar days of receipt of the appeal the Plan shall provide the beneficiary written acknowledgement of receipt of the appeal
- The Plan shall resolve appeals within 30 calendar days

- Extension of resolution (up to 14 calendar days)
  - If beneficiary requests the extension
  - The Plan demonstrates a need for additional information and the delay is in the beneficiary's best interest.
    - Extensions by the Plan require written notification to the beneficiary of the delay.

What if the beneficiary can't wait 30 days for a resolution

- Federal regulations requires the Plan to resolve the appeal within 72 hours from receipt of the appeal.

- A 14 calendar day extension may be granted in accordance with federal regulations.

  This may include an appeal for remaining at a residential facility which is time sensitive.

Appeal Outcomes

County Overturns the original decision and agrees with the beneficiary/designee regarding the appeal. The county will provide the *Adverse Benefit Determination Overturned (Notice of Appeal Resolution-NAR)* letter to the beneficiary

County Upholds the original decision that led to a NOABD and provides the beneficiary the *Adverse Benefit Determination Upheld (NAR)* letter as well as the *NAR "Your Rights" attachment.*

- If the beneficiary is unsatisfied with the decision, they have the right to request a State Hearing.

State Hearing

- Must be requested within 120 calendar days from the NAR

Or

- If the Plan fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Plan's appeals process. The enrollee may then initiate a State hearing.

- State is to come to a decision within 90 calendar days from the date of the hearing request or three working days for Expedited Hearings.

How Else Might NOABDs Impact Programs

- County generated Denial and Authorization Delays NOABDs may impact workflow of submissions of service authorizations.

- If QI/UM Care Managers are requesting additional information and do not receive it in a timely manner this may generate a NOABD

- A patient may request your assistance in explaining what the letter means.

TIP: ensure listed clinical contacts have their voicemails set up to say it is a confidential voicemail

Summary

- Effective November 1th, 2019 Providers will begin completing NOABDs related to Timely Access and Termination.
- Timely Access notifications apply to all providers
- Termination notifications apply to pre-authorized services (Residential)
- Logs of NOABDs are provided to SAPC on a quarterly basis.
- Copies of the notification letters are provided to your CPA.
- Appeal process is led by SAPC.

Questions

THANK YOU

For more information, contact
SAPC QI/UM at:

sapc.qi.um@ph.lacounty.gov