Policy Number	120
Policy Title	Notice of Adverse Benefit Determination Forms (NOABD)
References	Title IX California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services, Section 1850.210; MCBH Policy #128
Forms	Notice of Adverse Benefit Determination A/B/C/D/E; NOA BACK & NOA BACK (SPANISH)
Effective	October 1, 1997 Revised: February 4, 1999 Revised: April 25, 2003 Revised: March 27, 2003 Revised: April 1, 2011 Revised: September 25, 2014 Revised: June 22, 2017

Policy

A Notice of Adverse Benefit Determination (NOABD) must be given to a Medi-Cal beneficiary whenever services are denied, changed, or terminated. The NOA must contain:

- A statement of what action the agency intends to take;
- The reasons for the action;
- The specific regulations supporting the action [Title 22, of the California Code of Regulations, Section 51014.1; and Federal Code of Regulations: 42 CFR 431.210 (a)];
- The effective date of the action;
- An explanation of the beneficiary's right to request a fair hearing (MCBH Policy #128);
- An explanation on how to request to keep the same services while awaiting a hearing;
- An explanation of the circumstances under which Aid Paid Pending is in effect;
- An explanation of the procedure to request a fair hearing and Aid Paid Pending.

A Notice of Adverse Benefit Determination NOABD-A is a form given to a beneficiary whenever any of the following occur:

When the MHP or its providers assess a Medi-Cal beneficiary and decide that the beneficiary does not meet medical necessity and no specialty mental health services will be provided.

Not meeting medical necessity means any of the following:

- That the beneficiary doesn't have a diagnosis covered by the MHP (an included diagnosis);
- That a beneficiary who is 21 or over has an included diagnosis, but doesn't have a significant impairment;
- That a beneficiary who is under 21 years of age has an included diagnosis, but there is no covered intervention that will correct or ameliorate the condition;
- That the beneficiary has an included diagnosis, but the condition would be responsive to physical health care based treatment.

A NOABD-B is used when the MHP denies or modifies MHP payment authorization of a requested service, including the type or level of service; reduces, suspends, or terminates a previously authorized service; or denies, in whole or in part, payment for a service prior to the delivery of the service.

A NOABD-C is used when the MHP denies, in whole or in part, payment for a service, post-service delivery, but pre-payment based on a determination that the service was not medically necessary or otherwise not a covered service.

A NOABD-D is used when the MHP fails to act within the time frames for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

A NOABD-E is used when the MHP or its providers fail to provide services in a timely manner, as determined by the MHP.

The purpose of the NOABD is to advise the beneficiary of the action and to provide information on the beneficiary's right to appeal the decision. A NOABD-back must be issued in conjunction with all the NOABD forms. The NOABD-back contains important information about the beneficiary's appeal and state Fair Hearing rights.

NOTE: The beneficiaries right to a NOABD is independent of the beneficiary's right to request a fair hearing, to utilize the appeal process, and, when applicable, to the right of a second opinion.

<u>Exceptions:</u>
There is no right to a state fair hearing when the sole issue is the application of a state or federal law and both of the following conditions are met:

- The applicant or beneficiary does not question that the state or federal law has been correctly applied;
- The state or federal law requires a reduction in Medi-Cal entitlement for some or all beneficiaries.

<u>Definition of Terms:</u>

- Treatment Authorization Request (TAR): The MCBHD authorization for payment of services to be delivered.
- Denial of service: A refusal on the part of the provider, provider staff, or managed care system to deliver the TAR for type, mode, or method of behavioral health treatment or services requested by the applicant, consumer, or person lawfully entitled to consent for treatment on the consumer’s behalf.

- Change of service: Any alteration in the mode or method of services, including but not limited to variation in the type, frequency, or duration, in the therapist/case manager assigned, or in location of the provider. NOTE: Temporary changes due to missed appointments, illness, or emergency staffing needs are not considered "changes of services".
- Termination of service: The cessation or suspension of any mode or method of treatment or services the consumer has been receiving due to a decision made by the behavioral health care provider and/or managed care provider. If the consumer is terminated, s/he must request a fair hearing within 10 days of receipt of a Notice of Adverse Benefit Determination to ensure that their treatment is continued.

Procedures

1. Staff who has determined the need for a Notice of Adverse Benefit Determination will go to the "Notice of Adverse Benefit Determination" from in the EMR (all types NOABDs can be accessed from the Notice of Adverse Benefit Determination form).

2. The therapist/case manager shall select the appropriate client episode in the EMR. The data elements within the Notice of Adverse Benefit Determination form **for the NOABD A & B** include:
    - Date of the decision: This field should indicate the date the decision was made that the client needs an adjustment in services provided.
    - Date of Letter: This field should indicate the date the letter will be sent to the client. This field will be shown in the letter generated for the client.
    - Decision: The decision field indicates one of the following options:
        - *Not covered*- Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205 (b)(1)).
        - *Not eligible*- Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205 (b)(2)).
        - *No improvement*- The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205 (b)(3)(A) and (B)).
        - *Not responsive*- Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, Section 1830.205 (b)(3)(C)).
    - Staff completing NOABD. This field should indicate the staff completing the Notice of Adverse Benefit Determination Assessment.

    The data elements within the Notice of Adverse Benefit Determination form **for the NOABD C** include:
    - Date of the decision: This field should indicate the date the decision was made that the client needs an adjustment in services provided.
    - Date of Letter: This field should indicate the date the letter will be sent to the client. This field will be shown in the letter generated for the client.

- Staff completing NOABD: This field should indicate the staff completing the Notice of Adverse Benefit Determination Assessment.
- Medi-Cal number: Enter client's Medi-Cal number, if applicable
- Original Request from provider date: This is noted on the Treatment Authorization Request form (See Treatment Authorization Policy #112)
- Mental Health Plan for Monterey County decision: Select that the request has either been *changed* or *denied.*
- Inpatient treatment from: Enter dates of inpatient treatment
- Denial reason: This field indicates one of the following options:
    - *Additional information needed:* The mental health plan requested additional information from your provider that the plan needs to approve payment of the service you received. To date, the information has not been received.
    - *No medical necessity Inpatient:* The mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional.
    - *No medical necessity Specialty:* The mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason.
    - *Not covered by Mental Health Plan (MHP):* The service provided is not covered by the mental health plan
    - *Other:* Other reasons not noted above can be included here.

3. Once the appropriate NOABD has been completed under the Notice of Adverse Benefit Determination form staff should run the applicable Notice of Adverse Benefit Determination Report (i.e Notice of Adverse Benefit Determination-A Report, Notice of Adverse Benefit Determination-C report, etc.). This report generates the actual NOABD that will be sent to the client. The second page of this report (NOABD Back) will provide information to the beneficiary on of the beneficiary's right to appeal the decision. This completed form may be given to the client, in person or by mail; if mailed, it should be done so no later than 3 working days after the action was taken. This form will serve to inform beneficiaries of their right to file an appeal if they do not agree with the proposed action (MCBH Policy #128). The NOABD Back form includes relevant grievance information in language accessible to the beneficiary and includes:
    - A description of the local grievance procedure and how to initiate the process (MCBH Policy #128).
    - The name and role of the consumer assistant, and how to reach him/her.
    - The State hearing procedure and the necessity of reporting such hearing within 10 days of the Notice of Adverse Benefit Determination in order to maintain the current level of services (MCBH Policy #128).

4. The therapist/case manager, or consumer assistant, shall make all appropriate efforts to assist consumers in preparing for the proposed action, including, but not limited to, pointing out alternate resources and/or support, such as self-help groups, and free community services.

5. Consumers shall be advised, where appropriate, that they may become eligible for an increased level of services if their condition worsens.

6. The consumer shall be informed that s/he will not be subjected to any discrimination, penalty sanction, or restriction, for filing a complaint.

7. With exceptions, the NOABD, at the election of the MHP, must be hand delivered or put in the mail no later than the third working day after the action was taken.

   The most common exceptions include:
   - Within one working day when the beneficiary is in a psychiatric inpatient hospital;
   - At least 10 calendar days before the effective date of action when the MHP elects to reduce or terminate authorization it already approved.
   - On the day the timeframe expires if the NOABD is being sent because the grievance appeal or expedited appeal wasn't resolved on time or if the MHP failed to provide services with their timelines standard.

(See Title 22, California Code of Regulations, Section 51014.1, for additional exceptions.)

8. For minors, unless it is a minor consent case, the original NOABD should be sent to the minor and a copy should be sent to the minor's parent or legal guardian.

   For minor consent cases, the NOABD should be handled in one of the following ways:
   - Given to the minor in person
   - Given to the minor's eligibility worker to give to the minor next time s/he comes in
   - Held by the MHP until the next time the minor comes into the office/clinic.

   In minor consent cases, the NOABD must not be mailed to the minor's address and the minor's parent/guardian must not receive a copy or be otherwise notified.

Additional Resources

Link to the DHCS NOABD FAQ:
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/NOA-FAQ.aspx

SAMPLE NOABD-A

Monterey County Health Department
Behavioral Health Bureau
Medi-cal Specialty Mental Health Program
729 Notice of Adverse Benefit Determination - A

Client Name:	CLIENT,TEST	**Date of Decision:**	6/28/2017
Client ID:	800292	**Date Issued/Sent:**	6/28/2017

The mental health plan for Monterey County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason below:

DECISION: Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205 (b)(1)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at ***(831) 755-5505*** or write to: ***Access Services, 1441 Constitution Blvd., Bldg. 400, Ste 200, Salinas CA 93906***

If you do not agree with the plan's decision, you may do one or more of the following:
You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at ***(831)796-1700*** or write to: ***Medical Director - 1441 Constitution Blvd. Bldg. 400, Ste 200, Salinas, CA 93906***

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at ***(831) 755-4518*** or write to: ***Monterey County Behavioral Health Deputy Director, 1441 Constitution Blvd. Bldg 400, Suite 200, Salinas, CA 93906***, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 workings days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at ***(831)755-4518*** or write to ***Patient's Rights Advocate, David Vandenberg: 1270 Natividad Road, Ste. 143, Salinas, CA 93906 or call (866) 908-4375***

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing

Staff issuing Notice of Action: _____

SAMPLE NOABD-B

ENCLOSURE 4

Medi-Cal Specialty Mental Health Services Program Date:_____

NOTICE OF ACTION

To: _____, Medi-Cal Number_____

The mental health plan for _____ County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____

_____

_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____

_____

☐ Other _____

_____

If you don't agree with the plan's decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at _____ or write to:_____

_____, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at _____ or write to: _____

_____.

NOA-B (revised 6-1-05)

SAMPLE NOABD-C

Medi-Cal Specialty Mental Health Services Program
746 Notice of Adverse Benefit Determination - C
(Post-Service Denial of Payment)

To Whom It May Concern:

Attached is a form that the State of California requires us to provide you. It is regarding your recent hospitalization in an inpatient mental health treatment facility. It is NOT an outright denial of all mental health services to you. It is also NOT a bill.

Inpatient mental health facilities are required to submit a bill and medical records to Monterey County for each day of treatment you receive at their facility. State laws and regulations require that we review each day they are billing to make sure it meets requirements set by the State. If it does not meet State requirements, we may deny payment for those days or ask the facility provide additional documents in order for payment. When every Monterey County denies or requires more information before payment of these types of bills, the State requires that we inform you of what is going on.

This should NOT affect the services you received or will receive in the future from these facilities. It does NOT mean you will be obligated to pay the hospital for the services they provided you. It also does NOT mean you are no longer eligible for any current or future mental health services.

Please feel free to contact us at ***831-755-4545*** for any questions or concerns. Ask for a member of the clinical team when you call.

Sincerely,

Quality Improvement Team
Monterey County Behavioral Health

1611 Bunker Hill Way, Suite 120
Salinas, CA 93906

SAMPLE NOABD-D

ENCLOSURE 6

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Delays in Grievance/Appeal Processing)

Date:_____

To: _____, Medi-Cal Number_____

The mental health plan for _____ County has not processed your
☐ grievance ☐ appeal ☐ expedited appeal on time.

Our records show you made your request on
_____

You requested that _____
_____
_____

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

If your request was about the denial of or a change in the mental health services you receive from the mental health plan and you do not want to wait for our decision, you may request a state hearing to consider the denial or change. You may also ask that the state hearing consider the reason for the delay.

If your request was about another issue, you may request a state hearing to consider the reason for the delay. The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

NOA-D Delays (revised 6-1-05)

SAMPLE NOABD-E

ENCLOSURE 1

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Lack of Timely Service)

Date: _____

To: _____, Medi-Cal Number_____

The mental health plan for _____ County has not provided services within _____ working days of the date of the initial service request.

Our records show that you requested services, or services were requested on your behalf on _____

The following services were requested by you or on your behalf:

_____
_____
_____

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

You may request a state hearing to consider the reason for the delay.

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

NOA-E Timeliness (revised 6-1-05)

SAMPLE NOABD BACK PAGE (Applies to all types of NOABDs)

ENCLOSURE 2

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free:	1-800-952-5253
If you are deaf and use TDD, call:	1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of _____ County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My name: (print) _____

My Social Security Number: _____

My Address:(print) _____

_____

My phone number: (_____)_____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

_____

Phone number: _____

Draft NOA-BACK (6-1-05)