Notice of "Adverse Benefit Determination" (NOABD) for Clinics

Authority & Quality Improvement Services

Managed Care Support Team

Adverse Benefit Determinations

- The Final Rule replaced the term "Action" with "Adverse Benefit Determination"
- The definition of an "Adverse Benefit Determination" encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability

Adverse Benefit Determinations

- An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:
  1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit
  2. The reduction, suspension, or termination of a previously authorized service
  3. The denial, in whole or in part, of payment for a service
  4. The failure to provide services in a timely manner
  5. The failure to act within the required timeframes for standard resolution of grievances and appeals
  6. The denial of a beneficiary's request to dispute financial liability

Written Notice of Adverse Benefit Determination Requirements

- Beneficiaries must receive a written NOABD when the Plan takes any of the actions described in prior slide.
- The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing
- Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.
- For written notification to the provider, the Plan must also include the name and direct telephone number or extension of the decision-maker.

Written Notice of Adverse Benefit Determination Requirements

- The NOABD **must explain all** of the following:
  - The adverse benefit determination the Plan has made or intends to make
  - A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations
  - A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The Plan shall explicitly state why the beneficiary's condition does not meet specialty mental health services medical necessity criteria
- The beneficiary has a right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination

Timing of the Notice

- The Plan must **mail or hand deliver** the notice to the beneficiary within the following timeframes:
  - 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**, except as permitted under 42 CFR §§ 431.213 and 431.214
  - For denial of payment, at the time of any action denying the provider's claim or 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**.

Timing of the Notice

The Plan must mail or hand deliver the notice to the beneficiary within the following timeframes:

At least 10 days before the date of action	For termination, suspension, or reduction of a previously authorized specialty mental health and service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214
Within two business days of the decision	For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services
At the time of any action denying the provider's claim	For denial of payment
Within 24 hours of making the decision	The Plan must also communicate the decision to the affected provider

Which programs will issue NOABDs?

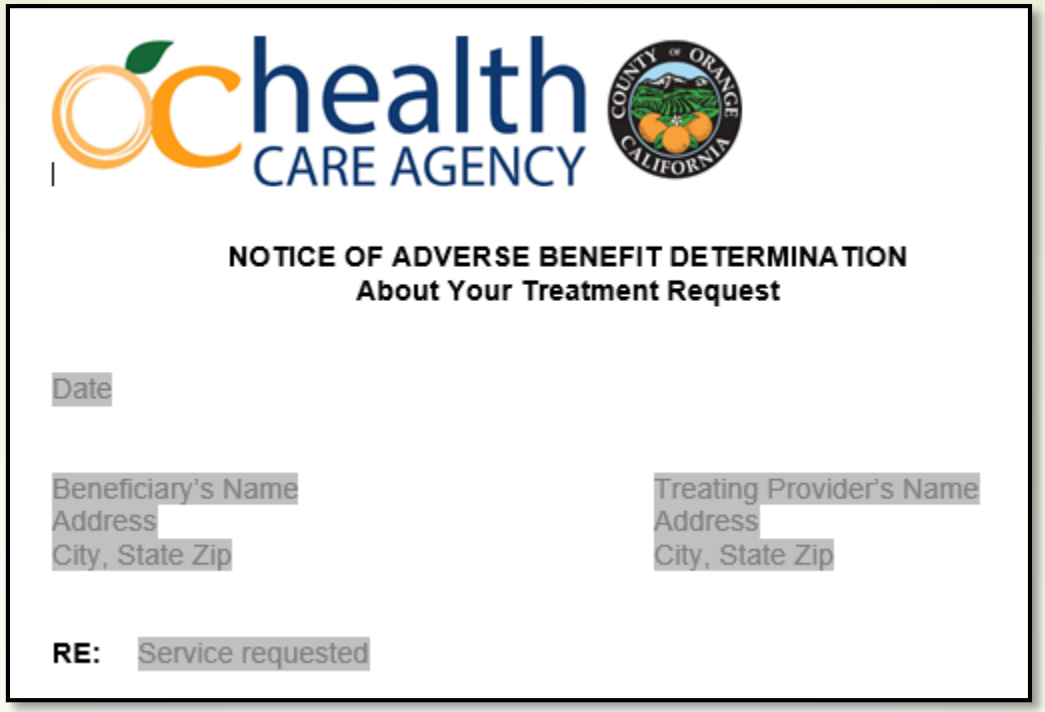
- NOABDs are only for MHP programs that bill Medi-Cal
- Issuing new NOABDs effective September 17th, 2018

Written NOABD Templates

- ALL NOABD Templates:
  - Denial of authorization for requested services
  - Denial of payment for services rendered by provider
  - Delivery system
  - Modification or requested services
  - Termination of previously authorized service
  - Failure to provide timely access to services
  - Dispute of financial liability
  - Failure to timely resolve grievance and appeals

Written NOABD Templates

- We will be focusing on these NOABD templates in this presentation:
  - Delivery System
  - Denial of authorization for requested services
  - Termination of previously authorized service
  - Modification of requested services
  - Failure to provide timely access to services
- All NOABD templates are protected "forms." There are only certain fields (the gray fill in text) that can be edited. You will know the fields that can be edited because they will activate when you tab into them.
- Other than the gray fill in text boxes, you may not alter anything else such as the text size or font. You may not add text outside of the gray fill in text box.



ochealth CARE AGENCY

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

- **Date**: Enter the date that the NOABD is being written (today)
- **Beneficiary's Name, Address, City and Zip Code:** Enter the beneficiary's information
- **Treating provider's Name, Address, City, State and Zip Code:** If there is an identified provider organization around this NOABD enter the provider's information (the organization, not the individual provider)
- **RE: Service requested:** Write "Specialty Mental Health Services"

Delivery System NOABD (MHP Only)

- The MHP will issue the Delivery System NOABD
- It will be rare for the MHP to issue the Denial of authorization for requested services NOABD.
- DMC-ODS does not have the option of providing the Delivery System NOABD and therefore will issue the Denial of authorization for requested services NOABD

Delivery System NOABD (MHP Only)

- **Use this template when the MHP has determined that the Beneficiary's mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services.**
- Used for MHP Only

Delivery System NOABD (MHP Only)

"Delivery System"

ochealth CARE AGENCY

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

This notice lets you know that Orange County Mental Health Plan (MHP) has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services. Using plain language, insert: 1. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and, 2. The clinical reasons for the decision regarding medical necessity.

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from Health Plan or Entity responsible for mental health services, e.g., physical health care provider. You can call them at telephone number. **If applicable, insert additional action taken by the Mental Health Plan to coordinate care and/or additional follow-up needed by the Member.**

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 Orange County Mental Health Plan at (866) 308-3074.

"Delivery System"

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 your mental health plan says services will be stopped or reduced.

The Plan can help you with any questions you have about this notice. For help, you may call Orange County Mental Health Plan 8:00 AM to 5:00 PM, Monday through Friday at (866) 308-3074. If you have trouble speaking or hearing, please call TTY/TTD number (866) 308-3073, between 8:00 AM to 5:00 PM, Monday through Friday for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Orange County Mental Health Plan by calling (866) 308-3074.

If the Plan 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.

Kelly Sabet, LCSW
Administrative Manager, Authority and Quality Improvement Services

Enclosed: "Your Rights"
Language Assistance Taglines
Non-Discrimination Notice

Enclose notice with each letter

F346-797 (New 10/18) NOABD – Delivery System Notice

Delivery System NOABD (MHP Only)

- Use this template when the MHP has determined that the Beneficiary's mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services.
- MHP previously issued the NOA-A but will now issue this NOABD within the 60 day assessment window. Always issue this NOABD regardless of Beneficiary agreeing or disagreeing with the outcome
- Issue Delivery System NOABD within 2 business days of the decision
- Ex: After intake appt, Beneficiary does not meet criteria for specialty mental health services due to having a non-included primary Dx (i.e. Intellectual Delay, Developmental Delay only) or has mild to moderate symptoms without impairments due to mental health

"Delivery System" NOABD

"Delivery System"

ochealth CARE AGENCY

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

This notice lets you know that Orange County Mental Health Plan (MHP) has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services. Using plain language, insert: 1. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and, 2. The clinical reasons for the decision regarding medical necessity.

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from Health Plan or Entity responsible for mental health services, e.g., physical health care provider. You can call them at telephone number. **If applicable, insert additional action taken by the Mental Health Plan to coordinate care and/or additional follow-up needed by the Member**.

"Delivery System" NOABD

- **Service requested:** Write "Specialty Mental Health Services"
- **Description of criteria or guidelines used:** Write "Medical Necessity must be met in order for a Beneficiary to be deemed eligible to receive Specialty Mental Health Services. Criteria includes an Included Diagnosis, significant impairment and/or deterioration in important areas of life functioning related to the Beneficiary's mental illness."
- **The clinical reasons for the decision regarding medical necessity:** Write "You do not meet Medical Necessity for Specialty Mental Health Services due to" (select a reason on the next slide for why a Beneficiary would receive the Delivery System NOABD after the initial intake assessment/within the 60 day assessment period)

"Delivery System" NOABD

- **The clinical reasons for the decision regarding medical necessity:** (select a reason)
  - Having a diagnosis not covered by MHP and having a non-included diagnosis as a primary diagnosis (such as Intellectual Delay, Development Delay)
  - Having a problem which does not qualify for MHP as your intake has indicated mild to moderate symptoms, but you do not meet the severe and persistent mental illness criteria
  - MHP Services not likely to help you benefit from our services due to your intake indicating denial of all major symptoms, behaviors, and impairments related to mental health (i.e. your issue being situational or primarily substance abuse)
  - A Primary Care Physician who can treat your mental health condition through medication only services
  - Your indicating that you solely need a psychiatrist for only medication services
  - Your indicating that you solely need a therapist for only counseling services

Denial of authorization for requested services NOABD

"Denial"

health CARE AGENCY

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 has asked *Orange County, Drug Medi-Cal Organized Delivery System (DMC-ODS)* 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 *Orange County DMC-ODS* at *(866) 308-3074*.

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 the Plan says services will be stopped or reduced.

The Plan can help you with any questions you have about this notice. For help, you may call *Orange County DMC-ODS 8:00 AM to 5:00 PM, Monday through*

"Denial"

Friday at (866) 308-3074. If you have trouble speaking or hearing, please call TTY/TTD number (866) 308-3073, between 8:00 AM to 5:00 PM, Monday through Friday for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Orange County DMC-ODS by calling (866) 308-3074.

If the Plan 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.

Kathleen Murray, LMFT, CHC
Director, Authority and Quality Improvement Services

Enclosed: "Your Rights"
Language Assistance Taglines
Non-Discrimination Notice

Enclose notice with each letter

Denial of authorization for requested services NOABD

- **Use this template when the Plan denies a request for a service.**
- Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
  - Ex: For DMC-ODS use this template for denied residential service requests.
- This is more likely to occur for DMC-ODS (as DMC-ODS does not have the option of providing the Delivery System NOABD).
- This is not likely to be provided for the MHP (as MHP has the option of providing the Delivery System NOABD instead).
- Issue NOABD regardless of whether the Beneficiary agrees with MHP/DMC-ODS's decision or not.

Termination of a previously authorized service NOABD

"Termination"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

You are currently receiving Service to be terminated. Beginning on termination date we will no longer approve this treatment. This is because 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 plan 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 Orange County Mental Health Plan (MHP) at (866) 308-3074.

If you want to keep getting this service 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 your plan says services will be stopped or reduced, listed above.

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

"Termination"

The Plan can help you with any questions you have about this notice. For help, you may call Orange County MHP 8:00 AM to 5:00 PM, Monday through Friday at (866) 308-3074. If you have trouble speaking or hearing, please call TTY/TTD number (866) 308-3073, between 8:00 AM to 5:00 PM, Monday through Friday for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Orange County MHP by calling (866) 308-3074.

If the Plan 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.

Kelly Sabet, LCSW
Administrative Manager, Authority and Quality Improvement Services

Enclosed: "Your Rights"
Language Assistance Taglines
Non-Discrimination Notice

Enclose notice with each letter

F346-803 (New 10/18) NOABD – Termination Notice

Termination of a previously authorized service NOABD

- The termination NOABD is issued when the plan (treatment provider) makes a decision to end treatment regardless of whether the beneficiary agrees with the decision or not.

- Reasons for termination need to be clearly justified.
  - It will be important to cite the reasons clearly and to refer to the policy or participant agreement that is being violated. A termination may be grieved or appealed, so it will be particularly important that the person completing the NOABD includes compelling reasons for the decision and is ready to provide additional documentation to justify the decision in the event the beneficiary and/or the plan requests to see the information used to make the decision, as is their right.

Termination of a previously authorized service NOABD

- The termination may be issued in these instances:
  - Plan is terminating Beneficiary after a year of treatment due to Beneficiary not meeting medical necessity since Beneficiary's sole issue is substance.
  - If Provider cannot get a hold of the Beneficiary after multiple outreach attempts (phone, letter, home visit) over a period of time, and the Beneficiary drops out of treatment
  - Beneficiary is admitted to an institution where he or she is ineligible for further services (incarceration), Beneficiary is in long term hospitalization, Beneficiary is deceased
  - The Beneficiary requests or agrees with the decision for their services to be terminated

"Termination" NOABD

"Termination"

ochealth CARE AGENCY

COUNTY OF ORANGE CALIFORNIA

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

You are currently receiving Service to be terminated. Beginning on termination date we will no longer approve this treatment. This is because 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 plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

"Termination" NOABD

- Termination date should **always** be at least10 days from the date of the letter (add ten to date of letter to get termination date).
- However, if Beneficiary is incarcerated, in long term hospitalization, or is deceased, then you may issue NOABD and close on the same date. This needs to be indicated in the Termination NOABD letter.
- In the Termination NOABD letter, for the missing clients who drop out of treatment, please be specific:
  - Indicate outreach attempts and dates, including both phone calls and outreach letter
  - Indicate dates of no contact/lack of engagement from client (i.e. 1/1/18 to 4/1/18)
  - If applicable, indicate that there is no address to mail outreach letter to and that there were no address or phone numbers listed in chart
  - If there's an invalid address, proof of returned mail with date of returned mail to indicate beneficiary's address is determined unknown/invalid. You would also need to scan into the chart a copy of the top of the envelope that says "returned mail/return to sender"

"Termination" NOABD

- Here's a termination NOABD example for letter dated 10/1/18:

  You are currently receiving Specialty Mental Health Services. Beginning on 10/11/18 we will no longer approve this treatment. This is because you have not engaged in services with your Plan Coordinator and Psychiatrist from 6/15/18 to 9/15/18. Staff made multiple phone calls to reach out to you on 7/1/18, 8/1/18, and 9/1/18. A home visit was made on 9/3/18 but no one responded. A letter was sent to you on 9/5/18 to the current address on file to further reach out to you to engage in services and to advise you of possible termination of services due to lack of engagement. We have not received any response. You may always call our clinic at (*insert clinic number*) and request a new intake appointment to assess for specialty mental health services.

Modification of requested services NOABD

"Modification"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

Name of requestor has asked the Orange County Mental Health Plan (MHP) to approve Service requested. We cannot approve this treatment as requested. This is because 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 reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

We will instead approve the following treatment: Service or service length approved.

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 Orange County MHP at (866) 308-3074.

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 your mental health plan says services will be stopped or reduced.

"Modification"

The Plan can help you with any questions you have about this notice. For help, you may call Orange County MHP 8:00 AM to 5:00 PM, Monday through Friday at (866) 308-3074. If you have trouble speaking or hearing, please call TTY/TTD number (866) 308-3073, between 8:00 AM to 5:00 PM, Monday through Friday for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Orange County MHP by calling (866) 308-3074.

If the Plan 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.

Kelly Sabet, LCSW
Administrative Manager, Authority and Quality Improvement Services

Enclosed: "Your Rights"
Language Assistance Taglines
Non-Discrimination Notice

Enclose notice with each letter

F346-801 (New 10/18) NOABD – Modification Notice

"Modification" NOABD

- **Use this template when the Plan modifies or limits a provider's request for a service**, including reductions in frequency and/or duration of services, and approval of alternative treatments and services within the MHP
- Issue NOABD if Beneficiary does not agree with MHP's decision. If Beneficiary agrees with the decision, then there is no need to send an NOABD
  - If the Beneficiary agrees with the modification of services, a reassessment should be conducted prior to the modification to justify the need for a change in services. A Modification NOABD will not be issued in this case

Modification of requested services NOABD

- Issued once the Beneficiary is in treatment and receiving services and when the treatment provider makes a decision to modify or limit a request for services including reductions in frequency and/or change in the level or duration of covered services, and approval of alternative treatments and covered services, but the Beneficiary does not agree with the decision
- Issue Modification NOABD within 2 business days of decision
- This would rarely be issued as clinicians would most likely work with the Medi-Cal beneficiary during transitions and linkages
- Ex: Client does not agree with decision to go to a different level of care within the MHP such as the PACT program or Recovery Services
- **Please call AQIS to consult prior to issuing Modification NOABD**

"Modification" NOABD

"Modification"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

Name of requestor has asked the Orange County Mental Health Plan (MHP) to approve Service requested. We cannot approve this treatment as requested. This is because 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 reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

We will instead approve the following treatment: Service or service length approved.

Failure to provide timely access to services NOABD

"Timely Access"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

You have or your provider [Name of requesting provider] has asked the Orange County Mental Health Plan (MHP) to obtain or approve Service requested. The Plan or Name of requesting provider has not provided services within number of working days. Our records show that you requested service(s), or service(s) were requested on your behalf on date requested.

We apologize for the delay in providing timely services. We are working on your request and will provide you with Service requested soon.

You may appeal this decision. 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.

The Plan can help you with any questions you have about this notice. For help, you may call Orange County MHP 8:00 AM to 5:00 PM, Monday through Friday at (866) 308-3074. If you have trouble speaking or hearing, please call TTY/TTD number (866) 308-3073, between 8:00 AM to 5:00 PM, Monday through Friday for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such

"Timely Access"

as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Orange County MHP by calling (866) 308-3074.

If the Plan 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.

Kelly Sabet, LCSW
Administrative Manager, Authority and Quality Improvement Services

Enclosed: "Your Rights"
Language Assistance Taglines
Notice of Non Discrimination

Enclose notice with each letter

F346-804 (New 10/18) NOABD – Timely Access Notice

Failure to provide timely access to services NOABD

- **Use this template when there is a delay in providing the beneficiary with timely services**, as required by the timely access standards applicable to the delayed service. For the MHP
  - Routine: 10 days
  - Urgent: 24 hours
  - Emergent: 4 hours
- Ex: Client calls seeking services and to ask for an intake appointment but does not receive a scheduled intake appointment within the next 10 ten days.
- **This type of NOABD is generated at access points:**
  - 1. Beneficiary Access Line (BAL)
  - 2. County Contracted outpatient clinics
  - 3. County operated outpatient clinics

Failure to provide timely access to services NOABD

- Timely Access NOABDs are issued by Program ONLY after consultation and verification with AQIS
- Timely Access NOABDs are NOT downloadable on the AQIS internet site, in order to ensure consultation and verification with AQIS
- Program is responsible to ensure that IF a Timely Access NOABD may need to be issued they have consulted with and verified this with the AQIS Managed Care Support Team (MCST) immediately, as issuance of this NOABD needs to be done within 2 business days. Program must also communicate this decision to any Provider (if there is one) within 24hrs of the determination. This can be a phone call prior to the written notice.
- AQIS MCST will continue to run reports weekly to ensure compliance with access regulatory requirements
- **Please note that IF AQIS has determined that a Timely Access NOABD has to be issued, the Program will be placed on an immediate Plan of Correction per DHCS requirements.**

"Timely Access" NOABD

"Timely Access"

ochealth CARE AGENCY

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Organization's Name
Address
City, State Zip

RE: Service requested

You have or your provider [Name of requesting provider] has asked the Orange County Mental Health Plan (MHP) to obtain or approve Service requested. The Plan or Name of requesting provider has not provided services within number of working days. Our records show that you requested service(s), or service(s) were requested on your behalf on date requested.

We apologize for the delay in providing timely services. We are working on your request and will provide you with Service requested soon.

NOABD "Your Rights" Attachment

- Is a new form that informs beneficiaries of critical appeal and State hearing rights.
- There are two types of "Your Rights" attachments.
  - One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution.
  - These attachments must be sent to beneficiaries with each NOABD or NAR.
  - Effective immediately, Plans shall utilize the revised NOABD templates and corresponding "Your Rights" attachments or the electronic equivalents of these templates and attachments generated from the Plan's Electronic Health Record System.
  - Plans shall not make any changes to the NOABD templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required.

NOABD Enclosure Documents

- For all NOABDs, these three enclosure attachments must be sent to beneficiaries with each NOABD:
  - **"Your Rights"** Informs beneficiaries of critical appeal and State hearing rights
  - **Language Assistance Taglines.** Informs beneficiaries that language assistance services are available and free of charge
  - **Non-Discrimination Notice.** Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability
- Plans shall not make any changes to the NOABD templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required

When should an NOABD be sent out?

At least 10 calendar days before the date of the action	• Termination
2 business days	• Denial • Modification • Timely Access • Delivery System
24 hours	Must notify the affected provider of any action. This can be a phone call prior to the formal written notice
May mail/provide by the date of the action, if	Beneficiary is incarcerated, in long term hospitalization, or deceased

External workflow: Clinical staff

- Verify Medi-Cal status
  - If no, do not provide client NOABD
  - If yes, provide client NOABD
- Determine which NOABD to provide client
- Complete NOABD using letter template
- Rendering provider completing NOABD initials 3 times next to text of "Your Rights," Language Assistance Taglines and Notice of Non-discrimination notice of NOABD letter as a way to indicate 3 enclosure forms have been given to Beneficiary
- A copy of the NOABDs does need to be scanned into the client's chart and documented
- NOABDs do NOT need to be logged externally; AQIS will log internally once these are received

External workflow:
What to do once the NOABD is filled out

- Once the NOABD is filled out completely and reviewed for accuracy, follow these distribution instructions
- Make two copies of the completed NOABD (that has the three initials next to the text "Your Rights," Language Assistance Taglines, Notice of Non-Discrimination documents).
  - Copy #1 of the initialed NOABD is for Beneficiary's chart
  - Copy #2 of the initialed NOABD is to send to AQIS
- Mail or hand deliver the original NOABD along with the three enclosure documents to the Beneficiary and to the named provider (if there is an affected provider) within the required timeframe.
- Scan copy #1 of the NOABD (that has the three initials next to the text "Your Rights," Language Assistance Taglines, Notice of Non-Discrimination documents) into the client's chart
  - Complete necessary documentation that NOABD was issued to Beneficiary and that initials on NOABD indicate that the three enclosure documents were provided to the client along with the NOABD
- Send copy #2 of the NOABD (that has the three initials next to the text "Your Rights," Language Assistance Taglines, Notice of Non-Discrimination documents) to AQIS:
  - Secure/encrypted email AQISgrievances@ochca.com OR Fax (714) 834-6575

External workflow: What to do once the NOABD is filled out

- On email/fax coversheet, please provide the following information to be logged by AQIS:
  - Medi-Cal status (NOABDs are only to be issued to Medi-Cal clients)
  - Client MRN
  - Staff issuing NOABD
  - Clinic phone number
  - Program/clinic name
  - Supervisor name

Questions?

- If you have questions or are unsure about what NOABD form to use, when or how to use it, always consult your program's Quality Improvement coordinator. This may be your Service Chief or another person designated by your program to provide quality improvement support

- AQIS Main Line:
  - **(714) 834-5601**

Questions?

- **AQIS MCST Manager:**
  - Kelly K. Sabet, LCSW, AMIII
- **MCST NOABD Lead/Primary Contact:**
  - Staci Ziegler, LMFT, BHCII
  - Elizabeth Sobral, LMFT, BHCII (back up)