SALISH BHO

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: NOTICE OF ADVERSE BENEFIT DETERMINATION REQUIREMENTS

Policy Number: 6.05

Reference: 42 CFR 431.206; 42 CFR 438.210; 42 CFR 431.230; 42 CFR 438.52(b)(2)(ii); 42 CFR 438.10; 42 CFR 438.400; 42 CFR 438.402; 42 CFR 438.404; Social Security Act; WAC 182-538D-0665 – 182-538D-0675; State Grievance and Appeal System Instructions and Reporting Guidelines; PIHP and BHSC contracts

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Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Grievances
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping

PURPOSE

It is the policy of the Salish Behavioral Health Organization (SBHO) to establish a process for Medicaid individuals to be notified of denials, intended benefit determinations, adverse benefit determinations, and how to pursue appeals in a manner that gives timely, clear, and easily understood information to persons seeking and receiving publicly funded behavioral health services.

This policy is intended to outline the definitions, SBHO procedures and responsibilities as they relate to the federal Notice of Adverse Benefit Determination (NOABD) regulations. The SBHO subcontracted Administrative Service Organization (ASO) is responsible for sending the SBHO NOABD letter and conducting the standard and expedited NOABD Appeal process.

The SBHO is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid recipients/Enrollees receive more information and notification than required in this policy. The ASO procedure shall adhere to URAC (originally known as Utilization Review Accreditation Commission) standards.

DEFINITIONS

Appeal means a review by a Behavioral Health Organization (BHO) of an adverse benefit determination as defined in this section. There is an expedited appeal process that can be activated.

Adverse Benefit Determination (ABD) means, in the case of Medicaid services administered by the SBHO:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service/care, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state; or
- The failure of a BHO to act within the grievance system timeframes as provided in WAC 182-538D-0660 through 182-538D-0670.

Authorization is defined as the power and authority exercised by the SBHO, or their designated ASO, CommCare, to approve and disapprove authorization requests for behavioral health services.

Denial is a decision to not offer an intake assessment or a decision by the SBHO (or their formal designee) to:

- Not authorize requested behavioral health services to an individual. This includes a request for service for individuals that do not meet Access to Care standards, requested covered and non-covered services, requested level of care, as well as a disagreement with an ISP/Treatment Plan or treatment goal.
- Not authorize a service within the timeframes (e.g., 14 calendar day admission authorization), without a network provider extension request.
- Not authorize a request for inpatient services.

Individual means a person who applies for, is eligible for, or receives SBHO-authorized behavioral health services from an agency licensed by the department as a behavioral health agency. For the purposes of accessing the grievance and appeal system, and the Fair Hearing process, when another person is acting on the individual's behalf, the definition of individual also includes any of the following:

- In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
- The individual's legal guardian;
- The individual's representative if the individual gives written consent;

- The individual's behavioral health provider if the individual gives written consent, except that the behavioral health provider cannot request continuation of benefits on the individual's behalf.

Notice of adverse benefit determination (NOABD) is a written notice the SBHO, typically via CommCare, the subcontracted Administrative Service Organization (ASO), provides to an individual to communicate an adverse benefit determination.

Notice of Determination means a written notice that must be provided to an individual to communicate denial or limited authorization of a non-Medicaid service offered by the SBHO, via the ASO.

Reduction is a decision by the SBHO (or their formal designee) to:

- Decrease an Enrollee's previously authorized covered Medicaid behavioral health services described in the Level of Care (LOC) Guidelines.

A decrease or change to an authorized service documented in the ISP/Treatment Plan that is mutually agreed upon is not a reduction.

Suspension is a decision by the SBHO (or their formal designee) to:

- Temporarily stop an Enrollee's previously authorized covered Medicaid behavioral health services described in the Level of Care Guidelines.

A temporary stop or change to an authorized service documented in the ISP/Treatment Plan that is mutually agreed upon is not a suspension.

Termination is a decision by the SBHO (or their formal designee) to:

- Stop an Enrollee's previously authorized covered Medicaid behavioral health services described in the Level of Care Guidelines.

A stop or change to an authorized service in the ISP/Treatment Plan that is mutually agreed upon is not a termination.

Continuation of Services means to continue to provide services with no changes in type of frequency, where applicable, throughout the duration of the appeal process.

PROCEDURE

The SBHO community behavioral health network provider agencies are responsible for assessing, establishing, and documenting medical necessity based on statewide Access to Care criteria.

The service authorization process will ensure that any decision to deny a request for services or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Mental Health Professional or Chemical Dependency Professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

The SBHO subcontracted ASO is responsible for authorizing care for using the SBHO Levels of Care standards and clinical assessment documentation provided by the network agency.

Notice of Adverse Benefit Determination (NOABD) Requirements

1. All notices and forms discussed in this policy are available in English, Spanish, and

all other prevalent non-English language spoken in SBHO regional services area as defined by the state. The template letter will be made available and translated into an individual's primary language, when requested, to meet language requirements, per CFR 438.10 (c & d).

2. SBHO and the network providers shall explain the authorization and appeal process to all persons requesting and receiving services (or their legal guardian) at the time of assessment and when requesting continued services in a manner that is understandable to the individual.
    - This may include the use of qualified sign-language interpreters for those persons with hearing impairments, oral explanations for individuals with visual impairments, persons with limited ability to read English or are developmentally disabled, and explanations in languages other than English.
    - Copies of all authorizations are placed in an enrollee's clinical record (or scanned into the electronic medical record), thereby documenting the determination. Forms that are mailed will be mailed in a manner that documents date sent.

The SBHO receives copies of all notices resulting from an adverse benefit determination mailed to a client and/or facility (on behalf of a client) from the ASO.

The ASO mails approval letters for all outpatient authorizations directly to the enrollee.

These correspondence records are maintained in the ASO office.

3. The notice must provide all required information. Explanations provided by the SBHO and/or network provider regarding the reasons for the decision must be complete, written in commonly understood language and specific to the person receiving the services. Generic statements are not adequate.

4. All notices required by this policy are sent to :
    - The enrollee seeking behavioral health services (or their legal caretaker).
    - A legal guardian or parent who is the legal custodian of a person under the age of consent.
    - Notices on behalf of inpatient services are copied to the requesting network provider agency, inpatient facility, and SBHO office.

5. The SBHO NOABD letter is in writing, in their primary language, and must include an understandable explanation of:
    a. The ABD the SBHO or ASO has made or intends to make;
    b. The reason for the ABD, including citation of the rule(s) and criteria used for the basis of the decision;
    c. Explains the action the SBHO or the ASO has taken or intends to take.
    d. Provides definitions for reduction, termination, suspension, and denial.
    e. The enrollee's right to file an appeal with the SBHO, the process to file an appeal, including information on exhausting the SBHO's one level appeal process and the enrollee's right to request a fair hearing;
    f. The circumstances under which the expedited appeal process is available

and how to request it;

g. The right of the enrollee to be provided reasonable access to and copies of all documents, records, and other information relevant to the enrollee's ABD upon request and free of charge. Such information includes medical necessity criteria, and any processes, strategies, or standards used in setting coverage limits.

NOABD letters must also meet the format requirements identified in 42 CFR 438.10(d).

The SBHO office receives a copy of all notices the ASO provides for 100% review.

6. When the SBHO or its contracted behavioral health agency does not reach service authorization decisions within the required timeframes, or fails to provide services in a timely manner or to act within the grievance system timeframes, as defined in SBHO P&P 6.02, it is considered a denial. In these cases, the SBHO sends a formal notice of adverse benefit determination, which includes the individual's right to request a Fair Hearing.

Notification Timeframes

1. For utilization management decisions regarding a denial, including for a level of service/care, or limit of a request for standard authorization of services:
   - The SBHO ASO will mail notice as expeditiously as the individual's health condition requires, not exceeding fourteen (14) calendar days following the request for services, with a possible extension of up to fourteen (14) additional calendar days if:
     a. The individual requesting the services requests an extension, or
     b. The network provider or ASO justifies a need for an extension and how the extension is in the person's best interest. SBHO will provide a written notice of the reason to extend the timeframe and will inform the person of their grievance rights if they do not agree with the reason.

        For extensions, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.
     c. Service authorization decisions not reached in accordance with the timeframes established per contract constitutes a denial, which is subject to Appeal.

   - The SBHO ASO will mail the written notice by priority mail.
   - The SBHO ASO may determine that following the standard timeframes could seriously jeopardize the life, health, or ability to attain, maintain, or regain maximum functioning of the person making the request. If this determination is made, the SBHO ASO must make an authorization decision within 72 calendar hours after the receipt for request of service.
   - The SBHO ASO may extend the seventy-two (72) calendar hour time period by up to fourteen (14) calendar days if the request is made by the person requesting the services, or if the authorization decision and extension is in the person's interest.
   - The SBHO ASO must provide Notice on the date that the timeframes expire,

when service authorization decisions are not reached within applicable timeframes for either standard or expedited services authorizations.

2. For utilization management decisions regarding denials, termination, suspension, or reduction of previously authorized Medicaid covered services:
   - The SBHO ASO will mail notice at least ten (10) calendar days prior to the effective date of the ABD.
3. For utilization management decisions regarding cases of probable fraud:
   - The notice may shorten the period of advance notice to five (5) days before the date of the ABD if there are facts indicating that action should be taken because of probable fraud by the client and the facts have been verified, if possible, through secondary sources.

4. For utilization management decisions regarding denial of payment, the notice shall be provided at the time of any ABD effecting payment.

5. The ASO will send the SBHO Notice of Adverse Benefit Determination to Enrollees and effected parties with a copy mailed to the SBHO office for 100% review.

6. When any of the following occur, the ASO must issue the notice by the date of the ABD when:
   - The agency has factual information confirming the death of an Enrollee;
   - The agency receives a clear written statement signed by an Enrollee requesting service termination or provides information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;
   - The Enrollee has been admitted to an institution where they are ineligible under the plan for further services;
   - The Enrollee's whereabouts are unknown and the post office returns agency mail directed to them indicating no forwarding address. (Any discontinued services must be reinstated if their whereabouts become known during the time they are eligible for services (42 CFR §431.231 (d));
   - The agency establishes the fact that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
   - A change in the level of medical care is prescribed by the Enrollee's physician;
   - The notice involves an ABD made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act;
   - The date of action will occur in less than 10 days, in accordance with 42 CFR § 483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of 42 CFR § 483.15(b)(4)(i); or
   - The transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR § 483.12(c)(3).

<u>Requesting an Appeal</u>

An Enrollee, or their designated advocate, must request a SBHO Notice of Adverse Benefit Decision Appeal within sixty (60) days of the date on the SBHO NOABD letter. Appeals must be initiated within ten (10) calendar days of the receipt of the

SBHO notice to Enrollees to request that their previously authorized services continue or be reinstated during the appeals process.

If the initial request to file an Appeal was made orally in order to establish the earliest possible filling date, a SBHO Appeal request form will be sent to the Enrollee. The form must be returned and signed as a follow-up to oral filings within seven (7) days.

Notice of determination applies to an individual when there is a denial or limited authorization of a non-Medicaid service offered by the SBHO, via the ASO. A notice of determination must contain the following:

a. The reason for denial or offering of alternative services;
b. A description of alternative services, if available; and
c. The right to request a fair hearing, how to request a hearing, and the timeframes for requesting a hearing as identified in WAC 182-538D-0675.

The SBHO may follow an unofficial process, similar to the appeal process, if the individual requests prior to requesting a fair hearing. The official appeal process is not mandated for non-Medicaid individuals.

MONITORING

1. This policy is a federal and contract mandate. This policy will be monitored through use of SBHO:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - SBHO Trainings
   - SBHO Grievance Tracking Reports
   - 100% SBHO review of all service denial and NOABD letters
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for SBHO approval. Reference SBHO Corrective Action Plan Policy.