BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE: **Issuing Notices of Adverse Benefit Determination to Medi-Cal Members Receiving Specialized Mental Health or Drug Medi-Cal Organized Delivery System Services**

Issued By:
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Imo Momoh,
Director of Managed Care

Date: May 31, 2024

Manual Number: 3.11-04

References: MHSUDS IN No: 18-010E; Title 42, CFR, Part 431, Subpart E; Title 42, CFR, Part 438, Subparts A and F; DHCS BHIN No: 21-073, 21-074, 22-070; BHS policies 3.02-13, 3.03-19, 3.04-08, 3.04-09, and 3.11-01

Technical Revision. Amends Policy 3.11-04 of March 30, 2022.

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, members, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, lead with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse members. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our members' needs and lived experiences.

Purpose:
The purpose of this policy is to define an adverse benefit determination, to ensure that the rights of Medi-Cal members are protected, and to describe the situations that warrant a Notice of Adverse Benefit Determination (NOABD) and the process through which a NOABD is issued.

Scope:
This policy applies to all providers of Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services offered through San Francisco Behavioral Health Services (BHS).

Policy:
San Francisco Behavioral Health Services (BHS) is required to issue a Notice of Adverse Benefit Determination to eligible San Francisco Medi-Cal members when BHS, or a provider on behalf of BHS,

takes any action defined as an adverse benefit determination in regard to a Medi-Cal member's SMHS or DMC-ODS services. Adverse benefit determination means any of the following actions taken by BHS:

- 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;
- 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;
- The failure of BHS to act within the required timeframes for standard resolution of grievances and appeals; or
- The denial of a Medi-Cal member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities.

A Medi-Cal member who receives a Notice of Adverse Benefit Determination (NOABD) has a right to appeal this decision within 60 calendar days from the date on the NOABD. There are no filing deadlines if a NOABD is not issued. Should the Medi-Cal member decide to request an appeal, the Grievance/Appeal Office will review the adverse benefit determination to either uphold or overturn BHS's decision. If BHS determines that taking time for a standard appeal resolution could jeopardize the Medi-Cal member's health or functioning, Medi-Cal members can file an expedited appeal (see BHS policy 3.11-01 regarding *Grievance and Appeal System for Behavioral Health Services).* Medi-Cal members are informed of their right to a State Hearing by the Notice of Adverse Benefit Determination and the Notice of Appeal Resolution if the decision is to uphold the adverse benefit determination. Medi-Cal members must exhaust the BHS appeal process prior to requesting a State Hearing. In the event that BHS fails to adhere to the notice and timing requirements, the Medi-Cal member is deemed to have exhausted BHS's appeal process and may initiate a State Hearing. Members can also request a second opinion on the determination of not meeting medical necessity (see BHS policy 3.04-08).

Definition of Terms:

Appeal and Expedited Appeal – The standard appeal and expedited appeal procedure provides an avenue for a Medi-Cal member to request a review when BHS takes any action defined as an adverse benefit determination. A standard appeal or expedited appeal is processed according to BHS policy 3.11-01.

Continuation of Benefits (Aid Paid Pending) – Medi-Cal members who have filed a timely request can have their existing services (i.e., benefits) continue while an appeal or State Hearing are pending. *Timely* means that the Medi-Cal member requested an appeal within 10 calendar days from the date of the NOABD or before the intended effective date of BHS's proposed adverse benefit determination. BHS must continue the Medi-Cal member's services if all of the following occur: the Medi-Cal member files a timely request for an appeal; the appeal involves the termination, suspension, or reduction of an existing service authorization, which has not lapsed; and the Medi-Cal member timely files for continuation of services. If, at the Medi-Cal member's request, BHS continues or reinstates the Medi-Cal member's existing services, the services must be continued until one of the following occurs: the Medi-Cal member withdraws the appeal or request for a State Hearing; the Medi-Cal member fails to request

a State Hearing and continuation of services within 10 calendar days after BHS sends the Notice of Appeal Resolution upholding the adverse benefit determination; or the State Hearing office issues a hearing decision adverse to the Medi-Cal member. Medi-Cal members shall be informed that they may be held liable for the cost of those services if the State Hearing upholds the BHS adverse benefit determination.

Medi-Cal Members – Individuals enrolled in Medi-Cal who are eligible for SMHS or DMC-ODS services. Only Medi-Cal members may receive a Notice of Adverse Benefit Determination, request an appeal or expedited appeal, or request a State Hearing.

Medical Necessity – See Attachment 1 for definitions of medical necessity for Specialty Mental Health Services and for Drug Medi-Cal Organized Delivery System.

Notice of Adverse Benefit Determination (NOABD) – A Notice of Adverse Benefit Determination informs a Medi-Cal member of a denial or change to their SMHS or DMC-ODS services, and the Medi-Cal member's right to request an appeal if the Medi-Cal member does not agree with BHS's decision. The NOABD also informs the Medi-Cal member of delays in resolving grievances or appeals, providing services in a timely manner, delays in authorization, or to dispute financial liability.

State Hearing – A State Hearing is provided to Medi-Cal members pursuant to Title 42, CFR, Part 431, Subpart E. It is an independent review conducted by the California Department of Social Services to ensure that Medi-Cal members receive SMHS or DMC-ODS services entitled under the Medi-Cal program. A Medi-Cal member does not have access to the State Hearing process until the BHS appeal process has been exhausted and the adverse benefit determination is upheld.

Written NOABD Requirements: BHS, or a provider on behalf of BHS, must give Medi-Cal members timely and adequate notice of an adverse benefit determination in writing, which must explain all of the following:

- The adverse benefit determination that BHS has made or intends to make;
- 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. BHS shall explicitly state why the Medi-Cal member's condition does not meet SMHS and/or DMC-ODS medical necessity criteria;
- A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
- The Medi-Cal member's 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 Medi-Cal member's adverse benefit determination.

Timing of the NOABD: BHS, or a provider on behalf of BHS, must hand deliver or mail the NOABD to the Medi-Cal member within the following timeframes:

- For termination, suspension, or reduction of a previously authorized SMHS and/or DMC-ODS service, at least 10 days before the date of the action;

- 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 SMHS and/or DMC-ODS services, within 2 business days of the decision.
- BHS must also communicate the decision to the affected provider within 24 hours of making the decision. 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, BHS must also include the name and direct telephone number or extension (or other effective means for contact) of the decision-maker.

Written NOABD Templates: In accordance with the federal requirements, BHS must use the Department of Health Care Services' (DHCS) uniform notice templates when providing Medi-Cal members with a written NOABD. The notice templates include both the NOABD and the *NOABD Your Rights* documents to notify Medi-Cal members of their rights in compliance with the federal regulations. BHS, or providers on behalf of BHS, shall not make any changes to the NOABD templates or the *NOABD Your Rights* attachment without prior review and approval from DHCS, except to insert information specific to Medi-Cal members as required.

Definition of Types of NOABD:

NOABD – Denial (formerly NOA-A). Denial of authorization for requested services. Use this template when BHS, or a provider on behalf of BHS, 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. For DMC-ODS, also use this template for denied residential service requests.

NOABD – Payment Denial (formerly NOA-C). Denial of payment for a service rendered by provider. Use this template when BHS denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a Medi-Cal member. This notice reads "this is not a bill" so that the Medi-Cal member knows that one is not responsible for the cost of the service rendered, but that the service request has been retrospectively denied.

NOABD – Delivery System. Use this template when BHS has determined that the Medi-Cal member does not meet the criteria to be eligible for SMHS through BHS. The Medi-Cal member will be referred to Behavioral Health Access Center, or other appropriate system, for non-specialty mental health or other services.

NOABD – Modification. Modification of requested services. Use this template when BHS 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.

NOABD – Termination. Termination of a previously authorized service. Use this template when BHS terminates, reduces, or suspends a previously authorized service.

NOABD – Authorization Delay. Delay in processing authorization of services. Use this template when there is a delay in processing a provider's request for authorization of SMHS or DMC-ODS services. When BHS extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the Medi-Cal member or provider, and/or those granted when there is a need for additional information from the Medi-Cal member or provider, when the extension is in the Medi-Cal member's interest.

NOABD – Timely Access (formerly NOA-E). Failure to provide timely access to services. Use this template when there is a delay in providing the Medi-Cal member with timely services, as required by the timely access standards applicable to the delayed service.

NOABD – Financial Liability. Dispute of financial liability. Use this template when BHS denies a Medi-Cal member's request to dispute financial liability, including cost sharing and other Medi-Cal member financial liabilities.

NOABD - Grievance/Appeal Resolution (formerly NOA-D). Failure to timely resolve grievances and appeals. Use this template when BHS does not meet required time frames for resolution of grievances, standard appeals, or expedited appeals. This notice will be issued by the Grievance/Appeal Office.

NOABD "YOUR RIGHTS" Attachment. This document must be sent to Medi-Cal members with each NOABD. The NOABD "Your Rights" attachment provides Medi-Cal members the following required information pertaining to NOABD:

- The Medi-Cal member's or provider's right to request an appeal with BHS within 60 calendar days from the date on the NOABD;
- The Medi-Cal member's right to request a State Hearing only after filing an appeal with BHS and receiving a notice that the adverse benefit determination has been upheld;
- The Medi-Cal member's right to request a State Hearing if BHS fails to send a resolution notice in response to the appeal within the required timeframe;
- Procedures for exercising the Medi-Cal member's rights to request an appeal;
- Circumstances under which an expedited review is available and how to request it; and,
- The Medi-Cal member's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits.

Issuing NOABD and Required Enclosures:

- A *Provider Decision Grid* has been developed to assist providers in deciding if, when, and which NOABD type needs to be issued to the Medi-Cal member. This grid can be accessed on the SFGOV website at: https://www.sf.gov/resource/2024/notice-adverse-benefit-determination-documents
- The NOABD must be issued according to the required time frame as defined above.
- Each NOABD must be issued with the required enclosures which include the *NOABD Your Rights* attachment, the *Language Assistance* taglines, and the member *Nondiscrimination Notice*. In addition, whenever a *Denial*, *Delivery System*, *Modification*, or *Termination* NOABD

is issued and the determination is based on not meeting medical necessity criteria, providers are required to provide the BHS informational handout on *Requesting a Second Opinion*.

- Notices of Adverse Benefit Determination and the required enclosures are to be provided to the Medi-Cal member in one's primary language when indicated.
- BHS requires 3 copies of the issued Notice of Adverse Benefit Determination which are distributed as follows: 1) one copy is given or sent to the Medi-Cal member (or parent/legal guardian if not a minor consent case, or authorized representative); 2) the second copy is given to the affected provider where applicable and/or retained by the authorizer and a hard copy placed in the Medi-Cal member's medical record; and 3) the third copy is provided to Quality Management for central filing at 1380 Howard Street, 2nd Floor, San Francisco, CA 94103.
- Upon issuing a Notice of Adverse Benefit Determination, there begins the 60 day period that a Medi-Cal member may file an appeal; however, Medi-Cal members may request State Hearings in circumstances when no NOABD are generated, or when the appeal process has been completed and the decision is to uphold the adverse benefit determination.
- Medi-Cal members who are in on-going services must file a request for an appeal within 10 days of the date of issue to be eligible for services to continue while the appeal is pending.
- Programs/authorizers must document the pertinent background and criteria of the decisions resulting in issuing a Notice of Adverse Benefit Determination and maintain this documentation in the Medi-Cal member's medical record. In the event of a State Hearing, this documentation is critical to defending BHS's adverse benefit determination.

Obtaining NOABD Templates and Required Enclosures: These notices are available in our county threshold languages, including English, Chinese, Russian, Spanish, Tagalog, and Vietnamese. The Notice of Adverse Benefit Determination templates, the *NOABD Your Rights* attachment, *Language Assistance* taglines, the member *Nondiscrimination Notice,* and the BHS *Requesting a Second Opinion* handout can be accessed on the SFGOV website.

As each of the NOABD templates are fillable pdf documents only, the NOABD is downloaded, completed electronically, and printed. The NOABD templates in each of the threshold languages can be accessed on the SFGOV website at:
https://www.sf.gov/resource/2024/notice-adverse-benefit-determination-documents

Copies of the required enclosures (*NOABD Your Rights*, *Language Assistance* taglines, *Nondiscrimination Notice,* BHS *Requesting a Second Opinion* handout) in the threshold languages can be obtained on the SFGOV website at:
https://www.sf.gov/resource/2024/notice-adverse-benefit-determination-documents

Making requests for other means of communication or translations in additional languages should be submitted for review and consideration to the BHS Office of Equity, Social Justice, and Multicultural Education, 1380 Howard Street, 5th Floor, San Francisco, CA 94103, or by emailing: BHS-Lang-Support@sfdph.org.

Retention of Records: All copies of completed NOABD forms and related documentation that are centrally filed with Quality Management will be retained in locked administrative files for 10 years from the date the NOABD was issued unless there are program specific requirements that demand a longer retention period.

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Contact Person:
Quality Management and Regulatory Affairs, 628-754-9500

Attachment(s):

Attachment 1 – Definitions of Medical Necessity for Specialty Mental Health Services and Drug Medi-Cal Organized Delivery System

Distribution:
BHS Policies and Procedures are distributed by the DPH Quality Management and Regulatory Affairs

Administrative Manual Holders
BHS Programs
SOC Program Managers
BOCC Program Managers
CDTA Program Managers

Attachment 1

Definitions of Medical Necessity for Specialty Mental Health Services and Drug Medi-Cal Organized Delivery System

Specialty Mental Health Services (SMHS) - Meeting medical necessity criteria for SMHS, except for psychiatric inpatient hospital and psychiatric health facility services, includes the following:
Beneficiaries 21 years and older*:* The county mental health plan shall provide covered specialty mental health services for beneficiaries who meet **both of the following** criteria, (1) and (2) below:

(1) The beneficiary has **one or both** of the following:

a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b) A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:

a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

b) A suspected mental disorder that has not yet been diagnosed.

Beneficiaries under the age of 21*:* The county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following** criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The beneficiary meets **both of the following** requirements in a) and b) below:

a) The beneficiary has **at least one** of the following:

i. A significant impairment.

ii. A reasonable probability of significant deterioration in an important area of life functioning.

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access specialty mental health services; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

(See **BHS policy 3.04-10** - *Implementing Non-Hospital/Outpatient Specialty Mental Health Services' Medical Necessity Criteria to Ensure Access to Care for Medi-Cal Beneficiaries*).

Drug Medi-Cal Organized Delivery System (DMC-ODS) - Meeting medical necessity criteria for DMS-ODS after assessment includes the following:

Beneficiaries 21 years and older*:* To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age or older must meet **one of the following** criteria:

(1) Have at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

OR

(2) Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Beneficiaries under the age of 21*:* Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those service are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

(See **BHS policy 3.03-19** – *SF Drug Medi-Cal Organized Delivery System Requirements for Years 2022-2026*).