7.1.4 APPEALS AND NOTICE OF ADVERSE BENEFIT DETERMINATIONS (NOABDS)

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References: MHP Contract, Exhibit A, Attachment 5, Sec, 1(E), sec. 1(G) and Attachment 12; DMC-ODS Contract, Exhibit A, Attachment I, Item II.G.2; CCR Title 9, Ch. 11, 1850.210(a)-(j); 1850.212, DHCS MHSUDS Information Notice 18-010E, BHIN 23-041, BHIN 22-036, 42 CFR, 438.10; 438.210(c); 438.228(b), 438.400(b); 438.402(c); 438.404; 438.408; 438.420.

Policy Owner: Behavioral Health Division - Quality Assessment and Performance Improvement (QAPI), Quality Assurance (QA) Manager

Director Signature: **Signature on File**

I. Policy Statement

It is the policy of the Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) to ensure that all Medi-Cal clients and/or Medi-Cal providers are issued timely, adequate notice of an adverse benefit determinations made by DHS-BHD and that clients are informed of their right to appeal said determinations. In compliance with State and Federal regulations and guidelines, DHS-BHD has established a process for issuing Notices of Adverse Benefit Determinations (NOABDs) and maintains an appeal system, which provides clients with access to the appeal process, including expedited appeals.

II. Scope

This policy applies to all "Covered Persons", which includes all County of Sonoma employees (full-time, part-time, extra help) and all additional persons who are performing services for DHS, with the exception of Community Based Organization (CBO) staff.

III. Definitions

A. Notice of Adverse Benefit Determination (NOABD) means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, access criteria or 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, or;

6. The denial of a beneficiary's request to dispute financial liability.

B. Appeal: An oral or written request to DHS-BHD for review of an Adverse Benefit Determination. An appeal can be Standard or Expedited.

IV. Policy

A. Ensure beneficiaries receive a written NOABD when DHS-BHD makes adverse benefit determination.

B. Ensure beneficiaries receive timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR §438.10 (Information requirements) regarding written materials.

C. Ensure that all decision makers on appeals of Adverse Benefit Determinations have the appropriate clinical expertise in treating the beneficiary's condition, if the decision involves an appeal based on a denial of access criteria or medical necessity, a grievance regarding denial of a request for an expedited appeal, or a grievance involving a clinical issue.

D. Ensure that decision makers on appeals of Adverse Benefit Determinations are not included in the subsequent levels of review and are not subordinates of any individual who was involved in a previous level of review or decision making.

E. Allow a beneficiary, or a provider or authorized representative acting on the beneficiary's behalf, to file an appeal orally or in writing. An "Appeal" is a review by DHS-BHD of an Adverse Benefit Determination.

F. Allow a provider, or authorized representative acting on behalf of the beneficiary and with the beneficiary's written consent, to request an appeal, or request a state hearing.

G. At the beneficiary's request, identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including aiding with writing the appeal, or expedited appeal.

H. Not subject a beneficiary to discrimination or any other penalty for filing an appeal or expedited appeal.

I. Maintain the confidentiality of the beneficiary's information when carryout procedures related to the beneficiary problem resolution processes.

J. Ensure that written records of appeals are submitted at least quarterly to the Quality Improvement Committee (QIC) and Behavioral Health Plan Administration (BHPA) Committee for systematic aggregation and analysis for quality improvement. Appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

K. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. DHS-BHD must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals.

L. Ensure that decision makers on appeals of Adverse Benefit Determinations consider all comments, documents, records, and other information submitted by the beneficiary or their representative, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

M. Provide the beneficiary and their representative certain appeals related documents, including medical records, other documents, and records, and any new or additional evidence considered, relied upon, or generated by the DHS-BHD in connection with the appeal of the Notice of Adverse Benefit Determination, if there is no disclosure of the protected health information of any individual other than the beneficiary.

N. Provide the beneficiary and their representative with information about the beneficiary's case free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

O. Treat oral inquiries seeking to appeal an Adverse Benefit Determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing unless the beneficiary or the provider requests expedited resolution.

P. Allow the beneficiary, their representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

Q. Adhere to written Notice of Adverse Benefit Determination (NOABD) Requirements:

1. Follow the requirements of DHCS MHSUDS Information Notice No. 18-010E and any superseding BHINs regarding written material requirements for denial and termination NOABDs, including availability in threshold languages and alternative formats, "Non-Discrimination Notice" and "Language Assistance" taglines made available by DHCS or adapted for use by DHS-BHD, as permitted in DHCS MHSUDS Information Notice No.18-010E and any superseding BHINs.

2. Non-Discrimination Notice and Language Assistance taglines shall be included in all of the following documents:

    a. Notice of Adverse Benefit Determinations forms

    b. Appeal Acknowledgment Letters

    c. Notice of Appeal Resolution Letters

3. Mail the NOABD to the beneficiary within the following timeframes:

    a. For termination, suspension, or reduction of a previously authorized specialty service, at least **10 calendar days** before the date of action, except as permitted under 42 CFR § 431.213 (Exceptions from advanced notice). The Contractor shall be allowed to mail the NOABD as few as **five days** prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources 42CFR §431.214 (Notice in cases of probable fraud);42 C.F.R. § 438.404(c)(1)

    b. For denial of payment, at the time of any action denying the provider's claim; or,

    c. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within **two business days** of the decision.

    d. DHS-BHD must also communicate the decision to the affected provider **within 24 hours** of making the decision.

    e. The Contractor shall mail the NOABD by the date of the action when any of the following occur:

i. The recipient has died;

ii. The beneficiary submits a signed written statement requesting service termination;

iii. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that they understand that service termination or reduction will result;

iv. The beneficiary has been admitted to an institution where they are ineligible under the plan for further services;

v. The beneficiary's address is determined unknown based on returned mail with no forwarding address;

vi. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

vii. A change in the level of medical care is prescribed by the beneficiary's physician;

viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

ix. The transfer or discharge from a facility will occur in an expedited fashion.

R. Allow beneficiaries who are issued a NOABD while they are receiving services to request continuation of services pending a resolution of a State Hearing or an appeal.

1. The beneficiary's right to a NOABD is independent of the beneficiary's right to request a State Hearing, to utilize the appeal process, and, when applicable, the right to a second opinion.

2. A beneficiary may file an appeal or a State Hearing request whether or not a NOABD has been issued. However, beneficiaries may request a State Hearing only after completing the DHS-BHD appeal resolution process.

V. Procedures

A. Per federal regulations DHS-BHD staff shall ensure that all of the NOABDs contain all the following:

1. The adverse benefit determination DHS-BHD has made or intends to make;

2. A clear and concise explanation of the reason(s) for the decision. For determinations based on access criteria or medical necessity criteria, the notice must include the clinical reasons for the decision;

3. DHS-BHD shall explicitly state why the beneficiary's condition does not meet services access criteria and/or medical necessity criteria;

4. A description of the criteria used. This includes access criteria and/or medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;

5. The beneficiary'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 beneficiary's adverse benefit determination.

6. DHS-BHD staff will communicate adverse benefit determinations and appeals determinations to the beneficiary in writing. Communication regarding adverse benefit determinations will include the name and direct telephone number or extension of the person making the adverse determination.

7. DHS-BHD staff will communicate adverse benefit determinations and appeals determinations to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.

8. DHS -BHD staff will use the following State Department of Health Care Services (DHCS) uniform notice templates, or the electronic equivalent of these templates generated from DHS-BHD's Electronic Health Record System, when providing beneficiaries with a written NOABD, and adhere to timeframes for NOABD issuance:

    a. Denial of authorization for requested services: Use this template when DHS-BHD denies a request for a service. Denials include determinations based on type or level of service, requirements for access criteria or medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

    b. Denial of payment for a service rendered by provider: Use this template when DHS-BHD 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 beneficiary.

    c. Delivery system: Use this template when DHS-BHD has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through DHS-BHD. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

d. Modification of requested services: Use this template when DHS-BHD 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.

e. Termination of a previously authorized service: Use this template when DHS-BHD terminates, reduces, or suspends a previously authorized service.

f. Delay in processing authorization of services: Use this template when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When DHS-BHD 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 beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.

g. For standard authorization decisions, DHS-BHD will provide notices as expeditiously as the beneficiary's health condition requires and within **14 calendar days** following receipt of the request for service with a possible extension of up to **14 additional days**.

h. For expedited authorization decisions, DHS-BHD will provide notices as expeditiously as the beneficiary's health condition requires and within **72 hours** following receipt of the request for service with a possible extension of up to **14 calendar days**.

i. Failure to provide timely access to services: 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. Refer BHIN 23-041 or any superseding BHINs for the applicable timeframes, depending on the specific service provided by the MHP or DMC-ODS Plan.

j. Dispute of financial liability: Use this template when DHS-BHD denies a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

k. Failure to timely resolve grievances and appeals: Use this template when DHS-BHD does not meet required timeframes for the standard resolution of grievances (**30 calendar days** from when DHS-BHD receives the grievance) and appeals (**30 calendar days** from when DHS-BHD receives the appeal):

i. DHS-BHS staff will ensure inclusion of NOABD "Your Rights" Attachment.

ii. The "Your Rights" attachment informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments:

iii. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution (NAR).

iv. These attachments must be sent to beneficiaries with each NOABD or NAR.

v. The "NOABD Your Rights" attachment will provide beneficiaries with the following required information pertaining to NOABD:

(1) The beneficiary's or provider's right to request an internal appeal with DHS-BHD within **60 calendar days** from the date on the NOABD;

(2) The beneficiary's right to request a State Fair Hearing only after filing an appeal with DHS-BHD and receiving a notice that the Adverse Benefit Determination has been upheld;

(3) The beneficiary's right to request a State Fair Hearing if DHS-BHD fails to send a resolution notice in response to the appeal within the required timeframe;

(4) Procedures for exercising the beneficiary's rights to request an appeal;

vi. Circumstances under which an expedited review is available and how to request it, and; The beneficiary's right to request and receive continuation of benefits while the state hearing is pending and right to request continuation of benefits, within **10 calendar days** of the date the NOABD was mailed or given to the beneficiary or, if the effective date of the change is more than **10 calendar days** from the NOABD date, before the effective date of the change; and if all the following occur:

(1) The beneficiary files the request of an appeal **60 calendar days** from the date on the adverse benefit determination notice;

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired, and;

(5) The beneficiary timely files for continuation of benefits.

B. Appeal Process Informing

1. DHS-BHD staff shall ensure that all beneficiaries are informed of the NOABD Appeal process through the following informing materials located at DHS-BHD providers sites:

   a. The Sonoma County Mental Health Plan Beneficiary Specialty Mental Health Services Handbook and/or DMC-ODS Beneficiary Handbook;

   b. Client Rights Poster and Client Rights and Grievance/Appeal Process and Form.

      i. All DHS-BHD provider sites shall ensure that the Clients Rights Poster is posted in lobbies.

      ii. This Clients Rights Poster provides an explanation of the Grievance and Appeal Process including information on the availability of a State Hearing after exhaustion of an appeal or expedited appeal process, and that a State Hearing may be requested whether the beneficiary has received a NOABD.

   c. All informing materials shall be available in English and Spanish, and if needed can be interpreted in the beneficiary's preferred language.

   d. All informing materials are also available on the County of Sonoma website: Medi-Cal Informing Materials.

2. The Client Grievance and Appeal Process and Form includes:

   a. Grievance Process;

   b. Appeal process (only available to Medi-Cal beneficiaries);

   c. Expedited appeal process (only available to Medi-Cal beneficiaries);

   d. State hearing process;

   e. Information needed about how to access interpreter/translation services as needed;

   f. The toll-free 24-hours a day, 7 days a week (24/7) Access telephone line: 1-800-870-8786 or 707-565-6900; TTY number 711.

g. Language assistance shall be available upon request. Language assistance includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services, and toll-free numbers with TTY/TDD and interpreter capability.

h. All DHS-BHD provider sites shall ensure that the Grievance and Appeal Process and Form and self-addressed envelopes are freely available to the public, provider staff, and beneficiaries at without having to make a verbal or written request to anyone.

3. Appeal Filing and Processing

a. Beneficiaries have **60 calendar days** from the date on the NOABD to file an appeal.

b. A beneficiary, or a provider and/or authorized representative, may request an appeal either orally or in writing.

c. The date of the oral appeal establishes the filing date for the appeal. An oral appeal (excluding expedited appeals) must be followed by a written appeal signed by the beneficiary.

i. A request for an Expedited Appeal may be filed verbally, and it is not required to be followed by a written request.

d. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

e. DHS-BHD staff will assist the beneficiary in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the form on the DHS-BHD website or providing the form to the beneficiary upon request.

f. DHS-BHD staff will advise and assist the beneficiary in requesting continuation of benefits while the appeal of a NOABD.

g. DHS-BHD Quality Assurance (QA) staff will process all appeals.

h. QA staff will request that the beneficiary's oral request for a standard appeal be followed by written confirmation unless the beneficiary or provider requests expedited resolution.

i. If QA does not receive a written, signed appeal from the beneficiary, DHS-BHD shall neither dismiss nor delay resolution of the appeal.

ii. QA staff will ensure processing of Standard and Expedited and forward all appeals to the DHS-BHD BHPA committee for final review and resolution.

iii. DHS-BHD will have only one level of appeal.

iv. Beneficiaries must exhaust the DHS-BHD appeal process prior to requesting a state hearing unless DHS-BHD has failed to issue the appropriate NOABD form within the specified timeframe. An appeal can be Standard or Expedited.

i. Standard Appeal

i. QA staff shall provide written Notification of the Appeal Resolution (NAR) to the beneficiary or authorized representative, as expeditiously as the beneficiary's health condition requires, within **30 calendar days** of receipt of the appeal.

ii. DHS-BHD will also comply with the following additional federal requirements:

(1) QA staff shall resolve the appeal as expeditiously as the beneficiary's health condition requires; and,

j. If QA staff fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the DHS-BHD appeal process and may initiate a state hearing.

k. Expedited Appeals;

i. An expedited appeal process is used, at a minimum, when the beneficiary and/or the beneficiary's provider, or DHS-BHD, determines that taking the time for a standard appeal process could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

ii. A request for an Expedited Appeal may be filed verbally, and it is not required to be followed by a written request.

iii. QA staff shall provide written Notice of Appeal Resolution (NAR) to the beneficiary and affected parties as expeditiously as the beneficiary's health condition requires and no later than **72 hours** after receipt of the expedited appeal.

iv. In addition to the written NAR, reasonable efforts will be made to also provide verbal notice to the beneficiary and/or the beneficiary's representative.

v. QA staff will log the time and date of appeal receipt when expedited resolution is requested as the specific time of receipt drives the timeframe for resolution.

vi. DHS-BHD will not take punitive action against a beneficiary, their representative, or a DHS-BHD network provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

vii. If the request for an expedited appeal is denied:

(1) The request will default to the timeframe in accordance with the standard appeal process;

(2) Reasonable efforts will be made to give notice to the beneficiary and provider, if appropriate, prompt verbal notice of the denial of the request for an expedited appeal and provide written notice within **2 calendar days** of the denial;

(3) DHS-BHD shall resolve the appeal as expeditiously as the beneficiary's health condition requires and within the timeframe for standard resolution of an appeal (i.e., **within 30 days** of receipt of the appeal);

(4) The written notice of the denial of the request for an expedited appeal is not a NOABD.

(5) QA staff will provide to the beneficiary written acknowledgement of receipt of each appeal, and request for an expedited appeal of adverse benefit determination.

(a) The acknowledgment letter will include:

(i) The date of receipt, and;

(ii) Contact information (the name, telephone number, and address) of the QA staff person who may be contacted about the appeal.

(iii) The written acknowledgement to the beneficiary must be postmarked within **5 calendar days** of receipt of the appeal.

l. Notice of Appeal Resolution (NAR): QA staff will issue the NAR informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld, within the required timeframe.

i. The written NAR will include the following:

(1) The results of the resolution and the date it was completed;

(2) The reasons for the DHS-BHD determination, including the criteria, clinical guidelines, or policies used in reaching the determination;

(3) For appeals not resolved wholly in the favor of the beneficiary, the right to request a state hearing and how to request it;

(4) For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request, and;

(5) Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the DHS-BHD adverse benefit.

m. Adverse Benefit Determination Upheld: For appeals not resolved wholly in favor of the beneficiary QA staff will issue the NAR and include the following information:

i. The results of the resolution and the date it was completed;

ii. The reasons for the determination made by DHS-BHD, including the criteria, clinical guidelines, or policies used in reaching the determination;

iii. The right to request a State hearing and how to request it;

iv. The right to request and receive benefits while the State hearing is pending and how to make the request, and;

v. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the Plan's adverse benefit determination.

n. Adverse Benefit Determination Overturned - for appeals resolved wholly in favor of the beneficiary:

i. DHS-BHD will authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if DHS-BHD overturns the decision to deny, limit, or delay services that were not furnished while the appeal was pending;

ii. DHS-BHD shall authorize or provide services no later than **72 hours** from the date and time it reverses the determination;

iii. QA staff will issue the NAR to the beneficiary and include the following information:

(1) The results of the resolution and the date it was completed, and;

(2) The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination.

o. State Hearing

i. A beneficiary may request a State Hearing only after receiving notice that DHS-BHD is upholding the adverse benefit determination associated with the appeal:

(1) If DHS-BHD fails to adhere to notice and timing requirements for appeal resolution, the beneficiary is deemed to have exhausted the appeals process, and the beneficiary may initiate a State Hearing.

ii. Beneficiaries may request a State Hearing within **120 calendar days** from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld by DHS-BHD.

(1) The parties to State Hearing include the MHP, as well as the beneficiary and his or her authorized representative or the representative of a deceased beneficiary's estate.

iii. QA staff monitors the ACMS for notification of State Hearings and works with County Counsel to develop the Statement of Position.

iv. QA staff works with the DHS-BHD Director, Section Manager, and County Counsel to ensure complete case presentation in preparation for the State Hearing.

v. QA staff is responsible for submitting all required State Hearing documents to the ACMS platform and maintaining associated documents internally.

vi. QA staff coordinates with the DHCS hearing officer and the DHS-BHD Director, Section Manager, and County Counsel to appropriate internal staff attendance at the State Hearing.

vii. Standard Hearings: QA staff will notify beneficiaries that the State must reach its decision on the hearing within **90 calendar days** of the date of the request for the hearing.

viii. Expedited Hearings: QA staff will notify beneficiaries that the State must reach its decision on the state fair hearing within **three working days** of the date of the request for the hearing.

p. Continuation of Services

i. A beneficiary receiving specialty mental health services shall have a right to file for continuation of specialty mental health services pending the outcome of a State Hearing.

ii. DHS-BHD shall continue the beneficiary's benefits while an appeal is in process if all of the following occur:

(1) The beneficiary files the request for an appeal within **60 calendar days** following the date of the adverse benefit determination notice.

(2) The appeal involves the termination, suspension, or reduction of a previously authorized services.

(3) The beneficiary's services were ordered by an authorized provider.

(4) The period covered by the original authorization has not expired and;

(5) The request for continuation of benefits is filed on or before the later of the following:

(a) Within **10 calendar days** of DHS-BHD sending the notice of adverse benefit determination; or

(b) The intended effective date of the adverse benefit determination.

iii. At the beneficiary's request, DHS-BHD must continue the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:

(1) The beneficiary withdraws the appeal or request for a State Hearing;

(2) The beneficiary fails to request a State Hearing and continuation of benefits within **10 calendar days** after the MHP or DMC-ODS Plan sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal;

(3) A State Fair Hearing office issues a hearing decision adverse to the beneficiary.

iv. DHS-BHD shall not recover the cost of continued services furnished to the beneficiary while the appeal or State Hearing was pending if the final resolution of the appeal or State Hearing upholds DHS-BHD's adverse benefit determination.

v. DHS-BHD must automatically continue providing the disputed services to the member while the appeal and State Hearing are pending if all the following conditions are met:

(1) The beneficiary filed their appeal within the required timeframes;

(2) The appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

(3) The disputed services were ordered by the beneficiary's provider;

(4) The period covered by the original authorization has not expired.

vi. DHS-BHD must pay for disputed services if the beneficiary received the disputed services while the appeal or State Hearing was pending. DHS-BHD must ensure the beneficiary is not billed for the continued services even if the State Hearing finds the disputed services were not medically necessary.

vii. DHS-BHD shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires, but no later than **72 hours** from the date DHS-BHD receives notice reversing the determination if the services were not furnished while the appeal was pending and if DHS-BHD or State Hearing officer reverses a decision to deny, limit, or delay services.

viii. If the decision of an appeal reverses a decision to deny the authorization of services, and the beneficiary received the disputed services while the appeal was pending, the DHS-BHD shall cover the cost of such services.

ix. Beneficiaries who are issued a NOABD while they are receiving services may request continuation of services pending a resolution of a State Hearing or an appeal.

x. DHS-BHD will continue the beneficiary's benefits while the appeal is in process if all the following occur:

(1) The beneficiary files the request for an appeal within **60 calendar days** following the date on the adverse benefit determination notice;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(3) The beneficiary's services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired, and;

(5) The request for continuation of benefits is filed on or before the later of the following:

(a) Within **(10) calendar days** from the date the notice was mailed or given to the consumer, or; If the decision of an appeal reverses a decision to deny the authorization of services, and the beneficiary received the disputed services while the appeal was pending, DHS-BHD shall cover the cost of such services.

(b) DHS-BHD will authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires, but no later than **72 hours** from the date DHS-BHD receives notice reversing the determination if the services were not furnished while the appeal was pending and if DHS-BHD or the State Hearing officer reverses a decision to deny, limit, or delay services.

(c) QA staff shall notify the requesting provider and give the beneficiary written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

(d) If, at the beneficiary's request, DHS-BHD continues the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until:

(i) The beneficiary withdraws the appeal or request for State Hearing.

(ii) The beneficiary does not request a State Hearing and continuation of benefits within **10 calendar days** after the MHP sends the notice of adverse resolution (e.g.), NAR;

(iii) A State Hearing office issues a hearing decision adverse to the beneficiary.

q. Record Keeping, Monitoring, Review, and Reporting Requirements

i. QA staff maintains an appeal log which records appeals and expedited appeal receipt dates:

(1) QA staff shall log appeals within one working day of the date of receipt of the appeal, or expedited appeal.

ii. QA staff will ensure that each record includes, but not be limited to:

(1) The date and time of receipt of each appeal;

(2) The name of the beneficiary for whom the appeal was filed;

(3) The name of the representative recording the appeal;

(4) A general description of the reason for the appeal;

(5) The date of each review or review meeting, including a description of the action taken by the plan to investigate and resolve the appeal;

(6) Resolution information for each level of the appeal, if applicable;

(7) The name of the DHS-BHD staff responsible for resolving the appeal; and,

(8) The date of notification to the beneficiary resolution at each level, if applicable.

iii. QA staff will record in the appeal log, or another central location determined by DHS-BHD, the final dispositions of appeals and expedited appeals, including the date the decision is sent to the beneficiary.

iv. QA staff or other designated staff person will be responsible for providing information requested by the beneficiary, or the beneficiary's representative regarding the status of the appeal or expedited appeal.

v. QA staff will identify in its appeal and expedited appeal documentation, the roles and responsibilities of DHS-BHD, the provider, and the beneficiary.

vi. QA staff will provide notice, in writing, to any provider identified by the beneficiary or involved in the appeal or expedited appeal of the final disposition of the appeal, or expedited appeal.

vii. QA staff will submit to DHCS a report that summarizes NOABDS and appeals filed from **July 1st** of the previous year through **June 30th** annually by the **first business day of September**, consistent with the Managed Care Program Annual Report (MCPAR) reporting indicators specified in Behavioral Health Information Notice (BHIN) 22-036 or any subsequent updated BHIN.

viii. Additional information.

VI. Forms

A. NOABD Denial, BHD-001

B. NOABD Payment Denial, BHD-002

C. NOABD Delivery System, BHD-003

D. NOABD Modification, BHD-004

E. NOABD Termination, BHD-005

F. NOABD Authorization Delay, BHD-006

G. NOABD Timely Access Notice BHD-007

H. NOABD Financial Liability, BHD-008

I. NOABD Grievance/Appeal Timely Resolution, BHD-009

J. Member Non-Discrimination Notice, BHD-158

K. NAR Adverse Benefit Determination Overturned Notice, BHD-159

L. NAR Adverse Benefit Determination Upheld Notice, BHD-160

M. Notice of Grievance Resolution, BHD-161

N. Language Assistance Taglines, BHD-162

O. NOABD Your Rights Attachment, BHD-163

P. NAR Your Rights Attachment, BHD-164

VII. Attachments

#1: NOABD Overview Grid

#2: NOABD Issuance Procedure