Notice of Adverse Benefit Determination (NOABD)- Update
9/9/2021

Los Angeles County Dept. of Public Health
Substance Abuse Prevention and Control

Learning Objectives

Learn	Identify	Introduce	Understand
Learn Federal and State reasons for uniform letters for MHP & DMC-ODS services.	Identify which NOABDs apply to your agency.	Introduce SAPC's approach to NOABDs.	Understand the appeal process.

What are NOABDs and Why do I need to use them?

Department of Health Care Services released MHSUDS Information Notice 18-010E on 3/27/18

This notice provides the Plan clarification and guidance regarding the application of revised federal regulations for processing appeals.

NOABD letters provide information to Medi-Cal beneficiaries about their appeal rights and other beneficiary rights under the Medi-Cal program.

SAPC Network Treatment Providers began issuing NOABDs Nov 1,2019

Types of Beneficiary Notices

Enclosure 1 Notice of Grievance Resolution (NGR)

Enclosure 2 Denial Notice (NOABD)

Enclosure 3 Payment Denial Notice (NOABD)

Enclosure 6 Termination Notice (NOABD)

Enclosure 7 Timely Access Notice (NOABD)

Provider Responsibility

Enclosure 8 Financial Liability Notice (NOABD)

Enclosure 10 Adverse Benefit Determination Upheld (NAR)

Enclosure 12 Adverse Benefit Determination Overturned (NAR)

Enclosure 15 Authorization Delay Notice

Enclosure 16 NOABD Grievance and Appeal Timely Resolution Notice

Three attachments accompany beneficiary notices

Enclosure 9 NOABD Your Rights Attachment

Enclosure 11 NAR Your Rights Attachment

Enclosure 13 Beneficiary Non-Discrimination Notice

Enclosure 14 Language Assistance Taglines

Translated NOABDs

For copies of an NOABD letter template in a threshold language please send an email request to:

eapu@ph.lacounty.gov

Required Formatting

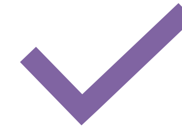
NOABD letters and required attachments are on State provided templates that have been customized for L.A. County users.

The type of letter name is located:

Document File name

Top of the Notice

Letter footer



Each available letter is a FINAL VERSION and shall not be modified except as permitted by the Plan. (Place on your agency letterhead.)

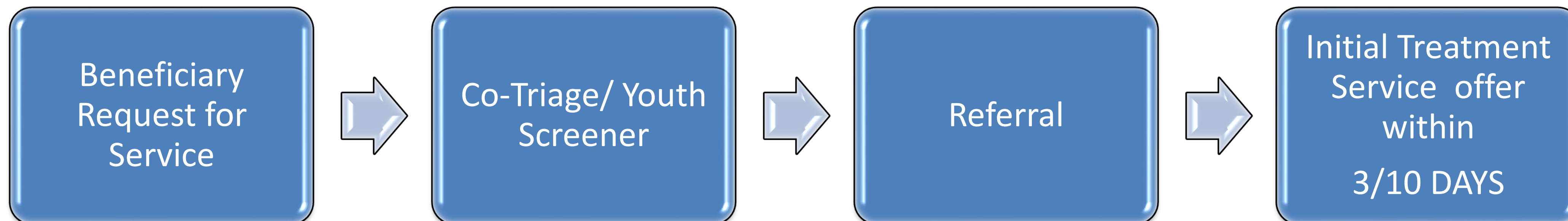
Do not change any font sizing or formatting

Timely Access: All Providers

This notice is completed if a beneficiary seeking services is not able to **OFFER** an Intake appointment within:

- Opioid Treatment Programs: 3 business days
- Outpatient/Intensive Outpatient: 10 business days
- Residential: 10 business days

Request for Service may only be initiated by the beneficiary or their legal representative (parent, conservator, court designee for wards/juvenile dependents)



Timely Access NOABD Letter: provided by treatment provider **within two (2) business days** when unable to offer an intake appointment.

Timely Access: Letter Layout

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

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

[Timely Access NOABD Letter]

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

For adult, adult's name.
For minor, "To the parent or guardian of…"

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

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

County of Los Angeles Public Health

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

Your agency name and site (if applicable)

RE: *Service req*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

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

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Type of service requested:
Ex. Outpatient (ASAM 1.0)

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

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

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

Your Agency's name

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

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

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services w[...] days from the initial request.

Enter the date of the initial request for services

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

COUNTY OF LOS ANGELES
Public Health

NOTICE OF ADVERSE BENEFIT DETERMINATION – TIMELY ACCESS
About Your Treatment Request

Date
Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider *[Name of requesting provider* has asked the Los Angeles County Substance Abuse Prevention and Control (SAPC) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf, on *date requested*.

Name of requesting provider has not provided services within *number* working days from the initial request.

W... providing ...g on your ...with a resp...

Your/Referred Agency name

Enter the number of days since request of services

Timely Access: NOABD Letter Language

1. Beneficiary’s Name: for adult, adult’s name; for child, “To the parent or guardian of”
2. Treating Provider’s Name
   - Agency name & Site (if applicable)
3. “Service requested” = Type of service requested:
   - Outpatient (ASAM 1.0); Residential (ASAM 3.3); Inpatient Withdrawal Management (ASAM 3.7)
4. “Name of requesting provider” = Treating provider’s name
5. “date requested” = Enter the date of the initial request for services
6. “number”= Enter the number of days since request of services
7. “Signature Block”= Enter the information of the letter’s author

Termination: Pre-Authorized Services ONLY
RESIDENTIAL ONLY (ASAM 3.1, 3.3, and 3.5)

An NOABD is required if the patient **disagrees** with the termination

- Notification is required *at least* 10 days prior to the date of action.
  - Examples:
    - Patient wants to remain in the residential setting but no longer meets medical necessity for that LOC
    - Patient is not participating/engaging in treatment
    - Patient nonadherence to program rules
- A facility may not transfer or discharge an individual while an appeal is pending for a termination notice, unless the failure to discharge would endanger the health or safety of the other individuals in the facility.

Termination: Exceptions to the 10-day notification are allowed under 42 CFR 431.213

431.213 Exceptions:

1. Confirmed death of individual
2. Individual provided a written statement declining further services
3. Ineligibility for further services (such as, loss of Medi-Cal, could include violation of program safety rules or not meeting medical necessity for services)
4. A change in the level of medical care is prescribed by the beneficiary's physician (facility Medical Director)
5. The beneficiary's whereabouts are unknown with no known address and failed outreach efforts.

Code of Federal Regulations https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/xml/CFR-2017-title42-vol4-part431.xml#seqnum431.213

Termination: Exceptions to the 10-day notification are allowed under 42 CFR 431.214

Advance notice may be shortened to 5 days before the date of action if –

a) Agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

b) The facts have been verified, if possible, through secondary sources.

Code of Federal Regulations https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/xml/CFR-2017-title42-vol4-part431.xml#seqnum431.214

Termination: Reasons for Termination in the Letter

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service Type*

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because

You may refer to SAPCs list of sample reasons that include citations. 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 that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

Termination NOABD Letter

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

For adult, adult's name.
For minor, "To the parent or guardian of…"

Treating Provider's Name
Address
City, State Zip

Your agency name and site (if applicable)

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because

You may refer to SAPCs list of sample reasons that include citations. 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 that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

NOTICE OF ADVERSE BENEFIT DETERMINATION – TERMINATION
About Your Treatment Request

Date

Type of service Terminated: Residential (ASAM 3.5)

Beneficiary's Na
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

Date services will be terminated

RE: *Service Type*

You are currently receiving *Service to be terminated*. Beginning on *termination date*, we will no longer approve this treatment. This is because

You may refer to SAPCs list of sample reasons that include citations. 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 that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

Termination: Reasons for Termination in the Letter

- ☐ you have violated *Treating Provider's Name* safety rules, as stated in your admission agreement, endangering your safety and the safety of individuals in the facility by engaging in:
  - ☐ unsafe behaviors to self and/or others
  - ☐ bringing drugs to program
  - ☐ violence
- ☐ you are no longer enrolled or eligible for Medi-Cal, My Health LA (MHLA), or other qualified Los Angeles County benefits (DMC-ODS Special Terms and Conditions (STC) 132(d)).
- ☐ you do not reside in Los Angeles County (DMC-ODS Special Terms and Conditions (STC) 132(d)).
- ☐ your substance use condition has improved, and the service is no longer appropriate;
  - ☐ your diagnosis no longer meets the criteria for Diagnostic and Statistical Manual of Mental Disorders (Title 22 CCR § 51341.1(h)(1)(A)(v)).
  - ☐ [If under 21 years old] you are no longer assessed as 'at-risk' for developing a substance use disorder.
- ☐ you left the program without formal notification and attempts to reach you have been unsuccessful.

[Sample Reasons for NOABD Termination](#)

Termination: The Letter

The following must be included in the NOABD termination letter

- Beneficiary's Name
- Treating Provider's Name and address
- Service Type patient is receiving at your agency
- Service to be Terminated
- Termination Date: at least 10 days after letter is sent unless it meets an exception as described in 42 CFR 431.213 or 431.214
- Reason for termination from the provided check box options.
- Signature Block

I Completed an NOABD, Now What?

- Complete Distribution Log provided by SAPC.
  - Log is submitted Quarterly to SAPC
    - Submit Log Securely to SAPCMonitoring@ph.lacounty.gov
  - Submit copies of the notification letters to your CPA.

NOTICE OF ADVERSE BENEFIT DETERMINATION

Distribution Log

Patient Information			Timely Access		Termination		Attachments Included (Y/N)	Additional Action/Comments
Last Name	*First Name*	*Tracking Number*	*Issue/Sent Date*	*Offered Service Date*	*Issue/Sent Date*	*Termination Date*		
			Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.	Choose an item.	

- Tracking number is composed of your agency initials as well as a six (6) digit number

When The Patient Disagrees with a NOABD

It is their right to file an appeal

Beneficiary or Provider may request an internal appeal within 60 calendar days from the date on the NOABD.

- Providers submitting appeals require written consent from the beneficiary.
- Verbal appeals by the beneficiary require follow up with a written appeal signed by the beneficiary, but the oral appeal is the official appeal filing date.

GRIEVANCE AND APPEALS - CLARIFICATION

- A grievance (or complaint) is considered an expression of dissatisfaction about any matter **EXCEPT an Adverse Benefit Determination**.
  - Grievances may include, but are not limited to,
    - the quality of care or services provided
    - aspects of interpersonal relationships such
    - failure to respect the patient's rights
    - a request by a non-DMC patient to have a decision reviewed
  - A patient does not need to formally say the word “grievance” or “complaint” for one to be filed.
  - Providers submitting grievances on behalf of the beneficiary require written consent/authorization.

GRIEVANCE AND APPEALS - CLARIFICATION

The Difference

Grievance (aka complaint) filed by ***any patient*** if dissatisfied with ANY aspect of their treatment (except adverse benefit determination or ABD)

vs.

Appeal may only be filed by a ***Medi-Cal enrolled*** patient for a decision regarding their care (often due to ABD)

Type of Form	Who May File		
	Medi-Cal Beneficiary	Any Patient	Patient Representative Requires Permission
Grievance	**Yes**	**Yes**	**Yes**
Appeal	**Yes**	**No**	**Yes**

Grievance and Appeals- Updated Forms

COUNTY OF LOS ANGELES **Public Health**

Tell us about your complaint by completing the information below. If you need assistance in completing this form, call 1-626-299-4532.

1. Date:		
PERSON FILING THE GRIEVANCE		
2. Name (First, Last and Middle):		Did anyone help you complete this form? ☐ Yes ☐ No
3. Street Address:	City:	Zip Code:
4. Phone Number or E-mail:	5. Is it okay to leave a voice message or e-mail? ☐ Yes ☐ No	

COMPLETE IF AUTHORIZING A REPRESENTATIVE TO FILE A COMPLAINT ON YOUR BEHALF		
6. Name of Representative:	7. Relationship or Agency:	8. Phone Number
9. If authorizing another person or entity to represent you in filing a complaint, please sign below:		
I authorize the person or entity named above to serve as my representative for this grievance/complaint.		
INFORMATION ABOUT YOUR GRIEVANCE		

10. Grievance/Complaint Type (check all that apply):

- ☐ Service not available/inaccessible
- ☐ Enrollment/disenrollment issues (Medi-Cal only)
- ☐ Problems with payment to provider
- ☐ Staff issue/customer service
- ☐ Denied services/referral/appointment
- ☐ Patient Rights violation
- ☐ Quality/appropriateness of care
- ☐ Billing
- ☐ Other

11. Please describe your grievance/complaint. Attach additional pages or supporting documentation.

Signature of Person or Authorized Representative   Date

YOU CAN SUBMIT THE GRIEVANCE ANY OF THE FOLLOWING WAYS:

Please complete the information in the boxes below:

1. **(Check One):** ☐ Standard Appeal ☐ Expedited Appeal		2. Date:
INFORMATION ABOUT MEDI-CAL BENEFICIARY FILING APPEAL		
3. Name (Last, First, and Middle):	4. Date of Birth:	5. Medi-Cal Number:
6. Street Address:	City:	Zip Code:
7. Phone Number and/or E-mail:	8. Is it okay to leave a voice message? ☐ Yes ☐ No	
COMPLETE IF AUTHORIZING A REPRESENTATIVE TO APPEAL ON YOUR BEHALF		
9. Name of Representative:	10. Agency Name/ Relationship:	11. Phone and/or E-mail:
12. Street Address:	City:	Zip Code:
13. **If you are authorizing another person or entity to represent you in filing this appeal, please sign below:**		
I authorize the person or entity named above to serve as my representative for this appeal.		
INFORMATION ABOUT THE APPEAL		
14. Did you receive a Notice of Adverse Benefit Determination (NOABD) letter? ☐ Yes ☐ No		
15. Did anyone help you complete this form? ☐ Yes ☐ No		
16. Which type of NOABD did you receive: ☐ Denial ☐ Payment Denial ☐ Other, describe ☐ Termination ☐ Timely Access to Services ☐ Notice of Grievance/Appeal Resolution		
17. Addition information on your appeal of the NOABD. Attach pages and documentation, if needed.		

Signature of Medi-Cal Beneficiary/Authorized Representative   Date

SUBMIT THE COMPLETED APPEAL BY:

- **Email: SAPCmonitoring@ph.lacounty.gov** ● **Phone: (626) 299-4532** ● **Fax: (626) 458-6692**
- **Mail: Substance Abuse Prevention and Control, Contract and Compliance Section 1000 South Fremont Avenue, Building A9 East, 3rd floor Alhambra, California 91803**

If you need this form in alternate format (e.g. another language, large print, braille), call 1-888-742-7900.

For more information on the problem resolution process, please refer to your patient handbook or visit us at http://publichealth.lacounty.gov/sapc/PatientPublic.htm

Appeal Process

- Within five (5) calendar days of receipt of the appeal the Plan shall provide the beneficiary written acknowledgement of receipt of the appeal
- The Plan shall resolve appeals within 30 calendar days

- Extension of resolution (up to 14 calendar days)
  - If beneficiary requests the extension
  - The Plan demonstrates a need for additional information and the delay is in the beneficiary's best interest.
    - Extensions by the Plan require written notification to the beneficiary of the delay.

What if the beneficiary can't wait 30 days for a resolution

- Federal regulations requires the Plan to resolve the appeal within 72 hours from receipt of the appeal.

- A 14 calendar day extension may be granted in accordance with federal regulations.

This may include an appeal for remaining at a residential facility which is time sensitive.

Appeal Outcomes

County Overturns the original decision and agrees with the beneficiary/designee regarding the appeal. The county will provide the *Adverse Benefit Determination Overturned (Notice of Appeal Resolution-NAR)* letter to the beneficiary

County Upholds the original decision that led to a NOABD and provides the beneficiary the *Adverse Benefit Determination Upheld (NAR)* letter as well as the *NAR "Your Rights" attachment.*

- If the beneficiary is unsatisfied with the decision, they have the right to request a State Hearing.

State Hearing

- Must be requested within 120 calendar days from the NAR

Or

- If the Plan fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Plan's appeals process. The enrollee may then initiate a State hearing.

- State is to come to a decision within 90 calendar days from the date of the hearing request or three working days for Expedited Hearings.

SAPC NOABD Generated Notifications

- SAPC will begin electronically generating NOABDs on Sept 15, 2021.
- SAPC is responsible for:

  Enclosure 1 Notice of Grievance Resolution (NGR)

  Enclosure 2 Denial Notice (NOABD)

  Enclosure 3 Payment Denial Notice (NOABD)

  Enclosure 7 Timely Access Notice (NOABD) → CORE Staff Only

  Enclosure 8 Financial Liability Notice (NOABD)

  Enclosure 10 Adverse Benefit Determination Upheld (NAR)

  Enclosure 12 Adverse Benefit Determination Overturned (NAR)

  Enclosure 16 NOABD Grievance and Appeal Timely Resolution Notice

SAPC NOABD Impact

- SAPC will send copies of notification letters to beneficiaries as well as the treatment provider.
- For Authorization Denials, comments about NOABDs will be added in the service authorization request including how to appeal.
  - This may cause concern for patient's if they think their treatment will be terminated, which is not the case.
- For financial denials- these will not occur after ever denial, but rather after the denial has been worked and cannot be fixed to result in an approved State claim.

COUNTY OF LOS ANGELES
Public Health

Summary

- Timely Access notifications apply to all providers
- Termination notifications apply to pre-authorized services (Residential) only
- Logs of NOABDs are provided to SAPC on a quarterly basis.
- Appeal process is led by SAPC.
- SAPC will begin mailing electronically generated NOABDs Sept 15, 2021