Notice of Adverse Benefit Determination (NOABD)

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

NOABD Reminders

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

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

This notice provided 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.

Types of NOABD

- Denial Notice (NOABD)
- Payment Denial Notice (NOABD)
- Modification Notice (NOABD)
- Termination Notice (NOABD)
- Timely Access Notice (NOABD)
- Financial Liability Notice (NOABD)
- Authorization Delay Notice
- NOABD Grievance and Appeal Timely Resolution Notice
- Notice of Grievance Resolution (NGR)
- Notice of Appeal Resolution (NAR)

Each NOABD notice also includes the following:

- NOABD “Your Rights” Attachment
- Beneficiary Non-Discrimination Notice
- Language Assistance Taglines

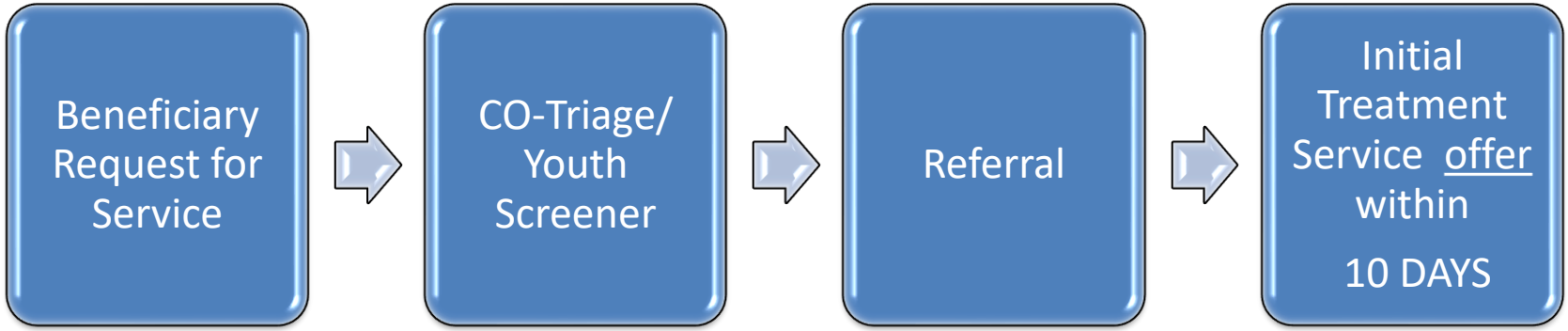
Each NOABD also has specific formatting: **Do not change any font sizing or formatting**

Timely Access: All Providers

Failure to offer services within designated timeframes from the initial request for service

- 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** if unable to admit

Termination: Pre-Authorized Services ONLY

- 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 non adherence to program rules.

  *for information on exceptions to this go to http://ph.lacounty.gov/sapc/NetworkProviders/Forms.htm NOABD
- 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.
- NOABD is required if the patient **disagrees** with the termination

ReCap Key Actions for NOABDs

- Effective November 1th, 2019 Providers were required to complete NOABDs related to Timely Access and Termination.
- This means:
  - **All Providers** should be sending Timely Access notifications to patients when services are not offered within the specified timeframes
  - **Residential Providers** should be distributing Termination notifications to patients when the authorized service is being terminated AND the patient disagrees with termination
  - **Log NOABDs** using the template AND submit to SAPC quarterly.
  - **Submit** copies of the notification letters to your CPA.

Future Changes to SAPC-Generated NOABDs

- Currently, SAPC generates NOABDs via a manual process.
- SAPC will begin using Sage to generate and then mail notices to providers and patients.
- A patient may request your assistance in explaining what the letter means.
- SAPC will update the provider when this process will begin in 2021.

Grievance & Appeals

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” in order for one to be filed.
  - Providers submitting grievances on behalf of the beneficiary require written consent/authorization.

GRIEVANCE AND APPEALS - CLARIFICATION

Appeal is a **Medi-Cal Beneficiary's** request to have a decision about their care review by SAPC, such as an adverse benefit determination (ABD) made by the SAPC or Provider

It is their right to file an appeal

A request for an appeal should be made within 60 calendar days from the decision.

- Providers submit appeals **ON BEHALF** of the patient with written consent
- 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

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

SUBSTANCE ABUSE PREVENTION AND CONTROL
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803

APPEAL FORM

The Department of Public Health Substance Abuse Prevention and Control (SAPC) is the specialty substance use disorder plan for the County of Los Angeles. While receiving substance use disorder treatment, you have the right to use SAPCs problem resolution process.

HOW THE PROBLEM RESOLUTION PROCESS WORKS - APPEALS:

If you are a Medi-Cal beneficiary, meaning you are currently enrolled in Medi-Cal, you have the right to file an appeal when you receive a Notice of Adverse Benefit Determination (NOABD) from SAPC or your substance use disorder treatment provider.

An NOABD is a document given to Medi-Cal beneficiaries telling them about a denial or change in services. If you disagree with a decision in the NOABD, you can file an appeal with SAPC. That means you can ask for the decision to be reviewed and possibly changed. If you request a standard appeal, SAPC may take up to 30 calendar days to review. If you think waiting 30 calendar days will put your health at risk, you may ask for an expedited appeal which, if it meets certain criteria, will be reviewed within 72 hours.

If you receive a NOABD and want to appeal the decision:

- Your request for an appeal must be received within 60 calendar days from the date of the original decision.
- You may request an "expedited" appeal under extreme circumstances.
- You will not be subject to discrimination or any other penalty.
- Your confidentiality will be protected according to government laws (*W&I 5328 and 42 CFR Part 2*).

After you submit this form, if you disagree with the decision made about your appeal, you can request a State Fair Hearing. A State Fair Hearing is an independent review conducted by the State Department of Social Services. You must make the request within 120 days from the date you received the appeal decision. If you are currently in treatment and want to continue while you appeal, you must ask for a State Fair Hearing within 10 days from the date of appeal decision. If you need assistance requesting a State Fair Hearing, ask your treatment provider or call SAPC at 1-888-742-7900.

To request a State Fair Hearing on your own		
Write to:	State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, California 94244-2430	Call: (800) 952-8349

If you want to have a complaint or decision about your care reviewed again, but did not receive an NOABD, please file another "Grievance" form.

NOTE: During the public health emergency resulting from the COVID-19 pandemic, you may appeal a decision for up to 120 days from the date of the original decision and request a State Fair hearing within 240 days from the date you received the appeal decision.

...se 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

UPDATED FORM - COMPLAINT

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

UPDATED FORM - APPEAL

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

Questions

THANK YOU

For more information, contact
SAPC QI & UM at:

sapc.qi.um@ph.lacounty.gov