DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

NOTICE OF ADVERSE BENEFIT

Section: Administrative Policies

Pages: 5

Subject: Notice of Adverse Benefit

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POLICY

DBH will maintain and implement policies and procedures related to Actions and for providing Notice of Adverse Benefit to Enrollees.

An action is defined as the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; or the failure of the health plan to act within required timeframes defined by the State for standard resolution of grievances and appeals and the denial of a member's request to dispute a member financial liability (cost sharing, copayments, premiums, deductibles, coinsurance, or other).

DBH uses the guidelines of least restrictive environment and medical necessity as the clinical basis for limiting services. DBH does not deny, reduce the amount, duration, or scope of service based solely on diagnosis, type of illness, or condition.

PROCEDURE

1. If DBH denies a service authorization request, or authorizes a service in an amount, duration, or scope that is less than requested, including the type or level of service, this constitutes an Action unless the Enrollee agrees with the services offered.
    a. If the request was made for a client being treated by a subcontractor, DBH will notify the requesting subcontractor (the notice need not be in writing) and give the Enrollee a written Notice of Adverse Benefit.
    b. If the request was made for a client being treated by an employed provider, DBH will give the Enrollee a written Notice of Adverse Benefit.
    c. It is not an Action if DBH agrees to give the requested covered service but does not approve the individual from whom the Enrollee wants to obtain the service.

2. If DBH does not reach service authorization decisions within the time frames specified in the Service Authorization policy for standard and expedited service authorization requests, this constitutes a denial and is thus an adverse Action.
    a. DBH will notify the requesting subcontractor (the notice need not be in writing) and give the Enrollee a written Notice of Adverse Benefit by or on the date of the applicable time frame for making decision expires.
    b. For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization.
    c. For expedited service authorization decisions, within 72 hours of the request for authorization.
    d. For service authorization decisions not reached within the 14-calendar day or 72-hour timeframes, on the date these timeframes expire.
3. If DBH terminates, suspends or reduces previously authorized covered services, and the Enrollee informs DBH that he or she disagrees with the change in his or her treatment plan, this constitutes an Action.
    a. DBH will notify the subcontractor (if services were provided by a subcontractor), and mail a Notice of Adverse Benefit to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following time frames:
        i. at least 10 days before the date of the Action, or
        ii. 5 days before the date of the Action if DBH has facts indicating that Action should be taken because of probable fraud by the Enrollee, and the facts have been verified, if possible, through secondary sources, or
        iii. By the date of the Action if:
            1. DBH has factual information confirming the death of the Enrollee
            2. DBH receives a clear written statement signed by the Enrollee that:
                a. he no longer wishes services, or
                b. he gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information
            3. the Enrollee has been admitted to an institution where he is ineligible for further services
            4. the Enrollee's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address. In this case any discontinued services must be reinstated if his whereabouts become known during the time is eligible for services,
            5. the Enrollee has been accepted for Medicaid services by another local jurisdiction, or
            6. the Enrollee's physician or other licensed mental health therapist authorized to prescribe mental health treatment under Utah law prescribes the change in the level of medical (mental health) care.
4. If DBH denies payment in whole or in part, this constitutes an action.
    a. DBH will notify the requesting subcontractor or other provider of decisions to deny payment in whole or in part.
    b. DBH will mail the Enrollee a written Notice of Adverse Benefit at the time of the Action affecting a claim.
    c. A Notice of Adverse Benefit to the Enrollee is not necessary if:
        i. the provider billed DBH in error for a non-authorized service, or

ii. the claim does not meet the definition of a clean claim.

d. DBH will make the necessary notifications at the time the payment decision is made.

5. If DBH fails to provide the first face-to-face service in a timely manner according to performance standards specified in the Access to Care policy, this may constitute an Action.
    a. DBH will give the Enrollee a Notice of Adverse Benefit when DBH fails to provide the first face-to-face service in a timely manner according to performance standards specified in the Access to Care policy, only when:
        i. the reason is due to DBH's limitations, and
        ii. the Enrollee is not satisfied with waiting beyond the required time frame
    b. If the Enrollee agrees to and is not dissatisfied with waiting beyond the required time frame, DBH determines the Enrollee should not be at risk as a result of waiting, and the Enrollee is told to contact DBH if his or her situation changes, then this does not constitute failure to provide covered services in a timely manner, and therefore is not an Action.
    c. DBH will provide the Notice of Adverse Benefit at the time it is determined the performance standard will not be met due to DBH's limitations and that the Enrollee is not satisfied with the situation.
6. Failure of DBH to act within the time frames provided for resolving and giving resolution notice for Appeals or Grievances constitutes and Action. These time frames are specified in the Time Frames for Standard Appeal policy, Time Frames for Expedited Appeals policy, and Time Frames for Grievances policy.
    a. If DBH does not resolve an Appeal within the required time frame, the Enrollee has already gone through DBH's Appeal process. Therefore, by declaring DBH's failure to provide resolution of the Appeal within the required time frame an Action, the Enrollee may now file a request for a State Fair Hearing as the Enrollee has already exhausted DBH's internal Appeal process. The Enrollee need not go through this process again.
    b. DBH will attach either the "Request for a Standard State Fair Hearing/Agency Action" form or the "Request for an Expedited State Fair Hearing/Agency Action" form that the Enrollee must complete and submit to the Division of Health Care Financing to request a State Fair Hearing, and continuation of benefits, if applicable. DBH will include a copy of the Request for an Expedited State Fair Hearing/Agency Action form if the Enrollee had an expedited Appeal.
    c. DBH will provide a Notice of Adverse Benefit letter to the Enrollee at the time DBH determines the time frame for resolving the Appeal or Grievance will not be met.
7. DBH's Notice of Adverse Benefit to the Enrollee will be in written in a manner and format that will ensure ease of understanding. This will include writing the Notice of Adverse Benefit at the sixth-grade level, whenever possible, and providing the Notice of Adverse Benefit in all non-English prevalent languages(s) and alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
    a. The written Notice of Adverse Benefit will explain the following:
        i. the Action DBH has taken or intends to take
        ii. the reason for the Action

iii. the date the Action will become effective when the Action is to terminate, suspend, or reduce a previously authorized covered service
iv. the reasons for the Action, including the right of the enrollee to be provided upon request at no cost reasonable access to documents, records relevant to the decision, including medical necessity criteria and information or processes used for setting coverage limits.
v. the Enrollee's or the provider's right to file an Appeal of the Action and that the providers may file an Appeal for the Enrollee only with the Enrollee's written consent or the Enrollee's right to request a State Fair Hearing if the action was failure to decide an Appeal within the required time frame
vi. the procedures for filing an Appeal, or the procedures for requesting a State Fair Hearing if the Action was failure to decide an Appeal within the required time frame
vii. In the instance where the Action is a denial in whole or in part of payment for a service, DBH may add language to the effect that;
    1. the Enrollee may be liable for payment if he or she has signed forms taking responsibility for the payment of services and therefore may receive requests for payment for the provider, and
    2. DBH's role during an Appeal would be to not only review its non-payment of services, but additionally, at the Enrollee's request, to act as an advocate for the Enrollee in payment negotiations with the provider
viii. the circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution
ix. the Enrollee's right to have benefits continue pending resolution of the Appeal of an Action to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider
x. how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is averse to the Enrollee, to the extent that they were furnished solely because of requirements based on 42 CFR 438.420.
xi. the time frames for filing an Appeal:
    1. If the Enrollee is not requesting continuation of benefits pending resolution of an Appeal of an Action to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider, and the original period covered by the original authorization has not expired, the Enrollee, or the provider with the Enrollee's written consent, must file the Appeal within 60 days from the date on DBH's Notice of Adverse Benefit of Action, or
    2. If the Enrollee is requesting continuation of benefits pending resolution of an Appeal of an Action to terminate, suspend, or reduce a previously authorized course of treatment that was ordered by an authorized provider, and the original period covered by the original authorization has not expired, the Enrolleeor provider

must request continued benefits on or before the later of the following:

i. within 10 days of DBH mailing the Notice of Adverse Benefit, or
ii. by the intended effective date of DBH's proposed Action.

8. DBH will develop and include as an attachment to the Notice of Adverse Benefit an appeal form that Enrollees may use as the written request for standard Appeals. This form may also be used for expedited Appeals if the Enrollee chooses to submit a written request for expedited Appeal resolution, even though only an oral filing is required.
    a. If the Action is due to failure to decide an Appeal within the required time frame, then DBH will provide a Notice of Adverse Benefit letter that informs Enrollees of their State Fair Hearing rights and include as an attachment a copy of the applicable State Fair Hearing Request Form that explains how to request a State Fair Hearing and the time frames for doing so.
    b. DBH will attach either the Request for a Standard State Fair Hearing/Agency Action form or the Request for an Expedited State Fair Hearing/Agency Action form that the Enrollee must complete and submit to the Division of Health Care financing to request a State Fair Hearing, and continuation of benefits, if applicable. DBH will include a copy of the Request for an Expedited State Fair Hearing/Agency Action form if the Enrollee had an expedited Appeal.
    c. The form will provide a prompt (through use of check boxes or other means) for Enrollees to:
        i. request expedited Appeal resolution if they choose to submit a written request for an expedited Appeal resolution, and
        ii. request continuation of benefits, if applicable
        iii. provide a statement that if continuation of benefits is requested when a previously authorized service is terminated, suspended or reduced, that the Enrollee agrees that DBH may recover from the enrollee the cost of the services furnished while the Appeal is pending if the Appeal decision is adverse to the Enrollee, to the extent that the services were furnished solely because of requirements based on 42 CFR 438.420
        iv. summarize assistance the Enrollee may request to complete the Appeal Request form and how to request the assistance