Policy Title: *Notice of Adverse Benefit Determination*  
Policy #: CSE-5  

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Revised: September 28, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Torella, Director Community Services, Housing, and Community Development Department</td>
<td>Reviewed:</td>
</tr>
<tr>
<td>Signature Date: 10/8/2018</td>
<td>Signing by authority of Res. No. 2007-0038</td>
</tr>
</tbody>
</table>

**References**

42 CFR 438.404 – Timely and Adequate Notice of Adverse Action  
42 CFR 438.10(c) and (d) – Information Requirements  
42 CFR 438.408(b) Resolution and Notification – Grievances and Appeals  
WAC 182-538D-0665 – Notice of Adverse Benefit Determination  
WAC 182-538D-0670 – Filing an appeal

**Scope**

The Spokane County Regional Behavioral Health Organization (SCRBHO) and its network providers.

1. **Policy**

1.1. The SCRBHO must ensure that Notices of Adverse Benefit Determinations meet all CFR and Health Care Authority (HCA) contract requirements.

1.2. The SCRBHO or its designee must provide a written Notice of Adverse Benefit Determination to a Medicaid Enrollee, in accordance with 42 CFR §438.404, when there is a denial, reduction, termination, or suspension based on the SCRBHO Level of Care Guidelines.

1.3. The Notice of Adverse Benefit Determination must include an understandable explanation of:

1.3.1. The action the SCRBHO has taken or intends to take;

1.3.2. The reasons for the action and a citation of the rule(s) being implemented;

1.3.2.1. The right of the Enrollee to be provided reasonable access to and copies of all documents, records, and other information relevant to the Enrollee’s adverse benefit determination upon request and free of charge. Such information includes medical necessity criteria, and any processes, strategies, or standards used in setting coverage limits;
1.3.3. The Enrollee's right to file an appeal with the SCR3HO, the process to file an appeal, including information on exhausting SCR3HO's one-level appeal process and the Enrollee's right to request an Administrative Hearing if the Enrollee does not agree with the decision or action;

1.3.4. The circumstances under which an expedited resolution is available and how to request it; and

1.3.5. The Enrollee's right to receive behavioral health services while an Appeal is pending, how to make the request that benefits be continued, and that the Enrollee may be held liable for the cost of services while the Appeal is pending if the Appeal decision upholds the decision in the Notice of Adverse Benefit Determination.

1.4. The Notice must be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements identified in 42 CFR Section 438.10 (d).

2. Definitions

2.1. Adverse Benefit Determination means:

2.1.1. The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;

2.1.2. The reduction, suspension, or termination of a previously authorized service;

2.1.3. The denial, in whole or in part, of payment for a service;

2.1.4. The failure to provide services in a timely manner, as defined by the state; and

2.1.5. The failure of SCR3HO or its designee to act within the timeframes provided in section 42 CFR § 438.408(b), WAC 182-538D-0665

2.2. Appeal means an oral or written request by an Enrollee, or with the Enrollee's written permission, the Enrollee's Authorized Representative, for the SCR3HO to review an Action as defined above.

2.3. Authorized Representative means an individual appointed by an Enrollee, or authorized under the State or other applicable law, to act on behalf of an Enrollee or other party involved in an Appeal or Grievance. If the Enrollee gives written permission, the Authorized Representative may include a behavioral health practitioner working on behalf of the Enrollee.

2.4. Denial means the decision by the SCR3HO or designee to refuse authorization of covered behavioral health services that have been requested by an Enrollee of a provider on behalf of an eligible Medicaid Enrollee. It is also a denial if an intake or assessment is not provided upon request by a Medicaid Enrollee.

2.5. Enrollee means a Medicaid recipient who is enrolled in a Pre-Paid Inpatient Health Plan (PIHP).

2.6. Reduction means the decision by the SCR3HO or designee to decrease a previously authorized covered Medicaid behavioral health service described in
the Level of Care Guidelines. The clinical decision by a behavioral health agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

2.7. Request for Service means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an Enrollee or the Authorized Representative. An Early Periodic Screening, Diagnostic and Treatment (EPSDT) referral is only a Request for Service when the Enrollee or the person authorized to consent to treatment for that Enrollee has confirmed that they are requesting service.

2.8. Suspension means the decision by the SCRBHO or designee to temporarily stop previously authorized covered Medicaid behavioral health services described in the Level of Care Guidelines or ASAM Criteria. The clinical decision by a behavioral health agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

2.9. Termination means the decision by the SCRBHO or designee to stop previously authorized covered Medicaid behavioral health services described in its Level of Care Guidelines. The clinical decision by a behavioral health agency to stop or change a covered service in the Individualized Service Plan is not a termination.

3. Procedures/Mechanisms

3.1. The SCRBHO or its designee must have Care Managers available twenty-four (24) hours a day, seven (7) days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve (12) hours of the initial request.

3.2. Only a psychiatrist or doctor level-clinical psychologist may deny a request for psychiatric inpatient care.

3.3. If the authorization is denied, a Notice of Adverse Benefit Determination must be provided to the Enrollee or their authorized representative.

3.4. The Notice of Adverse Benefit Determination must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding. The notice must be provided within the following formats:

3.4.1. Provide a written translation of the Notice of Adverse Benefit Determination to the Enrollee in the designated HCA prevalent non-English languages that are spoken by five percent (5%) or more of the population of the State of Washington, and in no less than twelve-point font.

3.4.1.1. HCA has determined that Spanish is the required language.

3.4.2. Provide the document in an alternative format when requested by the Enrollee or his or her authorized representative.

3.5. The SCRBHO or its designee must mail the Notice of Adverse Benefit Determination within the following timeframes:

3.5.1. For Routine Service authorization decision that deny or limit services, no longer than fourteen (14) days from the request for service;
3.5.2. For termination, suspension, or reduction of previously authorized services, no longer than ten (10) days before the date of the Adverse Benefit Determination; and

3.5.3. For Notice of Adverse Benefit Determinations that are issued because the SCRBHO has verifiable information indicating provable beneficiary fraud, the notice can be provided in as few as five (5) calendar days.

3.5.4. When any of the following occur, the SCRBHO or designee must issue the notice on the date:

3.5.4.1. The Enrollee has died;

3.5.4.2. The Enrollee submits a signed written statement requesting termination;

3.5.4.3. The Enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction may result;

3.5.4.4. The Enrollee has been admitted to an institution in which he or she is ineligible for Medicaid services;

3.5.4.5. The Enrollee’s address is determined unknown based on returned mail with no forwarding address;

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

3.5.4.7. A change in the level of medical care is prescribed by the Enrollee’s physician;

3.5.4.8. An adverse determination with regard to preadmission screening requirements has been made; and

3.5.4.9. The transfer or discharge from a facility that happened in an expedited fashion.

3.5.4.10. For Enrollees receiving (WISE):

3.5.4.10.1. A (CANS) screen results in the denial of a request for (WISE), or any other decision that meets the definition of an Adverse Benefit Determination); and

3.5.4.10.2. The Enrollee expresses disagreement with (the SCRBHO) a treatment decision or the individual service plan.

3.5.5. For standard service authorization decisions that deny services, the notice will be mailed within the time frame specified.

3.5.6. Under the following circumstances, fourteen (14) additional calendar days are possible:

3.5.6.1. The Enrollee or behavioral health agency requests an extension; and
3.5.6.2. The SCRBHO or designee demonstrates the need for additional information to make an authorization decision and that the extension is in the Enrollee’s best interest.

3.6. If the SCRBHO extends the timeframe it must:

3.6.1. Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and

3.6.2. Issue and carry out its determination as expeditiously as the Enrollee’s health condition requires and no later than the date the extension expires.

3.7. The SCRBHO or designee must provide a Notice of Adverse Benefit Determination on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

3.8. The SCRBHO or its designee will provide a Notice of Adverse Benefit Determination if the SCRBHO or its formal designee:

3.8.1. Denies a service authorization request; or

3.8.2. Authorizes a service in an amount, duration, or scope that is less than requested.

3.8.3. In such cases, the SCRBHO shall notify the requesting contracted provider and provide the Enrollee with a written Notice of Action within fourteen (14) days of the decision.

3.9. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Mental Health Professional (MHP) or Chemical Dependency Professional (CDP) with the appropriate clinical expertise to make that decision.

3.10. When an intake is denied or services beyond the intake have not been authorized for children in out-of-home placements, the Children, Youth, and Families Regional office must also be notified.

3.11. Standard authorization decisions not reached in accordance with the timeframes established above constitute a denial and an adverse action that are subject to appeal.

3.12. For expedited service authorizations, as expeditiously as the Enrollee’s health status requires, and no later than three (3) days of the receipt of a request for services (CFR 438.210(d)(2)).

3.13. The SCRBHO’s contracted providers must assure the most recent address for the Enrollee is documented in the SCRBHO MIS system in order to assure the Notice of Adverse Benefit Determination is sent to the correct address.

3.14. If the Enrollee has indicated a preference of not having mail regarding his or her behavioral health services sent to the listed home address, an alternate mailing address must be indicated.
3.15. Formulating the Notice of Adverse Benefit Determination is not delegated to the SCRHO’s contracted providers; however, the provider may deliver the notification to the Enrollee in person.

4. Monitoring

4.1. The SCRHO will monitor the provider’s corresponding policy through the annual contracted provider monitoring, with the appropriate recommendations, findings, and/or corrective actions required in performance improvement projects.