NORTHCARE NETWORK

POLICY TITLE: Adverse Benefit Determination	**CATEGORY:** Utilization Management	
EFFECTIVE DATE: 5/13/20	**BOARD APPROVAL DATE:** 5/13/20	
REVIEW DATE: 10/3/24	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: QI/UM Specialist & Senior Clinical Director	**CEO APPROVAL DATE:** 11/5/24 Megan Rooney, CEO	

APPLIES TO

NorthCare Network Personnel
Member CMHSPs
SUD Provider

POLICY

It is the Policy of NorthCare Network that all Network Providers follow the required guidelines regarding notifying Medicaid recipients of an Adverse Benefit Determination.

PURPOSE

This policy is intended to facilitate compliance with the guidelines set forth by MDHHS and the code of federal regulations regarding Medicaid notices and Adverse Benefit Determinations.

DEFINITIONS

1. ***Adverse Benefit Determination (ABD*)**: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:
    - Denial or limited authorization of a requested service, including the type or level of service.
    - Reduction, suspension, or termination of a previously authorized service.
    - Denial, in whole or in part, of payment for a service.
    - Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
    - Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization.
    - Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
    - Failure of the PIHP to act within **30 calendar days** from the date of a request for a standard appeal.
    - Failure of the PIHP to act within **72 hours** from the date of a request for an expedited appeal.
    - Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.
    - For a resident of a rural area, the denial of an Enrollee’s requests to exercise their right, to obtain services outside the network.

- Denial of Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility.

2. ***Adequate Notice of Adverse Benefit Determination:*** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect.

3. ***Advance Notice of Adverse Benefit Determination:*** Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notices must be provided/mailed to the Medicaid Enrollee at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect.

4. ***Mi Health Link:*** Mi Health Link (MHL) is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid and live in one of the four pilot regions of Michigan, including the Upper Peninsula. The Local health plan responsible for managing the MI Health Link program is Upper Peninsula Health Plan.

5. ***Service Authorization:*** the processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limit to 42 CFR 438.210

REFERENCES

- Balanced Budget Act of 1997
- Michigan Mental health Code
- 42 CFR 438.400
- 42 CFR 438.404
- NorthCare Network Service Authorization Policy
- NorthCare Network Enrollee Grievance and Appeal Policy
- 42 CFR 431.211; 42 CFR 431.213; 42 CFR 431.214
- 42 CFR 438.404(c)(2)
- 42 CFR 438.210(d)(1)
- MDHHS Policies & Practices Guidelines - Appeal and Grievance Resolution Processes Technical Requirement https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html

HISTORY

NEW POLICY: 5/13/20
REVISION DATE:9/24/20, 10/1/21, 12/5/23, 5/6/24
REVIEW DATE: 9/24/20, 10/1/21, 11/1/22, 12/5/23, 5/6/24
CEO APPROVAL DATE: 4/6/20, 9/24/20, 11/2/21, 11/1/22, 12/5/23, 5/7/24
BOARD APPROVAL DATE: 5/13/20

PROCEDURES

A. Notice of Adverse Benefit Determinations (ABD):

(Each agency is required to provide timely and "adequate" notice of any ABD.)

1. **Notice Content and Format:** The notices of ABD must meet the following requirements, and must include:
    a. Enrollee Notice must be in writing and must be in a manner and format that may be easily understood and readily accessible by such enrollees and potential enrollees, must meet the needs of those with limited English proficiency and or limited reading proficiency.
    b. The basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures to be included. (42 CFR 440.230(d))
    c. Description of the ABD
    d. The reason(s) for the ABD and policy/legal authority relied upon in making the determination.
    e. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's ABD (including medical necessity criteria, any processes, strategies, or evidentiary standard used in setting coverage limits).
    f. Notification of the Enrollee's right to request an Appeal, including information on exhausting the local appeal process first, and then their right to request a State Fair Hearing.
    g. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal
    h. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instruction on how to request benefit continuation and a description of the circumstances under which the Enrollee may be required to pay the costs of the continued services.
    i. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights.
    j. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

- The state developed notice of an adverse benefit determination template, must be used by each network provider. Templates are included in MDHHS/PIHP Appeal and Grievance Resolution Processes Technical Requirement.

2. Timing of Notices:

a. Adequate Notice of Adverse Benefit Determinations:
    i. For denial of payment for services requested (not currently provided), notices must be provided to the Enrollee at the time of the action affecting the claim.
    ii. For a service Authorization decision that denies, or limits services notices must be provided to the Enrollee within 14 days following receipt of the request for services for standard authorization decision, or with 72 hours after receipt of a request for an expedited authorization decision
    iii. For Service Authorization decisions not reached with 14 days for standard request, or 72 hours for an expedited request, (which

constitutes a denial and is thus an adverse benefit determination) on the date that the timeframes expire.

b. Extension of Service Authorization Timeframes: The standard or expedited Service Authorization timeframe can be extended for up to an additional 14 calendar days if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest. If the PIHP extends the time, the agency must:
    i. make reasonable efforts to give the Enrollee prompt oral notice of the delay,
    ii. within 2 calendar days, provide 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
    iii. issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
    iv. Decisions not made within the timeframe constitutes a denial and requires an adequate benefit determination.

c. Advance Notice of Adverse Benefit Determination:
    i. Required for reductions, suspensions, or terminations of previously authorized/ currently provided Medicaid Services.
    ii. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date**.**
    iii. If proper advance ABD is not sent and services are reduced, suspended, or terminated, when the provider becomes aware of the failure to send proper advance ABD, services previously reduced/suspended/terminated must be reinstated.

d. For services authorized but consistently underutilized for an extended period of time, ABD must be provided.
    i. When it is identified that the CMH does not have provider capacity* to provide the service, or provide the service in the Amount/Scope/Duration/Frequency authorized, ABD shall be sent.
        1. *provider capacity: CMH's must demonstrate due diligence to find providers when reason for ABD is capacity.
    ii. When it is identified that the CMH has not consistently provided the service in the A/S/D/F authorized, ABD shall be sent.
        1. The timeline for this will vary by how frequent the service is authorized. For example, daily services not provided for around a month should be provided ABD. Quarterly services not provided for 2 quarters should be provided ABD.

e. *Limited Exceptions to sending an Advance Notice of Adverse Benefit Determination:* The PIHP may mail an adequate notice of an Adverse Benefit Determination, not later than the date of action to terminate, suspend or reduce previously authorized services if:
    i. There is factual information confirming the death of an Enrollee;

ii. A clear written statement is received that is signed by an Enrollee that they no longer want services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;
iii. The Enrollee has been admitted to an institution where they are ineligible under the plan for further services;
iv. The Enrollee's whereabouts are unknown, and the post office returns agency mail directed to them indicated no forwarding address;
v. The Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
vi. A change in the level of medical care is prescribed by the Enrollee's physician;
vii. The ABD involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;
viii. The date of action will occur in less than 10 calendar days due to health and safety issues (CFR 483.15).
ix. There are facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case the period of advance ABD may be changed to 5 days before the date of action).

3. Required Recipients of Notice of Adverse Benefit Determination:

a. The Enrollee must be provided written notice of an Adverse Benefit Determination. *42 CFR 438.404(a); 42 CFR 438.210(c).*
b. The requesting provider must be provided ABD of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notification to the provider does NOT need to be in writing. *42 CFR 438.210(c).*
c. If the utilization review function is not performed within an identified organization, program, or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person-centered planning process still constitutes an adverse benefit determination, and requires a written ABD.
d. An Adverse Benefit Determination will be mailed to the member when there is a denial of payment, at the time of any action affecting the claim.

4. Requirements

a. Decisions to deny or authorize less of a service than requested must be made by an individual who has appropriate expertise in addressing the enrollees needs.

5. Distribution

a. NorthCare's decisions are mailed the first Tuesday or Friday after decisions/claims payments have been made (printed). Our mail is picked up between noon and 3 p.m. daily by the United States Postal Service (USPS). In the event an ABD is not printed by the time of mail pick-up, staff will place the ABD in the USPS drop-box located at 1401 O'Dovero

Drive in Marquette, MI by 5pm. Mail leaves NorthCare Network offices between noon and 3pm with the postal carrier who brings new mail. NorthCare's Customer Services Support manages incoming and outgoing mail. All mail is date stamped at the time of receipt from USPS.

6. ABD Requirement for Denial of Payment

An ABD (Adverse Benefit Determination) must be provided to any individual enrolled in Medicaid when a payment of a claim is denied in whole or in part. This ABD must be provided at the time of the action affecting the claim.

Scenarios where an ABD is and is not required: (This is not meant to be an all-inclusive list)

Examples	Yes - Required	No – Not Required
Billing provider has not included all required information on a claim (Does not meet definition of "clean claim"), so it is denied.		√
Service is neither authorized in IPOS nor meets medical necessity criteria and we receive a claim.	√	
Provider does not have appropriate credentials or service is outside of their scope of practice and we receive a claim.	√	
Provider submits claim for service provided without proper supervision, when required.	√	
Claim received for a medical device or service we don't provide (non-BH).		√
If claim is received for inpatient psychiatric service with no Pre-admission screening completed and a retrospective review is conducted resulting in medical necessity not met.	√	
Claim received for inpatient days beyond authorized units and not covered by GF.	√	
Primary payer pays full or over our contract rate and we receive a claim.		√
Clean claim not received within contracted time frame and claim is denied.	√	

ABDs are not dependent upon an individual's liability. An individual is NOT liable for payment of any Medicaid covered service provided by a paneled provider. A payer may approve payment for a service provided by a non-paneled provider if medically necessary.