Medicaid Grievance and Appeal System – Notice of Adverse Benefit Determination

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid* ☐ *PSA*

Government Policy

This policy outlines the requirements and actions of how PacificSource Community Solutions will accept, process and issue notice of adverse benefit determinations in line with Oregon Administrative Rules 410-141-3515, 410-141-3520, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875 – 410-141-3895.

This policy is subject to approval by the Oregon Health Authority (OHA) and must be submitted annually as directed by OHA, or anytime thereafter upon a significant change.

Definitions

Adverse benefit determination means any of the following:

1) 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;

2) The reduction, suspension or termination of a previously authorized service;

3) The denial, in whole or in part, of payment for a service. This excludes any claim that is not a clean claim. Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

4) The failure to provide services in a timely manner pursuant to 410-141-3515;

5) The MCE's failure to act within the timeframes provided in 410-141-3875 through 410-141-3895 regarding the standard resolution of grievances and appeals;

6) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right under §438.52(b)(2)(ii) to obtain services outside the network; or

7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Adverse Benefit Determination

(1) When PacificSource has made an adverse benefit determination, PacificSource shall notify the requesting provider and give the member and the member's representative a written notice of adverse benefit determination. The notice shall:

(a) PacificSource must use an Oregon Health Authority (OHA) approved form unless the member is dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in Oregon's NOABD.

(b) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal. This includes translating a NOABD for those members who speak prevalent non-English languages. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale and use of a minimum 12 point font or larger print (18 point). NOABD must include a language access tagline in 18 point font which explains:
1) The availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and
2) The toll-free and TTY/TDY telephone number of the MCE's member/customer service unit.
The NOABD includes a language access statement with the 24 translated languages in at least 12 point font.
A nondiscrimination policy is attached to each NOABD.

(c) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule;

(d) Meet the content notice requirements specified in 42 CFR § 438.404 and in PacificSource's contract, including the following information:

(A) Date of the notice;
(B) PacificSource's name, address, and telephone number;
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
(D) Member's name, address, and member ID number;
(E) Description and explanation of the service(s) requested or previously provided and explanation of the adverse benefit determination the MCE has made or intends to make, including whether the MCE is denying, terminating, suspending or reducing a service or payment for a service in whole or in part
(F) Date of the service or date service was requested by the provider or member;
(G) Name of the provider who performed or requested the service;
(H) Effective date of the adverse benefit determination if different from the date of the notice;
(I) Whether PacificSource considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830;
(J) Clear and thorough explanation of the specific reasons for the adverse benefit

determination;
(K) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;
(L) The member's or the provider's right to file an appeal of PacificSource's adverse benefit determination with PacificSource, including information on exhausting PacificSource's one level of appeal, and the procedures to exercise that right;
(M) The member's or the provider's right to request a contested case hearing with the Authority only after PacificSource's Appeal Notice of Resolution or where PacificSource failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;
(N) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;
(O) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and
(P) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by PacificSource in setting coverage limits or making the adverse benefit determination.
(Q) Provide copies of the following forms to members when it issues an NOABD:
1) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile (OHA preferred form); or
2) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030). .

(2) PacificSource shall provide copies of the following forms when PacificSource issues a Notice of Adverse Benefit Determination:
(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(b) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(3) For requirements of notice of adverse benefit determinations that affect services previously authorized, PacificSource shall mail the notice at least ten10 days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.

(4) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following:

(a) PacificSource may mail the notice no later than the date of adverse benefit determination if:

(A) PacificSource has factual information confirming the death of the member;

(B) PacificSource receives notice that the services requested by the member stating are no longer desired or PacificSource is provided with information that requires termination or reduction in services and indicates that he understands that this must be the result of supplying that information;

(i) All notices sent by a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;
(ii) All notices sent by PacificSource under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.

(C) PacificSource can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from PacificSource;

(D) PacificSource is unaware of the member's whereabouts and PacificSource receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;

(E) PacificSource verifies another state, territory, or commonwealth accepted the member for Medicaid services; or

(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.

(b) PacificSource must mail the notice five days before the adverse benefit determination when PacificSource:

(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and

(B) PacificSource has verified those facts, whenever possible, through secondary resources.

(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.

(5) For standard authorization decisions for services not previously authorized and that deny or limit the amount, duration or scope of services, the MCE must notify the requesting provider and mail the NOABD to the member as expeditiously as the member's condition requires and in all cases no later than 14 calendar days following receipt of the request for services with a possible extension for MCE up to 14 additional days, if:

1) The member, member's representative or provider requests an extension; or
2) The MCE justifies to OHA upon request a need for additional information and how the extension is in the member's best interest. MCE must provide its justification to OHA, via Administrative Notice to the email address identified by OHA in its request, within five days of OHA's request.

(6) For cases in which a provider indicates, or the MCE determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service which period of time is determined by the time and date stamp on the receipt of the request.

(7) The MCE may extend the 72 hour expedited authorization decision time period up to 14 additional calendar days if:
1) The member or the provider requests an extension; or
2) If the MCE justifies to OHA upon request a need for additional information; and
3) How the extension is in the member's interest.
MCE must provide its justification for any request to OHA, via Administrative Notice, upon request.

(8) If the MCE meets the criteria to extend the 14 calendar day NOABD timeframe for expedited and standard authorization decisions that deny or limit services, it must:
1) Give the member written notice of the reason for the decision to extend the timeframe;
2) Make reasonable effort to give the member oral notice of the reason for the decision to extend

the timeframe;
3) Inform the member of the right to file a grievance if the member disagrees with that decision; and
4) Issue and carry out its determination as expeditiously as the member's health or mental health condition requires, but no later than the date the extension expires.

(9) For either standard or expedited service authorization decisions not reached within the timeframes specified in 438.210(d) [which constitutes a denial and is thus an adverse benefit determination], the MCE must mail the notice on the date that the timeframes expire.

(10) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that PacificSource's adverse benefit determination is upheld; or if PacificSource fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider PacificSource appeals process
exhausted.

Timing of NOABD for Outpatient Drugs

Service authorization decisions for outpatient drugs include a practitioner administered drug (PAD). When the MCE has made or intends to make an adverse benefit determination for an initial outpatient drug request and is in receipt of the MCE's standard information collection tools for prior authorization, within 24 hours, the MCE must issue a written NOA/NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved.

If additional documentation needs to be requested from the prescribing practitioner in order to render a decision, this must not delay a decision to approve or deny the drug as expeditiously as the member's health requires and no later than 72 hours.

The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug.

If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the MCE must issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.

Participating Providers and Subcontractors

PacificSource must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth.

PacificSource must provide to all participating providers and subcontractors, at the time they enter into a subcontract, written notification of procedures and timeframes for notices of adverse benefit determination, grievances, appeals, and contested case hearings as set forth in Exhibit I and must provide all of its participating providers and other subcontractors written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.

PacificSource must monitor and document the compliance of its subcontractors, including its provider network, with all adverse benefit determination requirements in accordance with applicable law and the applicable provisions of this contract and take and document any necessary corrective action.

Recordkeeping Requirements

PacificSource must retain and keep accessible all notices of adverse determination and any documentation, logs and other records for adverse benefit determinations whether in paper, electronic, or other form for a minimum of 10 years.