


Adverse Benefit Determination Notice

St. Clair County
Community Mental Health
Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

2024

Objectives

At the end of this course you will be able to identify the following:

- What an Adverse Benefit Determination (ABD) Notice is
- What are the types of ABD Notices
- When an ABD Notice should be issued
- Proper implementation of an ABD Notice to an Enrollee
- Legal references required for an ABD Notice

Overview

The State of Michigan maintains a Medicaid Service contract with Region 10 PIHP. Within this contract, the requirements for issuing an Adverse Benefit Determination (ABD) Notice to a Medicaid Enrollee are defined.

An Enrollee should be provided an ABD Notice when any decision is made that denies their request for services or reduces, suspends or terminates the services they already receive.

According to the contract with the State of Michigan, an Adverse Benefit Determination is a decision that adversely impacts a Medicaid Enrollee's claim for service due to: *(42 CFR 438.400)*

- Denial or limited authorization of a requested service, including determinations based the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400 (b)(2).
- Denial, in whole or in part, of payment for a service. 42 CFR 438.400 (b) (3).

Overview

- Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of the standard request for service. 42 CFR 438.210 (d)(1).
- Failure to make an expediated Service Authorization decision within seventy-two (72) hours after receipt of a request for expediated Service Authorization. 42 CFR 438.210 (d)(2).
- 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. 42 CFR 438.400 (b)(4).
- Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 42 CFR 438.400 (b)(5); 42 CFR 438.408 (b)(2).
- Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. 42 CFR 438.400 (b)(5); 42 CFR 438.408 (b)(3).

Overview

Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. 42 CFR 438.400 (b)(5); 42 CFR 438.408 (b)(1).

For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under 438.52 (b)(2)(ii), to obtain services outside the network. 42 CFR 438.400 (b)(6).

Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400 (b)(7).

Issuance of an ABD Notice is defined by the State (including specified format) and is included in the PIHP/SUD Provider contracts as well.

Although the format of the ABD Notice has changed, the requirements and timeframes for issuing an ABD Notice have not.

Importance of ABD Notice

- This is how you educate the Enrollee on exactly what changes are being made to their services and when this will be effective.
- The ABD Notice also educates the Enrollee with contact information on their right to the appeal process, and their right to continue services during the appeal process.

* The ABD Notice needs to be issued in writing

Importance of a Compliant ABD Notice

- The ABD notice includes the reasons for the adverse benefit determination (e.g. reason for denying an individual, a reason for suspending, terminating, or reducing an Enrollees service(es)).
- It is important that Provider's train the appropriate staff on how to properly fill out an ABD Notice (e.g. needs to be specific to why the services were being terminated, why the individual was denied, etc.)
- The Notice needs to be composed in an easy to read format that a beneficiary or Enrollee can comprehend what is being portrayed.

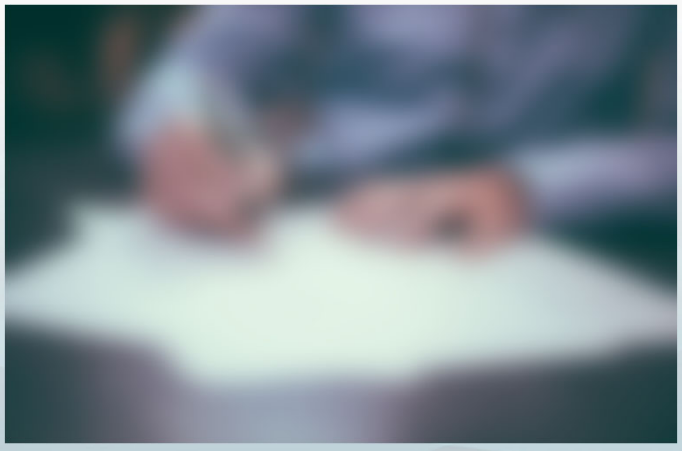
Adverse Benefit Determination (ABD) Notices

There are two types of Adverse Benefit Determination (ABD) Notices:

- Adequate Notice
- Advance Notice

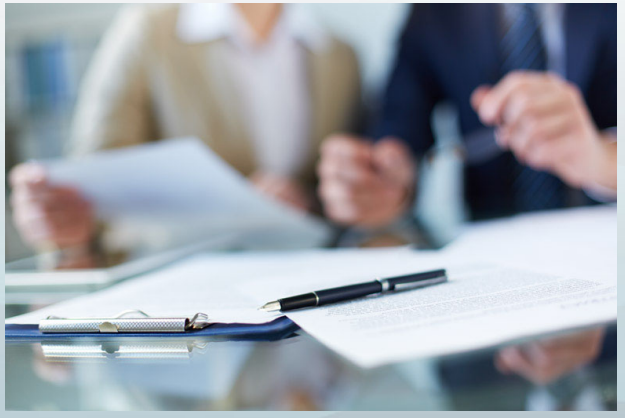
Adequate Notice

An Adequate Notice is a 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. *42 CFR 438.404(c)(2).* (e.g. A consumer is denied at Access for CMH services.)

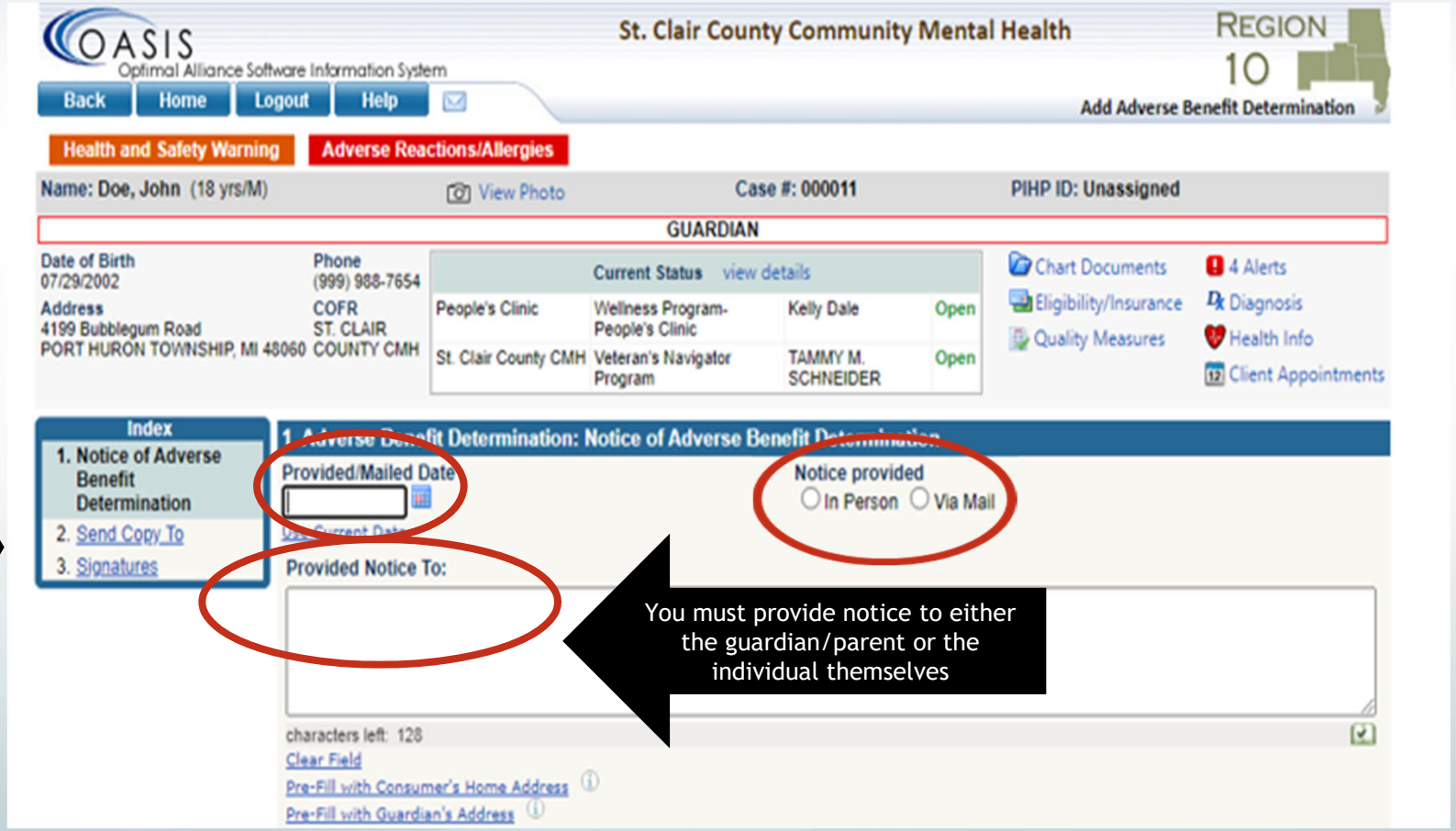


Advance Notice

An Advance Notice is a written statement advising the Enrollee of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice 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. 42 CFR 438.404 (c)(1); 42 CFR 431.211.



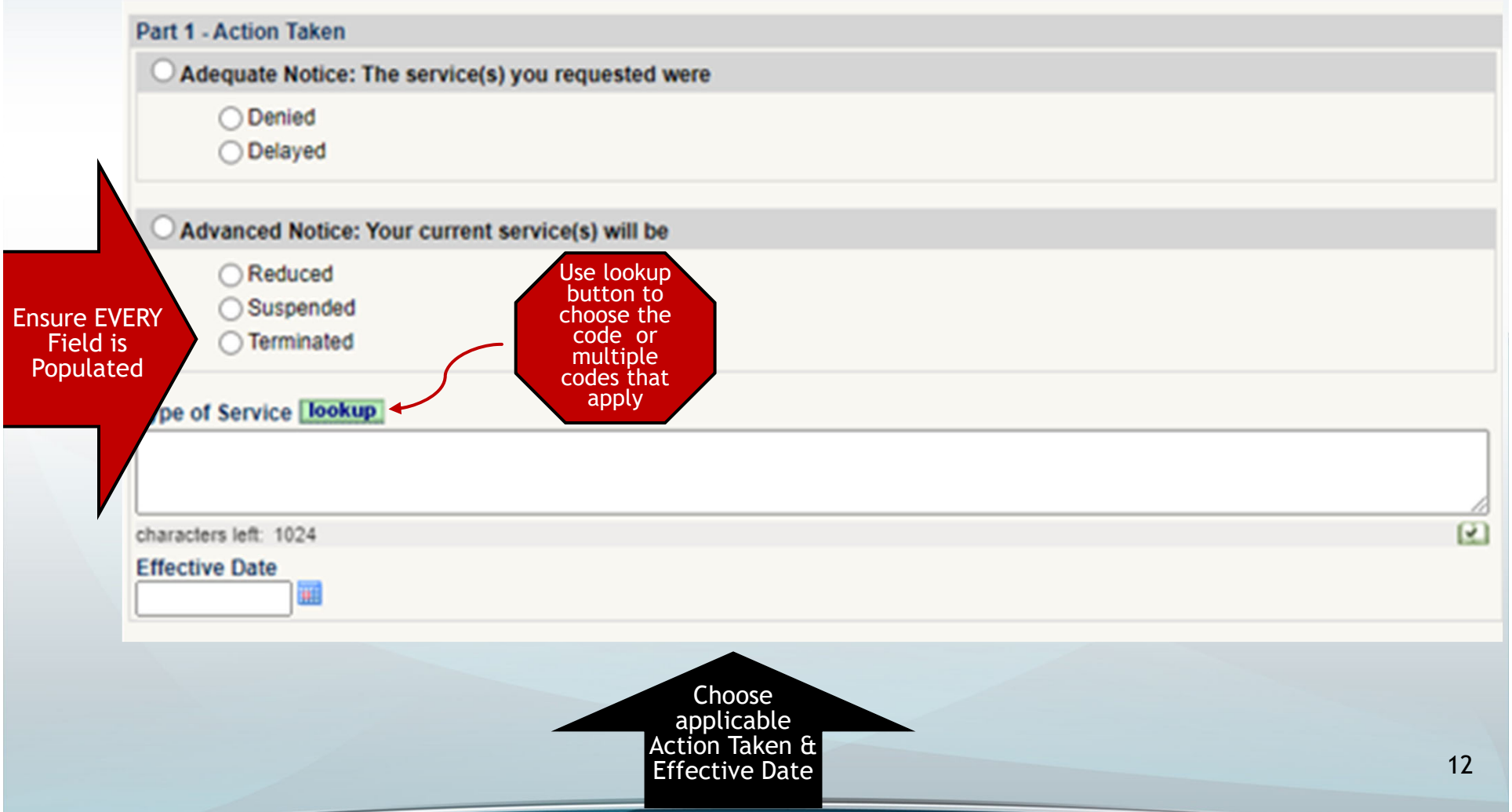
How to Fill out ABD Notice



Populate Every Field in OASIS

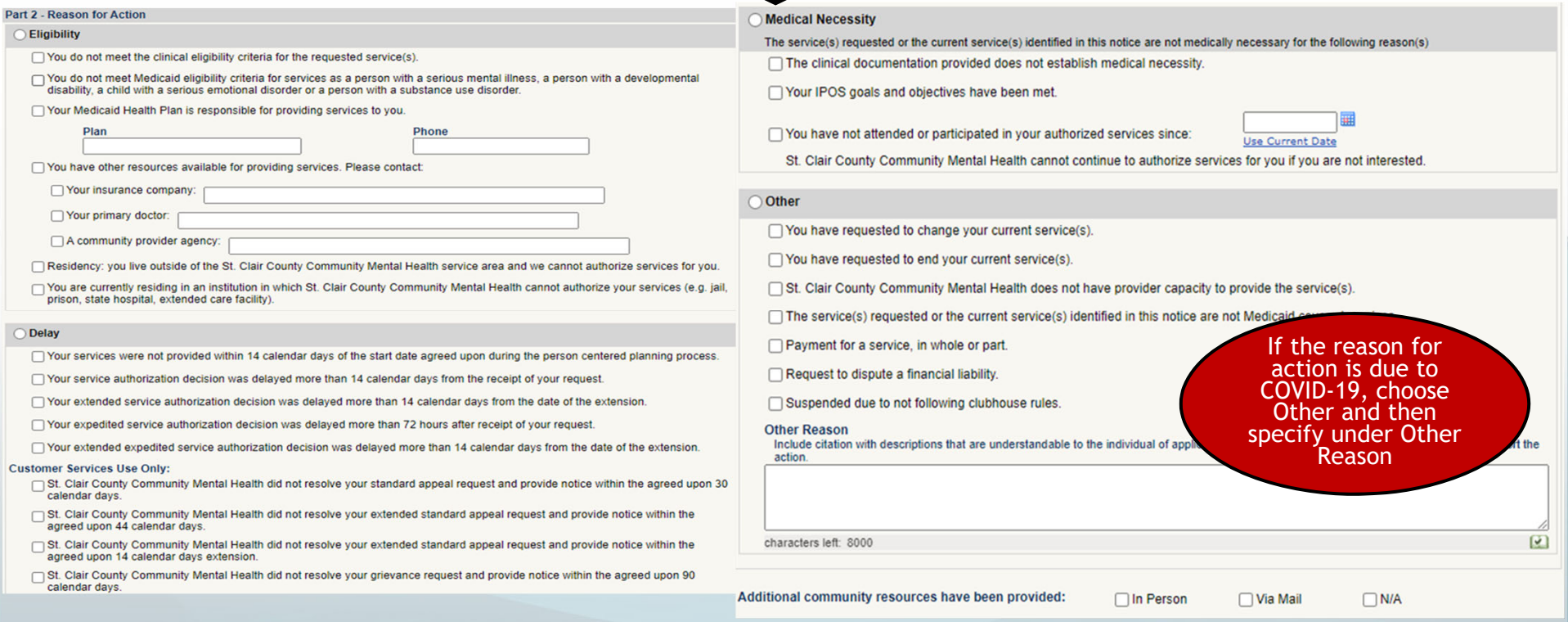
You must provide notice to either the guardian/parent or the individual themselves

How to Fill Out ABD Notice
Part 1 - Action Taken



How to Fill Out ABD Notice - Part 2 Reason for Action

Choose applicable Reason for Action



Part 2 - Reason for Action

Eligibility

- You do not meet the clinical eligibility criteria for the requested service(s).
- You do not meet Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance use disorder.
- Your Medicaid Health Plan is responsible for providing services to you.

Plan _____ Phone _____

- You have other resources available for providing services. Please contact:
  - Your insurance company: _____
  - Your primary doctor: _____
  - A community provider agency: _____
- Residency: you live outside of the St. Clair County Community Mental Health service area and we cannot authorize services for you.
- You are currently residing in an institution in which St. Clair County Community Mental Health cannot authorize your services (e.g. jail, prison, state hospital, extended care facility).

Delay

- Your services were not provided within 14 calendar days of the start date agreed upon during the person centered planning process.
- Your service authorization decision was delayed more than 14 calendar days from the receipt of your request.
- Your extended service authorization decision was delayed more than 14 calendar days from the date of the extension.
- Your expedited service authorization decision was delayed more than 72 hours after receipt of your request.
- Your extended expedited service authorization decision was delayed more than 14 calendar days from the date of the extension.

Customer Services Use Only:

- St. Clair County Community Mental Health did not resolve your standard appeal request and provide notice within the agreed upon 30 calendar days.
- St. Clair County Community Mental Health did not resolve your extended standard appeal request and provide notice within the agreed upon 44 calendar days.
- St. Clair County Community Mental Health did not resolve your extended standard appeal request and provide notice within the agreed upon 14 calendar days extension.
- St. Clair County Community Mental Health did not resolve your grievance request and provide notice within the agreed upon 90 calendar days.

Medical Necessity

The service(s) requested or the current service(s) identified in this notice are not medically necessary for the following reason(s)

- The clinical documentation provided does not establish medical necessity.
- Your IPOS goals and objectives have been met.
- You have not attended or participated in your authorized services since: _____ Use Current Date

St. Clair County Community Mental Health cannot continue to authorize services for you if you are not interested.

Other

- You have requested to change your current service(s).
- You have requested to end your current service(s).
- St. Clair County Community Mental Health does not have provider capacity to provide the service(s).
- The service(s) requested or the current service(s) identified in this notice are not Medicaid
- Payment for a service, in whole or part.
- Request to dispute a financial liability.
- Suspended due to not following clubhouse rules.

Other Reason

Include citation with descriptions that are understandable to the individual of appl… action.

characters left: 8000

If the reason for action is due to COVID-19, choose Other and then specify under Other Reason

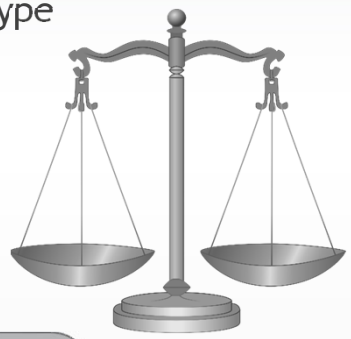
Additional community resources have been provided: In Person Via Mail N/A

Legal References

The following references are available to use for the type of ABD Notice you are issuing (Be mindful that this reference list may not all pertain for SUD Treatment specific denials. Staff will need to verify that each reference is appropriate to the specific type of SUD Treatment ABD Notice they are providing):

SUD Treatment Provider or PIHP staff reviewing service requests.

Eligibility Denials:



Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a (Definitions: A to E), 330.1100b (Definitions; F to N), 330.1100c (Definitions; P to R); 330.1100d (Definitions; S to W), and 330.1208

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.

Managed Care Rule, 42 CFR 438.400 (b)(1). MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria

Legal References

Adequate ABD

Not Eligible for CMH/SUD services:

- The legal basis for this decision is: 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. 42 CFR 438.400 (b)(1). Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a , 330.1100b , 330.1100c, 330.1100d, and 330.1208 MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5.B Determination Criteria

Legal References

Denial of Service Request (not medically necessary, other service being offered that is less restrictive/cost effective)	• The legal basis for this decision is: 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. *42 CFR 438.400 (b)(1). MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
Denial, in whole or in part, of payment for a service	• *The legal basis for this decision is: Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
Denial of a request to dispute a financial liability	• *The legal basis for this decision is: Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7)*

Legal References (Delays)

Denials based on service delays:

- Delay in request for service authorization: Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. *Managed Care Rule 42 CFR 438.210(d)(1)*.
- Delay in expedited service authorization: The legal basis for this decision is: Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. *Managed Care Rule 42 CFR 438.210(d)(2)*
- Delay in Providing Service: 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. *Managed Care Rule* 42 CFR 438.400(b)(4)
- Failure to meet local appeal timelines: Failure of the PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2)
- Delay Resolving Grievance: Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).

Legal References (Reductions)

Denials based on service reductions:

- Services reduced because no longer medically Necessity: Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
- Services reduced due to lack of utilization of services and therefore unable to validate the current amount of services to be medically Necessity: Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
- Consumer/Legal Rep requested services be suspended*: Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)

Legal References (Suspension)

Denials based on service suspension:

Suspended due to not yet having provider capacity to provide the service: The legal basis for this decision is; Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2)*

Suspended due to not following club house rules: The legal basis for this decision is; Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 5.2, Clubhouse Psychosocial Rehabilitation Programs; Target Population*

Suspended due to lack of contact and therefore unable to validate the current service(s) to be medically Necessity: The legal basis for this decision is; Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*

Consumer/Legal Rep requested services be suspended*: The legal basis for this decision is; Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)

** If have request in writing, do not have to do advance action notice*

Legal References (Termination)

Denials based on service termination

- Services terminated because no longer medically Necessity: The legal basis for this decision is; *Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
- Services terminated because of lack of contact therefore unable to continue to determine if the services continue to be medically Necessity: The legal basis for this decision is; *Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria*
- Services terminated because moved outside service area: The legal basis for this decision is; *Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) Michigan Mental Health Code (Act 258 of 1974), Section 330.1206*
- Consumer/Legal Rep requested services be terminated*: The legal basis for this decision is; Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)

** If have request in writing, do not have to do advance action notice*

Appeals

If an individual does not agree with our action, they have the right to an **Internal Appeal.** They have to ask Region 10 PIHP for an internal appeal within 60 calendar days of the date of the notice.

There are two kinds of Internal Appeals:

STANDARD APPEAL – We'll give the individual a written decision on a **Standard Appeal** within 30 calendar days after we get the appeal. Our decision might take longer if they ask for an extension, or if we need more information about their case. We'll tell them if we're taking extra time and will explain why more time is needed. If the appeal is for payment of a service they've already received, we'll give them a written decision within 60 calendar days. If they want to ask for an **Internal Appeal**, they can either call or send in a written request to Region 10 PIHP – phone: 888-225-4447; fax: 810-966-3388, Address: 3111 Electric Ave.Suite A, Port Huron, MI 48060.

EXPEDITED or "FAST" APPEAL – We'll give the individual a decision on a **Fast Appeal** within 72 hours after we get the appeal. The individual can ask for a fast appeal if they or their doctor believe their health could be seriously harmed by waiting up to 30 calendar days for a decision. We'll automatically give the individual a fast appeal if a doctor asks for one for the individual or if their doctor supports an individual's request. If the individual asks for a fast appeal without support from a doctor, we'll decide if their request requires a fast appeal. If we don't give an individual fast appeal, we'll give the individual a decision within 30 calendar days. To ask for a Fast Appeal, an individual must call 888-225-4447. For hearing or speech assistance, please have them call Michigan Relay Services (MRC) at 7-1-1 and ask to be connected to 888-225-4447.

Continuation of Services During an Internal Appeal

Continuation of services during an **Internal Appeal.** If an individual is receiving a Michigan Medicaid service and they file an appeal within 10 calendar days of the Notice of Adverse Benefit Determination, they may continue to receive the same level of services while their internal appeal is pending. The individual has the right to request and receive benefits while the internal appeal is pending and should submit the request to Region 10 PIHP.

If they want someone else to act for them:

They can name a relative, friend, attorney, doctor, or someone else to act as their representative. If you they want someone else to act for them, they can call us at: 888-225-4447 to learn how to name their representative. For TTY individuals, call 7-1-1. Both the individual and the person they want to act for them must sign and date a statement confirming this is what they want. They will need to mail or fax this statement to us. They should keep a copy for their records.

Help and Additional Information

GET HELP & MORE INFORMATION:

If an individual needs help or additional information about our decision and the internal appeal process, they can call Region 10 PIHP Customer Service Department 888-225-4447. For hearing or speech assistance, please call Michigan Relay Center (MRC) at 7-1-1. Region 10 PIHP Hours of operation are Monday – Friday between 8:00 a.m. – 5:00 p.m.

Website: http://www.region10pihp.org

The End

You have reached the end of this course. Please click the “EXIT” tab in right hand corner of this slide to exit course and take exam.