Provider Decision Grid

An Adverse Benefit Determination is defined to mean any of the following actions taken by Behavioral Health Services (BHS) regarding a SF Medi-Cal beneficiary's SMHS or DMC-ODS services: 1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, 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; 4) the failure to provide services in a timely manner; 5) the failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) the denial of a beneficiary's request to dispute financial liability. The beneficiary, parent/legal guardian and/or authorized representative must receive a written NOABD when BHS takes any actions described above. BHS must also communicate the decision to the affected provider within 24 hours of making the decision. BHS providers making authorization decisions must comply with NOABD requirements. The following documents must accompany any NOABD issued: 1) *NOABD Your Rights*, 2) *Nondiscrimination Notice*, and 3) *Language Assistance* taglines. In addition, beneficiaries are provided the BHS informational handout about *Requesting a Second Opinion* if the determination is based on not meeting medical necessity criteria subject to a *Denial*, *Delivery System*, *Modification*, or *Termination* NOABD.

NOABD Type	Criteria for NOABD Type	Timing of NOABD Type	Likely Users of NOABD Type
Denial *(formerly NOA-A)*	BHS denies a request for service authorization or reauthorization. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Also use this notice for denied residential services requests for both SMHS and DMC-ODS.	BHS must hand deliver or mail the notice **within two (2) business days** of the decision/action.	➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ ICM Authorizer ➢ MH Program PURQC ➢ SMHS/DMC-ODS Provider Completing Initial Assessment/Reassessment
Payment Denial *(formerly NOA-C)*	BHS denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary. This notice reads "this is not a bill" so that the beneficiary knows that one is not responsible for the cost of the service rendered, but that the service request has been retroactively denied.	BHS must hand deliver or mail the notice **at the time** of the decision/action denying the provider's claim.	➢ BHS Billing/SFMHP Claims Unit ➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ MH Program PURQC
Delivery System	BHS has determined that the beneficiary does not meet the medical necessity criteria to be eligible for SMHS. The beneficiary will be referred to Behavioral Health Access Center, or other appropriate system, for non-specialty mental health or other services. ***NOT applicable to DMC-ODS services.***	BHS must hand deliver or mail the notice **within two (2) business days** of the decision/action.	➢ Mental Health Access ➢ MH Program PURQC ➢ SMHS Provider Completing Initial Assessment/Reassessment
Modification	BHS modifies or limits a provider's request for a service authorization or reauthorization, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.	BHS must hand deliver or mail the notice **within two (2) business days** of the decision/action.	➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ MH Program PURQC

NOABD Type	Criteria for NOABD Type	Timing of NOABD Type	Likely Users of NOABD Type
Termination	BHS terminates, reduces or suspends a previously authorized service and the current authorization period has not lapsed. Beneficiaries may request (must request within 10 days of date of NOABD or before the effective date) a continuation of services while the appeal is pending.	BHS must hand deliver or mail the notice **at least ten (10) days before** the date of the action/effective date.	➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ ICM Authorizer ➢ MH Program PURQC ➢ SMHS Provider ➢ DMC-ODS Provider
Authorization Delay	BHS delays processing a provider's request for authorization of SMHS or DMC-ODS services as required by the authorization standards applicable to the requested service. When BHS extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.	BHS must hand deliver or mail the notice **within two (2) business days** of the decision/action.	➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ MH Program PURQC
Timely Access *(formerly NOA-E)*	BHS fails to provide a beneficiary timely services as required by the timely access standards applicable to the delayed service (e.g., BHS policy 3.02-13).	BHS must mail the notice **within two (2) business days** of the decision/action.	➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ MH Program PURQC ➢ SMHS Provider ➢ DMC-ODS Provider
Financial Liability	BHS denies a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities.	BHS must hand deliver or mail the notice **at the time** of the decision/action denying the beneficiary's request.	➢ BHS Billing/SF MHP Claims Unit ➢ Treatment Access Program ➢ Mental Health Access ➢ Transitions Unit ➢ SMHS Provider ➢ DMC-ODS Provider
Grievance/Appeal Resolution *(formerly NOA-D)*	BHS Grievance/Appeal Office fails to meet required time frames for resolution of grievances, appeals, or expedited appeals.	Grievance/Appeal Office must hand deliver or mail the notice **within two (2) business days** of the decision/action.	➢ **ONLY** Grievance/Appeal Office

NOTE: *Notices of Adverse Benefit Determination do not need to be issued if the services do not require authorization or if the beneficiary agrees with the decision.*