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 (PCS) will accept, process and issue Notice of Adverse Benefit Determinations (NOABDs) in line with Oregon Administrative Rules (OAR), Federal Regulation and Contract Requirements. Specific regulations are outlined in the applicable regulation section of this policy.

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

Procedure: Department

Adverse Benefit Determinations

1) When PCS makes an adverse benefit determination, PCS gives the requesting provider, the member and the member's representative a written notice of adverse benefit determination.
2) PCS uses an OHA approved letter unless the member is dually eligible member of affiliated Medicare and Medicaid plans, in which case the Centers for Medicare & Medicaid Services (CMS) Integrated Denial Notice may be used. PCS ensures such a notice incorporates required information fields from Oregon's NOABD.
3) PCS ensures that NOABDs meet the content notice requirements specified in federal regulation[2], OARs[3], and in and the CCO Contract[4]. Notices will contain all elements described within associated guidance documents, which are available on the CCO Contract Forms Website (https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx). Notices will contain the following information:
    a. Date of the notice.
    b. PCS', Health Share Oregon, and subcontractor's name and contact information, including name, address, and telephone number, if applicable, in the NOABD notice, excluding any cover pages as appropriate to the benefit and the member's current CCO assignment; Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) professional, if the member has an assigned practitioner.
        i. If the member is not assigned to a practitioner due to the clinic/facility model, the most specific information available will be used.
        ii. If the member has not been assigned to a practitioner because they enrolled in PCS within the last 90 days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred.

iii. This element does not apply to services regarding Non-Emergent Medical Transportation (NEMT) services

c. Member's name, date of birth, address, and OHP member ID number.
d. For post-service NOABDs:
    i. Date the service was provided.
    ii. Name of the provider who provided the service.
    iii. Effective date the claim was denied.
    iv. Service previously provided, in plain language, and the adverse benefit determination PCS made.
    v. Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language.
        1. For services that do not include a procedure code, PCS instead will include a description of the requested service in plain language.
    vi. Description and explanation of the service(s) provided in plain language. (e.g., explain diagnosis and/or procedure codes). The description and explanation should include information regarding how the provided service was intended to treat the diagnosed condition.
    vii. An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member, the authorized representative, or the member's provider may request it.
        1. An expedited appeal and hearing will not be granted for post-service denials as the service has already been provided.
    viii. A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166). Link to the OHP Agreement to pay form must be included in the NOABD.
    ix. Whether PCS considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services.
    x. NOABD will clearly indicate whether a medical review was performed and, if not, that the provider can resubmit the claim with chart notes for review of comorbidity.
        1. This does not apply to members who meet the definition of an EPSDT beneficiary.
e. For pre-service NOABDs:
    i. Date service was requested by the provider or member.
    ii. Name of the provider who requested the service.
    iii. Effective date of the NOABD.
    iv. Service requested in plain language and the adverse benefit determination PCS intends to make, including whether PCS is partially/fully approving or denying, terminating, suspending, or reducing a service.
    v. Diagnosis and procedure codes submitted with the authorization request including a description of all codes in plain language.
        1. For services that do not include a procedure code, PCS instead will include a description of the requested service in plain language.
    vi. Description and explanation of the service(s) requested in plain language (e.g., explain diagnosis and/or the procedure codes). The description and explanation will include information regarding how the provided service was intended to treat the diagnosed condition.
    vii. The circumstances under which an appeal process or contested case hearing can be expedited and how the member, the authorized representative, or the member's provider may request it.
        1. Standard appeal timeline: PCS will reply within 16 days.
        2. Expedited appeal timeline: PCS will reply within 72 hours.
            a. If an expedited appeal is denied, PCS will move it to the standard appeal timeline of 16 days.

viii. Whether PCS considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services.
    1. This does not apply to members who meet the definition of an EPSDT beneficiary.

f. Clear and thorough explanation of the specific reasons for the adverse benefit determination, including a description of review for medical necessity and medical/dental appropriateness for members who meet the definition of an EPSDT beneficiary.
g. When additional information is required, the member should be informed that attempts were made to obtain additional information from the provider.
h. A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD.
    i. As appropriate citations to EPSDT rules should be included on notices for members who meet the definition of an EPSDT beneficiary. ESPDT rules are found in OAR chapter 410, Division 151.
    ii. NOABDs should clearly indicate to the member what supported the denial (Guideline Notes, Only OAR specific sections and subsections that apply, HERC Clinical Guidance, medical policies or criteria, etc.)
i. PacificSource accepts written or oral appeals of PCS' adverse benefit determination from the member, member representative, or the provider with the member's written consent within 60 days from the date of the NOABD. This information will include information on exhausting PCS' single level of appeal, and the procedures to exercise that right.
j. PCS has 16 days to review and resolve the appeal from date of receipt with a possible extension of 14 days. If an extension is needed, PCS will call and send a letter to the member within 2 calendar days. PacificSource will make reasonable efforts to contact the member verbally, including as necessary multiple calls at different times of day. PacificSource will reassure the member that their appeal will be resolved as soon as their health requires and that they can file a grievance if they do not agree with the extension.
k. The member's, member's authorized representative, or the provider's (with member's written consent) right to request a contested case hearing with the Authority within 120 days from the date of the Notice of Appeal Resolution (NOAR). Information that a hearing can be requested only after the NOAR from PCS has been issued or when PCS failed to meet appeal timelines. Notice will include the procedures to exercise that right including the different ways a hearing can be requested. The notice will include all methods available to request a hearing such as phone, fax, mail, online, and the URL necessary to access the 3302 form.
l. The member's right to have benefits continue pending resolution of the appeal or contested case hearing, that continued benefits can be requested by the Member or member's representative with the members written consent, orally or in writing, and the circumstances under which the member may be required to pay the cost of these services;
    i. Member's must ask for this within 10 days of the date of the notice or by the date the decision is effective, whichever is later.
m. Information on requesting help and who to contact.
n. The member's right to be provided upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the member's adverse benefit determination including medical necessity criteria and any processes, strategies, or evidentiary standards used by PCS in setting coverage limits or making the adverse benefit determination.
o. To support their appeal, the member's right to give information and testimony in person or in writing and make legal and factual arguments in person or in writing within the appeal filing timelines.
p. Enclosure line, including all required forms (Appeal & Hearing Form - OHP3302).

q. Inclusion of the names of providers, clinics, and Authorized Representatives (if applicable) copied on the notice (CC line).

4) For NOABDs that affect services previously authorized, PCS will notify the requesting provider and mail the notice to the member at least 10 days before the date the adverse benefit determination takes effect. This includes a termination, suspension or reduction of previously authorized Medicaid-covered services.
5) PCS will mail the NOABD by the date of the action when any of the following occur:
    a. PCS has factual information confirming the death of a member.
    b. PCS receives notice that the services requested by the member are no longer desired or PCS is provided with information that requires termination or reduction in services:
        i. All notices sent to a member will be in writing, clearly indicate the member understands that the services previously requested shall be terminated or reduced because of the notice and signed by the member; and
        ii. All notices sent by PCS will be in writing and include a clear statement that advises the member of the information received and that such information caused the termination or reduction of the requested services.
    c. PCS verifies that the member has been admitted to an institution where the member is ineligible for OHP services from PCS.
    d. PCS is unaware of the member's whereabouts and PCS receives returned mail directed to the member from the post office indicating no forwarding address and OHA or the Department has no other address.
    e. PCS verifies that the member has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth.
    f. A change in the level of health services is prescribed by the member's primary care provider, primary care dentist or behavioral health professional.
    g. The member will be transferred or discharged from a long-term care facility in less than 10 days in accordance with Federal regulation which provides exceptions to the 30-day notice requirements also cited in Federal regulation; or
    h. The notice involves an adverse determination regarding preadmission screening requirements of section 1919(e)(7) of the SSA.
6) PCS may mail the NOABD as few as five (5) days before the date of adverse action if:
    a. PCS has facts indicating that adverse action should be taken because of probable fraud on the part of the member; and
    b. PCS has verified those facts, if possible, through secondary sources.
7) For denial of payment, an NOABD will be mailed at the time of any adverse benefit determination that affects a clean claim.
8) Standard authorization NOABD timing:
    a. For standard authorization decisions for services not previously authorized and that deny or limit the amount, duration or scope of services, PCS will 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 fourteen (14) calendar days following receipt of the request for services.
        i. Extensions of up to fourteen (14) additional days, may be utilized if:
            1. The member, member's representative or provider requests an extension; or
            2. PCS justifies to OHA upon request a need for additional information and how the extension is in the member's best interest.
                a. If requested, PCS 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.
        ii. If the extension criteria above is met, PCS will:
            1. Give the member written notice of the reason for the decision to extend the timeframe.
            2. Make reasonable effort (including multiple calls at different times of the day) to give the member oral notice of the reason for the decision to

extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision; and
3. 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) Expedited authorization NOABD timing:
   a. For cases in which a provider indicates, or PCS 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, PCS must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. The period of time is determined by the time and date stamp on the receipt of the request.
      i. PCS may extend the seventy-two (72) hour expedited authorization decision time period up to fourteen (14) additional calendar days if:
         1. The member or the provider requests an extension; or
         2. If PCS justifies to OHA upon request a need for additional information; and
         3. How the extension is in the member's interest; PCS will provide its justification for any request to OHA, via Administrative Notice, upon request.
      ii. If PCS meets the criteria to extend the fourteen (14) calendar day NOABD timeframe for expedited authorization decisions that deny or limit services, it will:
         1. Give the member written notice of the reason for the decision to extend the timeframe.
         2. Make reasonable effort (including as necessary multiple calls at different times of day) 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.
10) For either standard or expedited service authorization decisions not reached within the timeframes specified in Federal regulation (which constitutes a denial and is thus an adverse benefit determination), PCS will mail the notice on the date that the timeframes expire.

Timing of NOABD for Outpatient Drugs

1) Service authorization decisions for outpatient drugs include a practitioner administered drug (PAD). PCS addresses PAD requests as follows:
   a. Within 24 hours PCS will take one of the following actions:
      i. Provide a written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing practitioner, and when known to the PCS, the pharmacy; or
      ii. Provide a written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to PCS, the pharmacy if the drug is denied or partially approved; or
      iii. Provide a written, telephonic or electronic request for additional documentation to the prescribing practitioner when the PA request lacks PCS's standard information collection tools such as PA forms or other documentation necessary to render a decision; or
      iv. Provide a written, telephonic, or electronic acknowledgment of receipt of the PA request that gives an expected timeframe for a decision. An initial response

indicating only acceptance of a request does not delay a decision to approve or deny the drug. The decision to approve or deny the drug occus within 72 hours.

2) If requested additional documentation is not received within seventy-two (72) hours from the date and time stamp of the initial request for prior authorization, PCS shall issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to PCS, the pharmacy.
3) The seventy-two (72) hour window for coverage decisions begins with the initial date and time stamp of a prior authorization request for a drug.

Participating Providers and Subcontractors

PCS ensures and monitors that its participating providers and subcontractors comply with the Grievance and Appeal System requirements in accordance with applicable law and the applicable provisions of this contract.

PCS provides 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 provides 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.

PCS monitors and documents 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

PCS retains and keeps 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 ten (10) years.

Definitions

Adverse benefit determination[1] - Any of the following, consistent with the regulations listed below in the applicable regulation section of this document:

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. A payment denied solely because the claim does not meet the definition of a “clean claim” is not an adverse benefit determination.
4) The failure to provide services in a timely manner per OAR regulation.
5) PCS’s failure to act within the timeframes provided in OAR regulation regarding the standard resolution of grievances and appeals;
6) For a resident of a rural area with only one CCO, the denial of a member's request to exercise their legal right 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.

Appeal - a review of an adverse benefit determination by PCS, or PCS acting within its scope as a delegated entity/subcontractor under state regulation and contract. An appeal includes a request from the Authority for review of a notice.

Contested Case Hearing- a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860

Contract – The General Provisions together with all Exhibits, Exhibit attachments, and Reference Documents and any amendments (including restatements) that makeup the agreement between the State of Oregon and a CCO to provide health services to eligible members. The State of Oregon acts by and through the Oregon Health Authority.

Continuing benefits - a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910

EPSDT Beneficiary - Means an individual under the age of 21 who is covered by the Oregon Health Plan (OHP) or an individual in the Young Adults with Special Health Care Needs (YSHCN) program as defined in OAR 410-200-0455

Federal Law and Regulation – Includes the Code of Federal Regulations (CFR) and any other Federal statutes or laws.

Grievance- a member's expression of dissatisfaction to PCS or the Authority about any matter other than an adverse benefit determination, Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by PCS to make an authorization decision;

Member - "Member" With respect to actions taken regarding grievances, appeals and contested case hearings, includes, as appropriate, the member, the member's representative, and the representative of a deceased member's estate.

Notice of Adverse Benefit Determination (NOABD)- the notice issued to a member to communicate an adverse benefit determination. The notice must meet all requirements found at 42 CFR 438.44.

State regulation - Oregon state regulations include Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs).

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2022 **Next review:** 7/31/2026

Policy type: Government

Author(s):

Depts: Appeals and Grievance; Claims; Facets Business Support; Health Services; Pharmacy

Applicable regulation(s): Oregon Administrative Rules (OARs) 410-141-3505, 410-141-3515, 410-141-3520, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875[1]; 410-141-3880; 410-141-3885[3]; 410-141-3890; 410-141-3895; 410-151-0000

through 141-151-0004; 410-200-0455; 42 CFR §438.210(d), 438.404[2], 438.52(b)(2)(ii); 42 CFR §447.45(b); 42 CFR § 483.15(c)(4); Social Security Act §1919(e)(7); CCO contract Exhibit I[4]

External entities affected: [External Entities Affected]

Approved by: