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 (OARs) 410-141-3515, 410-141-3520, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875, and 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 OAR 410-141-3515;
5) PCS's failure to act within the timeframes provided in OARs 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 42 CFR §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.

Procedure: Department

Adverse Benefit Determination

1) When PCS has made an adverse benefit determination, PCS must notify the requesting provider and give the member and the member's representative a written notice of adverse benefit determination.

2) PCS must use an OHA approved form 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 as long as it incorporates required information fields in Oregon's NOABD.
    a. For timing of notices, PacificSource gives members timely and adequate NOABD in writing consistent with requirements in Exhibit I of the CCO Contract, OAR 410-141-3885 and in 42 CFR § 438.404.
    b. PCS follows 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;
3) Meet the content notice requirements specified in 42 CFR § 438.404 and in Exhibit I of the CCO Contract, including the following information:
    a. Date of the notice;
    b. PCS' name and subcontractor contract information including name, address, and telephone number, if applicable, included in the NOABD notice excluding any cover pages;
    c. 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 or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned to a practitioner because they enrolled in PCS within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred;
    d. Member's name, date of birth, address, and OHP member ID number;
    e. Post-service:
        i. Date the service was provided;
        ii. Name of the provider who provided the service;
        iii. Effective date is the date the claim was denied;
        iv. Service previously provided and the adverse benefit determination the PCS made including if the PCS is partially/fully approving or denying a claim.
        v. Diagnosis codes and procedure codes submitted with the claim.
        vi. Description and explanation of the service(s) provided including whether PCS is denying, terminating, suspending or reducing a service or payment for a service in whole or in part;
        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.
    f. Pre-service:
        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 and the adverse benefit determination PCS intends to make, including whether the PCS is partially/fully approving or denying, terminating, suspending, or reducing a service.
        v. Diagnosis codes and procedure codes submitted with the authorization request.
        vi. Description and explanation of the service(s) requested including whether PCS is denying, terminating, suspending or reducing a service or payment for a service in whole or in part;

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 must reply within 16 days.
2. Expedited appeal timeline: PCS must reply within 72 hours.
a. If an expedited appeal is denied, PCS will move it to the standard appeal timeline of 16 days.

g. Whether PCS 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 OARs 410-141-3820 and 410-141-3830;
h. Clear and thorough explanation of the specific reasons for the adverse benefit determination;
i. 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;
j. The member's right or, if the member provides their written consent as required under OAR 410-141-3890(1), the provider's right to file an appeal of PCS's adverse benefit determination with PCS, including information on exhausting PCS's one level of appeal and the procedures to exercise that right;
i. An appeal must be requested within 60 days from the date of the NOABD.
k. 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 member within 2 calendar days. Reassure 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;
l. The member's, member's authorized representative, or the provider's right to request a contested case hearing with the Authority only after PCS' Appeal Notice of Resolution or where PCS failed to meet appeal timelines and the procedures to exercise that right including the different ways a hearing can be requested (e.g., online, by phone, or by completing the request form);
i. A hearing must be requested within 120 days from the date of the NOAR.
m. 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;
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.
ii. Member's may request continuation of benefits orally or in writing.
n. Information on requesting help and who to contact.
o. 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 medical necessity criteria and any processes, strategies, or evidentiary standards used by PCS in setting coverage limits or making the adverse benefit determination;
p. 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;
q. Enclosure line.
i. Include all required forms (3302, Non-Discrimination Policy, Covid 19 hearing extension.)
r. Inclusion of the names of providers or clinics copied on the notice (CC line).

4) For NOABDs that affect services previously authorized, PCS must 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 must 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 by a member must 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; and
    ii. All notices sent by the MCE must 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 §483.15(c)(4) which provides exceptions to the 30-day notice requirements of §483.15(c)(4)(i) of this chapter; or
h. The notice involves an adverse determination with regard to 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 action if:
    a. PCS has facts indicating that 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, the NOABD must 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 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 fourteen (14) calendar days following receipt of the request for services with a possible extension for PCS up to fourteen (14) additional days, if:
        i. The member, member's representative or provider requests an extension; or
        ii. PCS justifies to OHA upon request a need for additional information and how the extension is in the member's best interest. 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.
    b. If the extension criteria above is met, PCS must:
        i. Give the member written notice of the reason for the decision to extend the timeframe;
        ii. 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
        iii. 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 which period of time is determined by the time and date stamp on the receipt of the request.

b. PCS may extend the seventy-two (72) hour expedited authorization decision time period up to fourteen (14) additional calendar days if:
    i. The member or the provider requests an extension; or
    ii. If PCS justifies to OHA upon request a need for additional information; and
    iii. How the extension is in the member's interest; PCS must provide its justification for any request to OHA, via Administrative Notice, upon request.
c. If PCS meets the criteria to extend the fourteen (14) calendar day NOABD timeframe for expedited authorization decisions that deny or limit services, it must:
    i. Give the member written notice of the reason for the decision to extend the timeframe;
    ii. 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;
    iii. Inform the member of the right to file a grievance if the member disagrees with that decision; and
    iv. 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 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), PCS must 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).
2) When PCS has made or intends to make an adverse benefit determination for an initial outpatient drug request and is in receipt of PCS's standard information collection tools for prior authorization, within twenty-four (24) hours, PCS must issue a written NOABD 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. Fully approved decision notifications are issued in writing to the member, and telephonically or electronically to the prescribing practitioner, and pharmacy, when known.
3) Acknowledgment of receipt including the expected timeframe of decision or if additional documentation needs to be requested from the prescribing practitioner in order to render a decision, shall be communicated within 24 hours of receipt, and not delay a decision to approve or deny the drug as expeditiously as the member's health requires, and no later than seventy-two (72) hours from the original date of the initial request.
4) If the requested 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 seventy-two (72) hours.
5) 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.
6) 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 must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth.

PCS 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 2022 PCS CCO 2.0 Contract Exhibit I part 3 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.

PCS 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

PCS 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 ten (10) years.