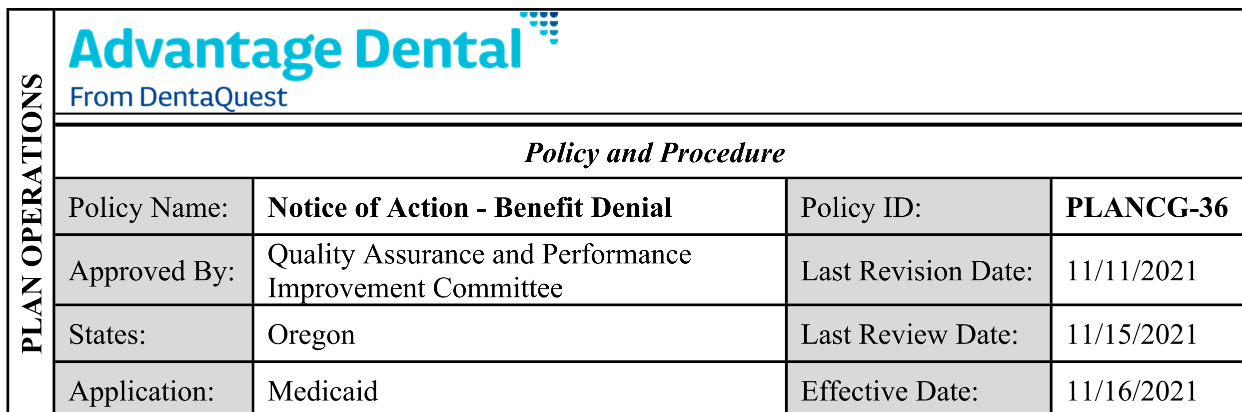

PLAN OPERATIONS

Advantage Dental
From DentaQuest

Policy and Procedure

Policy Name:	**Notice of Action - Benefit Denial**	Policy ID:	**PLANCG-36**
Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date:	11/11/2021
States:	Oregon	Last Review Date:	11/15/2021
Application:	Medicaid	Effective Date:	11/16/2021

PURPOSE

To establish Dental Care Organization's (DCO's) policy on when a Notice of Action - Benefit Denial (NOABD) is to be sent and the timelines.

POLICY

1. A NOABD is required when the DCO, makes an adverse benefit determination. For example, when the DCO denies a requested service or when a preauthorization for a requested service is denied. The DCO only makes coverage determinations for dental services and therefore only issues NOABDs for dental services. The DCO does not make coverage determinations or issue NOABDs for medical or mental health services, such as long-term psychiatric care.

2. The DCO has forms for NOABD letters that have been approved by the Oregon Health Authority (OHA) and include the following required information:
   A. Date of the NOABD, DCO's name, address and phone number, the Provider's name, and the enrollee's name, address and ID number.
   B. The date of service or date service was requested, who requested the service, the service or item requested, reason for the requested service, a statement of adverse benefit determination taken or intended, the effective date of the determination, and the basis for the denial.
   C. A statement that the enrollee has a right to appeal this determination by filing an appeal with DCO and by requesting a Medical Assistance Program (MAP) hearing after the DCO appeal has been completed;
   D. A statement that the enrollee has the right to have their benefits continue pending resolution of the appeal, how to request that benefit be continued and under what circumstances the enrollee may be required to pay the costs of those services;
   E. A copy of the Denial of medical services Appeal and hearing request form (OHP 3302) must be attached.
   F. Language clarifying that oral interpretation is available for all languages including sign language and how to access it.
   G. Statement of intent governing the use and application of the OHP Prioritized List to requests for health services and other coverage services addressed in the State's Waiver.
   H. The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination including any processes, strategies, or evidentiary standards used by the DCO in setting coverage limits or making the adverse benefit determination.

3. The NOABD template letters comply with the OHA formatting and readability standards and are written in plain 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.

4. A NOAB D must be mailed to the enrollee as follows:
   A. For pre-authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, and are standard authorization decisions, the NOABD must be sent as expeditiously as the enrollee's health condition requires, but no later than 14 days following receipt of the request for service.
   B. For the denial of an expedited preauthorization, the NOABD must be sent within 72 hours following receipt of the request for service.
   C. The above timeframes may be extended up to 14 days if the enrollee requests an extension or if the DCO justifies to the Authority upon request a need for additional information and how the extension is in the enrollee's interest.
   D. Whenever a timeframe is extended not at the request of the enrollee, the DCO will notify the enrollee in writing of the reason for the extension and the enrollee's right to file a grievance regarding the extension.
   E. For the termination, suspension or reduction of a previously authorized covered service, the notice must be mailed:
      1) At least 10 calendar days before the date the covered service is terminated, suspended or reduced, unless;
         a) The Provider or DCO receives a written statement from the enrollee stating the enrollee no longer wants the service or gives information that requires the service be terminated;
         b) The enrollee is admitted to an institution where the enrollee is ineligible for the covered service from the DCO or Provider;
         c) The whereabouts of the enrollee are unknown and the post office returns mail to the DCO or Provider;
         d) DCO establishes that another State has accepted the enrollee into it Medicaid services program;
         e) A change in the level of dental care is prescribed by the Provider;
         f) The date of action will occur in less than 10 calendar days related to discharges or transfers and long-term care facilities.
         g) Plan has factual information confirming the death of the enrollee.
   F. For the denial of payment, when a patient responsibility is indicated, the notice must be mailed at the time the payment is denied by the DCO.
   G. The notice must be mailed five business days before the date of determination taken because of probable fraud by the enrollee. DCO shall have facts indicating that an action should be taken because of fraud and when possible, these facts should be verified through secondary sources.
   H. For prior authorization decisions that are not reached within the appropriate timeframes (which constitute a denial and is thus an adverse benefit determination), the notice shall be mailed by the date that the timeframes expire.

REFERENCES

42 CFR 438.210 Coverage and authorization of services
42 CFR 438.228 Grievance and appeal systems
42 CFR 438.402 General requirements
42 CFR 438.404 Timely and adequate notice of adverse benefit determination
OAR 410-141-3835 MCE Service Authorization
OAR 410-141-3885 Grievances & Appeals: Notice of Action/Adverse Benefit Determination

DEFINITIONS

- **"Adverse Benefit Determination"** means 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. The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure to act within applicable timeframes regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one DCO, the denial of an enrollee's request to exercise his or her right to obtain services outside of the network. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

FORMS AND OTHER RELATED DOCUMENTS

- Notice of Action Benefit Denial Template

Revision History

Date:	Description
07/31/2012	Approval and adoption.
06/06/2014	Updates based on annual review.
02/23/2015	Updates based on annual review.
02/23/2016	Updates based on annual review.
02/14/2017	Updates based on annual review.
03/12/2018	Updates based on annual review.
05/20/2019	Updates based on annual review.
12/09/2019	Conversion to revised policy and procedure format and naming convention.
01/06/2020	Updates based on CCO partner audit findings.
05/19/20	Updates based on CCO partner audit findings.
7/10/2020	Updates based on OHA audit findings.
11/11/2021	Updates based on annual review.