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:	03/06/2024
States:	Oregon	Last Review Date:	04/26/2024
Application:	Medicaid	Effective Date:	04/27/2024

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. The DCO Policy for NOABD provision applies to both pre- and post-service adverse benefit determinations.
    (a) When the DCO makes an adverse benefit determination, the DCO will notify the requesting provider and give the enrollee and the enrollee's representative a written NOABD.
2. The DCO is required to use 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 requesting Provider's name, and the enrollee's name, address, date of birth, and ID number.
    B. Name of the provider who provided the service.
    C. Name of the enrollee's Primary Care Dentist (PCD) if the enrollee has an assigned practitioner or the most specific information available if a enrollee is not assigned to a practitioner due to the clinic/facility model. If the enrollee has not been assigned a practitioner because they enrolled in the DCO within the last 90 days, the NOABD shall state PCD assignment has not occurred;
    D. The date of service or date service was requested, who requested the service, description and explanation of the service or item requested or previously provided, reason for the requested service, a statement an explanation of adverse benefit determination taken or intended to make, including whether the DCO is denying, terminating, suspending or reducing a service or payment for a service in whole or in part, the effective date of the determination if different from the date of the notice (pre-service); Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice (post-service), and the basis for the denial.
    E. Diagnosis and procedure codes submitted with the authorization request or claim including a description of all codes in plain language. For services that do not include a procedure code a description of the service.
    F. Description and explanation of the services requested or provided in plain language.
    G. A statement that the enrollee, enrollee's representative or, if the enrollee provides their written consent as required under OAR 410-141-3890(1), the provider, has a right to appeal

this determination by filing an appeal with DCO within 60 days from the date of the NOABD. Information on exhausting the DCO's one level of appeal and the procedures to exercise that right. The right to request an OHA hearing after the DCO appeal has been completed. The right to exercise the right to a hearing when the DCO has failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895 and the procedures to exercise that right. To support their appeal, the enrollee'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 timelines.

H. A statement that the enrollee has the right to have their benefits continue pending resolution of the appeal, how the enrollee, enrollee's representative, or the provider with the enrollee's written consent, can request that benefit be continued and under what circumstances the enrollee may be required to pay the costs of those services; and that the right to have benefits continue also applies to contested case hearings.
I. A copy of the Denial of medical services Appeal and hearing request form (OHP 3302) must be attached. This form includes:
    a. Information on timeframes for review of an appeal, information on requesting a contested case hearing, and how to request help and who to contact,
J. Language clarifying that oral interpretation is available for all languages including sign language and how to access it.
K. For members 21 and over: Other conditions the DCO considered including, but not limited to, co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830 For post service NOABDs, the DCO shall clearly indicate whether a medical review was performed and if not that the provider can resubmit claim with chart notes for review of comorbidity.
L. A clear and thorough explanation of the specific 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 medical necessity criteria, processes, strategies, or evidentiary standards used by the DCO in setting coverage limits or making the adverse benefit determination. The explanation shall include 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 notice.
M. If additional information is required, an explanation to the member that attempts were made to obtain additional information from the provider.
N. An explanation to the enrollee that there are circumstances under which an appeal process or contested case hearing can be expedited and how the enrollee or the enrollee's provider may request it but that an expedited appeal and hearing will not be granted for post-service denials as the service has already been provided (post-service).
O. A statement that the provider cannot bill the enrollee for a service rendered unless the enrollee signed an OHP Agreement to Pay form (OHP 3165 or 3166) (post-service denial)
P. Enclosure line including all required forms: OHP 3302, Non-Discrimination Policy, etc.
Q. CC line listing the names of providers, clinics and authorized representative (if applicable) copied on the notice.

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. The NOABD includes taglines in the prevalent non-English languages in at least 12-point font, as well as large print, explaining the availability of written translation or oral interpretation (including

American Sign Language) to understand the information provided and the toll-free and TTY/TDY telephone number of the DCO's enrollee services team.

4. When an enrollee is a dually eligible enrollee of affiliated Medicare and Medicaid plans, the CMS Integrated Denial Notice may be used providing it incorporates required information fields in the Oregon's Notice of Action/Adverse Benefit Determination.

5. In the event that the DCO receives a service authorization request for pharmaceutical services, the DCO shall notify the prescribing provider to resubmit to the CCO who is responsible for a coverage decision.

6. A NOABD must be mailed to the enrollee or enrollee's representative 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 cases in which a provider indicates, or DCO determines, that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or enrollee's ability to attain, maintain or regain maximum function, the DCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 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..
   C. The above timeframe can be extended up to 14 days if the enrollee, the enrollee representative, or a provider requests it. Upon request, DCO 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
   D. The DCO will notify the enrollee, in writing, if the extension criteria is met providing the reason for the extension and the enrollee's right to file a grievance regarding the extension. DCO will make reasonable effort (including multiple calls at different times of the day) to give the enrollee oral notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision. The DCO will issue and carry out its determination as expeditiously as the enrollee's health or mental health condition requires, but no later than the date the extension expires.
   E. For the termination, suspension or reduction of a previously authorized covered service, the provider must be notified in the specific situations, the enrollee NOABD must be mailed by the date of the action:
      1) At least 10 calendar days before the date the covered service is terminated, suspended or reduced, unless;
         a)The DCO has factual information confirming the death of an enrollee
         b) 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. The notice from the enrollee must clearly indicate that they understand that the services will be terminated or reduced as a result of the notice, and that it must be signed by the enrollee. All notices sent by the DCO will be in writing and include a clear statement that advises the enrollee that the information was received and that it caused termination or reduction of the requested services;
         c) The enrollee is admitted to an institution an institution (and the DCO has verified admission) where the enrollee is ineligible for the covered service from the DCO or Provider;

d) The whereabouts of the enrollee are unknown and the post office returns mail to the DCO or Provider indicating no forwarding address, or the DCO receives returned mail directed to the enrollee from the post office indicating no forwarding address and the CCO has no other address;
e) DCO establishes that an enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth.
f) A change in the level of dental care is prescribed by the Provider;
g) The date of action will occur in less than 10 calendar days related to discharges or transfers and long-term care facilities and that the discharge or transfer is in accordance with § 483.15(c)(4) Timing of the notice, which provides exceptions to the 30 days notice requirements of § 483.15(b)(4)(i).
h) Plan has factual information confirming the death of the enrollee.

F. For the denial of payment, the notice is mailed at the time the payment is denied by the DCO, and affects a clean claim. An enrollee does not have patient responsibility unless an OHP Agreement to Pay Form has been signed prior to services being provided, for services that may not be covered..

G. The notice must be mailed five business days before the date of action 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 either standard or expedited authorization decisions that are not reached within the timeframes specified in 438.210(d) (which constitute a denial and is thus an adverse benefit determination), the notice shall be mailed by the date that the timeframes expire.

DEFINITIONS

- **"Adverse Benefit Determination"** means any of the following:
  - 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. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination;The failure to provide services in a timely manner pursuant to 410-141-3515;
  - The DCO's failure to act within the timeframes provided in 410-141-3875 through 410-141-3895 regarding the standard resolution of grievances and appeals;
  - For a resident of a rural area with only one DCO, the denial of a enrollee's request to exercise their legal right under §438.52(b)(2)(ii) to obtain services outside the network; or
  - The denial of a enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.
- **"Continuing benefits"** means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending.

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

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.
06/21/2022	Updates based on OHA audit findings.
12/20/2022	Updates based on CCO partner audit findings.
12/31/2022	Updates based on annual review.
12/31/2023	Updates based on annual review.
03/06/2024	Updates based on CCO Partner Findings