Advantage Dental
From DentaQuest

Policy Name: Notice of Adverse Benefit Determination	Policy Number: PL036-Notice of Adverse Benefit Determination- CARE
Type of Policy: DCO	Effective Date: 07/31/2012
Responsible Department: Plan Operations	
Page Number (s): 2	Revised Date: 25/20/2019
Approved By: Clinical and Credentialing Sub-Committee	Approved Date: 07/17/2019

PURPOSE: To establish Dental Care Organization's (DCO's) policy on when a Notice of Adverse Benefit Determination (NOABD) is to be sent and the timelines.

DEFINITIONS:

Adverse Benefit Determination- 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. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service.

FORMS: Notice of Adverse Benefit Determination Template

REFERENCES: 42 CFR 438.210; 42 CFR 438.228; 42 CFR 438.402; 42 CFR 438.404; OAR 410-141-3225; OAR 410-141-3240

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.
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 and contact information, the Provider's name, the enrollee's name and ID number.
   B. The date of service or date service was requested, who requested the service, the service or item requested, 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.
3. A NOABD must be mailed to the enrollee as follows:
   A. For the denial of a standard preauthorization, the NOABD must be sent as

expeditiously as possible, 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 by 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. 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;
   2) No later than the date of action if:
      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.

E. 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.

F. 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.

G. 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.

Reviewed and Revised By:

07/31/2012				
06/06/2014	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2015	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover
02/14/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
03/17/2017	QI/UR Committee			
03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak
05/20/2019	Missy Mitchell	Molly Johnson	Phebe Ditzler	Rosa Pedraza