MID-STATE HEALTH NETWORK

ADVERSE BENEFIT DETERMINATION REGIONAL TECHNICAL GUIDE

The Mid-State Health Network (MSHN) Customer Service Committee (CSC) prepared the regional technical guide to aid staff in understanding the Medicaid Adverse Benefit Determination process.

Adverse Benefit Determination: A (a) decision that adversely impacts the Medicaid Enrollee's claim for services due to: *(42 CFR 438.400)*

MDHHS Technical Guidance in Black

a. An action or determination reached by the provider regarding a service request or active authorized service(s) being provided to a Medicaid beneficiary.
   - Service change requests made by a beneficiary/parent/authorized representative do not require an ABD, but one is often provided as a means of recording the change that occurred by request of the beneficiary/parent/representative.

Regional Technical Guidance in Blue

1. Denial or (a) limited authorization of a requested service, including determinations based on the type or level of service, requirements for (b) medical necessity, (c) appropriateness, (d) setting, or (e) effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
   a. Limited authorization
      - To approve a service request at a lower duration than what was requested by the beneficiary or provider.

      a1. Partial Denial
      - When multiple services are requested, but not all are authorized, or the service is a lower amount than what was requested by the beneficiary or provider.
        - Scope - The focus or intent of the requested service.

   b. Medical Necessity
      - See Attachment A

   c. Appropriateness
      - Authorizing the suitable type of service for the individual's condition to receive the full benefit of the service being provided.
        - See FAQ #5 in Attachment B

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d. Setting
    - The place or surroundings where services are being requested to occur. Such as in the community, partial or inpatient hospitalization, residential, or community family setting.

    Note: A change in provider does not warrant a need to send an ABD Notice.

e. Effectiveness of a covered benefit
    - Authorizing the suitable type of service for the individual's condition to receive the full benefit of the provided service(s) based on their prior service engagement or the level of care determination.

2. (a.) Reduction, (b.) suspension, or (c.) termination of a previously authorized [Advance Notice] service. *42 CFR 438.400(b)(2).*
    a. Reduction
        - The service(s) will still be provided at fewer units than previously authorized units. (See Attachment B-7)

    b. Suspension
        - A temporary hold/pause when a service(s) cannot/will not be provided due to external factors, such as a lack of staff or the beneficiary will be away for an extended period.

    c. Termination
        - The end of previously authorized service(s).

3. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
    a. Instances may occur where contracted providers deliver a service in the amount, scope, or duration not authorized by the contracting agency. The payment for the service to the provider would be denied by the contracting agency, the provider would not be paid for the service, and the individual served would not be responsible/billed for the cost of the service. SUD Detox, SUD Residential, and Hospital Inpatient Mental Health treatment are commonly provided services that may not have been authorized or medically necessary for the individual served.

4. (a.) Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the (b.) date of receipt of a standard (c.) request for service. *42 CFR 438.210(d)(1*).

    *NOTE: The reason for the issuing of the Adverse Benefit Determination will be for a **Delay** in making a Service Authorization Decision.*

    a. Failure
        - A failure to make a final determination of an individual's request for a service(s).

        Note: Can be extended by 14 days.

b. Date of receipt
    - The date the request ("ask") is received from the individual.
        - May occur during a formal appointment or a PCP Addendum meeting, but can occur anytime.

c. Request
    - An "ask" for a service that is within the scope of CMH services.

Note: This ABD reason is commonly referred to as a delay.

5. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*

    Note: This ABD reason is commonly referred to as a delay.

6. Failure to (a.) provide services within **14 calendar days** of the (b.) start date (c.) agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. *42 CFR 438.400(b)(4).*

    a. Provide
        - The beginning of the service provision process…the individual receives the identified services.

    b. Start date
        - The specific date identified during the PCP meeting.

    c. Agreed upon during the PCP meeting
        - The specific date that is discussed, identified, and agreed on during the PCP meeting. The date may be any reasonable time set at a future date.

    Note: This ABD reason is commonly referred to as a delay.

7. Failure of the PIHP to (a) resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*

    a. Resolve
        - The completion of the appeal investigation led to a determination to approve or deny the request being appealed.

    Note: This ABD reason is commonly referred to as a delay.

8. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*

    Note: This ABD reason is commonly referred to as a delay.

9. Failure of the PIHP to (a) resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
    a. Resolve
        - The completion of the grievance that led to a determination.

    Note: This ABD reason is commonly referred to as a delay.

10. For a (a.) resident of a rural area with only one (b.) Managed Care Organization (MCO), the denial of the Enrollee's request to exercise his/her right, under *§ 438.52(b)(2)(ii)*, and to obtain services outside the network. *42 CFR 438.400(b)(6).*
    a. Resident of a rural area
        - Am I Rural? Tool - Rural Health Information Hub
    b. Managed Care Organization
        - A Medicaid managed care organization provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

11. Denial of the Enrollee's request to (a.) dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7).
    a. Dispute a financial liability
        - Due to the Enrollee's ability to pay and the qualifications to meet Medicaid eligibility requirements, the Enrollee would not be billed or held responsible for any financial responsibilities.

    Note: This ABD reason would be extremely rare.

Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to *deny or limit authorization* of Medicaid services requested, which notice must be provided to the Medicaid Enrollee (a.) on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

a. On the same date
    - The day/date of when…
        i. The decision is made that the individual does not meet medical necessity criteria for services.
        ii. The individual does not meet the clinical eligibility criteria for the requested service(s)/does not meet the Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance use disorder.

iii. Medicaid Health Plan is responsible for providing services to you.
iv. The individual has other resources available for the requested services.
v. The individual lives outside of the MSHN PIHP service area, and we cannot authorize services for you.
    - Note: There may be instances where the individual is temporarily located outside the service area or chooses services from a provider outside the county/region's service area.
vi. The individual is currently residing in a location in which the provider cannot authorize your services/another entity is responsible for the individual's care. (See #12 in the FAQ)

Note: An Adequate Notice can be sent if there is no active/current authorization for services.

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to *reduce, suspend, or terminate* Medicaid services currently provided [*an authorization is present*], which notice must be provided to the Medicaid Enrollee (a.) at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

a. At least (10 calendar days prior)
    - An agency may have extra days to account for mailing within their policy when providing an ABD Notice, but the ten (10) calendar days is the required minimum timeframe from the effective date for Advance Notice.

Note: An Advanced Notice is sent when there is an active/current authorization for services.

Authorization of Services: The processing of requests for initial and continuing services delivery. *42 CFR 438.210(b).*

Service Authorization: The PIHP [or delegated provider] processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

Attachment A

Medical Necessity Technical Assistance

Medical Necessity

A determination that a specific service is medically (clinically) appropriate, necessary to meet an individual's needs, consistent with the person's diagnosis, symptomology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care.

Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

The determination of a medically necessary support, service, or treatment must be:

- Based on the information provided by the beneficiary, the beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

Attachment B

Regional Frequently Asked Questions

1. What if the consumer is temporarily away from services within a detention center, jail, substance use treatment center, or nursing home…
   - Should an ABD be sent?
     - Yes, when the amount, scope, and/or duration of the service cannot be provided.
       - Interventions could be written as weekly or monthly; this would impact if the service required an ABD.
       - It would also depend on whether the type of service could be provided within the temporary location, since some services can still be provided.
     - Waiver Services – Waiver recipients must be made inactive (suspended) whenever they are out of the community for a full month; not 30 calendar days, but a full calendar month. When a recipient is inactive for 90 days, the provider must provide a termination notice and submit the waiver for termination.
   - What type of ABD would be sent?
     - Suspension
   - What is the period/length of time before sending an ABD?
     - The Adverse Benefit Determination should be provided at least ten (10) calendar days before the proposed suspension date takes effect. If it is not possible to provide the ten (10) days, then it should be sent as soon as the provider becomes aware of the event that is preventing the service from being provided.

2. When do I need to send an ABD when an individual does not start services right away?
     - As part of the PCP planning process, an agreed upon service start date is identified that may be beyond the standard 14-day service start date, but an ABD would not be required because the start date was the individual's choice.

   - When the delay is due to the individual selecting a preferred provider…
     - An ABD for the delay in the start can be sent when a delay occurs when the individual requests a provider who does not have the current capacity to service the individual. A clear narrative within the ABD to reflect the individual's choice should be included. Regular communication with the provider and the individual/family served is highly recommended. Other provider options should be communicated as the delay progresses.

   - When the appointment is canceled by the CMH/Provider…
     - An ABD would be needed for the delay if the rescheduled appointment is beyond the 14-day timeframe.

        - An extension can be sent if it is in the individual's best interest to extend, and the appointment would be rescheduled within the additional 14-day extension timeframe.

- When the individual cancels the appointment…
    - An ABD for the delay does not need to be sent because the delay is based on the choice of the individual served. Open communication and regular updates to the individual/family are encouraged. The individual's clinical record should include clear documentation noting what has occurred.
- Should the individual be placed on a waitlist?
    - Medicaid recipients cannot be placed on a waitlist.

3. When should a CMH/Provider send an ABD for a delay in determining a Service Authorization decision when more documentation (prescription, referral, vendor bids) is required to determine the eligibility for the service?
    - An ABD for the delay should be sent when it is determined that more documentation is necessary.

4. How long do we suspend an authorization before the service should be terminated?
    - The time before a termination is sent would be based on local CMHSP policy and practices.

5. When an individual is in the hospital due to medical rehab, does a CMHSP need to suspend or close/terminate?
    - The decision would be a case-by-case consideration based upon what is known for the individual's care. Generally, a suspension should be sent before considering a termination of services. Services may be terminated if the individual will be out of service(s) for an extended time.

6. Based on medical necessity, is it allowable to deny a request based on appropriateness?
    - If the youth was authorized for 40 hours of center-based ABA per week, 24 hours of Respite per month, and 15 hours of CLS per week but only utilizes 15 hours of ABA per week. The family requests an increase in Respite hours. The CMHSP considered the family's request but can deny it based on the belief that the youth could benefit more from receiving ABA at the authorized amount. The hope would be that the family's perceived need for Respite would diminish when the youth benefits from the ABA service.

- Note: A review of the PCP and a redetermination could be made during this process to note any service changes or necessary changes to the amount, scope, and duration of services.

7. Should services be suspended or terminated when an individual goes to jail in another county?
   - It would be on a case-by-case basis.
     - A suspension of Medicaid services could be provided while more information is gained on the individual's jail term.
     - Consideration would be given to the duration of the jail term and what services the individual could still receive while in jail.

8. What are some reasons to reduce services?
   - Medical Necessity
   - Provider capacity
   - By request of the individual served

9. Is not having provider capacity a reason to suspend?
   - A provider is needed to provide a service, and an ABD would be required if no providers are available to provide the service. If the individual/family served is asking to wait for a preferred provider, then an ABD would not be required, but could be sent to record the delay based on the individual's/family's request.

10. Should an ABD be sent for a denial, in whole or in part, of payment for a service when the provider's staff did not meet the credentialing requirements for providing the service, and a payback is requested?
    - It is encouraged that an ABD Notice be sent when a final decision to deny payment to the provider has been determined so that the individual/family knows they are not responsible for the cost of the service provided.

11. If an individual is hospitalized and their AFC refuses to take them back, is an ABD required?
    - The need would be case-by-case.
      - If an alternate AFC placement can be found, an ABD would not be required.
      - If another AFC placement cannot be found, an ABD for a suspension of the service would be required.
      - If there is a change in the individual's level of care needs, an ABD Notice for the change in service(s) should be provided.

12. What location would an individual reside in when the provider could not authorize a new service request?
    - Short-term Jail and/or juvenile detention
    - Short-term hospitalization
    - Short-term nursing home stay
    - When another entity is responsible for the individual's care

    Note: Your CMH may have a contracted program to provide services in these locations, and that should be taken into consideration.

13. Should a service request for an autism evaluation be fulfilled without any additional services (ABA) being requested or desired?
    - It is not expected that individuals will know all aspects of the CMHSP autism process. Discussion should occur throughout the process to ensure parents/guardians understand the benefit of ABA therapy and that the function of autism evaluation is not to rule-in / rule-out ASD diagnosis, but to determine a member's eligibility for CMH services [MCL - Section 330.1206]. Consideration should be taken when authorizing the autism/ABA assessment process. A CMHSP should provide an ASD evaluation if it may lead to possible CMH services, but not necessarily ABA, and the parents should inform the CMH upfront that they want services if the child is eligible. A MHP should provide the ASD evaluation if the parents only want to rule in / rule out an ASD diagnosis and state upfront that they wish no additional services beyond the ASD evaluation.
    - An ABD for the denial of the autism evaluation service request would be provided, which states that "Your Medicaid Health Plan is responsible for providing services to you" and the referral information to the MHP for the ASD evaluation request.

    a) If the stand-alone autism evaluation is completed, should an ABD for ABA therapy be provided if the evaluation does not determine a diagnosis of autism for the youth?
        - No, an ABD is not required because the requested service of the autism evaluation was provided; the outcome of the evaluation would not impact the requirement to provide an ABD. Since an ABD was not issued, a second opinion or appeal would not be available, as the requested service had already been provided. A referral to the MHP would be provided for a second ASD evaluation.

Attachment C

Second Opinion, Appeal Rights, and ABDs

1. When is a second opinion available?
    a. A second opinion is available after a denied initial service request or psychiatric hospitalization request.
        i. An initial service request if when an individual is new to CMH services and not open to any service through the CMH. A service denial for an individual who is open to services would be an appeal request.
        ii. Psychiatric hospitalization requests are always a second opinion. It does not matter if the individual is open to CMH service or not.

2. What is the main difference between a second opinion and an appeal request?
    a. A second opinion is a follow-up review after an individual did not initially meet the eligibility criteria for the initial service request or psychiatric hospitalization based upon the Michigan Mental Health Code.

3. What is the timeframe for a second opinion versus an appeal?
    a. Second Opinion
        i. When a CMH services program denies a psychiatric hospitalization request, the second opinion must be performed within 3 days, excluding Sundays and legal holidays, after receiving the request.
        ii. When a CMH services program denies an initial request for mental health services, the second opinion must be performed within 3 days, excluding Sundays and legal holidays, after receiving the request.
    b. Appeal
        i. A Medicaid enrollee has up to 60 days to request an appeal from the date on the ABD. An appeal must be resolved within 30 calendar days after receiving the standard appeal request, or within 72 hours of an approved expedited appeal request.

4. Who can perform a Second Opinion and an Appeal?
    a. Psychiatric hospitalization
        i. The second opinion is completed face-to-face with a CMH psychiatrist.
        ii. An appeal would be after a second opinion (not as often) and is a chart review completed by a CMH staff member who has not previously been involved, and with the appropriate clinical expertise to decide on the appeal.
    b. Initial service denial –

i. The second opinion is completed face-to-face by a previously not involved CMH staff member.
ii. An appeal would be after a second opinion (not as often) through a chart review by a CMH staff member who has not previously been involved and has the appropriate clinical expertise to decide on the appeal.

5. Request to perform a Second Opinion at the ER before leaving.
    a. A second opinion can be requested, but it would be completed within 3 days, excluding Sundays and legal holidays, after receiving the request; thus, not before leaving the ER.

6. Partial hospitalization request: Second opinion versus appeal?
    a. A partial hospitalization request would be an appeal and not a second opinion because the request is not a psychiatric hospitalization request.
        i. The appeal would be a second review by a staff member who was not previously involved and would be completed through a face-to-face assessment with a 72-hour maximum timeframe from the initial request and the re-review.
        ii. After 72 hours, a new crisis screen would be necessary because the process restarts after 72 hours.

7. Do individuals with a spend down have access to the second opinion process?
    a. Yes, the second opinion process would be the same regardless of the pay source since it is based on the Michigan Mental Health Code.

8. Should an appeal request by an individual with a spend down be a Medicaid appeal or a non-Medicaid appeal?
    a. The Appeal would be processed based on the type (Medicaid or non-Medicaid) of Adverse Benefit Determination originally provided based on their Medicaid status at the time of the ABD.

9. Should another ABD be provided if a CMHSP completes a second opinion, and the result upholds the original denial of services?
    a. No, another ABD is not required because the original denial of services ABD is still applicable.

10. Should an appeal be in conjunction with a second opinion request or after the second opinion is decided?
    a. An appeal would be available after the second opinion is decided. The information gained through the second opinion process may be incorporated into the appeal process.

11. Second Opinion for ABA services?
    a. Given the variability in opinions regarding diagnoses and the complexity of the evaluation process, there will inevitably be situations in which a second opinion evaluation is warranted. Historically, second opinion evaluations (i.e., second opinion requests that are initiated by the patient/client) have been more common in medical settings than in the mental health field. The second opinion process has the benefit of ensuring optimal care for the individual and increasing trust with treatment providers. Given the level of services associated with intensive ABA, many families will understandably be highly motivated to receive these services, especially since ABA can typically only be accessed when an individual has a diagnosis of ASD. Caregivers may become upset and frustrated when they feel their child needs BHT/ABA services, but the evaluator determines that the child does not qualify.

    b. Other factors that may contribute to seeking a second opinion include:
        - Evaluations that are too short,
        - Evaluations that do not include information about a child's functioning outside of the observational assessment,
        - Insufficient evaluation of possible comorbid or differential diagnoses,
        - Lack of explanation between the parent report and the clinician observation,
        - Poor rapport between the examiner and caregiver, and
        - Insufficient communication with the family during the feedback session and/or clinical report.