TITLE Notice of Adverse Benefit Determination (NOA), Notice of Extension (NOE) and Notice of Provider Restriction (NOR)	POLICY NUMBER HS-MM-09
RESPONSIBLE AREA Health Coordination	**EFFECTIVE DATE** 08/31/2023
Initiated: 02/25/14 **CHP Policy Committee Approval:** 04/15/14; 04/16/15; 12/04/15; 06/03/16; 10/19/17; 12/27/18; 06/20/19; 11/26/19; 05/21/20; 08/15/21; 08/15/22; 08/15/23	

STATEMENT/PURPOSE

The purpose of this policy is to define DCS Comprehensive Health Plan (DCS CHP) business standards for processing Notices of Adverse Benefit Determination (NOA), Notices of Extension (NOE) and Notices of Provider Restriction (NOR).

AUTHORITY

A.R.S. § 8-512, Comprehensive medical and dental care; guidelines.

A.A.C. R9-22-201, Scope of services.

A.A.C. R9-31-311, Eligibility and enrollment.

A.A.C. R9-34-202, Definition of "Action" by DCS CHP.

A.A.C. R9 34-302, Definition of "Action" by AHCCCS.

A.A.C. R21-1-204, Prior authorization.

A.A.C. R21-1-213, Claim disputes and appeals.

A.A.C. R21-1-305, Request for hearing: Form; Time Limits; Presumptions.

42 CFR 431.54, Exception to certain State plan requirements.

42 CFR 438.10(c)(4)(ii), Model enrollee handbooks and enrollee notices.

The Intergovernmental Agreement (IGA) between Arizona Heath Care Cost Containment System (AHCCCS) and the Arizona Department of Child Safety (DCS) for DCS CHP outlines the contractual requirements for compliance with continuity and quality of care coordination for all members.

The contract between the Department of Child Safety (DCS) for the Comprehensive Health Plan (CHP) and its Managed Care Organization (MCO) contractor outlines the contractual requirements for compliance with timeliness, quality and appropriateness of care/services.

DEFINITIONS

Authorized Representative: A person who is authorized to apply for medical assistance or act on behalf of another person.

Action: An Action is the:
- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial in whole or in part of payment for a service;
- Failure to provide a service in a timely manner; and
- Failure to act within the timeframes specified.

Adverse Benefit Determination: the denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.

Appeal: A request for review of an Action or Adverse Benefit Determination.

Calendar Days: Includes every day of the week including weekends and holidays.

Emergencies: Emergencies are defined as medical services provided for members for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- Placing the member's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

EPSDT: EPSDT services include screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment, and other measures described in Federal Law Subsection 42 USC 1396(d) (a) to correct or ameliorate (improve) defects, physical and mental illness, and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS state plan.

Exclusive Pharmacy: Individual pharmacy, which is chosen by the member or assigned by the health plan to provide all medically necessary federally reimbursable pharmaceuticals to the member. Written notice is provided to the member that explains the reasons for the restriction of the member to an exclusive pharmacy and/or provider to order the medication.

Notice of Adverse Benefit Determination (NOA): The written notice provided to the member/Health Care Decision Maker, and designated representative which explains the reasons for an Adverse Benefit Determination made by DCS CHP regarding a service authorization request and includes the information required AHCCCS.

Notice of Extension (NOE): The written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to fourteen (14) days if criteria for a service authorization extension are met.

Notice of Provider Restriction (NOR): The written notice to a member which explains the restriction of the member to an exclusive pharmacy and/or an exclusive provider,

Restriction: A member who over uses a service including medication overutilization may be restricted to an exclusive pharmacy and/or an exclusive provider.

Service Authorization Request: A request by the member, Health care decision maker, the designated representative, or a provider for a physical or behavioral health service for the member which requires Prior Authorization (PA) by DCS CHP dental benefit.

POLICY

Members/health care decision makers and health care providers, acting on behalf of members, are provided a written detailed Notice of Adverse Benefit Determination (NOA), in accordance with all relevant state and federal laws and regulations, when authorization requests are denied or limited, or when decisions to reduce, suspend, or terminate previously authorized services are made by the health plan. Healthcare provider notification may be in electronic format.

Members/health care decision makers and health care providers, are provided with a written Notice of Extension (NOE) when there is justification for additional information needed by the health plan to make a service determination, and when it is in the member's best interest.

As applicable, members and/or authorized representatives are informed of a Notice of Provider Restriction (NOR) which assigns the member to an exclusive pharmacy and/or an exclusive provider in accordance with all relevant state and federal laws and regulations. Notice of Provider Restrictions outline the restriction, as well as the opportunity to file a written request for a State Fairing Hearing and the timeframes and process for doing so. Federal Regulation 42 CFR 431.54 that states when a member over uses a service, the health plan may restrict the member to a chosen provider.

Members/health care decision makers are advised of their right to file an appeal to the health plan and to the AHCCCS Division of Health Care Management (DHCM) Medical Management if the health plan does not resolve complaints to their satisfaction, in response to NOAs and NOEs. Punitive action is not allowed, either by the health plan or health care providers, against members/health care decision makers, including health care providers acting on behalf of members, when members exercise their appeal rights or when members request expedited resolution to appeals.

Members/health care decision makers have the right to be assisted by third party representatives including attorneys during the appeal process.

NOAs, NOEs, and NORs are written in an easily understood language and include the information necessary for the member to understand what the decision is and the action the health plan has made, utilizing the AHCCCS developed member templates as outlined in AHCCCS Contractors Operations Manual (ACOM) 414.

Prior to the issuance of a NOA, all attempts are made to obtain any lacking clinical information necessary to, provide clarification or render the decision.

PROCEDURES

Health care providers submit service authorization requests to DCS CHP's contracted MCO before providing physical and/or behavioral health services that require prior authorization *[see DCS CHP Prior Authorization Policy, HS-MM-04]*. If the service authorization request is denied, limited, reduced, suspended or if previously authorized services are terminated, DCS CHP's contracted MCO sends notification, in the form of written Notice of Adverse Benefit Determination (NOA) to the member/health care decision maker, and to the provider. This includes denials for requests involving changes in service intensity, specialized provider or skilled caregiver and requests for increased staffing ratios.

The NOA is written in an easily understood language that contains and clearly explains the following information:

- Requested service, level of service or medication;
- Requirements for medical necessity; appropriateness, setting, or effectiveness of a covered benefit;
- Reason/purpose of the requested service or medication;
- Action taken by the health plan (i.e. denial, limited authorization, reduction, suspension or termination) with respect to the requested service or medication;
- Member specific reason for the action, including factual findings about the member's condition that were the basis for the health plan's decision, requirements for medical necessity; appropriateness, setting, or effectiveness of a covered benefit;
    - When medical necessity is the reason for denial, the NOA includes potential alternative options for consideration to address the member's condition;
- Legal basis for the Adverse Benefit Determination;
- Where members/health care decision makers can find copies of the legal basis used (e.g. the local public library and the web page with links to legal authorities);
- Listing of legal aid services programs available to assist the member;
- Explanation of members' right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, criteria and other information relevant to the adverse benefit determination;
- Effective date of the service denial, limited authorization, reduction, suspension, or termination;

- Members' right to request an appeal and the procedures for filing an appeal including information on the right to request a State Fair Hearing (or Administrative Hearing for non-Medicaid members);
- Circumstances under which an appeal process can be expedited and how to request it;
- Explanation of the members' right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which members may be required to pay the costs of continued services if the appeal is denied; and
- Information that the provider who requested the service has the option to request a peer to peer discussion with the MCO Medical Director. The provider is allowed 10 business days to request a peer to peer.

When the health plan extends the timeframe in order to make a service authorization decision, and it is in the members' best interest, a written Notice of Extension (NOE) is sent to the member/health care decision maker and to the provider. DCS CHP requires that its contracted MCO issues and carries out decisions as expeditiously as the member's condition requires and no later than the date the extension expires.

The NOE is written in an easily understood language that contains and clearly explains the following information:

- Requested service;
- Reason/purpose of the requested service;
- Reason for the decision to extend the timeframe;
- Specific information needed to make a determination;
- Date that the timeframe expires if the authorization decision has not been reached; and
- Members' right to file a grievance and the procedures for filing a grievance if the member disagrees with the decision to extend the timeframe.

Written notification is provided to a member's custodial agency representative that outlines Notice of Provider Restriction (NOR) when a member has been identified as requiring interventions to ensure the member receive the appropriate medication, dosage, quantity, and frequency.

NOAs, NOEs and NORs contain, and clearly explain in easily understood language, the reasons for the determination and include instructions on how to appeal decisions. If the reason for denial of a service is due to the lack of necessary information, members are clearly informed and are given the opportunity to provide the necessary information.

The AHCCCS Early Periodic Screening, Diagnostic and Treatment (EPSDT) Rule, A.A.C. R9-22-213 and Federal Law 42 USC 1396d(r)(5) is cited when denying, reducing, or terminating a service for a Medicaid member who is younger than 21 years of age when the provisions in these rules/laws are applicable to the service requested.

The notification to members explains the denial, reduction, limitation, suspension or termination of requested Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for members younger

than 21 years of age. The NOA includes a complete explanation of why the requested service does not meet EPSDT criteria and/or is not covered and a citation for all applicable state and federal rules and regulations.

Information on NOA, NOE and NOR processes is provided in the Mercy Care DCS CHP Member Handbook.

When the action to restrict and assign a member to an exclusive pharmacy or doctor for up to a 12-month period is taken, a written Notice of a Provider Restriction is sent to the member that contains the following information:

- Assigned exclusive pharmacy or doctor from which to obtain the medicine;
- Effective date of the restriction;
- Specific instructions to the member on how to obtain medications:
  - in the event of an emergency;
  - if the medication is out of stock;
  - if the exclusive pharmacy is closed.
- Factual and legal basis for the restriction;
- Where members can find copies of the legal basis (e.g. the local public library and the web page with links to legal authorities);
- Members' right to request an appeal through a State Fair Hearing, and the date by which a written appeal request must be received.

If the member has filed an appeal restrictions are not imposed until the:

- Restriction is affirmed by State Fair Hearing process; or
- Member has voluntarily withdrawn the appeal or request for hearing in a timely manner.

If there is no appeal in the 30-day notice timeframe provided, the NOR action is implemented.

Termination, Suspension, or Reduction of Service

DCS CHP requires its contracted MCO to give at least 10-day notice before the date of action whenever the action is termination, suspension, or reduction of previously authorized services, except under conditions specified in federal or state regulations.

Timeframes for Service Authorization Decisions and Notifications

The contracted MCO is required to make timely prior authorization determinations appropriate to the services requested and notifies DCS CHP members/health care decision makers and providers of those determinations in accordance with all relevant federal and state laws and regulations.

DCS CHP and its contacted MCO adhere to the following decision/notification time standards:

- Medication Authorizations: When an initial prior authorization request for medication is submitted and it contains all of the medically necessary information, a decision is made within 24 hours of

receipt of the initial request. If the decision is a denial, the NOA is sent out within 24 hours from the initial receipt date and time. If additional information is required, a request for additional information is sent to the prescriber no later than 24 hours of receipt of the request. A final determination is issued no later than seven calendar days from the receipt of the initial request.

- Standard Authorizations: Authorization decisions are as expeditiously as the member's condition warrants, but no later than 14 calendar days from receipt of the request. A NOE may be issued of up to 14 additional calendar days if the criteria for a service authorization extension are met.
- Expedited Authorizations: An expedited authorization is a request for service (that is not a medication) where the requesting provider determines that the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. In addition, requests for Behavioral Health Residential Facility (BHRF), participation on a clinical trial, and requests for services when a member is awaiting disposition in an emergency department are treated as expedited. Authorization decisions are as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request, with a possible extension of up to 14 additional calendar days, if the criteria for an extension are met.

If an expedited request is received for a service but is not of an urgent nature, the Expedited Authorization request may be downgraded to a Standard Authorization request after verifying the appropriateness with the requesting provider. The requesting provider is permitted to send additional documentation supporting the need for an Expedited Authorization.

Service authorization decisions not reached within the required timeframes as outlined for Standard or Expedited requests constitutes a denial (adverse decision). A NOA letter is issued denying the request on the date that the timeframe expires.

Service authorization decisions that are not reached within the timeframe outlined in the NOE constitutes a denial (adverse decision). An NOA letter is issued denying the request on the date that the timeframe expires.

Timeframes for Notice of Adverse Benefit Determination (NOA)

NOAs are sent within the following timeframes:

- Medication Authorizations: Notices regarding medication authorization decisions that deny or limit services, are sent no later than 24 hours from the receipt of the request. If additional information is required, a request for additional information is sent to the prescriber no later than 24 hours of receipt of the request. A final determination and/or Notice is issued no later than seven (7) calendar days from the receipt of the initial request.
- Previously Authorized Services: Notices regarding termination, suspension, or reduction of a previously authorized service, are sent at least 10 days before the date of the proposed termination, suspension, or reduction.
- Standard Authorization Decisions: Notices regarding standard service authorization decisions that deny or limit services, are sent no later than 14 days from the receipt of the request; unless there is a NOE.

- Standard Authorization Decisions with NOEs: NOAs issued for authorization where a NOE was sent, are sent by the end date of the NOE, not to exceed 14 additional calendar days from the end of the Standard decision timeframe, and may never exceed 28 calendar days.
- Expedited Authorization Decisions: Notices regarding expedited service authorization decisions that deny or limit services are sent as expeditiously as the member's health condition requires but no later than 72 hours from receipt of the expedited service authorization request.
- Expedited Authorization Decisions with NOEs: NOAs issued for authorization where a NOE was sent, are sent by the end date of the NOE, not to exceed 14 additional calendar days from the end of the Expedited decision timeframe.

Notice of Extension (NOE) Requirements

The timeframe to make a decision for a standard authorization request may be extended by up to 14 calendar days, not to exceed the 28 calendar days, from the receipt of the request. For Expedited Authorization requests, the decision timeframe may be extended from 72 hour timeframe, to make a decision, by up to an additional 14 calendar days.

If the timeframe is extended in order to make a decision, the health plan performs the following actions:

- Make sufficient attempts to obtain the needed information from the provider;
- Give the member (custodial agency representative) written notice of the reason for the decision to extend the timeframe;
- Include the information needed in order to make a determination;
- Inform the member (custodial agency representative) of their right to file a grievance (complaint) if he or she disagrees with the decision to extend the timeframe; and
- Make the decision as expeditiously as the member's condition allows, but no later than the date the extension expires.

Decision of a Service Authorization Request

Medical Directors review all authorization requests that are not approved by clinical staff members.

If the authorization request is denied, the Medical Director writes the reason for the denial, along with pertinent information regarding the member's specific facts. A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is an unacceptable reason for denial. If a service is not medically necessary, the decision must be explained in language which is easily understood by the member in the NOA and must include potential alternative options for consideration that may address the member's condition.

Providers who request services have the option to request a peer to peer discussion with the MCO Medical Director. The provider is allowed 10 business days after the notification is sent to request a peer to peer.

Member Complaints Regarding the Adequacy and/or Understandability of NOA

The Member Handbook outlines members' right to complain to health plan of an inadequate NOA. The Member Handbook also informs the member (custodial agency representative) that if the health plan does not resolve complaints about the NOA to the member's satisfaction, the member has the right to, and can complain to AHCCCS Division of Health Care Management (DHCM), Medical Management.

If a member complains about the adequacy of a NOA, the health plan reviews the initial notice to determine adherence to the NOA policy. If the health plan determines that the original notice is inadequate or deficient, an amended NOA is issued that adheres to the policy.

Should an amended NOA be required, the timeframe for the member (custodial agency representative) to appeal and continuation of services starts from the date of the amended NOA.

Continuation of Services During NOA Appeal

Members (custodial agency representative) or an authorized representative can appeal a decision on a service authorization. An appeal is a request from a member (custodial agency representative), or an authorized representative to reconsider or change a decision.

The member's has the right to be assisted by a representative, including an attorney, during an appeal. The appeals process registers the existence of the third party and ensures that the required communications related to the appeals process occur between the health plan and the representative. The member's representatives, upon request, are provided timely access to documentation relating to the decision under appeal.

Consistent with federal privacy regulations, the health plan makes reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member; however, if the health plan questions the authority of the representative or the sufficiency of a written authorization, it promptly communicates that to the representative.

Requests for continuation of a service must be filed within 10 days after the date the NOA is mailed or the effective date of the action as indicated in the NOA. Services continue if the:

- Appeal is filed before the:
  - later of 10 days from the mailing of the NOA; or
  - intended effective date of the proposed Adverse Benefit Determination;
- Appeal involves the termination, suspension, or reduction of previously authorized course of treatment;
- Appeal involves a denial, and the physician asserts the requested service/treatment is necessary for continuation of a previously authorized service;
- Services were ordered by an authorized provider;
- Original period covered by original authorization has not expired; and
- Member (custodial agency representative) requests that services continue.

Services continue until one of the following occurs:

- Member (custodial agency representative) withdraws the appeal;
- Ten (10) days pass after the Notice of Appeal Resolution has been mailed and the member (custodial agency representative) has not requested a State Fair Hearing; or
- AHCCCS mails an adverse Director's Decision (determined after State Fair Hearing) to the member (custodial agency representative).

If AHCCCS upholds the decision, the health plan may recover the cost of the services furnished to the member while the appeal was pending.

If AHCCCS reverses the plan's decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan authorizes the disputed services promptly and as expeditiously as the member's health condition requires.

If AHCCCS reverses the health plan's decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan pays the provider for those services.

Right to be Represented

Members/health care decision makers have the right to be assisted by third party representatives including attorneys during the appeal process. If assisted by a third party representative, any communications related to the appeals process includes the third party representative, after appropriate verification that they have authority to act on the members behalf. The third party representative, upon request, is provided timely access to documentation relating to the decision under appeal.

Auditing and Reporting of Notifications

DCS CHP has oversight of and requires its contracted MCO to conduct quarterly self-audits to ensure that member notification templates and processes are in compliance with AHCCCS guidelines. The auditor cannot be the staff member that writes or issues the NOA. The audit includes NOAs from medical, dental, pharmacy and behavioral health.

An executive summary and score sheet is sent to AHCCCS DHCM/Medical Management with the selection methodology, deficiencies, plan of action (if not in compliance) and staff members involved in the audit including their credentials and roles/responsibilities.

DCS CHP reserves the right to review the MCO self audit to verify accuracy of the audit, or specific NOA or NOE and associated records for further review.

REFERENCES

AHCCCS Contractor Operations Manual (ACOM) Policy 414, Requirements for Service Authorizations Decisions and Notices of Adverse Benefit Determination

DCS CHP Policy HS-MM-01, Prescription Medication Services

DCS CHP Policy, AD-CO-O1 Member Grievance and Appeals

Contract and Policy Dictionary (azahcccs.gov)

AHCCCS Guide to Language in Notice of Adverse Benefit Determination (NOA) (azahcccs.gov)

RELATED FORMS

AHCCCS Contractor Operations Manual (ACOM) 414, Attachment A, Notice of Adverse Benefit Determination

AHCCCS Contractor Operations Manual (ACOM) 414, Attachment B, Legal Services Program

AHCCCS Contractor Operations Manual (ACOM) 414, Attachment C, Notice of Extension

AHCCCS Medical Policy Manual (AMPM) 310-FF, Monitoring for Controlled and Non-Controlled Medication Utilization

AHCCCS Medical Policy Manual 300, Policy 310-FF, Attachment A, Notice of Provider Restriction