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Owner	Kristi Swank: Quality & Compliance Project Manager
Area	EOCCO Grievance & Appeals
Applicability	EOCCO
References	Behavioral Health, Dental, Healthcare Services + 4 more

EOCCO Notice of Adverse Benefit Determination Policy

I. Policy Statement and Purpose

When EOCCO takes or intends to take any action, including but not limited to denials or limiting prior authorizations of a requested service in an amount, duration or scope that is less than requested, or reductions, suspensions, discontinuation or termination of a previously authorized service, or any other action, EOCCO will mail a written Notice of Adverse Benefit Determination (NOABD) to the EOCCO member in accordance with Oregon Administrative Rule (OAR) 410-141-3885. EOCCO will inform providers and subcontractors, at the time they enter into a contract, written notifications of procedures and timeframes for Grievances, NOABDs, Appeals, and Contested Case Hearings. Written notification of updates to any procedures and time frames will be supplied to providers within five business days after approval of such updates by The Oregon Health Authority (OHA).

II. Definitions

A. **Adverse Benefit Determination:** A 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; the denial, in whole, or in part, of a payment for a service (excluding any claim that is not a clean claim). 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 (Network Adequacy); the failure to act within the timeframes regarding the standard resolution of grievances and appeals (42 CFR §438.408(b)(1) and (2)); the denial of a request by a member residing in a rural area to exercise his or her right to obtain services outside the network (42 CFR §438.52(b)(2)(ii)); or the denial of a request by a member to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

B. **Continuing Benefits**: a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending pursuant to 410-141-3910.

C. **Long Term Psychiatric Care (LTPC):** Inpatient psychiatric services delivered in an Oregon State-operated hospital after usual and customary care has been provided in an acute inpatient hospital psychiatric care setting or in a residential treatment facility for children under age 18 and the individual continues to require a hospital level of care (as hospital is defined in OAR 410-120-0000).

D. **Notice of Adverse Benefit Determination (NOABD):** A written notice to a member of an Adverse Benefit Determination. The NOABD includes information regarding the member's rights to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. This information may include, but is not limited to medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. The NOABD is available in the non-English languages prevalent in the EOCCO service area or enrollees preferred language upon request.

E. **Clean Claim:** Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity (42 CFR § 447.45 (b)).

III. Procedures

A. EOCCO receives a request for service authorization or referral and a reviewer evaluates the request

    1. Once the review is complete, the reviewer notifies the requesting provider and member or member's representative of the determination.

        a. If the service is approved, the reviewer approves the request in the utilization management system and mails an approval letter to the member and provider.

        b. If the service is not approved, the reviewer denies the request in the utilization management system and mails a Notice of Adverse Benefit Determination to the member and the member's representative and requesting provider. The reviewer indicates in the letter whether the service was denied because it is not covered or because it does not meet medical necessity. EOCCO must use an Oregon Health Authority(OHA) approved form unless the member is a dually eligible member of affiliated

Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in Oregon's NOABD.

B. EOCCO gives members timely and adequate NOABD in writing consistent with requirements in Exhibit I of the CCO Contract, OAR 410-141-3885 and in 438.404. when the decision about a health service constitutes an Adverse Benefit Determination.

1. The NOABD is written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the action and requesting a hearing
2. The NOABD complies with the Oregon Health Authority (OHA) formatting and readability standards:
    a. Provided using easily understood language and format. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale. EOCCO uses a minimum 12-point font or large print (18 point);
    b. Font size no smaller than 12 point
    c. Readily accessible by members and potential members;
    d. All materials available to members at no cost and within 5 business days;
    e. Includes a language access statement which at a minimum is translated to the prevalent languages in EOCCO's service area;
    f. Includes taglines in large print (18 point) and prevalent non-English language describing how to request auxiliary aids and services, including written translation or oral interpretation and toll-free and TTY/TDY customer service number, and availability of materials in alternative formats provided at no cost to the member.
    g. Materials include non-discrimination notice footer or attachment.
    h. Materials include statements on how to request alternative languages or formats.
    i. Materials are posted to the EOCCO.com website if appropriate and members are notified of the materials available in this location via mail or email after providing consent to EOCCO. Members who cannot access this information online are provided reasonably expected methods to receive this information such as auxiliary aids and services upon request and at no cost.
    j.
3. The Pre-service NOABD includes the following:
    a. Notice of Action - Benefit Denial in the title
    b. The date of the notice
    c. EOCCO and Subcontractor(if applicable) name, address, and telephone number (Not including the cover page), including information on

requesting help and who to contact.

d. The name of the primary care provider (PCP) or primary care dentist (PCD) or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model; If the member has not been assigned a practitioner because they enrolled in EOCCO within the last 90 days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred.

e. Member's name, D.O.B, address, and ID number

f. Date of the service or the date the item or service was requested by the provider or member

g. Description and explanation of the service requested in plain language, and an explanation of the Adverse Benefit Determination, including whether EOCCO is denying, terminating, suspending or reducing a service or payment of a service in whole or in part

h. The name of the provider who requested or performed the service

i. Effective date of the Adverse Benefit Determination if different from the date of the notice

j. Diagnosis and procedure codes submitted with the authorization request including a description of all codes in plain language.

k. For members over the age of 20: Other conditions EOCCO considered including, but not limited to, comorbidity factors if the service was below the funding line on the Oregon Health Plan (OHP) Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830; statement of intent governing the use and application of the Prioritized List to requests for health care services; and other coverage for services addressed in the State 1115(a) Waiver.

l. Clear and thorough explanation for the specific reasons for the Adverse Benefit Determination. Include a description of review for medical necessity/appropriateness for members under 21.

m. A reference to the specific sections of the Oregon Administrative Rules (OAR), to the highest level of specificity, for each reason and specific circumstances identified in the NOABD

n. The member, Member representative, or th eprovider with the member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of EOCCO's adverse benefit determination with EOCCO, within 60 days from the date of the NOABD, including information on exhausting EOCCO's one level of appeal, and the procedures to exercise that right. To support their appeal, the Member's right to give information and testimony in person or in writing, and make legal factual arguments in person or in writing with the appeal filing timelines. An EOCCO appeal form is included with the NOABD

    i. EOCCO has 16 days to review and resolve the appeal from date

of receipt with a possible extension of 14 days. If an extension is needed, EOCCO will call and send a letter to member within 2 calendar days. EOCCO reassures members that their appeal will be resolved as soon as their health requires and that they can file a grievance if they do not agree with the extension.

o. The member’s, Member's representative's, or the provider’s right to request a contested case hearing with OHA only after EOCCO's Appeal Notice of Resolution; or where EOCCO failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895 and the procedures to exercise that right; A copy of the Denial of Medical Services Appeal and Hearing Request (OHP 3302) is included with the NOABD.

p. The circumstances under which an expedited appeal process and an expedited contested case hearing are available and how to request it or the member'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;

q. The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefit(s) be continued, and the circumstances under which the member may be required to pay the costs of the continued services. Continuing benefits means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending pursuant to 410-141-3910. Member's must ask for this within 10 days of the date of the notice or by the date the decision is effective, whichever is later. Member's may request continuation of benefits orally or in writing.

r. Information on requesting help and who to contact.

s. The member's right to receive from EOCCO, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's Adverse Benefit Determination; such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used by EOCCO in setting coverage limits or making the adverse benefit determination, and language clarifying that oral interpretation is available for all languages and how to access it.

t. Enclosure line and all required forms (EOCCO Non-discrimination Policy, and OHP3302)

u. Names of provider, clinic, and authorized representative (if applicable) on the notice (CC line).

4. The Post-service NOABD includes the following:

    a. Notice of Action - Benefit Denial in title

    b. The date of the notice

    c. EOCCO name, address, and telephone number (not including the cover page), including information

d. Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in EOCCO within the last 90 days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred;

e. Member's name, D.O.B, address, and OHP member ID number;

f. Service previously provided and the adverse benefit determination EOCCO made;

g. Date the service was provided;

h. Name of the provider who provided the service;

i. Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;

j. Service previously provided and the adverse benefit determination EOCCO made including if the EOCCO is partially/fully approving or denying a claim.

k. Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language. For services that do not include a procedure code a description of the service provided in plain language.

l. For members over 20 years of age: Other conditions EOCCO considered including, but not limited to, comorbidity factors if the service was below the funding line on the Oregon Health Plan (OHP) Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830. The NOABD 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.

m. Clear and thorough explanation of the specific reasons for the adverse benefit determination. Include a description of review for medical necessity/appropriateness for members under 21.

n. A reference to the specific sections of the Oregon Administrative Rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD.

o. The member, Member representative or the provider with the Member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of EOCCO's adverse benefit determination with EOCCO, including information on exhausting EOCCO's one level of appeal, and the procedures to exercise that right. To support their appeal, the member's right to give informationand testimony in person or in writing, and make legal and factual argument in person or in writing within the appeal timeframe.

    i. EOCCO has 16 days to review and resolve the appeal from date of receipt with a possible extension of 14 days. If an extension is

needed, EOCCO will call and send a letter to member within 2 calendar days. EOCCO reassures member that their appeal will be resolved as soon as their health requires and that they can file a grievance if they do not agree with the extension.

p. The member's, member's authorized representative or the provider's right to request a contested case hearing with the Authority only after EOCCO's Appeal Notice of Resolution or where EOCCO failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right; A copy of the Denial of Medical Services Appeal and Hearing Request (OHP 3302) is included with the NOABD. A hearing must be requested within 120 days from the date of the NOAR.

q. An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member'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;

r. The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services. Member's must ask for this within 10 days of the date of the notice or by the date the decision is effective, whichever is later. Member's may request continuation of benefits orally or in writing.

s. Information on requesting help and who to contact.

t. The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including medical necessity criteria and any processes, strategies, or evidentiary standards used by EOCCO in setting coverage limits or making the adverse benefit determination; and

u. A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166).

v. Enclosure line and all required forms (EOCCO Non-discrimination Policy, 3302)

w. Names of provider, clinics, and authorized representative (if applicable) copied on the notice (CC line)

C. EOCCO mails an NOABD within the following time frames:

1. Prior Authorizations and Referrals that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, EOCCO must notify the requesting provider and mail the NOABD to the member as expeditiously as the member's condition requires:

a. For denial of payment, the NOABD must be mailed at the time of any

adverse benefit determination that affects a clean claim.

b. Standard Requests: When an Adverse Benefit Determination is made, EOCCO provides written notice as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the request for service, except that:
    i. EOCCO may have a possible extension of up to 14 additional calendar days if the EOCCO member or the provider requests the extension; or if EOCCO justifies (to OHA upon request) a need for additional information and how the extension is in the member's interest. When OHA requests justification for the extension, it must be provided within 5 days of the request.
    ii. EOCCO gives the member written notice of the reason for the decision to extend the timeframe and informs the member of their right to file a grievance if he or she disagrees with the decision.
    iii. EOCCO makes reasonable effort (including multiple calls at different times of the day) to give the member oral notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision;
    iv. EOCCO carries out its prior authorization determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
    v. Expedited Requests: For cases in which a provider indicates, or EOCCO determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, EOCCO must make an expedited authorization decision and provide notice as expeditiously as the member’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.
        a. EOCCO may have a possible extension of up to 14 additional calendar days if the EOCCO member or the provider requests the extension; or if EOCCO justifies (to OHA upon request) a need for additional information and how the extension is in the member's interest.
        b. If EOCCO meets the criteria to extend the 14 calendar day NOABD timeframe for expedited authorization decisions that deny or limit services, it must:
            i. give the member written notice of the reason for the decision to extend the timeframe and informs the member of their

right to file a grievance if he or she disagrees with the decision.

ii. Make reasonable effort (including multiple calls at different times of the day) to give the member oral notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision;

iii. Issue and carry out its prior authorization determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

vi. For requests for non-emergent medical transportation (NEMT) services and reimbursements:

a. EOCCO and the transportation subcontractor provide a secondary review by another employee when the initial screener denies a ride prior to sending the notice of adverse benefit determination.

b. If a driver fails to show for a requested transport, EOCCO logs this into the database and follows up with the member and provider.

c. If an Adverse Benefit Determination is made, an NOABD is mailed within 72 hours of denial to the member and the provider or other third party with which the member was scheduled for an appointment.

d. If an Adverse Benefit Determination is made for a reimbursement request, an NOABD is mailed to the member within 72 hours of the denial.

vii. For prior authorization decisions not reached within the timeframes specified above, (which constitutes an Adverse Benefit Determination), EOCCO mails a NOABD on the date that the timeframe expires.

D. For adverse decisions affecting previously authorized services; including termination, suspension or reduction of previously authorized Medicaid-covered services, EOCCO must notify the requesting provider and mail the notice to the member at least 10 calendar days before the date of action with the exception of circumstances noted below:

1. The notice will be mailed no later than the date of action and may be mailed less than 10 calendar days before the date of action if:

a. EOCCO has factual information confirming the death of the member;

b. EOCCO receives notice that the services requested by the member are no longer desired or EOCCO is provided with information that requires termination or reduction in services:

i. All notices sent by a member must be in writing, clearly indicate the member understands that the service previously requested shall be termination or reduced as a result of the notice and signed they the member; and

ii. All notices sent the OHSU IDS must be in writing and include a clear statement that advises the member of the information received and that such information caused the termination ro reduction of the requested service.

c. EOCCO can verify that the member is in an institution where the member is no longer eligible for service provided by the plan;

d. EOCCO is unaware of the member's whereabouts, the post office returns EOCCO mail directed to the member indicating that there is no forwarding address, and the OHA has no other address on file;

e. EOCCO verifies that another state, territory, or commonwealth has accepted the member for Medicaid services;

f. The member's PCP, PCD, or behavioral health professional has prescribed a change in the level of health services;

g. The member will be transferred or discharged from a long term care facility in less than 10 days in accordance with 483.15©(4) wich provides exceptions to the 30 day notice requirements of §483.15(c)(4)(i) of this chapter; or

h. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the SSA.

2. The date of action will occur in as few as 5 calendar days when EOCCO:

a. Has facts indicating probable fraud by the member, and EOCCO has certified those facts, if possible, through a secondary resource; or

b. Denies payment for a claim.

c. For denial of payment, EOCCO will mail the NOABD at the time of any Adverse Benefit Determination that affects a clean claim.

3. EOCCO ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

E. Service authorization decisions for outpatient drugs include a practitioner administered drug (PAD).
When EOCCO has made or intends to make an adverse benefit determination for an initial outpatient drug request and is in receipt of EOCCO's standard information collection tools for prior authorization, within 24 hours, EOCCO must issue a written NOA/NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to EOCCO, the pharmacy if the drug is denied or partially approved.

1. If additional documentation needs to be requested from the prescribing practitioner

in order to render a decision, this must not delay a decision to approve or deny the drug as expeditiously as the member's health requires and no later than 72 hours.

2. The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug.
3. If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, EOCCO must issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to the EOCCO, the pharmacy.

F. Monitoring Denials

1. The EOCCO Quality Improvement Committee and the Grievance System Report Subcommittee review member denials and complaints quarterly for persistent or significant problems regarding denials. The committee identifies areas for improvement and implements appropriate interventions. The Grievance System Report is presented quarterly to the EOCCO Quality Improvement Committee and the Regulatory Compliance Committee. At least annually the grievance system summary is presented to the EOCCO Governance Board.

G. Delegation -If EOCCO chooses to delegate any other portion of the grievance and appeal process, including NOABDs, to a subcontractor, EOCCO, in addition to the general obligations established under OAR 410-141-3505, do the following:

1. EOCCO will monitor the compliance of its subcontators, including its provider network, with all adverse benefit determination requirements in accordance with applicable law and the applicable provisions of this contract;
2. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3875 through 410-141-3915.

IV. Related Policies & Procedures, Forms and References

EOCCO Medicaid Member Grievance and Appeals Policy and Procedure

Claim Processing procedures

Denial of Medical Services Appeal and Hearing Request (OHP 3302)

OAR 410-120-0000

OAR 410-141-3500

OAR 410-141-3835

OAR 410-141-3885

42 CFR § 438.52

42 CFR § 438.210(c)

42 CFR § 438.400

42 CFR § 447.45 (b)

Coordinated Care Organization contract, Exhibit I(3)

V. Affected Departments:

Medical Customer Service
Medical Claims
Medicaid Services
Healthcare Services
Behavioral Health Services
Oral Health Services

Approval Signatures

Step Description	Approver	Date
EOCCO QIC Policy Subcommittee	Becky Miller: GOBHI Policy Analyst	03/2024
	Kristi Swank: Quality & Compliance Project Manager	02/2024

Applicability

EOCCO

References

Behavioral Health, Dental, Healthcare Services, Medical, Pharmacy, Submit to OHA upon material change, Submit to OHA within 5 business days of request