CORPORATE POLICY & PROCEDURE

	Policy Name: CE21 - Adverse Benefit Determinations
Department: Health Plan Operations	Policy Number: CE21
Version: 11	Creation Date: 08/14/2018
Revised Date: 4/1/19, 10/23/19, 7/24/20, 8/6/20, 3/1/21, 5/28/21, 7/19/21, 10/12/22, 1/24/23	
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health Management ☐ Umpqua Health - Newton Creek ☐ Umpqua Health Network	
Approved By: Oregon Health Authority, Quality Improvement Committee, Douglas Carr (Medical Director) Date: 03/07/2023	

POLICY STATEMENT

Umpqua Health Alliance (UHA) issues written notification to members and/or representatives when it has made or intends to make an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), Oregon Administrative Rules (OAR) 410-141-3835 through 410-141-3915, and Code of Federal Regulations (CFR) 42 CFR §§ 438.400 through 438.424. This policy is applied in conjunction with the policies for prior authorizations, grievances, appeals, hearings and customer care (i.e., Member Handbook).

PURPOSE

To provide all members with opportunity to appeal an adverse benefit determination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Adverse Benefit Determination (ABD): 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 (This excludes any claim that is not a 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); the failure to provide services in a timely manner pursuant to 410-141-3515; the MCE'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 MCE, the denial of a member's request to exercise their legal right under §438.52(b)(2)(ii) to obtain services outside the network; or the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Appeal: A request for review of an adverse benefit determination issued by UHA. Members have

one level of appeal with UHA.

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.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make Oregon Health Plan (OHP) related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through person's familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in Oregon Revised Statutes (ORS) 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

PROCEDURES

1. UHA issues a written notification approved by OHA for an ABD, for any of the following:
    a. 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.
    b. The reduction, suspension, or termination of a previously authorized service.

c. The denial, in whole or in part, of payment for a service. This excludes any claim that is not a 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.
d. The failure to provide services in a timely manner, as defined by the State.
e. The failure of UHA to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
f. For a resident of a rural area with only one managed care organization, the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

2. UHA gives the member, member's representative and requesting provider, and when applicable and known to UHA, the pharmacy, timely and adequate NOABD in writing by meeting the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885 by including the Appeal and Hearing Request Form (OHP 3302) and including the following information for both pre-service and post-service denials:
    a. Date of the notice;
    b. UHA's name, address, and telephone number;
    c. 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 with UHA within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred;
    d. Member's name, date of birth, address, and member OHP ID number;
    e. Description and explanation of the service(s) requested or previously provided, and the ABD UHA made or intends to make, including whether UHA is denying, terminating, suspending, or reducing a service or denial of payment in whole or in part;
    f. Date of the service or date service was requested by the provider or member;
    g. Name of the provider who performed or requested the service;
    h. Effective date of the ABD if different from the date of the notice (pre-service) or effective date (date claim denied) of the ABD if different from the date of the notice (post-service).

i. Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if UHA is denying a requested service because of line placement on the Prioritized List or the diagnosis and procedure code do not pair on the Prioritized List;
j. Other conditions UHA considered including, but not limited to, co-morbidity factors if the service was below the funding line on the 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;
k. Clear and thorough explanation of the specific reasons for the adverse benefit rules including specific sections of the statues and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:
    i. The item requiring prior authorization but not authorized;
    ii. The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-0000;
    iii. The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;
    iv. The service or item received in an emergency care setting that does not qualify as an emergency service;
    v. The person is not a member at the time of the service or not a member at the time of the requested service;
    vi. Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;
    vii. Prior approval not obtained (except as allowed in OAR 410-141-3840); or
    viii. UHA's denial of member's disenrollment request and findings that there is no good cause for the request.
l. The members right or, if the member provides written consent as required under OAR 410-141-3890 (1), the providers right to file a written or oral appeal of UHAs Adverse Benefit Determination with UHA, including information on exhausting UHAs one level of appeal, and the procedures to exercise that right;
m. The members or the providers right to request a contested case hearing with OHA only after UHAs Notice of Appeal Resolution or where UHA failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

n. The circumstances under which an expedited appeal process and an expedited contested case hearing are available and how to request (pre-service). 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 members 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. 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) (post-service);

p. 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 costs of the 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. The member shall complete a UHA appeal request or an Authority contested case hearing request for continuing benefits no later than:

q. The tenth day following the date of the notice of ABD or the notice of appeal resolution (NOAR); and the effective date of the ABD proposed in the notice, if applicable.
The members right to receive from UHA, 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; and copies of the appropriate forms as listed in OAR 410-141-3885, including, but not limited to, the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

r. The member's right or, if the member provides their written consent as required under OAR 410-141-3890 (1), the provider's right to file an appeal of the adverse benefit determination with the UHA within 60 days from the date of notice on the ABD, including information on exhausting the UHA's one level of appeal and the procedures to exercise that right;

s. The member's or the provider's right to request a contested case hearing with OHA only after the Appeal Notice of Resolution (NOAR) or where UHA failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895 and the procedures to exercise that right within 120 days from the date of notice on the NOAR.

t. They include an insert of UHA's nondiscrimination policy statement and process to report a complaint of discrimination on the basis of age, color, disability, gender, identity, marital status, national origin, race, religion, sex and sexual orientation in accordance with all Applicable Laws including Title VI of the Civil Rights Act, ACA Section 1557, and ORS Chapter 659A (see policy MS2 – Nondiscrimination of Members).

u. Language access taglines in 18-point font which explains availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and the toll-free and TTY/TDY telephone number of the UHA's Customer Care.

v. Language access statement translated to the prevalent languages in UHA's service area in at least 12-point font. (Taglines are also found in the beginning of the member handbook for the ease of the member.) These statements include clarifying that oral interpretation is available for all languages and how to access it.

3. UHA uses 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.
4. The notice must comply with the OHA's formatting and readability standards in OARs 410-141-3580, 410-141-3585 and 42 CFR § 438.10, including, without limitation, translating a notice of adverse benefit determination (ABD) for those members who speak prevalent non-English language and be written in 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.
    a. UHA uses easily understood language and format. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale. Notices are in a 12-point font unless the member requests large print (18 point).
5. UHA provides notice of an ABD expeditiously as the member's condition requires within state-established timeframes for authorization requests consistent with OAR 410-141-3885:
    a. For standard authorization requests for services not previously authorized, and that deny or limit the amount, duration or scope of services, UHA will notify the requesting provider and mail the NOABD to the member and/or representative as applicable and provide notice as expeditiously as the member's condition requires and no later than:

i. 24 hours following receipt of the request for outpatient drugs, with a possible extension up to 72 hours from the date and time stamp on the initial request if UHA has requested additional information or time is needed for review (CE12 – Prior Authorizations, section Pharmacy);
    1. If the drug is denied or partially approved, UHA will issue a written NOABD to the member and/or representative as applicable and telephonic or electronic notice to the prescribing practitioner, and when known to UHA, the pharmacy.
    2. If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for PA, UHA will issue a written NOABD to the member, and/or representative as applicable and telephonic or electronic notice to the prescribing practitioner, and when known to UHA, the pharmacy.
    3. When UHA has made or intends to make an ABD for an initial outpatient drug request and is in receipt of UHA's standard information collection tools for prior authorization, within 24 hours, UHA will issue a written NOA/NOABD to the member, and/or representative as applicable and telephonic or electronic notice to the prescribing practitioner, and when known to UHA, the pharmacy if the drug is denied or partially approved.

ii. 14 days following receipt of the request for all other services with a possible extension of up to 14 additional days if the following applies:
    1. The member, the member's representative, or provider requests an extension; or
    2. UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via administrative notice to the email address identified by OHA in its request, within five (5) days of OHA's request.

b. For notice of ABDs that affect standard services previously authorized, UHA shall mail the notice at least 10 days before the date the ABD takes effect:
    i. For cases in which a provider indicates, or UHA 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, UHA shall 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.

ii. UHA may extend the 72-hour expedited authorization decision time period up to 14 additional days if the member or provider requests an extension or if UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request.

c. If UHA meets the criteria to extends the ABD timeframe for standard or expedited authorization decisions that deny or limit services, it must:
   i. Give the member and/or representative as applicable written notice of the reason for the decision to extend the timeframe and make reasonable effort (including as necessary multiple calls at different times of day) to give oral notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision.
   ii. Issue and carry out its determination as expeditiously as the member's health or mental health condition requires and no later than the date the extension expires.

d. UHA mails the notice of ABD by the date of the action when any of the following occur:
   i. UHA has factual information confirming the death of a member;
   ii. UHA receives notice that the services requested by the member are no longer desired or UHA is provided with information that requires termination or reduction in services:
      1. All notices sent by a member must be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member; and
      2. All notices sent by UHA must be in writing and include a clear statement that advises the member of the information received and that such information caused the termination or reduction of the requested services.
   iii. UHA verifies the member has been admitted to an institution where the member is ineligible for OHP services from UHA.
   iv. The member's whereabouts unknown based on returned mail and UHA receives returned mail directed to the member from the post office indicating no forwarding address and OHA or the Department has no other address listed on file.
   v. The member is accepted for Medicaid services by another local

jurisdiction, state, territory, or commonwealth.

vi. A change in the level of medical care is prescribed by the member's primary care provider, primary care dentist or behavioral health professional.

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

viii. The member will be transferred or discharged from a long-term care facility in less than 10 days in accordance with § 483.15(c)(4), which provides exceptions to the 30 days' notice requirements of § 483.15(c)(4)(i).

ix. The denial of payment (the NOABD must be mailed at the time of any adverse benefit determination that affects the claim).

x. Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an ABD. A notice of ABD shall be issued on the date the timeframe expires.

xi. For ABDs for long term psychiatric care (LTPC) transfers, the safety or health of individuals in the facility would be endangered, the member's health improved sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the LTPC for 30 days.

e. For ABDs that affect services previously authorized, UHA will notify the requesting provider and mails the notice to the member and/or representative as applicable at least 10 days before the date of ABD, when the ABD is a termination, suspension, or reduction of previously authorized Medicaid-covered services or there is a change in the level of health services prescribed by the member's PCP, PCD, or behavioral health professional. UHA may mail the ABD as few as five (5) days prior to the date of ABD if the agency has facts indicating that ABD should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources.

6. UHA will give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.
7. UHA maintains a record of each notice of ABD and any documentation, logs and other records for adverse benefit determination in a manner accessible to the state and available upon request to the Centers for Medicare & Medicaid Services. Records shall be retained for ten (10) years (CO23 – Record Retention & Destruction Policy).
8. In addition to the content of the ABD and the Appeal and Hearing Request Form (OHP 3302), members may also access information regarding their rights to an

appeals, hearing, and grievance on the UHA website and in the Member Handbook.

9. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA member services for assistance.
10. UHA annually reviews and updates its grievance systems policies and procedures and its member notifications. Written notification of updates to these procedures and timeframes within 5 business days after approval of such updates by OHA.

Subcontracted Entities

1. If UHA subcontracts the prior authorization, appeal, or grievance process to a subcontractor, it must:
    a. Provide to OHA all subcontracts for grievance services to be approved prior to such subcontracts being implemented (CCO Contract Exhibit B, Part 3, Section 14(c)(4).
    b. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 and 42 CFR §§ 438.400 through 438.424;
    c. Monitor the subcontractor's performance on an ongoing basis;
    d. Perform a formal compliance review annually to assess performance, deficiencies, or areas for improvement, including but not limited to, updates to the grievance systems policies and procedures and its member notifications; and
    e. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement. UHA will document all monitoring and corrective action activities for subcontractors.
2. Subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. ABD, NOAR, and grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.

4. UHA shall not subcontract to a subcontractor or participating provider the adjudication of an appeal, in accordance with OAR 410-141-3875 (14).

Department	Standard Operating Procedure	Effective Date	Version Number
Health Plan Operations	UM & Services Authorization Handbook	8/09/2020	1