Notice of Adverse Benefit Determination
Workgroup Questions and Answers

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LANGUAGE ACCESS

1. **Do MCEs need to offer translation in prevalent languages in their area only?**
   MCEs must send notices in a member's preferred language for all prevalent, non-English languages in the service area. For all other languages, translations must be provided when a member request is received. Reference: 42 CFR § 438.10 (d)

2. **Can you clarify what "made available" means in OAR 410-141-3585 (3)? Does this mean for members who speak a prevalent non-English language in our service area, all written materials must automatically be sent in that language? Or does made available mean that we have them on hand and can send upon request? Does this apply to all written materials?**
   If a member's preference is a prevalent non-English language in your service area, you have to proactively/automatically send materials in their preferred language. If it is not a prevalent non-English language in your area, you have to send materials in their preferred language upon request. This applies to all written materials.

3. **When determining if a member will require materials translated into a language other than English, which data field in the 834 file should we use?**
   "Language reading" is the 834 field that would correlate to written correspondence preference.

4. **Do language access taglines need to be in 18-point font?**
   Language Access taglines in English and the MCE's prevalent non-English languages must be in 18 point font. Taglines in other languages should be in 12 point font at a minimum, 14 point font as a best practice. References: 42 CFR § 438.10(d); OAR 410-141-3585(5)

5. **What are the OARs that list language access requirements for member education, potential members, and marketing?**
   OAR 410-141-3585(5) lists language access requirements for member education and information. Those requirements apply to all written materials considered member education and information, not just Grievance and Appeal notices.

   - Requirements for potential member information are covered under OAR 410-141-3580. As OAR 410-141-3580(1) states, potential member information

must also comply with 42 CFR § 438.104 and OAR 410-141-3575 and any requirements or guidelines adopted by the Authority.
- Requirements for marketing and definitions are outlined in OAR 410-141-3575.

FORMATTING

6. Does the MCE logo and contact information need to be on the NOABD template?

The MCE must include contact information in the body of the notice, excluding all cover pages. MCEs are not required to have a letterhead, but an MCE may opt to use a letterhead. Following a discussion during the NOABD workgroup, OHA recently revised OARs (effective 7/1/2021) to address this change in guidance. OAR 410-141-3885 (2) "The following are notice requirements for pre-service denials: A) MCE contact information (MCE Name, address, and telephone number) and subcontractor contact information, if applicable, included in the ABD notice excluding any cover pages."

7. For the NOABD and NOAR templates, can MCEs use just the table or just the narrative?

Yes, MCEs can choose which format they prefer for Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NOAR) templates. The templates are set up so that all required elements are included.

8. Can MCEs submit different templates for other services like pharmacy?

OHA requests that the MCE submit one template for post- service NOABD, one template for pre- service NOABD and one template for NOAR for approval. Once OHA approves the notice templates the expectation would be that those notices be used for all service denials.

9. Can the post-service denial notice include a list of different services and different dates of service, all in one NOABD?

From the member's perspective, it would be better to get one notice instead of multiple. It is important to have the information clearly defined, so it is not confusing for the member. As long as the design of the claim denial notice is clear, OHA supports sending out one notice for multiple claim denials. The Claims Denial Notice Template has been updated with a list option.

10. Should secondary OARs be included in the table?

You can include secondary OARs in either the table or in the narrative. The table can expand to fit as much information as needed.

11. Should contact information be referenced throughout the NOABD and NOAR letters or can the location of the information be used for subsequent

references?

At least one instance of MCE contact information must be found in the member notice. MCEs can reference its location throughout the rest of the notice. For example: “Use the contact information at the top of this letter.”

12. When a provider resubmits a request and a member starts the appeal process, how should they handle the denial notices issued? Should they issue or should they hold the notice?

If a provider submits a prior authorization request or claim and the MCE intends on denying the service, a NOABD must be issued. If the provider resubmits a prior authorization or claims with additional or new information, the MCE must also respond by either approving or denying that request within the required time frames.

FORMS

13. Can OHA create an appeal form that is separate from the hearings form?

The Quality Assurance team will work with OHA Hearings unit in the near future to create an appeal form that is separate from the hearings form. There are a few barriers that could potentially hinder our ability to create a separate form that requires further discussion.

14. Does OHA plan to create a form for the MCEs to use to document verbal/oral appeals from the member?

Because members have been allowed to file an oral appeal prior to the federal rule change, OHA feels that each MCE should have a standing appeal form and process that captures verbal appeals.

15. Can the 3302 be updated to align with language in the notice for continuation of benefits?

Quality Assurance will be working on updating the 3302 in the near future.

New

16. What if a member submits an appeal request without an appeal form?

Members may submit appeal requests orally or in writing (with or without an OHA appeals form). The MCE shall ensure all requests for appeal are treated equally to assure appeal requests are routed as expeditiously as possible to abide required timeframes. The clock begins as soon as the MCE receives the appeal no matter how the member submits (orally or in writing). See also Question #25.

NOTICE CONTENT

17. Is it optional to include diagnosis code and description in the notice?

Per a discussion with OHA Hearings unit and the Department of Justice (DOJ), OHA will require MCEs to include diagnosis and procedure codes in pre-service and post-service denials effective July 1, 2021. This requirement should have been in effect previously but is now being explicitly called out in state rules.

Inclusion of this information is necessary because it is often reviewed by OHA Hearings and the Administrative Law Judge in the determination of the appropriateness of a denial. OHA recently revised OARs (effective 7/1/2021) to address this change resulting from discussions with the NOABD workgroup, DOJ, and the OHA Hearings unit.

OAR 410-141-3885 (2) was revised to read "The following are notice requirements for pre-service and post-service denials: (I) Diagnosis and procedure codes submitted with the authorization request including a description in layman terminology if the MCE is denying a requested service because of line placement on the Prioritized List of Health Services or the diagnosis and procedure code do not pair on the Prioritized List."

18. Is there an existing Diagnosis and Service Request Codes crosswalk in 6th grade / plain language?

An OHA-provided crosswalk does not currently exist. During an upcoming CCO Contracts and Compliance meeting, we will discuss the challenge this poses to system automation and try to identify a possible solution to address the challenge.

19. Is OAR 410-141-3885 specific to post-service denials, applicable to the denied claims specific to the NEMT Service Type?

The rule requires diagnosis and procedure codes for pre- and post-service denials be included if a service is denied based on the Prioritized List of Covered Services. This applies to NEMT.

If a member was not enrolled with the CCO on the date of service, a denial notice for NEMT must be issued with the reason being that the member was not enrolled in the CCO on the date the ride took place.

20. What is the highest level of specificity intended to apply to Dx code and description of service?

MCEs must include language in the NOABD that references the following:

- Specific reasons for the adverse benefit determination;
- Specific statutes and administrative rules for each denial reason and specific circumstance in the adverse benefit determination; and,
- Specific diagnosis codes and procedure codes including a description in plain language if the MCE is denying the authorization request because the diagnosis and procedure code do not pair on the Prioritized List.

21. Should reasons for dismissal of an appeal be included in the NOAR? For example, invalid waiver, no member consent, or withdrawn by member.

OHA recommends MCEs provide a member notice of the reason(s) for dismissing an appeal through an appeal dismissal letter separate from the NOAR. Appeal dismissals should not be communicated through the NOAR letter.

22. Does a provider need member consent before submitting appeal through the standard and expedited processes? Is consent needed before proceeding with appeal?

DOJ has indicated that written consent from the member would be required in standard and expedited appeals for a provider or authorized representative to request an appeal on the member's behalf. The MCE must be able to document all instances in which member consent was requested. Once written consent is received back from the member, the MCE would start the appeal process.

If the provider submits an appeal independent of the member, the provider does not need consent because the provider will follow the appeal process in OAR 410-120-1560.

23. If the provider submits an appeal on behalf of the member, does the member need to follow-up in writing? What is the timeframe for the member to respond with the written consent?

DOJ has indicated that written consent from the member would be required in standard and expedited appeals for a provider or authorized representative to request an appeal on the member's behalf. The MCE must be able to document all instances in which member consent was requested. Once written consent is received back from the member, the MCE would start the appeal process.
The member or member's representative/provider with the member's written consent has 60 days from the date of the NOABD to submit an appeal with the MCE. If written consent from the member is not received within the 60 days than the appeal can be dismissed by the MCE.

24. When does the oral appeal timeframe begin?

The oral appeal timeframe begins when contact is established between the member and the MCE representative. If the member leaves a voicemail message with the MCE indicating that they wish to appeal a denial, the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt to reach the member (date(s) and time(s)) by phone and make a note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.

OAR 410-141-3890(1) was updated to reflect the federal change to the Managed Care regulations §438.406(b)(3). State rules are effective July 1, 2021, but because the order of precedence applies (OAR 410-141-3501), CCOs should have updated their Appeal and Grievance systems to reflect the federal Managed Care regulation changes that were effective December 2020.

New

25. When does the clock begin if the member reaches a different MCE unit that is not the Appeal and Grievance unit and it takes a day or two to get the message to the Appeal and Grievance unit?

The clock begins as soon as the MCE receives the appeal no matter which internal department receives it first.

For example, if an appeal is received by another MCE unit, other than A&G, on day 60 and the appeal does not make it to the A&G unit until day 62, the appeal would still be considered as submitted timely by the member and should be acted upon accordingly. The time it takes an appeal to reach the MCE A&G team is an internal process and MCEs should ensure appeals are sent over to the A&G team in a timely manner. A couple of best practices are to utilize date and time stamps in the mailroom and internal information systems for accurate compliance monitoring and ensure staff is properly trained to route appeal requests as expeditiously as possible to abide required timeframes.

26. Does the MCE need to list all programs and services in the "Get Help" section?

No, as long as the NOABD refers to the required language access services below, the MCE does not need to list additional services.

"Get help or copies of paperwork
All members have a right to know about and use our programs and services. We give these kinds of free help: Sign language; Spoken language interpreters; Materials in other languages Braille, large print, audio, and anyway that works better for you"

27. Can the Continuation of Benefit section be removed from the NOABD and NOAR notices or modified for services the member was not previously receiving?

Continuation of Benefit language is required by CFR. However, language was modified based on group discussion to be more specific: "If you have been getting this service and we stopped providing it, you can ask us to continue it."

28. Do you have an estimate on how long the approval process will take once we submit our templates? Would it be acceptable for CCOs to implement the new templates before they are officially approved by OHA, with the understanding that we may need to go back and make changes after the fact?

CCOs may not use the templates before OHA approval. OHA will complete the first review of the A&G member notice submissions within 30 days. Any re-submissions will be reviewed within 14 days of submission.

29. When completing the NOABD do we need to include services that were approved as well as denied?

NOABDs are issued when denying, terminating, suspending, or reducing services in part or in whole. As such, approved services should be included on the NOABD when there is a partial approval / partial denial of the prior authorization (PA). The

NOABD should address all services requested on a PA even if each service has its own procedure code.

30. When there is a partial approval/partial denial, where on the OHA templates should that information be included?

We recommend updating the "Service <<denied, terminated, reduced, suspended>>:" section to include the partial approval/partial denial. If you are not using the OHA template, you can include the information in the section where you address the service denied, terminated, reduced, or suspended.

CLAIMS-RELATED CONTENT

31. The member may ask for Continuation of Benefits during appeal and/or hearing process within the 10 days of receiving NOABD. That said, provider(s) have up to 365 calendar days to bill/submit claim(s) from the date of service. Will OHA include the Continuation of Benefits language in the payment denial template?

OHA will have to do further research on this question.

32. What is the definition of a "clean claim" and is it defined in rule?

A clean claim can be processed with no additional information and no additional documentation; there are no defects or improprieties.

The definition of a clean claim in the CCO contract (42 CFR 447.45(b)) has been added to state rules (effective July 1, 2021). A 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.

For the purpose of this rule, pharmacy claims processed at point-of-sale (POS) that are rejected or denied shall not be considered "clean claims" that would trigger a NOABD. OHA is further researching the approach used for Medicare to develop a process to inform and educate members about their rights following the rejection of a pharmacy claim at the point-of-sale.

33. Do MCEs have to send out NOABDs for claim denials?

Please see the memo clarifying claim denial guidance, shared on August 9.

Under Section 42 CFR 438.404(a), managed care plans are required to give enrollees timely notice of an adverse benefit determination. With the exception of the changes to § 438.400(c), MCEs are required to issue a Notice of Adverse Benefit Determination in all instances in which a clean claim is denied. § 438.400(c) finalizes proposed change to specify that a provider claim denied by a plan in whole or in part due to not meeting the definition of a clean claim is not an adverse benefit determination, and thus does not require notice to beneficiaries.

Notice requirements to all future claims, including resubmission of the initial claim, would be independently determined. In other words, if a provider resubmits a claim and it is now clean, but is subsequently denied by the plan, this would constitute an

adverse benefit determination and require the issuance of timely notice to the beneficiary.

34. **For purposes of logging on the A & G log does the MCE measure by the number of claims denied or notices sent out? If one CCO decides to send individual notices and another sends multiple in one, the CCO sending individual notices may be seen as sending out to many claim denial notices. How do we solve for this issue?**
    OHA will be working on the Appeal and Grievance Log and Report required by Exhibit I and will consider this question in any proposed revisions to existing reporting requirements.

35. **CFR 438.404 (5) requires the NOABD include the circumstances under which an appeal process can be expedited and how to request it. If this is in CFR wouldn't it have to remain in the NOABD even if it is a service that already took place? Can the NOABD contain expedited language but add a statement that an expedited appeal would not include post service denials?**
    An expedited appeal would never be approved for post-service denials. MCEs may include a statement in the claim denial notice that informs the member the expedited appeal process does not apply to claim denial notices. This language is in the Claims Denial Notice Template as well.

    As a result of the discussions with the NOABD workgroup, OHA updated state rules to reflect this approach. New OAR language effective July 1, 2021:
    OAR 410-141-3885 (2) "The following are notice requirements for post-service denials: (O) 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."

36. **Post-service authorizations received after a service is rendered; do we need to add the same note to pre-service denial where the expedited process will not be approved for a service that was already rendered for which a retro PA is submitted?**
    If the service has already taken place and a retro PA is submitted the NOABD template could indicate that an expedited appeal would not be granted as the service has already been received.

37. **The comorbidity consideration is in OAR but is not in CFR. Does comorbidity need to be considered before denying a claim?**
    MCEs should include language in the claim denial notice to prompt providers to submit info if they feel the comorbidity rule applies. This language is in the Claims Denial Notice Template. We also encourage MCEs to include information in the provider manual to make providers aware of the process for comorbidity consideration in the context of claim denials.

38. What is the difference between prior authorization and claim denial timeframes (i.e., timeframe for pre-service denial is triggered by the date the PA is received and for claims it is at the point of adjudication of the claim)?

Please refer to the following rules for further clarification.

- **OAR 410-141-3835 (9)** For authorization of services:
  (a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:
  (A) For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:
  (B) For notices of adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination takes effect:
- **OAR 410-141-3565 (8) (b)** MCEs shall pay or deny at least 90 percent of valid claims within 30 days of receipt and at least 99 percent of valid claims within 90 days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt;
  (c) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3885;
- **OAR 410-141-3885 (c)** For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.

39. Should the letters include instructions for what to do if a member gets a bill?

The NOABD and NOAR should inform the member that a provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166). The notice should inform the member to call the MCE if they receive a bill.

40. Currently, MCEs have up to 16 calendar days to process appeals. If we are following Medicare rules, Medicare allows 60 calendar days to process post-service (claim) appeals. Is OHA allowing CCOs 60 calendar days as well?

MCEs will still be required to follow the current time frame of processing an appeal within 16 calendar days. However, OHA will discuss this further to determine alternative approaches.

41. For pharmacy, CCOs has 24 hours to provide a decision for a PA request, how does this NOABD requirement affect the Point of Sales denials?

OHA will have to do further research on this question.