Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Problem Resolution 02.02.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	_Signature on File__	____9/8/17_____

SUBJECT:	Continuation of Benefits Pending Appeal Resolution (AKA "Aid Paid Pending")

PURPOSE:

To ensure that the benefits of a Medi-Cal Mental Health Plan (MHP) and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) consumer receiving services through Orange County's Behavioral Health Services (BHS) County operated and County contracted clinics continues while an appeal of a MHP and/or DMC-ODS adverse benefit determination decision (including a State Fair Hearing) is in process, if all of the regulatory requirements are met.

POLICY:

The MHP and or DMC-ODS shall continue a Medi-Cal Mental Health Plan (MHP) and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) consumer's benefits and services pending the final outcome of an appeal of an adverse benefit determination, when the regulatory requirements (see specifics below) are met. This includes during the time of the State Fair Hearing, should the beneficiary file for a State Fair Hearing.

SCOPE:

All County operated and County contracted clinics providing Specialty Mental Health Services (SMHS) through BHS MHP and/or providing substance use treatment services through BHS DMC-ODS.

REFERENCES:

Mental Health Plan Contract with the Department of Health Care Services

Drug Medi-Cal Organized Delivery System Contract with the Department of Health Care Services

Code of Federal Regulations (CFR) Title 42, Section 438.420

FORMS:

Grievance or Appeal Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

DEFINITIONS:

Adverse benefit determination:

(1) 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.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeals - Appeals are explicitly defined as a request for a review of an "adverse benefit determination" (see above for definition).

Notice of Adverse Benefit Determination (NOA) - Written notification to the requesting provider and the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

PROCEDURE:

I. The MHP and/or DMC-ODS shall notify the requesting provider and give the consumer (and parent/guardian/conservator) written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. This is a Notice of Adverse Benefit Determination (NOA).

II. Benefits/services shall continue while an appeal is in process if all of the following occur:

   A. The consumer (parent/guardian/conservator) files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice; and

   B. The appeal involves the termination, suspension, or reduction of a previously authorized service; and

C. The consumer’s services were ordered by an authorized provider; and

D. The period covered by the original authorization has not expired; and,

E. The request for continuation of benefits is filed on or before the later of the following:

1. Within 10 calendar days of the MHP and/or DMC-ODS sending the notice of adverse benefit determination; or

2. The intended effective date of the adverse benefit determination.

III. If, at the consumer’s (parent/guardian/conservator) request, the MHP and/or DMC-ODS continues the consumer’s benefits/services while the appeal or state fair hearing is pending, the benefits must be continued until:

A. The consumer (parent/guardian/conservator) withdraws the appeal or request for state fair hearing, or

B. The consumer (parent/guardian/conservator) does not request a state fair hearing and continuation of benefits within 10 calendar days from the date the MHP and//or DMC-ODS sends the notice of an adverse appeal resolution, or

C. A state fair hearing decision adverse to the consumer is issued.

IV. The MHP and/or DMC-ODS may recover the cost of continued services furnished to the consumer while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds the MHP’s and/or DMC-ODS’ adverse benefit determination. The consumer shall be informed of this in the appeal resolution letter that includes the State Fair Hearing information.

V. The MHP and/or DMC-ODS shall authorize or provide the disputed services promptly, and as expeditiously as the consumer's health condition requires, but no later than 72 hours from the date the MHP and/or DMC-ODS receives notice reversing the determination if the services were not furnished while the appeal was pending and if the MHP and/or DMC-ODS appeal or the state fair hearing officer reverses a decision to deny, limit, or delay services.

VI. If the decision of an appeal reverses a decision to deny the authorization of services, and the consumer received the disputed services while the appeal was pending, the MHP and/or DMC-ODS shall cover the cost of such services.