



SAN MATEO COUNTY HEALTH  
**BEHAVIORAL HEALTH  
 & RECOVERY SERVICES**

**NOABD Quick Guide (with FAQ)**

- A Grievance is an expression of dissatisfaction from the client about the relationship between them and their provider.
- All requests for service must be considered and a decision must be made within 14 days (Expedited decisions are 72 hours)
- **Timing of the Notice** BHRS must mail the notice to the beneficiary within the following timeframes:
  1. **For termination, suspension, or reduction** of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214.
  2. **For denial of payment**, at the time of any action denying the provider’s claim; or,
  3. **For decisions resulting in denial, delay, or modification** of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.
- The 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;
  1. The reduction, suspension, or termination of a previously authorized service;
  2. The denial, in whole or in part, of payment for a service;
  3. The failure to provide services in a timely manner;
  4. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
  5. The denial of a beneficiary’s request to dispute financial liability. Beneficiaries must receive a written NOABD when BHRS takes any actions described above. BHRS must also communicate the decision to the affected provider within 24 hours of making the decision.

NOABD	Responsible Staff	Criteria for Beneficiary Notice
<b>Denial</b>	Access Call Center UM Teams (Adult/Youth) Clinician/Supervisor at Program CBO Conducting Assessment DMC-ODS Authorizer	<ul style="list-style-type: none"> <li>• Beneficiary request covered MH or SUDS service - BHRS denies/does not approve services after completing assessment.</li> <li>• Denial-Based: Assessment determining no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective with diagnosis.</li> </ul>



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<b>Delivery System</b>	Access Call Center SDA Clinician/Supervisor SDA CBO	<b>Beneficiary does not meet the criteria for specialty mental health services or SUDS</b> but does meet criteria for other mental health/SUDS systems of care. <ul style="list-style-type: none"> <li>Mild to Moderate referred Health Plan of San Mateo(HPSM)</li> <li>SED - referred to School District for mental health.</li> </ul>
<b>Modification</b>	Access Call Center UM Team/Coordinator (Adult/Youth) CBO Conducting Assessment	Beneficiary is already <u>authorized for mental health treatment</u> by BHRS call center or UM Teams (Adult/Youth) <ul style="list-style-type: none"> <li>Reduced frequency and/or duration of authorized services</li> </ul>
<b>Termination</b>	Access Call Center UM Teams (Adult/Youth) DMC-ODS Authorizer	BHRS terminates or suspends a currently authorized service (or ends treatment that a client still wants)
<b>Timely Access</b>	Access Call Center UM Team/Coordinator (Adult/Youth) Clinician/supervisor at Program CBO Agency	<u>Timely access standards not met for FIRST ASSESSMENT APPOINTMENT And/or TREATMENT</u> Not OFFERED APPOINTMENT DATE or Placed client on WAITLIST within <ul style="list-style-type: none"> <li>MH/SUDS OP within 10 business days from request.</li> <li>MED SUPPORT within 15 business days from request</li> <li>Opioid treatment within 3 business days</li> </ul> Urgent Services: if not OFFERED APPOINTMENT WITHIN <ul style="list-style-type: none"> <li>48 hours for services not requiring preauthorization.</li> <li>96 hours for services that do require preauthorization</li> </ul>
<b>Authorization Delay</b>	Access Call Center UM Team/Coordinator (Adult/Youth) Clinician/supervisor at Program CBO Agency	If Authorization decision is not made on time: <ul style="list-style-type: none"> <li>Updates on this to come. Contact Ask QM if you have any questions about issuing this NOABD.</li> </ul>



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<b>Financial Liability Notice</b>	MIS	BHRS MIS/Billing denies a client's request to dispute financial liability for services provided.
<b>Payment Denial Notice</b>	MIS/UM	When BHRS Billing Dept. Denies—in whole or in part for any reason—a request for payment for services already delivered to the beneficiary because: <ul style="list-style-type: none"><li>• Condition as described by provider did not meet the medical necessity criteria for DMC-ODS, psychiatric inpatient hospital services, or specialty MH services.</li><li>• Services provided are not covered by BHRS.</li><li>• BHRS MIS/QM requested but has not received additional info from the provider needed to approve payment.</li><li>• Provider did not meet documentation standards.</li></ul>
<b>Grievance/Appeal Delay</b>	OCFA	The Plan does not meet required timeframes for the standard resolution of grievances and appeals.



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## Frequently Asked Questions (updated 4.14.2021)

### 1) Can you clarify when we DO NOT need to send a NOABD?

If a client falls under any of the categories below, a NOABD does NOT need to be issued:

- Finishes treatment.
- Chooses to leave treatment.
- Is lost to follow-up.
- Does not have Medi-Cal.
- Does not want treatment.
- Meets medical necessity for any BHRS (or CBO) service AND service is offered BUT the client also wants additional services which the clinical staff do not think are appropriate. (Example: the client wants to participate in a group but the clinical staff does not think a group is appropriate for the client.)

### 2) Who is responsible for sending NOABDs for Mild-To-Moderate cases?

For Mild-To-Moderate referrals:

- If you screen or assess a client and determine that they are Mild-to-Moderate and refer them back to the Call Center- the Call Center will complete the **Delivery System** NOABD.
- If you assess a client and determine they DO NOT meet medical necessity for any BHRS (or CBO) service, and you ARE NOT referring them to Mild to Moderate - Call Center, you complete the **Denial** NOABD.
- A NOABD is not needed if referring to BHRS Interface Mild-To-Moderate program.

### 3) What about BHRS Interface? BHRS Interface has several different episode types, including a mild to moderate program.

For BHRS Interface: If you open the client to any of your avatar programs, you do not issue a NOABD, even if the client is Mild to Moderate.



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**4) I see that we don't need to issue NOABDs if we refer out to a BHRS mild to moderate program. What about the reverse: if we receive a transfer from a BHRS mild-to-moderate program?**

If your program is being transferred from a BHRS internal mild-to-moderate program (such as Interface Mild-To-Moderate), then you do not need to issue a NOABD. The BHRS mild-to-moderate program should continue to see the client until they are successfully linked to the transfer program. While no NOABD needs to be issued, these clients should still be tracked for CSI Timely Access if they meet criteria for CSI Timely Access tracking (see CSI Timely Access webinar trainings and resources).

**5) What if we intend to provide services, but we won't have any available clinicians for several weeks?**

- If your program is unable to offer an assessment appointment within 10 business days (15 for med support) of the request for service, or is unable to offer a treatment appointment within 10 business days (15 for med support) after the assessment is completed (the client meets medical necessity), the clinical program staff will issue the **Timely Access** NOABD.

**6) Who is responsible for sending the Modification, Termination, and Authorization Delay NOABDs?**

- BHRS UM Teams and Call Center completes **Modification, Termination, and Authorization Delay** NOABDs related to services that require an Authorization.