Health Care Agency **BHS Adult Mental Health Services** **Policies and Procedures**	Section Name:	Managed Care
	Section Number:	800.04
	Policy Status:	☐New ☒ Revised

APPROVED	**SIGNATURE**	**DATE**
ADAS Division Manager	Brett O'Brien	08/28/07
AMHS Division Manager	Annette Mugrditchian	09/05/07
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SUBJECT: Notice of Action Forms

PURPOSE:

This policy is to standardize the use of the Notice of Action forms (A, B, C, D, and E), informing consumers of the Mental Health Plan's decision to deny or change requested Mental Health Services and their right to appeal. This policy establishes a uniform standard of tracking Notice of Action (NOA) forms and pertinent information contained on the form..

SCOPE:

This procedure is to be followed by all clinical staff, students, volunteers and administrative staff working for Adult Mental Health Services (AMHS) and Alcohol Drug Abuse Services (ADAS), and/or working under the Mental Health Plan (MHP), Title IX Regulations.

FORMS:

Medi-Cal Specialty Mental Health Program, Notice Of Action-A (NOA-A)
Medi-Cal Specialty Mental Health Program, Notice Of Action-B (NOA-B)
Medi-Cal Specialty Mental Health Program, Notice Of Action-C (NOA-C)
Medi-Cal Specialty Mental Health Program, Notice Of Action-D (NOA-D)
Medi-Cal Specialty Mental Health Program, Notice Of Action-E (NOA-E)

REFERENCES:

Orange County Health Care Agency/Behavioral Health Care Implementation Plan, March, 1998.

Title IX California Code of Regulations; Chapter 11, Medi-Cal Specialty Mental Health Services; Reference Number 1850.210.

Welfare and Institution Code, Section 14684.

METHOD:

Forms NOA-A and NOA-E are utilized by staff working in AMHS, ADAS and Contract Program Clinics.

I. NOA-A

If a consumer initially requesting services does not meet the medical necessity criteria for Specialty Mental Health Services following assessment, services will be denied. A Notice of Action-A shall be sent to the consumer explaining the reason the services have been denied. The clinician will note the date, the name of the consumer,

the Medi-Cal number and the county on the spaces provided on the NOA-A form. The clinician will check the appropriate box indicating the reason the services are being denied.

The clinician shall give the completed Notice of Action-A, along with a copy of the NOA-BACK, to the consumer or will mail it through the US Postal Service no later than three (3) working days after the decision to deny specialty mental health services has been made.

A copy of the NOA-A shall be logged in the NOA log filed on site, and a copy shall be sent to the Quality Review and Training Unit, quarterly.

NOTE: **If a consumer is referred within the Mental Health Plan, a Notice of Action shall not be issued.**

Examples:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

Ex: This box would be checked if the Consumer was diagnosed with Antisocial Personality Disorder (a non-included diagnosis) and does not meet criteria for another included mental health disorder.

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

Ex: This box would be checked if the Consumer suffers no serious impairments at work, home, school, in relationships, self-care, or any other major areas of life as a result of their included mental health disorder.

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

This box would be checked if the Consumer was diagnosed with Anti-Social Personality Disorder (non-included) and Intermittent Explosive Disorder (included) The consumer would not benefit from case management, rehabilitative therapy, or medication support services as the intermittent explosive behavior arises from the Antisocial Disorder and would not be diagnosed separate.

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

This box would be checked when a person diagnosed with Diabetes I or II exhibited depressive symptoms that arose from this condition and could be ameliorated with treatment for Diabetes.

II. NOA-E

An NOA-E form is sent to a consumer or his representative when the Mental Health Plan fails to provide services within a pre-determined time frame. The clinician will enter the date, the name of the consumer, the Medi-Cal number, the county, the number of working days required to provide the respective requested services, the date services were requested, and the service/s requested on the spaces provided on the NOA-E form.

The clinician shall give the completed Notice of Action-E form, along with a copy of the NOA-BACK, to the consumer or will mail it through the US Postal Service when the service requested is not provided within the established timeframes of Emergent (4 hours), Urgent (24 hours) or Routine (14 days).

A copy of the NOA-E shall be given to the client, the NOA-E recorded in the NOA log, a copy shall be filed on site, and a copy shall be sent to the Quality Review and Training Unit.

Tracking and Log

1. A Notice of Action Log shall be kept at each clinic location in a designated notebook.

2. The Notice of Action Log shall be used by all clinic staff to document all Notices of Action initiated.

3. The person initiating the Notice of Action shall be responsible for recording the entry in the Notice of Action Log.

4. Clinic Supervisors shall perform routine spot checks of the Notice of Action Log to ensure the Log is complete and that appropriate, alternate referrals were made if indicated.

5. Clinic Supervisors shall send copies of the Notice of Action Log to QRT for review on a quarterly basis.

6. The Notice of Action Log shall include:

    - Date
    - Consumer's name
    - Consumer's Medi-Cal number
    - Date form was mailed/given to consumer
    - Date form was entered into notebook
    - Date form was sent to QRT Unit
    - Date a copy of the form was given to the clinician
    - Whether a second opinion was requested
    - Whether a grievance or appeal was filed
    - Whether a state fair hearing was held
    - Initials of the person completing the log entry

A separate log must be completed for each type of NOA (A, B, C, D, or E) and a copy of the log included in the "client grievance file."

NOA-B, NOA-C, and NOA-D are utilized by staff working in AMHS/ADAS Administration.

III. NOA-B

An NOA-B form applies to pre-authorized services only, a situation which does not occur in Adult Outpatient Rehabilitation County Clinics or Contract Programs as Adult Mental Health Services does not provide pre-authorized services.

The following information is provided for informational purposes only. An NOA-B form would be sent in the following situations:

1. When a clinician of the Mental Health Plan requests services for a consumer receiving pre-authorized services, and the services are denied by the Mental Health Plan.

2. When services previously requested by a clinician and approved by the MHP are decreased or changed in frequency, level or type.

3. When services previously requested by a clinician and approved by the MHP are terminated.

A copy of the NOA-B shall be shall be filed in a log on site, and a copy shall be sent to the Quality Review and Training Unit.

IV. NOA-C

An NOA-C form applies to services that have been rendered to a consumer at the time he/she was hospitalized. This form does not apply to Adult Outpatient Rehabilitation County Clinics or Contract Programs.

However, a clinician with an Adult Outpatient County Clinic or Contract Program may receive questions from consumers regarding the receipt of an NOA-C. It is important for clinicians to understand that the Consumer is not responsible for payment of provided, but denied, services indicated on the Notice of Action-C.

The following information is provided for informational purposes only. The NOA-C form would be utilized in the following situations:

1. When the Mental Health Plan retrospectively reviews the services provided and determines that the services did not meet medical necessity for psychiatric inpatient hospital services or related professional services.

2. When the Mental Health Plan retrospectively reviews the services provided and determines that the mental health condition, as described by the provider, did not meet medical necessity for specialty mental health services provided during an inpatient psychiatric stay.

The notice states that payment for a service, which has already been provided and has been denied. The notice further states that the client is not responsible for the bill and does not have to pay for the services rendered.

A copy of the NOA-C shall be given to the clinician, a copy shall be filed on site, and a copy shall be sent to the Quality Review and Training Unit.

V. NOA-D

An NOA-D form will be utilized by the Quality Review and Training Unit (QRT) when there is a delay in processing a consumer grievance or appeal within the stated time frame. QRT will complete the form, entering the date, the name of the consumer, the Medi-Cal number, the county, the date the consumer filed the grievance/appeal, and the initial request made by the consumer in the spaces provided on the form.

QRT will give the completed Notice of Action-D form, along with a copy of the NOA-BACK, to the consumer or will mail it through the US Postal Service.

A copy of the NOA-D shall be filed in a log on site.

Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To:_____, Medi-Cal Number _____

The mental health plan for ORANGE County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at (714) 834-5647 or write to:

Patient's Rights Advocacy Services, 405 W. 5th St., Ste. # 477, Santa Ana, CA 92701.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at 1 (800) 723-8641 or write to:

Patient's Rights Advocacy Services, 405 W. 5th St., Ste. # 477, Santa Ana, CA 92701 (714) 834-5647.

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (866) 308-3074 or write to:

Behavioral Health Services, QIPC, P.O. Box 355, Santa Ana, CA 92702-0355,

or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. If you have questions about this notice, you may call and talk to a representative of your mental health plan at (714) 834-5647 or write to:

Patient's Rights Advocacy Services, 405 W. 5th St., Ste. # 477, Santa Ana, CA 92701

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.

Medi-Cal Specialty Mental Health Services Program Date:_____
NOTICE OF ACTION

To: _____, Medi-Cal Number_____

The mental health plan for Orange County has ☐ denied ☐ changed your provider's request for payment of the following service(s):
_____

The request was made by: (provider name) _____

The original request from your provider was dated _____.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
_____

☐ Other _____
_____

<u>If you don't agree with the plan's decision, you may:</u>

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (866) 308-3074 or write to: Behavioral Health Services, QIPC, P.O. Box 355, Santa Ana, CA 92702-0355, or follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____.The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at 1 (800) 723-8641 or write to: Patient's Rights Advocacy Services, 405 W. 5th Street, Ste. #477, Santa Ana, CA 92701 (714) 834-5647.

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)

Date:_____

To:_____ Medi-Cal Number_____

The mental health plan for Orange County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____ and your provider says that you received the service on the following date or dates: _____

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the service you received. To date, the information has not been received.

☐ Other _____
_____

<u>If you don't agree with the plan's decision, you may:</u>

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (866) 308-3074 or write to: Behavioral Health Services, QIPC, P.O. Box 355, Santa Ana, CA 92702-0355, or follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice.

2. **If you are unhappy with the outcome of your appeal you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the state hearing decision, you will not have to pay for the service.**

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Delays in Grievance/Appeal Processing)

Date:_____

To: _____, Medi-Cal Number_____

The mental health plan for _____Orange_____ County has not processed your ☐ grievance ☐ appeal ☐ expedited appeal on time.

Our records show you made your request on _____

You requested that _____
_____
_____

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

If your request was about the denial of or a change in the mental health services you receive from the mental health plan and you do not want to wait for our decision, you may request a state hearing to consider the denial or change. You may also ask that the state hearing consider the reason for the delay.

If your request was about another issue, you may request a state hearing to consider the reason for the delay. The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Lack of Timely Service)

Date: _____

To: _____, Medi-Cal Number_____

The mental health plan for _____ County has not provided services within _____ working days of the date of the initial service request.

Our records show that you requested services, or services were requested on your behalf on _____

The following services were requested by you or on your behalf: _____
_____
_____

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

You may request a state hearing to consider the reason for the delay.

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, **OR**
2. the day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happen first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of Orange County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My name: (print) _____

My Social Security Number: _____

My Address:(print) _____

_____

My phone number : (_____)_____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

_____

Phone number: (_____)_____

NOA-BACK (revised 6-1-05)