6003-H ARIZONA LONG TERM CARE SERVICE NOTICE OF ADVERSE BENEFIT DETERMINATION

REVISION DATE: 7/10/2019, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCE: CHAPTER 400 AMPM

Intended Use

The purpose of a Notice of Adverse Benefit Determination (NOA) is to notify members of adverse decisions and provide them with the factual basis or reason for that decision. The NOA must contain and explain, in easily understood language, the information necessary to understand the adverse benefit determination. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically necessary. Failure to provide the reasons and explanation supporting the lack of medical necessity in the adverse benefit determination will result in regulatory action by AHCCCS.

Standard Request

For termination, suspension, or reduction of a previously authorized service, the NOA must be mailed at least ten (10) calendar days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice.

For service authorization decisions that deny or limit services, the contractor must provide an NOA no later than 24 hours from the receipt of a request for authorization of a medication regardless of whether the due date falls on a weekend or legal holiday as defined by the State of Arizona. When the prior authorization request for a medication lacks enough information to render a decision, the contractor must request additional information from the prescriber no later than 24 hours from receipt of request. A final decision and an NOA must be rendered no later than seven (7) working days from the initial date of request.

For a non-medication request for authorization, as expeditiously as the member's health condition requires but no later than 14 calendar days from receipt of request regardless of whether the due date falls on a weekend or legal holiday as defined by the State of Arizona, unless there is a Notice of Extension (NOE).

Notice of Extension

The written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within three working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.

A Notice of Adverse Benefit Determination will be issued within three working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Adverse Benefit Determination will be issued.

If a service request does not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than two calendar days to the member/responsible person. If the member/responsible person disagrees, he/she can submit additional documentation to support the expedited request.

Procedure

The notice must be issued on Division or health plan letterhead, clearly explained and written in an easily understood manner, and available in alternate formats:

A. The requested service

B. The reason/purpose of the requested service

C. Reasons for the Adverse Benefit Determination the contractor has made or intends to make (i.e. denial, limited authorization, reduction, suspension or termination) with respect to the requested service consistent with 42 438.404(b)(1)

D. The effective date of a service denial, limited authorization, reduction, suspension, or termination

E. The right of the member to be provided, 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2)

F. The legal basis for the Adverse Benefit Determination

G. Where members can find copies of the legal basis (e.g. the public library and web page with links to legal authorities). When a legal authority or an internal reference to the contractor's policy manual is available online, the contractor must provide the URL site to enable the member to find it

H. A listing of legal aid resources

I. The member's right to request an appeal and the procedures for filing an appeal of the Contractor Adverse Benefit Determination, including information on exhausting the contractor's appeals process described in 42 CFR 438.402(b) and the right to request a state fair hearing consistent with 42 CFR 438.402(c)

J. The procedures for exercising the member's rights as described in 42 CFR 438.404(b)(4)

K. The circumstances under which an appeal process can be expedited and how to request

it

L. Explanation of the member's right to have benefits continue pending the resolution of the appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied (42 CFR438.420, how to request benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied (42 CFR 438.420(d)