alameda county behavioral health

SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

NOABD Frequently Asked Questions

A collaboration of ACBH QA, UM, and ACCESS units

To better support the great work ACBH Providers are doing, ACBH Administration is offering the following Frequently Asked Questions regarding the NOABD process and obligation. The majority of these questions come directly from you, our providers, who have requested technical assistance.

Do you have a question? **Need Technical Assistance?**	Contact QA Technical Assistance

For more information regarding NOABD, click here.

A. Questions Regarding Templates

1. Question:	Can counties update the NOABDs? If not, will DHCS be issuing a NOABD that is specific to SUD services?
Response:	NOABD template language cannot be amended or modified. All templates must be used with the approved language and approved font. The section of each NOABD pertaining to the availability of large font, braille or electronic formats must be in 18-point font; the rest of the NOABD should be in 12-point font. The #4 Delivery System NOABD does not apply to SUD services. All of the other NOABDs apply to SUD services and should be used accordingly.
2. Question:	In the NOABD forms that list all the threshold languages, our form does not have any telephone or TTD numbers listed for each culture. Will you please direct me where to get that particular form?
Response:	Forms in our Threshold Languages are available here.

	Provider/NOABD Issuer inserts program telephone number. If a beneficiary contacts provider speaking a language that the provider doesn't have the language capacity for, then provider utilizes Language Line. For TTY/TTD sections of the templates and enclosures, please enter "711" for California Relay
Tool:	Language Line Implantation Memo
3. Question:	Can the NOABD templates not have the ACBH logo, but rather the program's logo/letterhead or no logo/letterhead? (Concern: Potentially confusing for a beneficiary to receive a letter from ACBH when he/she received an adverse benefit determination from a county-contracted providers—no knowledge of contractor status. Also, some programs may contract with multiple counties and it would be a burden for staff to have to use various county logo/letterhead NOABD templates).
Response:	When it comes to logos on the NOABD template, the MHP can opt to select any logo of their choosing to add to the template. Please be advised that the actual language/verbiage on the template should not be altered.
4. Question:	Can the NOABD templates be incorporated into a provider's electronic health record?
Response:	We see no issue with the NOABD templates being incorporated in or accessed through providers EHR.
5. Question:	If a program has other authorities (e.g. Joint Commission) and beneficiary notification requirements, can their existing notification template(s) supplant the NOABD-template(s) (inclusive of all required NOABD content)?
6. **Response:**	The NOABDs should not be supplanted by another form of notification.

B. Issuing NOABDs

1. Question:	Should providers send NOABDs when discharging clients for noncompliance? Do providers issue NOABD letters or only counties?
Response:	A NOABD must be sent to the beneficiary when discharging for non-compliance. The county is ultimately responsible for ensuring that the NOABD letters appropriately reach the beneficiary and in Alameda County, this responsibility is delegated to the rendering provider.
2. Question:	What happens if a beneficiary never shows up for treatment after admission or never returns to treatment?
Response:	If the beneficiary has been opened to the program, the program is responsible for issuing the Termination NOABD to the beneficiary. If the beneficiary has only been opened to a P code, inform ACBH ACCESS of the situation and ACCESS will send the NOABD.
3. Scenario:	BHC Screening Form indicates that a beneficiary's current clinical condition is mild-to-moderate and should either be referred to the appropriate Managed Care Plan (MCP) or Primary Care.
Response:	NOABD Template to be Issued: NOABD-Delivery System
4. Question:	Is a NOABD required if the provider changes the Tx provided to the beneficiary?
Response:	If a beneficiary's treatment plan is modified by the provider (e.g., change in level, frequency or type of service) a Modification of Requested Service NOABD must be issued to the beneficiary.
5. Question:	In case of a client death and the provider completes a NOABD Termination, does the provider still send the client copy?

Response:	You do not have to send a termination NOABD to a beneficiary who has been confirmed deceased.
6. Question:	Is a NOABD required when we deny or modify requested services for a beneficiary who has Medicare and Medi-Cal insurances?
Response:	Yes, a NOABD is required when services are denied or modified for all Medi-cal beneficiaries, regardless of Medicare enrollment status.
7. Question:	How do you issue/report NOABDs to a Homeless Beneficiary?
Response:	In the address section type" Address Unknown" & "Unable to Deliver" then report as usual.
8. Question:	NOABD Denial template vs. NOABD Termination template: When to use each one:
Response:	**Denial template** to be used when a beneficiary is not currently receiving a service type (e.g. SUD Residential Treatment); Residential Treatment Provider has requested service authorization; service request is denied. **Termination template** to be used when a beneficiary is currently receiving a service type (e.g. SUD Residential Treatment); Residential Treatment Provider has requested a continued service authorization; request is denied.
9. Question:	A provider receives a referral and is able to offer an appointment within applicable timeliness requirements. However, the provider does not make successful contact with the beneficiary/guardian to offer an appointment. By the time the beneficiary/guardian contacts the provider, the provider is no longer able to offer a timely appointment. Does a NOABD-Timely Access need to be sent?
Response:	No, timely access is whether or not the provider is able to offer a timely appointment. The provider should call and leave

	a message with the first offered appointment (timely) and request a call back to confirm prior to the appointment being released.
10. Question:	If we have to refer back to ACCESS, due to not being able to provide timely access, do we need to do a NOABD ?
Response:	Yes, please issue a NOABD Timely-Access. On the template, in the second paragraph where it states "Service Requested" , of service enter the type requested and add "through ACBH ACCESS".
11. Question:	What should a provider do to meet the timeliness expectation if the beneficiary is unavailable to confirm the appointment?
Response:	Provider to leave a message with offered appointment and request a call back to confirm; informing the beneficiary that if the call is not returned the appointment will be released by "date".

C. Reporting NOABDs

Provider Type	Type of NOABD likely used
SMHS Adult	• Termination • Timely-Access • *Grievance only if your manage your own Grievance System*
SMHS Children's / Access Point	o Denial o Delivery o Modification o Termination o Timely-Access o *Grievance only if your manage your own Grievance System*
SUD Tx	➢ Denial ➢ Termination ➢ Timely-Access ➢ *Grievance only if your manage your own Grievance System*

All NOABDs shall be reported to ACBH QA Office via Fax: 510.639.1346 or Mail to: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

Regulations:

Establishing Medical Necessity

Mental Health Services for Adults: CCR 1830.205

Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition

(G) Mood Disorders, except Mood Disorders due to a General Medical Condition

(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:
(A) A significant impairment in an important area of life functioning.
(B) A reasonable probability of significant deterioration in an important area of life functioning.
(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.
(3) Meet each of the intervention criteria listed below:
(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
(C) The condition would not be responsive to physical health care based treatment.
(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.
Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

Mental Health Services for Children: CCR 1830.210

Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.
(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:
(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

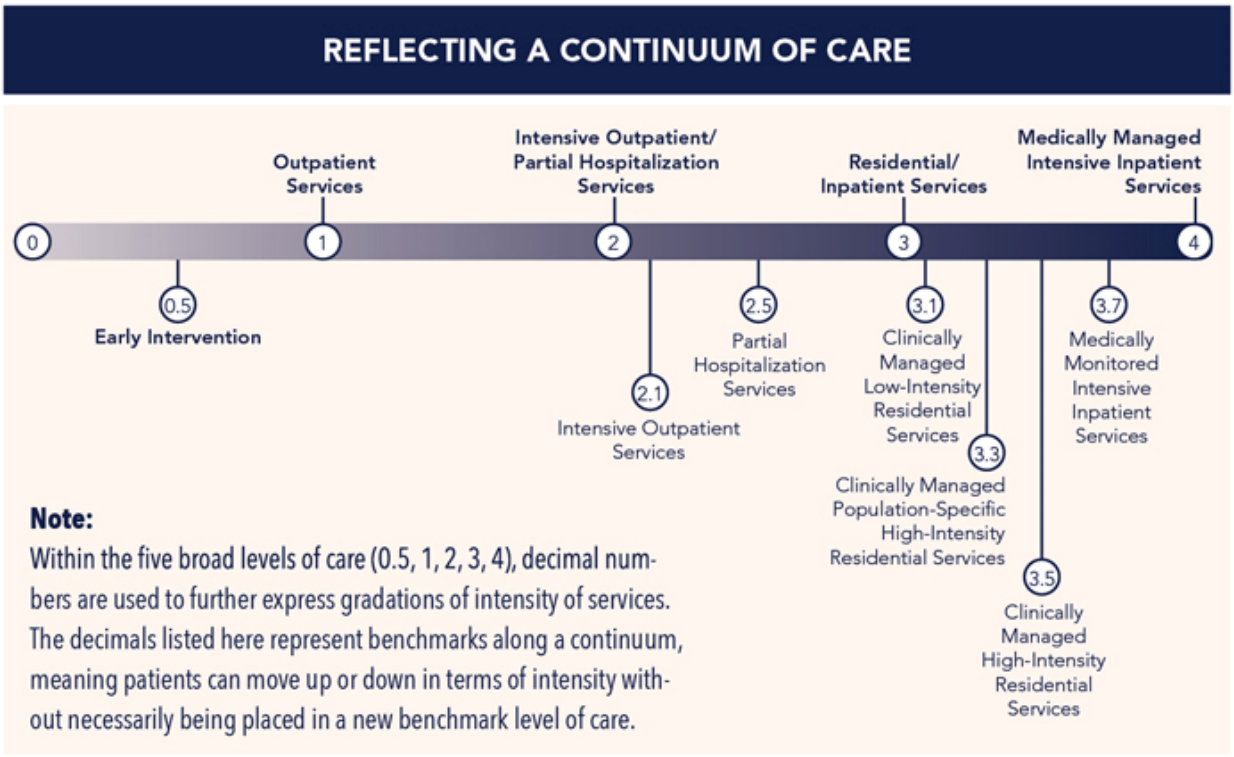
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.
(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.
(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.
Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code; Title 42, Section 1396d(r), United States Code; and T.L. v. Belshe, United States District Court, Eastern District of California, Case No. CV-S-93-1782 LKK PAN.

Substance Use Disorder: ASAM Levels of Care

ASAM Levels of Care Criteria

The ASAM Criteria text describes treatment as a continuum marked by four broad levels of service and an early intervention level. Within the five broad levels of care, decimal numbers are used to further express gradations of intensity of services. These levels of care

provide a standard nomenclature for describing the continuum of recovery-oriented addiction services. With the ASAM CONTINUUM™, clinicians are able to conduct a multidimensional assessment that explores individual risks and needs, as well as strengths, skills and resources. ASAM CONTINUUM then provides clinicians with a recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.



Do you have a question? **Need Technical Assistance?**	Contact QA Technical Assistance