Notice of Adverse Benefit Determination (NOABD) Notices

For Medi-Cal Beneficiaries

An Adverse Benefit Determination is defined to mean any of the following actions taken by The Plan: 1) 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; 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; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary's request to dispute financial liability. Beneficiaries must receive a written NOABD when The Plan takes any actions described above. The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

Note: All notices shall be received by either the client or the parent/legal guardian.

For additional information regarding these notices, please refer to https://www.dhcs.ca.gov/Documents/BHIN-25-014-Mental-Health-Plan-and-Drug-Medi-Cal-Organized-Delivery-System-Plan-Grievance-and-Appeal-Requirements-with-Revised-Member-Notice-Templates.pdf

NOABD	Timing of Notice	Criteria	Suggested Content for Completing Forms
Denial of Authorization Notice	Within 2 business days of the decision	The Plan denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Use this notice for denied residential services requests (both MHP and DMC-ODS).	Narrative Completion: 1. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; a) Denial of Authorization Ex: "The reason for the denial is The Plan has reviewed your request for services and determined we are unable to provide such services based on Medi-Cal managed care guideline criteria due to…" i) … type or level of service; requirements for medical necessity; appropriateness, setting; or effectiveness of a covered benefit b) Delivery System Ex: "Our assessment is based on Medi-Cal managed care guidelines and state regulations which staff utilized to determine if medical necessity criteria are met…" i) … your diagnosis is not covered by the MHP; your MH condition does not cause problems in your daily life that are serious enough for SMH services; services are not likely to maintain or improve your MH condition; your MH condition would be responsive to treatment by a PCP. c) Modification Ex: "We cannot approve this treatment as requested. This is because The Plan has reviewed your
Delivery System Notice	Within 2 business days of the decision	The Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services or DMC-ODS services* through the Plan. The beneficiary will be referred to the Managed Care Plan (MCP), or other appropriate system, for mental health, substance use disorder, or other services. ***DMC-ODS Providers:** The Delivery System NOABD is now required for SUD clients as indicated in BHIN 25-014 (4/24/25) when referring clients to an MCP or other services when eligibility criteria for DMC-ODS services is not met.	
Modification Notice	Within 2 business days of the decision	The Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.	

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Termination Notice	At least 10 days before the date of Action	The Plan terminates, reduces or suspends a previously authorized service. Notice is **<u>required</u>** for all clients who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to, client AWOL, client unwilling to continue services, client terminates AMA, etc.	provider's request for services and has changed the services based on…" i) … your condition has improved and you require less service less often; services are no longer appropriate for the condition
Timely Access Notice	Within 2 business days of the decision	When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.	
Authorization Delay Notice	Within 2 business days of the decision	When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When The Plan extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.	
Financial Liability Notice	At the time of the action	The Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.	
Payment Denial Notice	At the time of the action	The Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.	

For MHP and DMC-ODS Beneficiaries: Services that are reduced, modified, or terminated by outpatient providers that are not subject to prior authorization and are the result of a treatment Team/Clinician decision based on the individual's clinical condition and/or progress in treatment is not subject to an adverse benefit determination notification. The client may appeal the decision with the appropriate advocacy agency.

For DMC-ODS Beneficiaries Only: A NOABD must be issued for non-compliance/not returning for treatment for **all programs**, which includes services from DMC-ODS outpatient and NTP providers that are not subject to prior authorization.