Medicaid - Advance and Adequate Adverse Benefit Determination Notice Requirements - Quick Guide

Notice is given whenever a Medicaid State Plan or waiver service is denied, reduced, suspended or terminated. The Notice must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency).

Action Taken	Type of Action Notice Required	Time Frame for Mailed/Provided Notice	Noticing Responsibility
Reduction, suspension or termination of service (currently being received) previously authorized	**Advance**	10-days before action to be implemented*	Access Center or Entity where services are delivered
Denial of Service Request	**Adequate**	At the time of decision	Access Center or Entity performing review function
Person-centered Plan Development	**Adequate**	At the time of Plan development	Entity where services are delivered
Increase in benefits	**Adequate**	At the time of the action	Entity where services are delivered
Standard authorization decision that denies or limits services requested	**Adequate**	Within 14-days of receipt of request	Access or Entity performing review function
Expedited authorization decision that denies or limits services requested	**Adequate**	Within 72-hours of receipt of request	Access or Entity performing review function
Unreasonable delay of authorization/start of services	**Adequate**	Measured from date of request (more than 14-days or 72-hours for expedited authorization); for start of services, failure to provide services within 14 calendar days of start date agreed upon during PCP and as authorized by the PIHP	Access or Entity performing review function
Physician determination that services are not medically necessary (even if during current authorization period)	**Adequate**	Not later than the date of action	Entity where services are delivered
Extension of Standard timeframe to resolve Medicaid Grievance or Appeal, or Expedited timeframe to resolve Appeal, not at the request of the Medicaid Enrollee	**Follow-up** (See MCCMH MCO-9-171)	Prompt oral notice of the delay; and, within 2-calendar days, written notice of reason for extension and their right to file a Medicaid Grievance	MCCMH LAP/LDR Hearing Officer
PIHP denied a request for expedited resolution of an appeal	**Follow-up** (See MCCMH MCO 9-171)	Prompt oral notice of the decision, and within 2-calendar days of denial, written notice of reason for decision and their right to file a Medicaid Grievance Within 2 calendar days of the denial	MCCMH LAP/LDR Hearing Officer

* See Section V(E)(2)(d) of this Policy for a description of those *limited circumstances* where the PIHP may mail an adequate notice of action fewer than 10-days before the date of the action to terminate, suspend or reduce previously authorized services (e.g., death of Medicaid Enrollee, Medicaid Enrollee no longer wishes to receive services, etc.).**MCCMH MCO Policy 4-020, Ex. D, "Advance and Adequate Adverse Benefit Determination Notice Requirements - Quick Guide" (rev. 9/17)**