

~~**NABD SELF-MONITORING REQUIREMENTS GENERAL INSTRUCTIONS**~~

~~1. The Contractor shall conduct quarterly audits as specified in ACOM Policy 414 and outlined below:~~

- ~~— a. Utilizing the AHCCCS provided forms;~~
- ~~— b. Reporting Notice of Adverse Benefit Determination (NABD) issued within the quarter prior;~~
- ~~— c. Report by line of business:~~
 - ~~— i. DDDs issued for services provided by DDD;~~
 - ~~— ii. DDDs issued for services provided by contracted Health Plans shall report DDD as a line of business when submitting the Scores and Summary described below.~~
- ~~— d. The auditor shall not be the staff member that writes or issues the NABD.~~

~~2. NABD Self-Audit Scores~~

- ~~— a. The sample shall include NABD's from each of the following categories: Medical, Dental, Pharmacy, and Behavioral Health. The Contractor will randomly select 30 NABDs from each of the categories.~~
 - ~~— From the 30, eight NABDs will be randomly selected to be audited. If the initial eight NABDs are found to be in compliance (95%), the remaining 22 NABDs will not need to be audited. If any of the eight NABDs issues are found to be out of compliance (below 95%), the remaining 22 must be audited.~~

~~3. NABD Comprehensive Score Summary~~

- ~~— a. The Contractor will report audit scores on the NABD Comprehensive Score Summary for each section. The total score and the average score will auto-populate.~~

~~4. The Executive Summary shall include an analysis of the audit including but not limited to:~~

- ~~— a. A methodology for pulling the sample~~
- ~~— b. Deficiencies;~~
- ~~— c. Plan of action to bring back into compliance;~~
- ~~— d. Staff member involved in audit and credentials or role in the organization; and~~
- ~~— e. NABD Comprehensive Score Summary.~~

~~5. The Contractor shall submit an NABD Self-Audit Letter Scores, Executive Summary and NABD Comprehensive Score Summary to DHCM/Medical Management 15 days after the end of each quarter as specified in~~

~~Contract.~~

Removed and replaced below with new instructions.



AHCCCS CONTRACTOR OPERATIONS MANUAL
POLICY 414 - ATTACHMENT D -
NOTICE OF ADVERSE BENEFIT DETERMINATION
SELF-AUDIT SCORES AND EXECUTIVE SUMMARY
DRAFT

The NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD) SELF-MONITORING REQUIREMENTS GENERAL INSTRUCTIONS

1. The Contractor shall conduct quarterly self-audits as specified in ACOM Policy 414 and outlined below:

- a. Utilizing the AHCCCS provided Reporting Forms,
- b. Reporting Notice of Adverse Benefit Determination (NABD) issued within the quarter prior,
- c. Report by Line Of Business (LOB),
- d. The DDD shall separately submit Attachment D for services provided by DDD and separate Attachment for DDD's Subcontracted Health Plans,
- e. The auditor shall not be the staff member that writes or issues the NABD.

2. The NABD Self-Audit Scores shall be a sample that includes NABD's from each of the following categories: Medical, Dental, Pharmacy, and Behavioral Health. The Contractor will randomly select 30 NABDs from each of the categories. From the 30, 12 NABDs will be randomly selected to be audited. If the initial 12 NABDs are found to be in compliance (95%), the remaining 18 NABDs will not need to be audited. If any of the 12 NABDs issues are found to be out of compliance (below 95%), the remaining 18 must be audited.

3. The NABD Comprehensive Score Summary shall report audit scores on the NABD Comprehensive Score Summary for each section. The total score and the average score will auto populate.

4. The Executive Summary shall include an analysis of the audit.

***AHCCCS reserves the right to request specific NABDs and associated records for further review.**

NABD COMPREHENSIVE SCORE SUMMARY QUARTER: CYE: Date:																															
Health Plan:	NABD #1	NABD #2	NABD #3	NABD #4	NABD #5	NABD #6	NABD #7	NABD #8	NABD #9	NABD #10	NABD #11	NABD #12	NABD #13	NABD #14	NABD #15	NABD #16	NABD #17	NABD #18	NABD #19	NABD #20	NABD #21	NABD #22	NABD #23	NABD #24	NABD #25	NABD #26	NABD #27	NABD #28	NABD #29	NABD #30	Average Score
NABD ID ---->																															
1	<p>Non-Medication Service Request Service request receipt date: _____ Letter date: _____ Standard authorization decision is made as expeditiously as the member's health condition requires and shall not exceed 7 calendar days from receipt (absent extension). An expedited request decision is made as expeditiously as the member's health condition required but no later than 72 hours (absent extension) Standard request letter date is ≤ 7 calendar days after service request date. Expedited request letter date is ≤ 72 hours after service request date.</p> <p>Medication Service Request Service request date: _____ Letter date: _____ The NABD shall not exceed 24 hours from receipt date of the request, unless additional information is needed to render a decision.</p>																														#DIV/0!
2	<p>Appeal date: _____ Must be 60 calendar days after letter date</p>																														#DIV/0!
3	<p>If action is a termination, suspension, or limitation of a previously authorized service, the NABD shall be mailed at least 10 days before the date of the proposed change in service.</p>																														#DIV/0!
4	<p>Notice of Extension Non-Medication Service Request Standard request, if an NOE is issued for additional information in the interest of the member, the contractor may extend the 7 day timeframe to make a decision by up to 14 additional days, ≤21 days from the service request date. Expedited requests, NOE shall be issued NO later than 72 hours plus 14 calendar days from receipt for expedited request, <17 days from the service request date.</p> <p>Medication Service Request Requiring Additional Information The final decision and a NABD shall be rendered no later than seven working days from the initial date of the service request.</p>																														#DIV/0!
5	AHCCCS template used																														#DIV/0!
6	Requested service(s) and reason(s) for requested service(s) are accurately stated/For continuation of HCB services, NABD MUST indicate that member wants same level of services to continue even if not specifically requested as such																														#DIV/0!
7	Member specific facts that are the basis for the decision are explained and the reasons for the adverse benefit determination, including the legal authorities that support the contractors determination																														#DIV/0!
8	Requested service(s), reason(s) for requested service(s), and member specific facts are written in ≤ 6th grade language																														#DIV/0!
9	If reason for denial is medical necessity, criteria needed to meet medical necessity are included and state why the service is not medically necessary. If denied for any other reason, must include alternatives available to member. It is unacceptable to refer member to a third party for more information without explaining why the service is denied. For HCB services, the decision includes a description of the member's needs or change in condition that make the requested level of service excessive. For denials, NABD is to explain alternative services for members to consider or receive.																														#DIV/0!
10	Letter states correct action: approved, partially approved, or denied																														#DIV/0!
11	Letter is free of errors such as incorrect grammar or misspelled words and is written in a manner that is understandable for the particular service authorization request.																														#DIV/0!
12	Decision is made by a qualified health care professional (not involved in any previous level of review)																														#DIV/0!

Health Plan:	NABD #1	NABD #2	NABD #3	NABD #4	NABD #5	NABD #6	NABD #7	NABD #8	NABD #9	NABD #10	NABD #11	NABD #12	NABD #13	NABD #14	NABD #15	NABD #16	NABD #17	NABD #18	NABD #19	NABD #20	NABD #21	NABD #22	NABD #23	NABD #24	NABD #25	NABD #26	NABD #27	NABD #28	NABD #29	NABD #30	Average Score
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2 Appeal date is equal to or greater than 60 calendar days after letter date																															#DIV/0!
3 If action is a termination, suspension, or limitation of a previously authorized service, the NABD shall be mailed at least 10 days before the date of the proposed change in service.																															#DIV/0!
4 NOE Non-Medication Service Request For Standard request, if an NOE is issued for additional information in the interest of the member, the contractor may extend the 14 day timeframe to make a decision by up to 14 additional days, ≤21 calendar days from the service request date. For Expedited requests, NOE shall be issued NO later than 72 hours plus 14 calendar days from receipt for expedited request. Medication Service Request Requiring Additional Information The final decision and a NABD shall be rendered no later than seven working days from the initial date of the service request.																															#DIV/0!
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		NABD COMPREHENSIVE SCORE SUMMARY QUARTER: CYE: Date:																												Average Score			
Health Plan:	NABD ID ---->	NABD #1	NABD #2	NABD #3	NABD #4	NABD #5	NABD #6	NABD #7	NABD #8	NABD #9	NABD #10	NABD #11	NABD #12	NABD #13	NABD #14	NABD #15	NABD #16	NABD #17	NABD #18	NABD #19	NABD #20	NABD #21	NABD #22	NABD #23	NABD #24	NABD #25	NABD #26	NABD #27	NABD #28	NABD #29	NABD #30	Average Score	
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Health Plan:		NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD) COMPREHENSIVE SCORE SUMMARY QUARTER: CYE: Date:																												Average Score			
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12	Decision is made by a qualified health care professional (not involved in any previous level of review)																																#DIV/0!
13	Non-Medication Service Request by Health Care Professional Standard decision date: _____ is as expeditiously as the members condition requires but no later than 14 calendar days after service request receipt. Expedited decision date: _____ is as expeditiously as the member's condition requires but no later than 72 hours from receipt of request. NOE decision date: _____ is no later than 28 calendar days from receipt of standard request or no more than 72 hours plus 14 calendar days from receipt of expedited request. Medication Service Request by Health Care Professional The Contractor shall issue service authorization decisions for medications no later than 24 hours from receipt of the submitted request.																																#DIV/0!
14	The reason(s) for the denial matches the reason(s) cited by the health care professional in making the determination.																																#DIV/0!
15	If expedited request was downgraded to standard request, the requesting provider was contacted and had opportunity to disagree and to provide additional information.																																#DIV/0!
16	Correct legal basis or bases used for decision which pertain to the particular facts of the service authorization request																																#DIV/0!
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

TOPICS

**METHODOLOGY FOR PULLING
THE SAMPLE.**

DEFICIENCIES

**PLAN OF ACTION TO BRING
BACK INTO COMPLIANCE**

**STAFF MEMBERS INVOLVED IN
AUDIT INCLUDING CREDENTIALS
OR ROLE IN THE ORGANIZATION**

**ADDITIONAL FINDINGS, IF
APPLICABLE**

SUMMARY OF FINDINGS
