alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Consumer Assistance
Toll Free: 1 (800) 779-0787
California Relay Service, Dial 711

GRIEVANCE AND APPEALS PROCESS

If you have a concern or problem or are not satisfied with your behavioral health services, the Behavioral Health Plan (BHP) wants to be sure your concerns are resolved simply and quickly. You or your representative may file a Grievance or Appeal with the Consumer Assistance office at 1(800) 779-0787. You may also ask your provider if they have a process for resolving grievances. **Please use the Grievance and Appeal Request Form to file a Grievance or to request an Appeal.** Please note that appeals may only be filed with Consumer Assistance and *not* with your provider. **You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal.**

A **Grievance** is defined as an expression of dissatisfaction about any matter regarding your behavioral health services that are not one of the problems covered by the Appeal and State Fair Hearing processes described below. Examples of grievances might be as follows: the quality of care of services provided, aspects of interpersonal relationships – such as rudeness of an employee, etc. **Steps to file a Grievance:**

- File a Grievance orally or in writing. Oral grievances do not have to be followed up in writing. You may authorize another person to act on your behalf.
- You may file a Grievance at any time.
- You will receive a written acknowledge of receipt of your Grievance postmarked within 5 days of receipt of the Grievance.
- The BHP has 90 calendar days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision. If resolution of your grievance is not reached within 90 calendar days you will be provided prompt oral and/or written notification of your rights and specific information on your grievance.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit in which case you will receive oral and written notice from the BHP.

Where to File Your Grievance

With Alameda County Behavioral Health (ACBH):

By phone: 1-800-779-0787 Consumer Assistance
For assistance with hearing or speaking, call 711, California Relay Service

Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

In Person: By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

With your provider: Your provider may resolve your grievance internally or direct you to ACBH above. You may obtain forms and assistance from your provider.

An **Appeal** is a review by the BHP of an Adverse Benefit Determination (ABD). An **Adverse Benefit Determination** is defined to mean any of the following actions taken by the BHP or a BHP-contracted provider regarding Medi-Cal behavioral health care services: 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. The decision made by the BHP about your behavioral health services may be described in a **Notice of Adverse Benefit Determination (NOABD)** letter sent or given personally to you.
Steps to file an Appeal:

- Only Medi-Cal beneficiaries may file a Standard or Expedited Appeal with ACBH regarding a NOABD for a Medi-Cal behavioral health service.
- File an Appeal in person, on the phone or in writing within 60 days of the date of a NOABD. If you file the Appeal orally, you must follow it up with a signed written Appeal. If you did not receive a NOABD, there is no deadline for filing; so you may file at any time. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Appeal is pending IF you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- You will receive a written acknowledge of receipt of your Appeal postmarked within 5 calendar days of receipt of the Appeal.
- The BHP has 30 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision. During this time you may provide verbal or written supporting documentation including presenting evidence and testimony and make legal and factual arguments.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit in which case you will receive oral and written notice from the BHP.
- Appeals are not available to beneficiaries that are not happy with the outcome of a grievance.

An **Expedited Appeal** can be requested <u>if you think waiting 30 days could seriously jeopardize your mental health or substance use disorder condition and/or your ability to attain, maintain or regain maximum function</u>. If the BHP agrees that your appeal meets the requirements for an Expedited Appeal, the BHP will resolve it within 72 hours after the Expedited Appeal is received.
Steps to file an Expedited Appeal:

- File an Expedited Appeal in person, on the phone or in writing within 60 days of the date of a Notice of Adverse Benefit Determination (NOABD). Verbal and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another

person to act on your behalf.

- Upon request, your benefits will continue while the Expedited Appeal is pending IF you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- The BHP has 72 hours after the receipt of your Expedited Appeal to review it and notify you or your representative in a written Notice of Appeal Resolution (NAR), and may notify you verbally as well. During this time you may provide verbal or written supporting documentation including presenting evidence and testimony and make legal and factual arguments.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit.
- If the BHP decides that your appeal does not qualify for an Expedited Appeal, they will notify you right away verbally and in writing within 2 calendar days. Your appeal will then follow the Standard Appeal process.

Where to File Your Appeal

With Alameda County ACBH:

By phone:	1-800-779-0787 Consumer Assistance
	For assistance with hearing or speaking, call 711, California Relay Service
Via US Mail:	2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
In Person:	By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

You have a right to a **State Fair Hearing**, an independent review conducted by the California Department of Social Services, if you have completed the BHP's Appeals process and the problem is not resolved to your satisfaction. A request for a State Fair Hearing is included with each Notice of Appeal Resolution (NAR); you must submit the request within 120 days of the postmark date or the day that the BHP personally gave you the NAR. You may request a State Fair Hearing whether or not you have received a NOABD. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NAR was mailed or personally given to you or before the effective date of the change in service, whichever is later. The State must reach its decision within 90 calendar days of the date of request for Standard Hearings and for Expedited Hearings within 3 days of the date of request. The BHP shall authorize or provide the disputed services promptly within 72 hours from the date it receives notice reversing the BHP's ABD. You may request a State Fair Hearing by calling 1(800) 952-5253, or for TTY 1 (800) 952-8349, online to https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx or writing to: California Department of Social Services/State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, CA 94244-2430.

For more detailed information on the Grievance or Appeals process, please ask your provider for a copy of *Guide to Medi-Cal Mental Health Services* OR *Guide to Drug Medi-Cal Services*. For questions or assistance with filling out forms, you may ask your provider or call:

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GRIEVANCE or APPEAL REQUEST

This form is used to file a Grievance or to request an Appeal. If you need assistance in completing this form, you can request help from your provider or by calling Consumer Assistance at (800) 779-0787. **A signed *Authorization for Release of Confidential Information* needs to be submitted along with this form.** The Grievance or Appeal Request can be submitted to your provider (MD, case manager, clinician, the Program Supervisor, etc.) or mailed directly to Consumer Assistance at: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. **Please fill out both sides of this form.**

I wish to file: (choose one) ☐ **Grievance** ☐ **Appeal**

☐ **Check here if you are requesting that your Appeal be processed through the Expedited Appeals Process** *(see requirements for an Expedited Appeal)*

Your address and phone number are important. We need this information to contact you about the outcome of your Grievance or Appeal. ***PLEASE PRINT*:**

Your Name:_____

Your Address:_____

Your Daytime Phone:_____ Date of Birth:_____

May we leave a message at the above #? ☐ Yes ☐ No

Current Provider:_____

If Applicable, Person Representing You:_____

Their Address:_____

Their Daytime Phone:_____

Please answer the following questions. Attach additional pages if needed.

What is the problem? _____

_____

_____

_____

_____

What have you done to try to resolve the problem?_____

_____

_____

_____

_____

What would you like the solution to be? _____

_____

_____

_____

_____

_____ _____

Consumer (or Consumer's Representative) Signature Date

You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal. Your confidentiality will be protected at all times in accordance with State and Federal law. You may request a State Fair Hearing following the completion of the Appeal Process.

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Authorization for Release of Confidential Information

(Please fill out both sides of this form)

Consumer's Last Name First Name Middle Name Date of Birth

Street Address City Zip Code Daytime Telephone

Social Security Number ***(Required)**

I, request that my protected health information (PHI) from:

Health Care Provider Name Telephone

Street Address City/State Zip Code FAX # (if known)

Be disclosed to: ACBH – QA Office
Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

I authorize the following PHI to be released from my medical record(s):

- ☐ Emergency Room Record
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Immunization Record
- ☐ Complete Medical Record (all pgs.)
- ☐ Other: _____
- ☐ Pathology Slides/Report
- ☐ Itemized Billing Records
- ☐ Discharge Summary
- ☐ History and Physical, Consultations
- ☐ Operative Reports

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Mental Health Records	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
HIV Testing and Results	☐ Yes	☐ No
Alcohol, Drug, or Substance Abuse Record	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Covering the period of healthcare from: Specific Date(s)_____to_____**OR**
☐ All past, present, and future encounters/visits

Purpose for requesting information: Resolving my grievance or appeal request

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate six (6) months from the date of consent. The signer may revoke this release in writing or by verbally informing Consumer Assistance.

_____

Client or Authorized Representative Signature Date

_____

Print Name Relationship to Patient (if applicable)

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure. PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR Part 2 prohibits unauthorized disclosure of these records.