WASATCH BEHAVIORAL HEALTH

SPECIAL SERVICE DISTRICT

Medicaid Enrollee Grievances – C – 3.08

Purpose:

Wasatch Behavioral Health Special Service District (WBH) is committed to providing quality services for Medicaid Enrollees, family members and providers. The purpose of this policy is to provide a timely means to address client grievances and to provide an opportunity for improving WBH services. WBH must provide a decision with regard to a grievance within 90 calendar days, and in certain circumstances may extend the decision for an additional 14 calendar days. **Failure to act within the required timeframe constitutes an Adverse Benefit Determination.**

Definitions:

Adverse Benefit Determination (ABD): A written notice informing the Enrollee of a ABD WBH has taken and of their right to appeal the ABD. ABD's are defined by the following categories:

Enrollee:

Any Medicaid eligible person whose eligibility has been established by Utah Department of Health and who resides within the geographic boundaries of Utah County, excluding residents of the Utah State Hospital and Utah State Developmental Center.

Grievance:

A grievance is defined as a complaint or any expression (written or oral) of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD) related to the administration, conduct, or performance of the Center or its staff relative to the delivery and provision of mental health and substance use services. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness by WBH or an employee, failure to respect the Enrollee's rights.

Grievance and Appeals System: An overall system that includes a Grievance process, an Appeal process, and access to the Medicaid State's fair hearing system. See policy C-3.08 Medicaid ABD and Appeals policy for Appeal and State Fair Hearing processes.

Receipt:

An oral or written acknowledgment of the following:

- WBH will notify the client and affected parties, orally or in writing, of the decision within 90 calendar days of receipt of the grievance. Enrollees who expressed their grievance in writing shall receive a written resolution.
- WBH may extend the time frame for making a decision on the grievance by up to 14 additional calendar days.
- If needed, WBH will provide toll-free numbers that have adequate TTY/TTD and interpreter capability.

The receipt, of the above acknowledgement information, is printed on the back of the grievance form. The staff member must document the date of the receipt on the grievance form.

Policy:

A. Care Management Services (CMS) and its Enrollee Customer Service Representative (CSR) will exercise oversight responsibility for ensuring all policy, procedure, and processes associated with WBH's Grievance System are adhered to including tracking, report preparation and writing, timeliness compliance, and records documentation. WBH shall maintain complete records of all grievances, including decision for a period of six years.

B. WBH shall inform Enrollees orally and/or in writing of their right to file a grievance and of their right to appeal when WBH fails to act within the time frames established for resolution and notification of Grievances.

C. The information provided to the Enrollee will be stated in simple, clear, language and include information needed for the Enrollee and/or the provider to file a grievance. WBH will provide reasonable assistance as needed.

D. WBH shall not retaliate, inhibit, or take any discriminatory action against an Enrollee or Enrollee's provider who files a grievance. Grievances shall be received in confidence and discussed only with persons involved in the decision process.

E. WBH shall provide oral interpreter and oral translation services, sign language assistance and access to the grievance system through a toll-free number with TTY/TDD and interpreter capability.

F. WBH shall make grievance informational and instructional materials available in the prevalent non-English language. Information and instruction materials will also be made available to Enrollees who are visually limited or have limited reading proficiency.

G. WBH shall submit written summaries of all grievances, with the exception of fee for service Medicaid Enrollees, to the Utah State Department of Health, using department templates as required by the Medicaid contract. In addition, WBH's Customer Service Representative will log, monitor and track all Enrollee/affected parties grievances and decisions in the Grievance Spreadsheet (See attachments B). As per Medicaid Contract requirements, all fields in the spreadsheet must be completed.

H. WBH's CSR shall monitor and report to the Quality Improvement Committee all grievances and decisions for quality improvement purposes including, the determination of trends, and any systemic issues that need to be addressed.

Grievance Procedures:

1. See attachment A for flowchart process.

2. Enrollees, at the time of their admission, will be given a Medicaid Member Handbook and informed of their rights including the right to file a grievance.

3. WBH will provide a Suggestions/Complaint box in reception areas where Enrollees may leave their grievances. WBH's Customer Service Representative (CSR) shall check and maintain the complaint boxes and initiate a grievance resolution process in behalf of the Enrollee. Enrollees may also express a grievance directly to any employee.

4. A provider, acting on behalf of an Enrollee as an authorized representative, may file a grievance orally or in writing at any time.

5. Program managers or administrators who immediately handle grievances that are not the result of an Action will complete a **7.59 WBH Enrollee Grievance form** or send an e-mail to the CMS including the following information:
   a) date the grievance was received;
   b) name of the staff member taking the grievance;
   c) date and method of receipt (acknowledge) either orally in writing. **(Use form 7.59i-N8 Notice of Receipt of Grievance)**.
   d) a summary of the nature of the grievance, including the name of the Provider or other staff or individual involved/named in the Grievance, if it involves a person;
   e) date and summary of the resolution of the grievance;
   f) name, title and credentials of the individual(s) resolving the grievance;
   g) date the client was notified of the resolution of the grievance and how the client was notified;
   h) Indicate if there is any other pertinent documentation needed to maintain a complete record of the grievances. Information must be forwarded to the CSR.

6. When a grievance cannot be handled immediately, the assisting staff member shall:
   1. Give the Enrollee assistance in completing the required form for submitting a written grievance. **(Use form 7.59 WBH Enrollee Grievance Form)**. If the client gives an oral grievance, the staff member may complete the grievance form or send an e-mail to the CSR including the information in 5 above, a-h).
   2. Provide, if needed, reasonable assistance in taking procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
   3. Acknowledge receipt of the grievance orally or written **(Use form 7.59i-N8 Notice of Receipt of Grievance)** and appropriately notify all affected parties of the disposition of the grievance.
   4. Submit written grievances to the CSR. If the receipt was written, attach a copy to the form.

7. The CSR shall enter oral and written grievance in the grievance spreadsheet and forward a copy of the grievance (form or email) to the appropriate program manager or administrator for review and decision.

8. The program manager or administrator shall ensure that the staff who make the decision on the grievance are individuals who:
    1. Were not involved in any previous level of review or decision-making, if applicable to the nature of the grievance and;
    2. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by Medicaid, in treating the Enrollee's condition or disease:
        a) A grievance regarding denial of a request for an expedited resolution of an Appeal; or
        b) A grievance that involves clinical issues.

9. When the program manager or administrator is able to make a *decision within the 90-calandar* day Medicaid required time frame, the program manager or administrator shall provide a response to the Enrollee and affected parties regarding the grievance and report the decision back to the CSR. The program manager's decision, does not by necessity, need to be in the Enrollee's favor. The decision may be given to the parties either orally or in writing. If the manager is not able to talk with the client verbally, the manager will send a decision letter to the client's last known address. All grievances received in writing must be followed up with a written decision letter.

10. The program manager or administrator, when necessary, will make any changes needed in the department's operations, address any deficits in employee/Enrollee relations, and train staff in the new procedures. Any organizational policy or operations that need to be changed will be reported to the program manager's division director.

11. The CSR will log information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet **(See attachments B for example)**. If the grievance and decision is in writing, the CSR will maintain a copy of the grievance and any other pertinent documentation needed to maintain a complete record of all written and oral grievances.

Extensions for Grievance:

1. The program manager or administrator may extend the time frame for making a decision on the grievance by up to 14 additional calendar days if:
    a) The Enrollee requests an extension; or
    b) WBH justifies (to Medicaid upon request) a need for additional information and how the extension is in the Enrollee's interest.

2. When an Enrollee requests a grievance extension, the CSR will acknowledge receipt orally or in writing. When the program manager or administrator extends the time frame, and the Enrollee did not request the extension, the program manager will give the Enrollee, and all affected parties, written notice of the reason for the delay **(use form 7.59j-N9 Notice of Grievance Extension).**

3. The CSR will log the information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet The CSR will maintain documentation of any extension request.

Adverse Benefit Determination (ABD) For failure to act within the time frames for solution and notification of grievances:

Procedures:

Failure to Resolve Grievance within Required Time Frame Constitutes an ABD

1. When a program manager or administrator does not notify the Enrollee of the grievance decision within the 90-day Medicaid required time frame and the additional 14 calendar day extension was not filed, the program manager or administrator shall notify the CSR.

2. The CSR will send the Enrollee, and all affected parties, a written ABD letter explaining the reason why WBH did not make a decision about the grievance within the required time frame, the Enrollee's right to appeal, and explain that they may receive reasonable assistance with the appeal process from staff **(use form 7.59b-N2a Notice of Action and Appeal Rights).**

3. The notice of ABD shall clearly indicate the action that has been taken and provide a clear statement of the basis for the action. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format *(See policy C-3.10 Readability of Documents for testing procedures).*

4. Should the Enrollee or other affected parties decide to appeal the ABD, the program manager or administrator will be excluded from the review of the appeal. The program manager or administrator must continue to try to resolve the grievance.
(See procedures in the ABD, Appeal and State Fair Hearing policy C-3.08B).

5. The CSR will log information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet. The CSR will maintain a copy of the ABD, appeal request, extension, and any other pertinent documentation needed to maintain a complete record.

Grievance Filed with PHMP (Medicaid):

When the Enrollee, or provider on behalf of an Enrollee, files a grievance with Medicaid, Medicaid will apprize the Enrollee or provider, of his/her right to file the grievance with WBH and instruction on how to do so. If the Enrollee/provider prefers, Medicaid will promptly notify the CMS Director or the CSR. Grievances submitted by Medicaid are considered an oral grievance. The CSR will follow the procedures and time frames outlined for grievances.

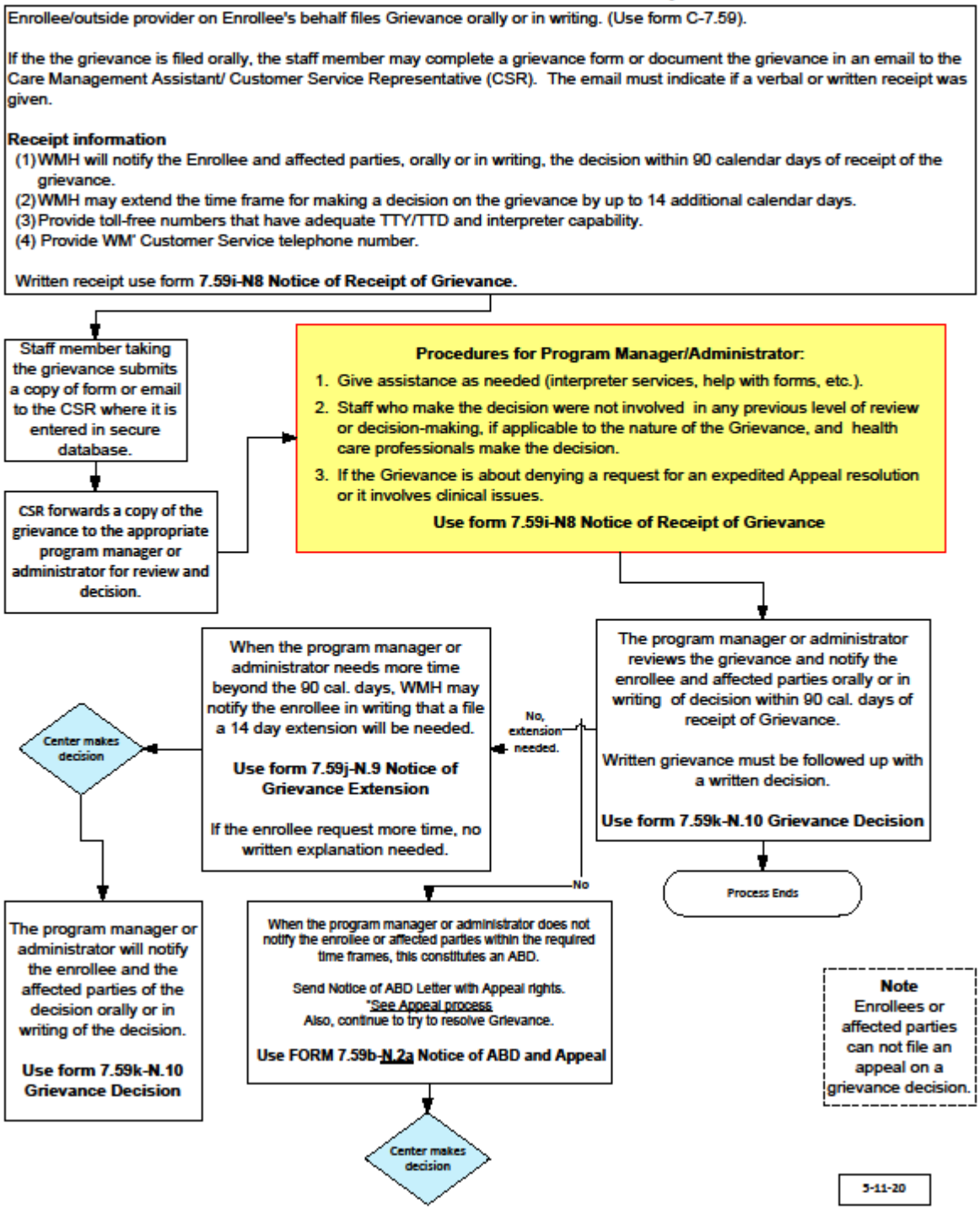
Right to Change and/or Terminate Policy:

Reasonable efforts will be made to keep employees informed of any changes in the policy; however, WBH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Attachment A: Grievance Process

Flowchart 6

Grievance Process
and ABD 5, Failure to Resolve Grievance within Required Time Frame



Attachment B: Grievance Log

Wasatch Behavioral Health Grievance System Log 7/1/2020 to 12/31/2020					
Date Grievance Received:		Staff documenting Grievance:		Access Related:	
Client Name:		Feedback Type:		Quality Related:	
Client ID#:		Category:		Other:	
Division:		Retrieval Mode:		Resolution Status:	
Dept where the grievance took place:		Call Client:		Timeline (45 Days): 90	2/14/00
Staff name/Credentials:		Acknowledgment-Receipt Type:		# of days between receipt and decision:	0
Insurance Type:		Receipt Date:		14 Day Extension Needed?	
				Requested by:	

Summary of Grievance

Grievance Decision

Date Resolved:		Staff resolving grievance (Include Title/Position/Credentials:	
Date Client Notified:			
Method of Notification:		Other pertinent info in file:	
Other Individuals Notified:			
Grievance resolved within in the required time frame?		Medicaid Reporting Period:	7/1/20 to 12/31/20

Example Form

Attachment B: Adverse Benefit Determination (ABD) Log

Wasatch Behavioral Health Adverse Benefit Determination (ABD) Log

Reporting Period:

Client Name	Client #	Affected Parties	Provider Name	ABD Process	Date of ABD Letter	Extension Needed Y/N?	Extension request by	Other pertinent ABD information in file Y/N?

Total:

ABD Type Key

1 - Denial or limited authorization of a requested service, including the type or level of service.
2 - Reduction, suspension, or termination of a previously authorized service.
3 - Denial in whole or in part of payment for services.
4 - Failure to provide first face-to-face services in a timely manner, due to Center limitations, and resulting in client dissatisfaction.
5 - Failure to act within the required time frames for solution and notification of appeals and grievances.

Example Form

Grievances Spreadsheet Definitions

WBH's Compliance Coordinator will log all Enrollee/affected parties Grievances, ABD, and Appeals in the Grievance, ABD, and Appeal spreadsheet. As per PMHP Medicaid Contract requirements, all fields in the spreadsheet must be completed.

Date Grievance Received: Enter the date the oral/written grievance was received and documented.	**Access/Quality/Other Related**: Select the type of code from the drop down menu - Access Related, Quality Related, Other: (See attachment "Type of Grievance Codes and Grievance Resolution Codes:)
Client Name: Enter Enrollee's name.	**Resolution Status**: Select the type of code from the drop down menu (See attachment "Type of Grievance Codes and Grievance Resolution Codes:)
Client ID#: Enter Enrollee WBH ID number.	**Timeline (90) days**: A date will automatically be entered. This will help determine when the 90 day deadline will be.
Division: From the field's drop down menu, select the program the Enrollee receives services from (Youth or Adult).	**# of days between receipt and resolution:** automatically calculate the number of days it took to resolve the grievance.
Dept where the grievance took place:: From the field's drop down menu, select the program where the grievance occurred.	**14 Day Extension Needed?** Yes or No if an extension was requested.
Staff name/Credentials: If the grievance involves a staff member, enter staff members name.	**Requested by**: Name of individual requesting the extension.
Insurance Type: Enter Enrollees insurance provider. This will determine if it will need to be reported to Medicaid.	**Summary of Grievance**: Enter a summary of what the grievance is about. Include dates and individuals involved.
Staff Documenting Grievance: Enter the name of the staff member who accepted the grievance.	**Summary of Resolution**: Enter a summary of the decision/resolution. Include dates and individuals involved.
Feedback Type: From the field's drop down menu, select how the grievance was received (Verbal or Written)	**Date Resolved**: Date the Enrollee was notified of the grievance decision/resolution.
Category: From the field's drop down menu, select (medical, therapy, personnel, center procedures, facility)	**Date Client Notified:** Enter the date the Enrollee/other-affected parties were notified of the decision.
Retrieval Mode: From the field's drop down menu, select how the grievance was received (in-person, telephone, mail, suggestion box.)	**Method of Notification**: From the field's drop down menu, select how the Enrollee/other-affected parties were notified of the decision.
Call client: From the field's drop down menu, select Yes or No if the client requested a call back.	**Other individuals Notified:** Enter the name of the other-affected parties.
Acknowledgement (Receipt) Type: From the field's drop down menu, select how the Enrollee was informed that WBH will give the Enrollee a decision within 90 calendar days from the date their grievance was filed. If more time is needed, WBH will let them know (see sample of a written acknowledgment form # C-7.59i-N8).	**Staff resolving grievance:** Name of the individual(s) resolving the grievance include the individual(s) title and credentials. Ensure that individuals were not involved in any previous level of review or decision-making and are health care professionals who have the appropriate clinical expertise.
Receipt Date: Enter the date the Enrollee was given the Acknowledgment.	**Other Pertinent Info in file**: Yes or No. Any other pertinent documentation needed to maintain a complete record and to demonstrate that they were adjudicated according to the PMHP contract provisions. The CMS will keep a complete hard copy record.
Grievance resolved within the required time frame? Yes or No. resolved within 90 days (14 additional days) from when the grievance was filed**.**	**Medicaid Reporting Period:** Enter annual reporting period.

Type of Grievance Codes and Grievance Resolution

Code	Access/Capacity Related	Code	Quality Related	Code	Other
	Timely access to prescriber services (psychiatrist, PA or APRN)	Q-1	Disagree with treatment plan goals	O-1	Coordination with Health Plan, primary care physician or other provider, or with other agencies
A-2	Timely access to other treatment services, other than not meeting performance standards for first face-to-face service	Q-2	Clinical knowledge or expertise	O-2	A grievance regarding Center's denial of expedited resolution of an appeal
A-3	Emergency Services, other than not meeting performance standards for emergency services	Q-3	Clinician attitude (i.e., rude, impersonal)	O-3	Civil rights/other discrimination (e.g., race, color, religion, sex, age, disability, etc.)
A-4	Time of service	Q-4	Other staff attitude	O-4	Violation of Center's patient rights
A-5	Location of service	Q-5	Communication problems	O-5	Cultural /Ethnic Health Insensitivity
A-6	Waiting time for appointments too long	Q-6	Unethical behavior (including clinician discrimination)	O-6	Facility-related
A-7	Frequency of scheduled service	Q-7	Treatment impasse	O-7	Other
A-8	Access to requested therapist	Q-8	Other quality related–other than quality issues that constitute an action		
A-9	Requested therapist change denied	**** Grievance Resolution Codes**			
A-10	Provider turnover	**R-1**	**Grievance resolved within required time frame (i.e. 90 days + 14 calendar day extension)**		
A-11	Denial of a requested second opinion	**R-2**	**Resolution in progress - still within 90 days**		
A-12	Health Plan failed to make service authorization decision within 14 calendar days	**R-3**	**Resolution in progress, 59-day time frame has expired***		
A-13	Other access related–other than access issues that constitute an ACTION	**R-4**	**Grievance resolved after 59-day time frame expired***		
		R-5	**Not resolved due to client moving, phone disconnected, unable to locate, etc.**		
		R-6	**Not resolved –Client discontinued treatment**		
		R-7	**Not resolved– Client withdrew grievance**		

Wasatch Behavioral Health
CLIENT GRIEVANCE FORM (Form 7.59)

WASATCH BEHAVIORAL HEALTH
CLIENT GRIEVANCE FORM

If you have a complaint with the Center, this is called a grievance. If you have a grievance about your treatment or services at Wasatch Behavioral Health, you may complete this form stating your concerns and give it to any Wasatch Behavioral Health staff member. If you need help filling out this form, any Wasatch Behavioral Health Department staff member will assist you. If you would rather file a grievance verbally, you can call our customer service representative weekdays, 8:00 am – 5:00 pm., at 801-373-4760 or toll free at 1-866-366-7987. If you have Medicaid health insurance, you may contact the Medicaid office by calling 800-662-9651 or 801-538-6155 any time you are unsatisfied with the grievance process.

Today's Date: _____

Client Name: _____ **Phone**: (H)_____(W)_____

If not client, person filing grievance for client: _____**Relationship to client**: _____

_____

Mailing Address: _____

Apt. # City State Zip

Grievance made by: ___ Telephone ___ Mail ___ In person _____ Other

Date the issue occurred:_____

(client) Describe the issue or event you are concerned about

Example Form

(client) Explain what you would like done:

(over)

Grievance Form | Policy # C-3.08 | Form # C - 7.59 | 04-06-2020 | Page 1 of 2

Form # 7.59b-N2a Adverse Benefit Determination (ABD)
If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative
at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client…Use 12 pt font

(The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)**Use form 7.59c-N3a for ABD to either decrease, suspend or end services, individualized to the Enrollee.**

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Behavioral Health took the following Adverse Benefit Determination (ABD);

☐ We denied or limited approval of your requested service/provider.

(Explain why services were limited or denied. If limited, explain the details of the request and the limited approval. Limited approvals may include: a. provider asked for certain number of sessions, you approve less with no chance for approval of the remaining sessions requested; or b). provider asks for certain number of sessions and services are approved in segments and you do not end up approving the original amount requested.)

☐ We denied payment for a service you received that you may have to pay for.

(Explain what led to the ABD, individualized to the Enrollee. Refer to your handbook section on payment liability and provide information to the Enrollee as to which reason fits their situation.)

☐ We did not offer your first appointment within the required amount of time, and you were unhappy with this.

(Explain what led to the ABD, individualized to the Enrollee)

☐ We did not make a decision about your request service within the required amount of time (14 days for a standard request or 72 hours for an expedited (quick) request).

(Summarize request and explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

☐ We did not make a decision about your Grievance within the required amount of time (90 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this ABD, you have the right to appeal. The rest of this letter explains how to file an Appeal.

You must file your Appeal within 60 calendar days from the date on this letter.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760. Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801-373-4760. Outside of Utah County call 866-366-7987. You or your authorized representative will be provided, upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to the ABD.

To file an Appeal:

1. You may file your appeal orally or in writing. You may file your appeal by calling us at 801- 373-4760 and asking for the Wasatch Behavioral Health customer service representative. The Customer Service Representative will fill out the Appeal Request form for you.

3. If you do not want to call first, you must complete the enclosed Appeal Request form and send to us within 60 calendar days of the date on this notice.

4. If your authorized representative or your provider sends us your Appeal Request form, the Appeal Request form must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed Appeal Request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the ABD.

5. Send the complete Appeal Request form to:

Wasatch Behavioral Health
c/o Care Management Department
750 North Freedom Blvd., Suite 300
Provo, UT 84601

If you call us first to file your Appeal, we plan to make a decision within 30 **calendar days** from the date **you called.** If you send us your Appeal Request Form, **we plan to make a decision within 30 calendar days from the date we get your Appeal Request form.**

Sometimes we will need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

Expedited (Quick) Appeal:

You may ask us to make a faster decision on your Appeal if:

1. You or your provider believes **your life is in danger because of our Adverse Benefit Determination (ABD).**
2. You or your provider believes **your health is in danger because of our Adverse Benefit Determination (ABD).**
3. You or your provider believes **you might have a permanent setback because of our Adverse Benefit Determination (ABD).**

To file:

1. You may ask for an expedited appeal by calling the Wasatch Behavioral Health customer services representative at 801- 373-4760.

2. If you do not want to call first, check the “expedited Appeal” box on the enclosed Appeal form and send it to us.

3. If your authorized representative or your provider sends us your Appeal Request form, the Appeal Request form must include your written permission. You may give your written permission by completing and signing

the bottom of the enclosed Appeal Request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the ABD.

If we agree the decision needs to be made quickly, we will make a decision in **72 hours after we receive your expedited Appeal request**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

If your Appeal is denied, we will send you a letter explaining the reason why it was denied and tell you how to ask for a State Fair Hearing.

If you have any questions, please contact the Wasatch Behavioral Health customer services representative at 801-373-4760.

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Enclosure: Appeal Request Form

Wasatch Behavioral Health
APPEAL REQUEST FORM

1. Is the client or a provider requesting this ***Appeal***? Client? Or Provider? (Circle)

2. Name of Client: _____

   Client's Address: _____

3. Name of Provider Involved: _____

   Provider's Address: _____

4. The reason you are requesting the Appeal: _____

   _____

5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

   ___ Check here if you want an expedited Appeal.

6. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services if the Appeal is not decided in your favor. use form Form # 7.59c-N3a ABD for Decreasing or Ending Services

   ___ Check here if you want these services continued.

7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).

8. **REMINDER**!! If you are **not** asking for an expedited (quick) Appeal, and you call us first to file your Appeal, you must confirm your oral appeal in writing within 60 calendar days of the ABD.
   If you have evidence or additional documentation to submit. Please attached to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence or documentation at a later time **Provider Permission Statement**

If your provider is filing the Appeal for you, you must give your written permission.

I _____ (your name) give my permission for

_____ (provider's name) to file this Appeal for me.

_____ _____
Client's Signature Date

Example Form

Form # 7.59i-N8 Notice of Receipt of Grievance
If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client… (Centers – You are not required to give a written receipt of either an oral or written grievance. You may just give oral acknowledgement. This is a sample of a written acknowledgement. The same information needs to be given to Enrollees if you give oral acknowledgement)

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

On "[Click here and type date]" we received your Grievance regarding **(explain details)**. We will give you our decision within 90 calendar days. Sometimes, we'll need more time to make a decision, or you may ask us to take more time. If we need to take extra time, we will send you a letter telling you that.

If a provider filed the Grievance on Enrollee's behalf, adjust letter accordingly.

If you have questions, call the Center's customer services representative at 801- 373-4760.

Sincerely,

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Example Form

Form # 7.59j-N9 Notice of Grievance Extension

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client… (Centers – This form is only required for written grievances. You may use it for decisions on oral grievances if you want.)

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" , we received a grievance from you.

We have not been able to make a decision on your Grievance yet. This letter is to let you know we need to take more time.

We need more time because (Explain reason for the delay, including type of information needed and from whom, if applicable**).**

We will give you our decision within 14 calendar days.

(Could individualize this further and explain how you'll give them decision – in writing if they gave you the Grievance in writing, or if oral Grievance, whether you'll call them/talk to them/give in writing.)

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Example Form

Form # 7.59k-N10 Grievance Decision

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client… ***(This written Grievance decision letter is only required if the Grievance was filed in writing. It is optional for oral Grievances.)***

"[Click here and type date]"

Example Form

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

We received your *Grievance on "[Click here and type date]" At that time your grievance was about **(summarize Grievance)**.

***(if a provider filed the Grievance on Enrollee's behalf, adjust letter accordingly**)

We have decided **(summarize resolution).**

If you have questions, call the Center's customer services representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Grievance Decision from CMS

DATE
The Wasatch Behavioral Health Care Management Services Department received notification of your experience with STAFF MEMBER. As a result of our review, we found that you have discussed your concern with the Program Manager, NAME OF PROGRAM MANAGER and your concerns were addressed.

CAN LIST DECISION

We apologize for any inconvenience and personal distress that you experienced do to this unfortunate event and hope that you do not have any further problems. However, please contact us if you have questions about the quality of your treatment or issues with staff.

Sincerely,

Care Management Services Department

Example Form