Member appeals and grievances

Last updated: July 10, 2018

Customer service

The Fallon Health Customer Service Department is available to assist members and member prospects with their servicing needs. The direct telephone number is 1-800-868-5200. For Fallon Health MassHealth ACO members, the number is 1-800-341-4848. TDD/TTY access for those who are hearing impaired is 877-608-7677. The Customer Service Department assists customers with routine inquiries such as questions regarding benefits, ID card requests and PCP selections (see section on “Access services”).

The Customer Service staff can also assist members with more complex needs such as administrative discrepancies and difficulties with obtaining access to care. More complex cases are documented to ensure follow-through and a record for future reference. On some occasions, you may be contacted by a member of the Customer Service staff for assistance with servicing a member.

The Customer Service staff also works closely with the Member Appeals and Grievances Department to make sure that members wishing to file a grievance or appeal are handled in an appropriate fashion.

The Customer Service Department can also assist you with urgent member eligibility questions. All routine eligibility questions that cannot be resolved by reviewing your panel report should be directed to Customer Service at 1-800-868-5200. Please note that for Fallon Health MassHealth members, call Fallon Health MassHealth Customer Service at 1-800-341-4848. All routine requests will be responded to within one business day.

If you or your office staff has questions regarding prior authorization or case management claims for all your Fallon Health members, you can contact the Provider Service Line at 1-866-ASK-FCHP to be directed to the appropriate department.

Fallon Health’s Member Appeals and Grievances Department coordinators are available to assist Members if they have grievances about plan policies, providers or services, or wish to appeal an adverse determination made by the plan regarding their coverage or service.

Coordinators are trained to assist Members with their grievances and appeals in accordance with their rights and in a confidential manner. The staff follows policies and procedures which protect Member rights and adhere to quality standards set by the National Committee for Quality Assurance (NCQA), MassHealth contract, Medicare guidelines as defined by the Centers for Medicare & Medicaid (CMS) and regulations as defined under the Massachusetts Managed Care Act.

The Member Appeals and Grievances Department has dedicated staff to promote Member retention, to make every effort to satisfy Member expectations and strengthen customer confidence. When any Fallon Health Member is dissatisfied with plan policy, plan providers or services, they have a right to file a grievance. Member Appeals and Grievances coordinators work with Fallon Health providers or management staff to review and resolve the grievance. The standard for resolving all Member grievances is 30 calendar days.

All grievance data is tracked to report trends, corrective action plans and improvement measures to Fallon Health Performance Improvement Committees.

Member appeals and grievances

When plan Members are dissatisfied with the outcome of a plan review regarding denial of coverage or services, they have the right to appeal the decision. The Member Appeals and Grievances staff coordinates the plan's Member appeals procedure for all product lines.

Commercial plan appeals and grievance procedure

Standard appeals process
A Fallon Health commercial Member has the right to file a grievance if he/she does not agree with the above decision and would like a review.

The Member may file the grievance, or someone else (family member, friend, physician/ practitioner, etc.) may do this for him/her. He/she must file the grievance within regulatory requirements for specific product lines. Grievance requests should include the following information:

- The Member's name
- The Fallon Health Member identification number
- The facts of the request
- The outcome that the Member is seeking
- The name of any Fallon Health representative with whom the Member has spoken

The Member can file a grievance in any of the following ways:

- Send a letter to us at:
  Fallon Health
  Member Appeals and Grievances
  10 Chestnut St.
  Worcester, MA 01608
- Call 1-800-333-2535 (TRS 711) from 8:00 a.m. to 5:00 p.m., Monday through Friday
- Send e-mail to grievance@fallonhealth.org
- Send a fax to 1-508-755-7393
- Speak to a representative at the Fallon Health administrative offices located at: Fallon Health, Member Appeals and Grievances, 10 Chestnut St. Worcester, MA 01608

Fallon Health will respond to the grievance in writing within 30 calendar days from the date we receive the request. In the case that we need to review medical records, this date will be 30 calendar days from the date we receive the medical records, unless an extension is filed.

Expedited review
The Member or Authorized Appeal Representative can request an expedited (fast) review by asking for one either orally or in writing. The Member can file for an expedited review in any of the following circumstances:

- He/she is an inpatient in the hospital and the grievance concerns Fallon Health's termination of coverage for the hospital stay.

- The Member's physician certifies that, unless action is taken within 48 hours, he/she could sustain immediate and severe harm.
- The Member believes that not receiving the services which have been denied could pose a threat to his/her health, life, or ability to regain maximum function
- The Member has an illness in which his/her life expectancy is less than six months.

If the Member has an illness in which his/her life expectancy is less than six months and if Fallon Health's review of the expedited review results in denial of coverage, the Member may request a conference. Fallon Health will schedule the conference as expeditiously as the Member's health requires, but no later than 10 business days from the date, we receive the request. Or, within five business days if the Member's physician determines, after consultation with a Fallon Health medical director, that, based on standard medical practice, the effectiveness of the proposed treatment, service or supplies or any alternative treatment, services or supplies would be materially reduced if not provided at the earliest possible date. The Member may attend the conference, but his/her attendance is not required.

External review
If the grievance involved is an adverse determination, and the member is not satisfied with Fallon Health's final decision, he/she has the right to file the case with the Department of Public Health (DPH), Office of Patient Protection. The request must be made in writing within 4 months from receiving the written notice of the final adverse determination.

An adverse determination means that Fallon Health has denied, reduced, modified or terminated an admission, continued inpatient stay or the availability of any health care services for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Expedited external review
The Member may request an expedited (fast) external review. In this case the Member must submit a written certification from his/her physician stating that a delay in providing or continuing the health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the Member's health.

The Member must file the request for external review or expedited external review with:

Department of Public Health Office of Patient Protection
50 Milk Street
Boston, MA 02109
Phone: 1-800-436-7757
Fax: 617-624-5046

The request should:

- Be on the standardized form from the Department of Public Health Office of Patient Protection
- Include the Member's signature or his/her authorized representative's signature
- Include a copy of the written final adverse determination made by Fallon Health
- Include the required $25 fee payable to the Department of Public Health

Fallon Senior Plan™ appeals procedure

72-hour appeals process
If the Member or his/her physician believes that his/her health, life, or ability to regain maximum function could be adversely affected without a particular service, the Member or Authorized Appeal Representative may appeal the denial of coverage for that service through the 72-hour appeal process.

72-hour appeal requests may be made either orally or in writing.

The health plan must make a decision to accept or deny the request for the expedited appeal. If the decision is to deny the request for an expedited appeal, the health plan must notify the Member of this decision in writing within 72 hours of the initial request and process the request through the standard appeals process. NOTE: If any physician requests a 72-hour appeal on behalf of a Member, the health plan must accept the request.

If the health plan accepts the request for an expedited appeal, the health plan must make a decision to approve or deny coverage for the requested service and notify the Member in writing of this decision as expeditiously as the Member's health requires, but no later than within 72 hours of the initial request.

Under certain circumstances, the health plan may take an additional 14 calendar days to make a decision if the extension of time benefits the member (e.g. additional consultation or testing is necessary or the health plan is waiting for the receipt of outside records).

If the health plan does not rule fully in favor of the member, the entire case file must be forwarded to the MAXIMUS, CMS' contracted agency, within 24 hours of the health plan's decision. MAXIMUS will render a determination.

Standard appeals process
The Member or Authorized Appeal Representative may appeal if he/she does not agree with health plan's decisions about medical bills or services. The Member must submit the appeal request within 60 days of receipt of the health plan's initial determination notice.

The health plan must process the appeal and notify the member of its determination in writing as expeditiously as the Member's health requires but no later than within 30 calendar days of receipt of the appeal request.

If the health plan does not rule fully in favor of the Member, the entire case file must be forwarded to the MAXIMUS, CMS' contracted agency, within the above specified time frame.

MassHealth grievances and appeals procedures

Definitions

The following definitions apply to the MassHealth Grievances and Appeals policies and procedures:

Adverse Action	The following actions or inactions by Fallon Health: (1) the failure to provide Covered Services in a timely manner in accordance with the MassHealth waiting time standards in Section 2.9.B of the contract with EOHHS; (2) the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service; (3) the reduction, suspension, or termination of a previous authorization for a service; (4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following: (i) failure to follow prior authorization procedures; (ii) failure to follow referral rules; (iii) failure to file a timely claim; (5) the failure to act within the timeframes in Section 2.6.C.5 of the contract with EOHHS for making authorization decisions. Also referred to as an "Initial Determination."; and (6) the failure to act within the timeframes specified in Section 2.12.B.4 a for reviewing an Internal Appeal and issuing a decision. It is not necessary to receive an Adverse Action notice to appeal. It is only necessary that an Adverse Action has taken place. For those Adverse Actions where notice is not possible or was not provided for any reason, the Member must appeal within 60 calendar days from the day the Adverse Action occurred.
Authorized Appeal Representative	Any individual that has been designated by the Member in writing to represent the Member with respect to a Grievance, an Internal Appeal or BOH Hearing Appeal. Fallon Health must allow the Member to give a standing authorization to an Authorized Appeal Representative to act on his/her behalf for all Grievances and Internal Appeals. A standard authorization must be done in writing and may be revoked by the Enrollee at any time. Appeal Representatives may include but are not limited to the following: a. Physician; b. Family Member; c. Legal Counsel; (Refer Appeal information to Fallon Health legal counsel where appropriate.) d. Guardian; e. Conservator;

	f. Holder of Power of Attorney; g. Health care agent; or h. Community Advocacy Group.
Board of Hearings (BOH)	The Board of Hearings within the Executive Office of Health and Human Services' Office of Medicaid.
Continuing Services	ACO Covered Services that were previously authorized by Fallon Health and are the subject of an Internal Appeal and/or BOH Appeal, if applicable, involving a decision by Fallon Health to terminate, suspend, or reduce the previous authorization and which are provided by Fallon Health pending the resolution of the Internal Appeal and BOH Appeal, if applicable.
Designated Reviewer	Health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action.
Executive Office of Health and Human Services (EOHHS)	The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.
Expedited Internal Appeal	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for review of an Adverse Action, which is processed within 72 hours (unless there is an extension). This fast appeal process is available to Members who believe that their health or ability to function could be seriously harmed by waiting 30 calendar days for an appeal determination, which is the timeframe for the Standard first level Internal Appeal process (unless there is an extension). There is only one level of review available for an expedited internal appeal.
Extension	The process that allows a Member, Authorized Appeal Representative or Fallon Health to extend the timeframe for completing the Standard Internal Appeal or Expedited Internal Appeal
External Appeal	A written request to the BOH, made by a Member or an Authorized Appeal Representative on behalf of a Member to review a Final Standard Internal Appeal decision by Fallon Health or an Expedited Internal Appeal.
First Level Review	A review conducted during the First Level Internal Appeal by a Fallon Health Medical Director or a health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action.
Grievance	Any expression of dissatisfaction by a Member or Authorized Appeal Representative about any action or inaction by Fallon Health other than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of Fallon Health, or failure to respect the Member's rights. Also the decision to extend the timeframes for deciding an Internal Appeal or authorization request, and the decision to deny a request that an Internal Appeal be considered as an Expedited Internal Appeal.
Internal Appeal	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for review of an Adverse Action

Inquiry	Any oral or written question by a Member received by Fallon Health regarding any aspect of Fallon Health operations that does not express dissatisfaction about Fallon Health.
Protected Health Information (PHI)	Individual identifiable health information that is transmitted or maintained in any form or medium, excluding employment records held by Fallon Health in its role as employer.
Personal Representative Authorization Form	A form that, when signed, authorizes a third party to act on Member's behalf during the Grievance.
Standard First Level Appeal Request	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for a First Level Review of an Adverse Action, which is processed within 30 calendar days (unless there is an extension).

Grievances

A Member may file the grievance

- On his or her own behalf; or
- By giving someone (family member, friend, physician/practitioner, etc.) permission to act on his or her behalf.

If a Member chooses to appoint an individual to act on their behalf during the Grievance process, Fallon Health requires the Member to sign and return a Personal Representative Authorization form that can be requested by contacting the Fallon Health Member Appeals and Grievances Department at 1-800-333-2535, Monday through Friday, 8 a.m. to 5 p.m.

For any questions about the Grievance procedure, please call Fallon Health's MassHealth Customer Service Department at 1-800-341-4848 (TRS 711), Monday through Friday, 8 a.m. to 6 p.m.

A Member or Authorized Appeal Representative has the right to file a Grievance if they are not satisfied with an action or inaction taken by Fallon Health other than an Adverse Actions which entitles the Member or Authorized Appeal Representative to file an Appeal.

Examples of Grievances that are appropriate to file include:

- Dissatisfaction with the quality of care or service a Member has received
- Any aspect of Fallon Health operations
- Lack of courtesy by health care providers
- Failure of health care providers to respect a Member's rights
- Disagreement with Fallon Health's decision to extend the timelines for making an authorization decision or resolving a standard or an Expedited Internal Appeal
- Disagreement with Fallon Health's disapproval of a request for an Expedited Internal Appeal.

Note: This includes behavioral health services.

If someone other than the Member files a Grievance and Fallon Health does not receive a Personal Representative Authorization form within thirty (30) calendar days, Fallon Health will dismiss the Grievance and notify the Member of this decision in writing. Fallon Health will not begin to resolve a Grievance filed by someone other than the Member until this form is received.

A Member or Authorized Appeal Representative may file a Grievance over the telephone, in person, or in writing via mail, email or fax, by:

- Fallon Health's MassHealth Customer Service Department at 1-800-341-4848 (TRS 711), Monday through Friday from 8 a.m. to 6 p.m.

- Fallon Health's Member Appeals & Grievances Department at 1-800-333-2535 (TRS 711), Monday through Friday from 8:00 a.m. to 5:00 p.m.

- Presenting the request, in person, Monday through Friday from 8:00 a.m. to 5:00 p.m. at Fallon Health, 10 Chestnut St., Worcester, MA 01608

If a Member or Authorized Appeal Representative prefers to send a written Grievance, via mail, fax or email, to the Member Appeals & Grievances Department, include all details about the Grievance, any pertinent dates and, if applicable, names of providers from whom a Member has received care.

Please send the Grievance to:

Fallon Health
10 Chestnut St.
Worcester, MA 01608
Attn: Member Appeals & Grievances Department

Or:

- Send an email to: grievance@fallonhealth.org
- Fax a detailed letter to: 508-755-7393

If necessary, Fallon Health can assist a Member with interpreter services. Additionally, if a Member or Authorized Appeal Representative needs any assistance with filing a Grievance, completing any necessary forms or would like further explanation regarding the Fallon Health Grievance process, the Member Appeals & Grievances Department is available to help and can be reached at 1-800-333-2535, Monday through Friday, 8 a.m. to 5 p.m.

Fallon Health will acknowledge the Grievance within one (1) business day of receipt.

The Member Appeals & Grievances Department will research the request and send the Member and Authorized Appeal Representative a written notice of our resolution as quickly as the Member's health condition requires and always within thirty (30) calendar days of the receipt of the Grievance.

Appeals

A Member may file the appeal:

- On his or her own behalf; or
- By giving someone (family member, friend, physician/practitioner, etc.) permission to act on his or her behalf.

If a Member chooses to give someone permission to act on his or her behalf during the Internal Appeal, Fallon Health requires the Member to sign and return a Personal Representative Authorization form. This person is referred to as the Member's Authorized Appeal Representative.

Please note for Expedited Internal Appeals, the physician/treating provider can file an expedited appeal on the Member's behalf and act as the Authorized Appeal Representative without written authorization from the member being received prior to processing the Expedited Appeal Request.

The Personal Representative Authorization form can be obtained by calling the Fallon Health Member Appeals & Grievances Department at 1-800-333-2535, Monday through Friday from 8:00 a.m. to 5:00 p.m., or the Fallon Health MassHealth Customer Service Department at 1-800-341-4848 (TDD/TTY: 1-800-608-7677), Monday through Friday from 8 a.m. to 6 p.m. If Fallon Health does not receive this form by the time the deadlines expire for resolving the Standard Internal Appeal, Fallon Health will notify the Member in writing that their Standard Internal Appeal has been dismissed. If the Member believes that he or she did in fact submit the Personal Representative Authorization form within the standard Internal Appeal deadlines, the Member can request that the dismissal be reversed by sending a letter to Fallon Health within ten (10) calendar days of the dismissal. Fallon Health will consider the request and will decide to either reverse the dismissal and continue with the Appeal or will uphold its dismissal.

Fallon Health will notify the Member of this decision in writing. If Fallon Health upholds the Member's dismissal, the dismissal will become final. If the Member disagrees with this decision, the Member can Appeal to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) (see Option 3).

Fallon Health provides their MassHealth Members with one level of a Standard Internal Appeal review or one level of Expedited Internal Appeal review. The Member or Authorized Appeal Representative has the right to file an Internal Appeal if they disagree with one of the following actions or inactions by Fallon Health:

- Fallon Health denied or decided to provide limited authorization for a service requested by the Member's health care provider.
- Fallon Health reduced, suspended or terminated a service covered by Fallon Health that Fallon Health previously authorized.
- Fallon Health denied, in whole or in part, payment for a Fallon Health covered service due to service coverage issues.
- Fallon Health did not decide a standard or expedited service authorization request within the required timeframes.
- A Member was unable to obtain health care services within the time frames described in the "how long should one wait to see a doctor" section of this Member Handbook.

Note: This includes behavioral health services.

A Member or Authorized Appeal Representative may file an Internal Appeal over the telephone, in writing, in person or via e-mail or fax; which includes:

- Calling Fallon Health's Member Appeals & Grievances Department at: 1-800-333-2535 (TRS 711), Monday through Friday from 8:00 a.m. to 5:00 p.m.

- Sending a letter describing the request to: Fallon Health
  10 Chestnut St. Worcester, MA 01608
  Attn: Member Appeals & Grievances Department

- Presenting the request, in person, Monday through Friday from 8:00 a.m. to 5:00p.m. at: Fallon Health
  10 Chestnut St. Worcester, MA 01608

- Sending an email to: grievance@fallonhealth.org

- Faxing a detailed letter to: 508-755-7393

When a Member or Authorized Appeal Representative files an Internal Appeal, it should include:

1. Member's name.
2. Member's Fallon Health plan identification number (located on the Fallon Health member ID card).
3. The facts of the request. Please note, a Member or Authorized Appeal Representative can present evidence and allegation of fact or law in person or in writing during the Appeals process by contacting the Member Appeals & Grievances Coordinator at 1-800-333-2535, Monday through Friday, 8 a.m. to 5 p.m. This information must be received by Fallon Health prior to the review of the Appeal or final decision.
4. Information about the outcome that the Member or Authorized Appeal Representative wants.
5. The name of any Fallon Health representative that either the Member or Authorized Appeal Representative may have spoken to.
6. A request for an Expedited Internal Appeal if the Member or Authorized Appeal Representative thinks the Member's condition requires this level of Appeal.

To ask for help with any of the Appeal process options, call the Fallon Health Member Appeals and Grievances Department at 1-800-333-2535, Monday through Friday from 8:00 a.m. to 5:00 p.m., or the Fallon Health MassHealth Customer Service Department at 1-800-341-4848 (TRS 71), Monday through Friday from 8 a.m. to 6 p.m.

Remember that, if necessary, Fallon Health can assist a Member or Authorized Appeal Representative with interpreter services during the Internal Appeal process.

Option 1: Filing a Standard or Expedited Internal Appeal

Steps to take to file a Standard or Expedited Internal Appeal

A Member or Authorized Appeal Representative may file a Standard or Expedited Internal Appeal within thirty (30) calendar days of Fallon Health's notice that informs the Member about any action or inaction that entitles the Member or Authorized Appeal Representative to an Internal Appeal. But, if the Member did not receive such a notice, the Internal Appeal request must be filed within thirty (30) calendar days of learning on his/her own about Fallon Health's actions or inactions described above. If applicable, a Member can choose to continue receiving requested services from Fallon Health during the Internal Appeal process, but if the Member loses the Appeal, the Member may have to pay back for the cost of these services. If a Member wants to receive such continuing services, the Member or Authorized Appeal Representative must submit the Internal Appeal request within ten (10) calendar days from the date of the letter notifying the Member of denial (or, if the Member did not receive a denial notice, ten (10) calendar days from the date of the action or inaction) and indicate that he/she wants to continue to get these services. If the Internal Appeal request is received more than thirty (30) calendar days after the denial letter notifying the Member of the action that the Member or Authorized Appeal Representative are appealing (or, if the Member did not receive a denial notice thirty (30) calendar days from the date he/she learned of the action or inaction), Fallon Health will dismiss the Internal Appeal and will notify the Member and Authorized Appeal Representative in writing that the Appeal has been dismissed. If the Member or Authorized Appeal Representative believes that he/she did in fact submit the Internal Appeal within the deadlines, the Member or Authorized Appeal Representative can request that the dismissal be reversed by sending a letter to Fallon Health within ten (10) calendar days of the dismissal. Fallon Health will consider the request and will decide either to reverse the dismissal and continue with the Appeal or will uphold its dismissal. Fallon Health will notify the Member and Authorized Appeal Representative of this decision in writing. If Fallon Health upholds the dismissal, the dismissal will become final. If the Member or Authorized Appeal Representative disagrees with this decision, then the Member or Authorized Appeal Representative can Appeal to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) (see Option 3).

How the Standard Internal Appeal process works
Fallon Health will process the Appeal as quickly as the Member's health requires and will notify the Member and Authorized Appeal Representative of our decision no later than thirty (30) calendar days from the date the Standard Internal Appeal request is received unless an extension is taken as described in the following section.

Getting a Standard Internal Appeal Extension

1. If the Member or Authorized Appeal Representative wants to send Fallon Health more information regarding the Appeal, the Member or Authorized Appeal Representative may request an extension of up to fourteen (14) calendar days to have more time to obtain the information.
2. Fallon Health may also take an extension of up to five fourteen (14) calendar days to obtain necessary information.
3. Please note that Fallon Health can only request an extension if:
    - The extension is in the best interest of the Member
    - Fallon Health needs additional information that we believe, if we receive it, will lead to approval of the Member or Authorized Appeal Representative's request
    - Such outstanding information is reasonably expected to be received within fourteen

(14) calendar days.

If the Member or Authorized Appeal Representative does not agree with the extension taken by Fallon Health, the Member or Authorized Appeal Representative may file a Grievance. For more information about Grievances, refer to the Grievances section described above.

If the Member or Authorized Appeal Representative is not satisfied with the outcome of the Standard Internal Appeal, he/she may:

1. File an external appeal with the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) for further Appeal (see Option 3).

How to request an Expedited Internal Appeal
The Member or Authorized Appeal Representative can request an Expedited Internal Appeal if the Member or Authorized Appeal Representative feel that the thirty (30) calendar day time frame for a standard resolution could seriously jeopardize the Member's life, health or ability to get, maintain or regain maximum function. If the request for an Expedited Internal Appeal is filed by the Member's provider acting as their Authorized Appeal Representative, or if the Member's provider supports the request for an Expedited Internal Appeal, then the request that the Appeal be expedited will be approved unless it is unrelated to the Member's health status. Otherwise, Fallon Health has the right to determine whether or not to process the Appeal as an Expedited Internal Appeal.

If the Member or Authorized Appeal Representative wants to request an Expedited Internal Appeal and if the Appeal does not apply to denials of payment:

1. File the Appeal over the telephone, in writing, in person, via e-mail or fax.
2. The Member or Authorized Appeal Representative should clearly state the request by stating, "I want a fast Appeal," or "I believe that the Member's health could be seriously harmed by waiting 30 calendar days for a normal Appeal."

How the Expedited Internal Appeal process works
If the Member meets the qualifications for an Expedited Internal Appeal, Fallon Health will process the Appeal request and let the Member and Authorized Appeal Representative know of our decision orally and in writing, as quickly as the Member's health requires, but not later than 72 hours from when we received the request.

Getting an Expedited Internal Appeal Extension

1. If the Member or Authorized Appeal Representative wants to send us additional information that's important to the Appeal, the Member or Authorized Appeal Representative may request an extension of up to fourteen (14) calendar days.
2. Fallon Health may also make an extension of up to fourteen (14) calendar days only if:
   - The extension is in the best interest of the Member
   - Fallon Health needs additional information that we believe, if we receive it, will lead to approval of the request.
   - Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

If the Member or Authorized Appeal Representative does not agree with the extension taken by Fallon Health, the Member or Authorized Appeal Representative may file a Grievance. For more information about Grievances, refer to the Grievances section described above.

If the Member or Authorized Appeal Representative's request does not qualify for an Expedited Internal Appeal

1. The Appeal request will be processed within the time frame for a standard Internal Appeal of thirty (30) calendar days.
2. The Member and Authorized Appeal Representative will be notified, in writing, that the Appeal request will be handled as a Standard Internal Appeal.
3. If the Member or Authorized Appeal Representative disagrees with this decision, they may file a Grievance. For more information about Grievances, refer to the Grievances section described above.

If the Member or Authorized Appeal Representative is not satisfied with the outcome of the Expedited Internal Appeal, he/she may:

- Request, within thirty (30) calendar days, an Appeal at the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) (see Option 3).

However, if the Member or Authorized Appeal Representative would like the Appeal to be treated as an Expedited Appeal at BOH, he/she should request the Appeal within twenty (20) calendar days.

Option 2: Request a hearing for a Board of Hearings Appeal

Steps to take:

The Member or Authorized Appeal Representative can request a hearing from the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) if:

1. The Member or Authorized Appeal Representative is dissatisfied with the Fallon Health Second-Level Internal Appeal or Expedited Internal Appeal determination;
2. The Member or Authorized Appeal Representative is dissatisfied with the Fallon Health First-Level Standard Internal Appeal and wishes to skip the Second-Level Internal Appeal hearing; or
3. If Fallon Health did not resolve the First-Level Standard Internal Appeal within thirty (30) calendar days (or within fourteen (14) extra calendar days if there is an extension), or did not resolve the Expedited Internal Appeal within 72 hours (or within fourteen (14) extra calendar days if there is an extension).

To do so, the Member or Authorized Appeal Representative needs to complete the Fair Hearing Request form which he/she will receive with the Appeal determination letter and mail or fax it to the following address:

Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
2 Boylston St. Boston, MA 02116

Or fax to 617-210-5820

The Member or Authorized Appeal Representative must file the Fair Hearing Request Form within thirty (30) calendar days of Fallon Health's decision resolving his/her Internal Appeal.

To ask for help with any of the Appeal process options, call the Fallon Health Member Appeals and Grievances Department at 1-800-333-2535 (TRS 711).

Board of Hearings: Expedited Internal Appeal

If the Appeal was an Expedited Internal Appeal and the Member or Authorized Appeal Representative wants BOH to make an Expedited decision too, the Member or Authorized Appeal Representative must request a BOH Appeal within twenty (20) calendar days of Fallon Health's decision resolving the Expedited Internal Appeal. If BOH receives the request between days twenty-one (21) and one hundred-twenty (120) the Appeal will be processed as a standard Appeal.

How to receive continuing services

If the Member or Authorized Appeal Representative wants to receive continuing coverage of previously authorized services through the outcome of the BOH Appeal, the request must be received by the BOH within ten (10) calendar days of Fallon Health's decision resolving the Internal Appeal. The Member or Authorized Appeal Representative also has the option of canceling these services. If the Member chooses to receive continuing services through the Appeal and if the BOH upholds Fallon Health's original denial, the Member may be responsible for paying back for the cost of the continuing services.

Reviewing the Appeal file

Before or during the Appeals process, the Member or Authorized Appeal Representative can request to review the case file, including medical records and any other documentation or records that Fallon Health considered during the Appeal process.

NaviCare® HMO SNP appeals and grievances rights

Appeals

An appeal is the type of complaint you make when you want NaviCare to reconsider and change a decision we have made:

- To deny, stop, suspend, or reduce any services
- About what services are covered for you
- About what we will pay for a service

Below is the process for filing an appeal for drugs that are covered under Medicare Part D. There are two kinds of appeals you can request:

1. Expedited (72 hours)—You can request an expedited (fast) appeal if you or your doctor or other prescriber believes that your health could be seriously harmed by waiting up to seven days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after receiving your appeal.
    - If the doctor or other prescriber who prescribed the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting for seven days could seriously harm your health, we will automatically expedite the appeal.
    - If you ask for an expedited appeal without support from a doctor or other prescriber, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within seven days.
    - Your appeal will not be expedited if you've already received the drug you are appealing.

2. Standard (seven days)—You can request a standard appeal. We must give you a decision no later than seven days after we get your appeal.

What do I include with my appeal?

You should include your name, address, member ID number, reasons for appealing and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (our formulary), your doctor or other prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How do I request an appeal?

You need to file your appeal in writing, by faxing or contacting an Enrollee Services Representative by telephone within 60 calendar days from receiving the denial notice. NaviCare can give you more time if you have a good reason for missing the deadline. If the appeal is made by someone other than yourself, your doctor or other prescriber, you must submit a document appointing him or her to act on your behalf.

For a standard appeal
You, the person you choose to represent you, or your physician or other prescriber should mail, fax or deliver your written appeal request to:

NaviCare Enrollee Services
Fallon Health
10 Chestnut St. Worcester, MA
01608
Fax: 1-508-755-7393

For an expedited appeal

You, the person you choose to represent you, or your physician or other prescriber should contact us in writing or by telephone or fax at:

NaviCare Enrollee Services
Fallon Health
10 Chestnut St. Worcester, MA 01608
Toll-free: 1-877-700-6996 (TDD/TTY: 1-877-795-6526)
Monday through Friday, from 8 a.m. to 6 p.m. (Expedited appeals can be made and are processed 24 hours a day, seven days a week by leaving a voice message.)
Fax: 1-508-755-7393

What happens next?

If you appeal, we will review our decision. If any of the prescription drugs you requested are approved, you will receive a letter letting you know of the approval, and for expedited appeals, you will also receive a phone call. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of Fallon Health. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact information

If you need information or help, call to speak to a NaviCare Enrollee Service Representative at 1-877-700-6996 (TDD/TTY: 1-877-795-6526), Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we're available seven days a week.)

Other resources to help you
Medicare Rights Center: 1-888-HMO-9050
Elder Care Locator: 1-800-677-1116
Medicare: 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048

Grievances

A grievance is the type of complaint you make if you have any other type of problem with Fallon Health, NaviCare or one of our plan providers. If the grievance is made by someone other than yourself, you must submit a document appointing him or her to act on your behalf. You, or the person you choose to represent you, would file a grievance if you have a problem with things such as:

- Waiting times when you fill a prescription
- The way your network pharmacist or others behave
- Being able to reach someone by phone
- Getting the information you need
- The cleanliness or condition of a network pharmacy
- Whenever we do not provide a fast decision about your initial request for a service or your request to appeal our denial of a service.

There are two kinds of grievances you can file:

1. Expedited (72 hours)—You can file an expedited grievance whenever we do not provide a fast decision about your initial request for a service or your request to appeal our denial of a service.

3. Standard (30 days)—You can file a standard grievance. We will contact you within 30 calendar days of receiving your grievance to discuss a possible resolution to your concern.

How do I file a grievance?

For an expedited grievance:

Call the NaviCare Enrollee Services Department at:
1-877-700-6996 (TDD/TTY: 1-877-795-6526)
Monday through Friday, from 8 a.m. to 6 p.m. (Expedited grievances can be made and are processed 24 hours a day, seven days a week by leaving a voice message.) Fax: 1-508-755-7393

For a standard grievance:
Call the NaviCare Enrollee Services Department at the number below or, send a letter including all details of your grievance to:
NaviCare Enrollee Services
Fallon Health
10 Chestnut St. Worcester, MA 01608

1-877-700-6996 (TDD/TTY: 1-877-795-6526) Monday through Friday, from 8 a.m. to 6 p.m.
Fax: 1-508-755-7393

A NaviCare Enrollee Services Representative will let you know that we received your letter within 24 to 48 hours of receipt. Every reasonable attempt will be made to resolve your complaint within 30 days. All grievances submitted in writing will be responded to in writing.

Grievances made orally will be responded to orally and in writing. All quality of care grievances will be responded to in writing and will include information of your rights to file a written complaint to the Quality Improvement Organization.

Exceptions to the formulary (list of covered medications)
You can ask NaviCare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to remove coverage restrictions or limits on your drug. For example, for certain drugs, NaviCare may limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to remove the limit and cover more.

Generally, NaviCare will only approve your request for an exception if the alternative drugs included on the plan's formulary or additional restrictions on use would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Please note that because we do not cover drugs to treat erectile dysfunction (ED), you will not be able to request a formulary exception for ED drugs when used to treat ED.

You should contact us to ask us for a preliminary coverage decision for a coverage exception. When you are requesting a coverage exception, or utilization restriction exception, we encourage you to submit a statement from your doctor or other prescriber supporting your request. Generally, we must make our decision within 72 hours of getting your doctor's or other prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor or other prescriber believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must decide no later than 24 hours after we get your doctor's or other prescriber's supporting statement.

For more information about your appeals, grievances, and exceptions, see your Evidence of Coverage or call a NaviCare Enrollee Service Representative at 1-877-700-6996 (TDD/TTY: 1-877-795-6526), Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we're available seven days a week.)

A Coordinated Care plan with a Medicare Advantage contract and a contract with theMassachusetts Medicaid program. NaviCare HMO SNP is available to individuals age 65 and older who have Medicare Parts A and B and MassHealth Standard and live in the service area.

NaviCare SCO is available to individuals age 65 and older who have MassHealth Standard and live in the service area. (Individuals with MassHealth Standard do not have to be covered by Medicare Parts A and B to enroll in NaviCare SCO). Eligible beneficiaries may enroll in NaviCare HMO SNP or NaviCare SCO at any time. Except in emergent and urgent care situations, you must use network pharmacies to access the prescription drug benefit. Quantity limits and restrictions may apply.

You must use plan providers except in emergency or urgent care situations or for out-of- area renal dialysis. If you obtain routine care from out-of-network providers, neither Medicare nor NaviCare will be responsible for the costs. This information is available for free in other languages. Please contact our enrollee services at 1-877-700-6996 for additional information.

Your member rights and responsibilities: Fallon Health

All products excluding Fallon Health MassHealth and Fallon Preferred Care, Fallon MassHealth members and Fallon Preferred Care members, please refer to plan- specific rights and responsibilities beginning on pages 24 and 25, respectively.

Fallon Health recognizes the specific needs of and maintains a mutually respectful relationship with members and Fallon is committed to treating members in a manner that respects their rights as well as its expectations of members' responsibilities in its Statements of Members' Rights and Responsibilities, which include at least the following:

1. Be informed about Fallon Health and covered services.

2. Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.

3. Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Health, including payment structure.

4. Choose a qualified contracted primary care physician and contracted hospital.

5. Know the names and qualifications of physicians and health care professionals involved in your medical treatment.

6. Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.

7. Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.

8. Enrollees have a right to receive a second opinion on a medical procedure from an in-plan Provider and have Fallon pay for the second opinion consultation. Ask your Primary Care Physician to refer you to an in network contracted provider for a second opinion consultation. Prior approval from Fallon is required when a second medical opinion is being requested to a provider who is not part of the Fallon provider network.

9. Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.

10. Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.

11. Be treated with dignity and respect, and to have your privacy recognized.

12. Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal

health information (there may be a fee for photocopies).

13. Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.

14. If your grievance involved an adverse determination, and you are not satisfied with our final decision, you have the right to file an external review.

15. You may obtain the forms you need to file for an external review by calling the Department of Public Health Office of Patient Protection at 800-436-7757 or by accessing their website at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection/.

16. Federal employees may ask the United States Office of Personnel Management for an external review by writing to:
United States Office of Personnel Management
Insurance Services Programs, Health Insurance Group 3
1900 E. Street, NW
Washington, DC 20415-3630

17. Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Health and its contracted providers.

18. Make recommendations regarding Fallon Health's members' rights and responsibilities policies.

Member responsibilities

As a Fallon Health member, you have the responsibility to:

- Provide, to the extent possible, information that Fallon Health, your physician or other care providers need in order to care for you.
- Do your part to improve your own health condition by following treatment plan, instruction and care that you have agreed on with your physician(s).
- Understand your health problems, and participate in developing new and existing, mutually agreed-upon treatment goals to the degree possible.

Provider education

The Statements of Member Rights and Responsibilities are distributed to practitioners in Fallon's Provider Manual and copies are readily available to practitioners upon request.

Fallon does not restrict providers from advising or advocating on their patients' behalf.

Member education

The Statements of Rights and Responsibilities are distributed to new and existing members in Fallon's Evidence of Coverage manual, member newsletter and website, and copies are readily available to members upon request.

Fallon recognizes the specific needs of members and maintains a mutually respectful relationship with members.

Review and revisions

The Statements of Rights and Responsibilities are revised when necessary to fulfill requirements of CMS, the state's statutes, or to satisfy public concern in specific issues.

Review and revisions to the Statements are the responsibility of Fallon's Quality Programs Department to ensure compliance with external regulatory agencies and comply with Fallon's policy regarding Member Rights and Responsibilities.

Fallon notifies members upon enrollment and annually thereafter regarding their Rights and Responsibilities through the member newsletter.

Your rights and responsibilities: Fallon Preferred Care members

As a Fallon Preferred Care member, you have the right to:

- Be informed about Fallon Preferred Care and covered services.
- Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Preferred Care, including payment structure.
- Your choice of practitioners and hospitals.
- Know the names and qualifications of participating physicians and health care professionals involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.
- Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
- Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
- Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.
- Be treated with dignity and respect, and to have your privacy recognized.
- Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information. (There may be a fee for photocopies.)
- Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Preferred Care and its participating providers.
- Make recommendations regarding Fallon Preferred Care's member rights and responsibilities policies.

Member responsibilities

As a Fallon Preferred Care member, you have the responsibility to:

- Provide, to the extent possible, information that Fallon Preferred Care, your physician or other care providers need in order to care for you.
- Do your part to improve your own health condition by following any treatment plan, instruction and care that you have agreed on with your physician(s).
- Understand your health problems, and participate in developing new and existing mutually agreed-upon treatment goals to the degree possible.

For answers to questions

About your rights or responsibilities as a member of Fallon Health & Life Assurance Company:

Fallon Health & Life Assurance Company
10 Chestnut St.
Worcester, Massachusetts 01608
www.fchp.org
Toll-free phone: 888-468-1541
TDD/TTY: 877-608-7677

About your rights as a consumer:

Commonwealth of Massachusetts Department of Public Health Office of Patient Protection
Toll-free phone: 800-436-7757
Fax: 617-624-5046
Internet: www.state.ma.us/dph/opp

About a Massachusetts physician (including physician profiling information):

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Ave.
Suite G4
Boston, Massachusetts 02118
Phone: 1-617-654-9800

About a Massachusetts hospital:

Commonwealth of Massachusetts
Department of Public Health Division of Health Care Quality
10 West St.
Fifth floor
Boston, Massachusetts 02111
Phone: 1-617-753-8000

About Massachusetts nurses, dentists, chiropractors and other nonphysician health professionals:

Commonwealth of Massachusetts Office of Consumer Affairs/Business Regulation
Division of Registration
239 Causeway St.
Fifth floor
Boston, Massachusetts 02114
Phone: 1-617-727-7406

Out-of-area care

When out of area, in the case of urgently needed care that is not life-threatening, the member is instructed to seek care at the nearest medical facility if he or she is outside of their plan service area and to call Fallon Health as soon as medically possible.

Your rights and responsibilities as a Fallon MassHealth member

As a Fallon Health MassHealth member, you have the right to:

☐ Receive information about Fallon Health, its covered services, its health care providers, and members' rights and responsibilities.

☐ Be treated with dignity and respect and to have your privacy recognized.

☐ Be actively involved in decisions regarding your own health and treatment options, including the right to refuse treatment.

☐ Openly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a way that you can understand and that is appropriate to your condition.

☐ Enrollees have a right to receive a second opinion on a medical procedure from an in-plan provider and have Fallon pay for the second opinion consultation. Ask your Primary Care Physician to refer you to an in network contracted provider for a second opinion consultation. Prior approval from Fallon is required when a second medical opinion is being requested to a provider who is not part of the Fallon provider network.

☐ Members have a right to receive member materials in prevalent languages and in alternative formats, upon request.

☐ File Grievances and Appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.

☐ Make recommendations regarding Fallon Health's member rights and responsibilities policies.

☐ Be informed about how medical treatment decisions are made by Fallon Health or by providers that accept Fallon Health members, including payment structure.

☐ Choose a qualified primary care provider and hospital that accept Fallon Health members.

☐ Know the names and qualifications of physicians and health care professionals involved in your medical treatment.

☐ Receive information about an illness, the course of treatment and expectations for recovery in words that you can understand.

☐ Receive emergency services when you, as a non-health care professional, would have believed that an emergency medical condition existed.

☐ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

☐ Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information throughout Fallon Health. Unauthorized people do not see or change your records.

☐ Review and get a copy of certain personal health information. (There may be a fee for photocopies.) You also have the right to request that your medical records be changed or corrected.

☐Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual

health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Health and the providers who accept Fallon Health members.

☐ Receive the covered services in accordance with how they are described in the *Covered and Excluded Services List* insert of this *Member Handbook.*

Mental Health Parity:

Federal and state laws require that all managed care organizations, including Fallon Health (Fallon) provide behavioral health services to MassHealth members in the same way they provide physical health services. This is what is referred to as "parity". In general, this means that:
1. Fallon must provide the same level of benefits for any mental health and substance abuse problems you may have as for other physical problems you may have;
2. Fallon must have similar prior authorization requirements and treatment limitations for mental health and substance abuse services as it does for physical health services;
3. Fallon must provide you or your provider with the medical necessity criteria used by (insert Plan name) for prior authorization upon your or your provider's request; and
4. Fallon must also provide you within a reasonable time frame the reason for any denial of authorization for mental or substance abuse services.

If you think that Fallon is not providing parity as explained above, you have the right to file a Grievance with Fallon. For more information about Grievances and how to file them, please see page 35 of your *Member Handbook*.
You may also file a grievance with MassHealth. You can do this by calling the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648) Monday – Friday, 8:00 a.m. to 5:00 p.m. For more information, please see 130 CMR 450.117(J). Division of Medical Assistance Manual at www.mass.gov.

Member responsibilities

As a Fallon Health member, you have the responsibility to:

☐ Provide, to the extent possible, information that Fallon Health, your PCP or other health care providers need in order to care for you.

☐ Do your part to improve your own health condition by following the treatment plan, instructions and care that you have agreed to with your provider(s).

☐ Understand your health problems, and participate in developing new and existing treatment goals that you and your provider(s) agree to, as much as you possibly can.

If you have questions regarding care provided by a Fallon healthcare provider or physician profiling information, please contact:

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01881
Phone: 1-781-876-8200
Fax: 1-781-876-8383
mass.gov/medboard