

# Member appeals and grievances

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# Member appeals and grievances

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## 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 and for Fallon Health MassHealth ACO members 1-800-341-4848. TDD/TTY access for those who are hearing impaired is 1-877-608-7677. The Customer Service Department assists customers with routine inquiries such as questions regarding benefits, ID card requests and PCP selections.

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 ACO members, call Fallon Health MassHealth ACO 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 866-275-324, prompt 3, 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.

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

*Please note that the information contained in this section is a brief description of the member appeal process. The information and process is subject to change based on regulatory updates and changes. Once an appeal is filed, a more detailed description is provided to the appellant.*

## **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. Members should refer to plan specific documents such as the Member Handbook and Evidence of Coverage for complete information. In the following sections, 'you' or 'he/she' is referring to the Member.

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## Commercial member appeals and grievances procedures

### ***Filing an appeal: internal appeal review***

If the member disagrees with an adverse determination about coverage related to care, he/she may file an appeal. An appeal is a request to change a previous decision made by Fallon. The member may file the appeal, or with the completion of the appropriate authorization form, may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. The member must file an appeal within 180 calendar days from when he/she received the written denial.

If the member files an appeal, be sure to give us all of the following information:

- The member's name
- The Fallon identification number
- The facts of the request
- The outcome that you are seeking
- The name of any representative with whom you have spoken

The member can file an appeal in any of the following ways:

**Write:** Fallon Health Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608

**Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) or at [www.fallonhealth.org](http://www.fallonhealth.org). 24 Call: 1-800-333-2535, ext. 69950 (TRS 711) Monday through Friday, 8:00 a.m. to 5:00 p.m.

**E-mail:** [grievance@fallonhealth.org](mailto:grievance@fallonhealth.org)

**Fax:** 1-508-755-7393

**In person:** Fallon Health Member Appeals and Grievances Department  
10 Chestnut St. Worcester, MA 01608

If you send us a written or electronic appeal, we will acknowledge your request in writing within 15 business days from the date we receive the request, unless you and the plan both agree in writing to waive or extend this time period. We will put an oral appeal made by you or your authorized representative in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you, unless you and the plan both agree in writing to waive or extend this time period. We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. If the appeal followed from an unresolved inquiry, the 30-day period will start three business days from the date Fallon received the inquiry or on the day you advise us that you are not satisfied with the results of your inquiry, whichever comes first.

These time limits may be waived or extended if you and the plan both agree in writing to the change. This agreement must note the length of the extension, which can be up to 30 days from the date of the agreement. You have the right to provide any additional information, including evidence and allegations of fact or law, in support of your appeal.

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This may be done in person or in writing. Any new information received by Fallon during the course of the appeal may be sent to you for review. At any point before or during the appeal process, you may examine your case file, which may include medical records or any other documentation and records considered during the appeals process. In some cases, Fallon will need medical records to complete our review of your appeal. If we do, we may ask you to sign a form to authorize your provider to release the records to us. If you do not send this form within 30 calendar days from receipt of your appeal, Fallon will complete the review based on the information that we do have, without the medical records. Your appeal will be reviewed by individuals who are knowledgeable about the matters at issue in the appeal. If your appeal is about an adverse determination, the reviewer will be an individual who did not participate in any of the plan's prior decisions on the issue. The reviewer will consult with a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal. If the subject matter of the internal review involves the termination of ongoing services, the disputed coverage or treatment shall remain in effect at our expense through completion of the internal appeal process regardless of the final appeal decision. The appeal must be filed on a timely basis, based on the course of treatment. This includes only that medical care that, at the time it was initiated, was authorized by Fallon. It does not include medical care that was terminated due to a specific exclusion in your benefits. Our response will describe the specific information we considered as well as an explanation for the decision.

If the appeal is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative treatment options as appropriate; clinical guidelines or criteria used to make the decision; and your right to request external review and the process for doing so. Opportunity for reconsideration If relevant information was received too late, or is expected to become available within a reasonable time period, for internal review, you may ask for a reconsideration of a final adverse determination. In this case, Fallon would agree in writing to a new time period for review. This would not be longer than 30 days from the date Fallon agrees to the reconsideration.

## ***Expedited review***

The member can request an expedited (fast) review either orally or in writing concerning coverage for immediate and urgently needed services.

- 1. Inpatient admission:** During your inpatient admission and prior to discharge, a written decision will be provided to you. If the expedited review results in a denial of coverage regarding the continuation of inpatient care, you will have the opportunity to request an expedited external review and the opportunity to request continuation of services through the external review process available through the Office of Patient Protection (OPP).
- 2. Immediate and urgent services:** You will receive a written determination within 48 hours, if your treating physician certifies that the treatment or proposed treatment is:
  - a. Medically necessary;
  - b. A denial of coverage for the services would create a substantial risk of serious harm to you; and
  - c. Such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process. If the expedited review process results in an adverse determination, you

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will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

- 3. Durable medical equipment:** You will receive a written determination within less than 48 hours, if your physician: a. Certifies that this equipment is medically necessary; b. Certifies that the denial of the equipment would create a substantial risk of serious harm; c. Certifies that such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process; d. Describes the specific immediate and severe harm if no action is taken within the 48 hour time period; and e. Specifies a reasonable time period in which Fallon must respond.

If the expedited review process results in an adverse determination, you (member) will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services. In the specific instances noted above, you will receive a response within 48 hours. In all other expedited reviews, you will receive a response within 72 hours of receipt of your request.

### ***Expedited review for terminally ill members***

If the member is terminally ill, he/she can request an expedited review of the appeal. A determination will be provided within five business days from receipt of an appeal request, and will include the specific medical and scientific reasons for denying coverage or treatment, along with information on any covered alternative treatments, services or supplies. If the request for coverage or treatment is denied, the member may request and attend a conference at Fallon, for further review. The conference will be scheduled within 10 days of receiving your request unless your treating physician determines, after discussion with the Fallon Medical Director or designee, that an immediate conference is necessary. In that case, the conference will be held within five business days. The member may participate at the conference in person or via telephone; however, member attendance is not required. If the conference results in a final adverse determination, the member may request an expedited external review through the Office of Patient Protection.

If the appeal involves the termination of ongoing coverage or treatment, this coverage or treatment will continue at the plan's expense until we complete our review, regardless of the final decision. Inquiries, appeals and grievances Questions? Contact Customer Service at 1-800-868-5200 (TRS 711) or at [www.fallonhealth.org](http://www.fallonhealth.org).

### ***Filing an appeal: external appeal review***

An external appeal is a request for an independent review of the final decision made by Fallon through its internal appeal process. If the appeal involved an adverse determination, and you (member) are not satisfied with our final decision, you have the right to file the case with an external review agency. You must request this in writing within four months from receiving the written notice of the final adverse determination. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. You must file this

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request by the end of the second business day after receiving the final adverse determination. If the external review agency finds that termination of services would cause you substantial harm, they may order continuation of coverage at our expense, regardless of the final external review determination. In any case where we fail to meet our internal timelines, you have the right to file an external review, even if you have not yet exhausted our internal appeals process. Expedited external review You may request an expedited (fast) external review. In this case you must submit a written certification from your 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 your health.

You must file your request for external review or expedited external review with: Health Policy Commission Office of Patient Protection 50 Milk Street, 8th Floor Boston, MA 02109 For more information about this process, or to file an external review, please contact OPP at 1-800-436-7757 ([www.mass.gov/hpc/opp](http://www.mass.gov/hpc/opp)) Fax: 1-617-624-5046.

Your request should:

- Be on the form determined by the Office of Patient Protection
- Include your signature or your authorized representative's signature • Include a copy of the written final adverse determination made by Fallon
- Include the \$25 fee required.

The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the member. You may file an expedited external review even if you have not received a decision through our internal appeals process.

## ***Filing a grievance***

A grievance is the type of complaint you make if you have any other type of problem with Fallon Health or one of our plan providers. You would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. If you have a grievance, our Member Appeals and Grievances coordinators are available to assist you in accordance with your rights and in confidence.

You can file a grievance in any of the following ways:

**Write:** Fallon Health Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608

**Call:** 1-800-333-2535, ext.69950 (TRS 711) Monday through Friday, 8:00 a.m. to 5:00 p.m. E-mail: [grievance@fallonhealth.org](mailto:grievance@fallonhealth.org)

**Fax:** 1-508-755-7393 Walk-in: Fallon Health Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608

You may file the grievance yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your grievance within 180 calendar days.

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If you (member) file a grievance, be sure to provide all of the following information:

- Member name
- Member identification number
- Facts of the request
- Outcome that you are seeking
- Name of any representative with whom you have spoken

A Member Appeals and Grievances Coordinator will acknowledge your oral grievance within 24 to 48 hours of receipt. Written grievances will be acknowledged within 15 calendar days of receipt. We will contact you within 30 business days of receiving your grievance to discuss a possible resolution of your concern. Failure to meet time limits If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan.

ERISA If you are a participant or a beneficiary of an employee welfare benefit plan under ERISA (Employee Retirement Income Security Act of 1974), you may have a right to bring a civil action under ERISA section 502(a) following an adverse benefit determination. Please see your Summary Plan Description provided by your employer for a complete statement of your rights.

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## Fallon Medicare Plus members

### ***Making an appeal***

If we make a coverage decision and you (member) are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.)

### ***How to get help when you are asking for a coverage decision or making an appeal***

Would you like some help?

Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call us at Customer Service
- You can get free help from your State Health Insurance Assistance Program
- Your doctor can make a request for you.

For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf.

Generally we use the standard deadlines for giving you our decision. When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines.

### ***Standard coverage decision***

A standard coverage decision means we will give you (member) an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request. However, for a request for a medical item or service we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug. If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals.)

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## ***Fast coverage decision***

If your health requires it, ask us to give you a “fast coverage decision”

- A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours. However, for a request for a medical item or service we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug. If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. We will call you as soon as we make the decision.
- To get a fast coverage decision, you must meet two requirements: You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.) You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision. If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead). This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision. The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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## Fallon Health MassHealth Accountable Care Organization (ACO) members

How to file complaints, compliments, inquiries, grievances and appeals

- **Fallon Health Customer Service:** 1-855-203-4660 (TRS 711) Monday through Friday, 8 a.m. to 6 p.m.
- **Beacon Health Options Customer Service:** 1-888-877-7184 (TDD/TTY: 1-781-994-7660) 24 hours a day, seven days a week.
- **MassHealth Customer Service:** 1-800-841-2900 (TTY: 1-800-497-4648) Monday through Friday, 8 a.m. to 5 p.m.

### ***Filing a grievance***

The member has the right to file a Grievance if he/she is not satisfied with an action or inaction taken by Fallon other than Adverse Actions (see below under Appeals for examples of Adverse Actions), which entitle you to file an Appeal.

Examples of Grievances that are appropriate to file include:

- Dissatisfaction with the quality of care or service you have received,
- Dissatisfaction with Fallon Care operations,
- Lack of courtesy by health care providers,
- Failure of health care providers to respect your rights,
- Your disagreement with Fallon's decision to extend the timelines for making an authorization decision or a standard or an expedited (fast) Internal Appeal decision, or
- Your disagreement with Fallon's disapproval of your request for an expedited (fast) Internal Appeal.

When you have a Grievance, our representatives are available to help you. You may discuss your Grievance in person with a representative at our office, or you may call:

- Fallon's Customer Service Department at 1-855-508-3390 (TRS 711), Monday through Friday from 8 a.m. to 6 p.m.
- Fallon's Member Appeals and Grievances Department at 1-800-333-2535 (TRS 711), Monday through Friday from 8:00 a.m. to 5:00 p.m. If you prefer to send a written Grievance to the Member Appeals and Grievances Department, include all details about the Grievance, any pertinent dates and, if applicable, names of providers from whom you have received your care.

### ***Appeals***

Fallon provides its MassHealth members with one level of standard or expedited (fast) Internal Appeal review. You, or you authorized Appeal Representative have the right to file an Internal Appeal if you disagree with one of the following actions or inactions by Fallon:

- Fallon denied or decided to provide limited authorization for a service requested by your health care provider.
- Fallon reduced, suspended or terminated a service covered by Fallon that Fallon previously authorized.
- Fallon denied, in whole or in part, payment for a Fallon covered service due to service coverage issues.

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- Fallon did not decide a standard or expedited (fast) service authorization request within the required timeframes.
- Please refer to the Making authorization decisions section of this Member Handbook for more information on authorization time frames.
- You were unable to obtain health care services within the time frames described in the How long should you wait to see a doctor section of the Member Handbook.

You may file an Internal Appeal over the telephone, in writing, in person or via e-mail. You can:

1. **Call Fallon's Member Appeals and Grievances Department at:** 1-800-333-2535 (TRS 711), Monday through Friday from 8:00 a.m. to 5:00 p.m.
2. **Send a letter describing your request to:** Fallon Health Attn: Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608
3. **Present your 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
4. **Send an email to:** [grievance@fallonhealth.org](mailto:grievance@fallonhealth.org)

Once the request for an Internal Appeal is received, an acknowledgement letter is issued within one business day to you or to your authorized Appeal Representative. When you file an internal appeal, be sure to include:

1. Your name.
2. Your plan identification number (located on your member ID card).
3. The facts of your request. This information must be received by Fallon prior to the review of the Appeal. Also, you can present evidence and allegation of fact or law in person or in writing during the Appeals process.
4. Information about the outcome that you want.
5. The name of any Fallon representative that you have talked to.
6. If you think your condition requires an expedited (fast) Appeal as described in the How to file complaints, compliments, inquiries, grievances and appeals section of this Member Handbook, write or mention that you would like to request a 'fast' Appeal.

To ask for help with any of the Appeal process options, call the Fallon 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 Customer Service Department at 1-855-203-4660 (TTY users please call TRS Relay 711), Monday through Friday from 8 a.m. to 6 p.m. It's a good idea to fully review the Covered and Excluded Services List insert included with this Member Handbook prior to filing an Internal Appeal so that you will be aware of what is and what is not a covered service. If you need help with understanding your benefits, please call the Fallon Customer Service Department at the phone number listed above.

Remember that, if necessary, Fallon can assist you with interpreter services during the Internal Appeal process. You may file the appeal:

- On your own behalf; or
- By giving someone you trust (family member, friend, etc.) written permission to act on your behalf.

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If you choose to give someone you trust permission to act on your behalf during the Internal Appeal, Fallon requires you to sign and return a Personal Representative Authorization form. This person is referred to as your authorized Appeal Representative. If you choose to have your physician or treating provider file an expedited appeal on your behalf, written authorization is not required. To obtain the Personal Representative Authorization form, call the Fallon 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 Customer Service Department at 1-855-203-4660 (TRS 711), Monday through Friday from 8 a.m. to 6 p.m. If Fallon does not receive this form by the time that the deadlines expire for resolving your Internal Appeal, Fallon will notify you in writing that your Appeal has been dismissed.

If you believe that you or your authorized Appeal Representative did in fact submit the Personal Representative Authorization form within the Internal Appeal deadlines, you can request that the dismissal be reversed by sending a letter to Fallon within ten (10) calendar days of the dismissal. Fallon will consider your request and will decide either to reverse the dismissal and continue with your Appeal or will uphold its dismissal. Fallon will notify you of this decision in writing. If Fallon upholds your dismissal, the dismissal will become final. If you disagree with this decision, you can Appeal to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH).

## **Option 1: filing a standard or expedited (fast) internal appeal**

### *Steps to take to file a standard internal appeal*

You or your authorized Appeal Representative may file a standard or expedited (fast) Internal Appeal within thirty (30) calendar days of Fallon's notice to you telling you about any action or inaction that entitles you to an Appeal. But, if you did not receive such a notice, your Internal Appeal request must be filed within thirty (30) calendar days of learning on your own about Fallon's actions or inactions described above. If applicable, you can choose to continue receiving requested services from Fallon during the Internal Appeal process, but if you lose the Appeal, you may have to pay MassHealth back for the cost of these services.

If you want to receive such continuing services, you or your authorized Appeal Representative must submit your Internal Appeal request within ten (10) calendar days from the date of the letter notifying you of the denial (or, if you did not receive a denial notice, ten (10) calendar days from the date of the action or inaction) and indicate that you want to continue to get these services. If your Internal Appeal request is received more than thirty(30) calendar days after the denial letter notifying you of the action you are appealing (or, if you did not receive a denial notice thirty (30) calendar days from the date you learned of the action or inaction), Fallon will dismiss your Internal Appeal and will notify you in writing that your Appeal has been dismissed.

If you believe that you did in fact submit your Internal Appeal within the deadlines, you can request that the dismissal be reversed by sending a letter to Fallon within ten (10) calendar days of the dismissal. Fallon will consider your request and will decide either to reverse the dismissal and continue with your Appeal or will uphold its dismissal. Fallon will notify you of this decision in writing. If Fallon upholds your dismissal, the dismissal will become final. If you disagree with this decision, you can Appeal to the Executive Office of Health and

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Human Services, Office of Medicaid's Board of Hearings (BOH) (see Option 2). How the standard internal appeal process works. We will process your Appeal as quickly as your health requires and will notify you of our decision no later than thirty (30) calendar days from the date your standard Internal Appeal request is received.

1. If you want to send us more information regarding your Appeal, you or your authorized Appeal Representative may request an extension of up to fourteen (14) calendar days so you have more time to obtain your information.
2. Fallon may also take an extension of up to fourteen (14) calendar days to obtain necessary information.

Please note that Fallon can only request an extension if:

- The extension is in your best interest.
- Fallon needs additional information that we believe, if we receive it, will lead to approval of your request.
- Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

If you do not agree with the extension taken by Fallon, you may file a Grievance. For more information about Grievances, refer to the Grievances section described above. If you are not satisfied with the outcome of your standard internal appeal, you may:

1. Proceed to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH) for further Appeal (see Option 2). How to request an expedited (fast) internal appeal You or your authorized Appeal Representative can request an expedited (fast) Internal Appeal if you or your Appeal Representative feel that the thirty (30) calendar day time frame for a standard resolution could seriously jeopardize your life, health or your ability to get, maintain or regain maximum function.

If your request for an expedited (fast) Internal Appeal is filed by your provider acting as your authorized Appeal Representative, or if your provider supports your request for an expedited (fast) Internal Appeal, then the request that your Appeal be expedited will be approved unless it is unrelated to your health status. Otherwise, Fallon has the right to determine whether or not to process the Appeal as an expedited (fast) Internal Appeal. Punitive action is not taken against a provider who requests an expedited appeal or supports a member's appeal. If applicable, you can choose to continue receiving requested services from Fallon during the Internal Appeal process, but if you lose the Appeal, you may have to pay MassHealth back for the cost of these services.

If you want to receive such continuing services, you or your authorized Appeal Representative must submit your Internal Appeal request within ten (10) calendar days from the date of the letter notifying you of the denial (or, if you did not receive a denial notice, ten (10) calendar days from the date of the action or inaction) and indicate that you want to continue to get these services.

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If you want to request an expedited (fast) Internal Appeal and if the Appeal does not apply to denials of payment:

1. File your Appeal over the telephone, in writing, in person or via e-mail.
2. Make sure you are clear in your request by stating, “I want a fast Appeal,” or “I believe that my health could be seriously harmed by waiting 30 calendar days for a normal Appeal.”

## ***How the expedited (fast) internal appeal process works***

If you meet the qualifications for an expedited (fast) Internal Appeal, Fallon will process your Appeal request and attempt to let you know our decision orally, and in writing, as quickly as your health requires, but not later than 72 hours from when we received your request.

Getting an expedited (fast) internal appeal extension:

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

If you do not agree with the extension taken by Fallon, you or your authorized Appeal Representative may file a Grievance. For more information about Grievances, refer to the Grievances section described above. If your request does not qualify for an expedited (fast) internal appeal:

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

If you are not satisfied with the outcome of your expedited (fast) internal appeal, you may: If you would like your Appeal to be treated as an expedited (fast) Appeal at the Executive Office of Health and Human Services, Office of Medicaid’s Board of Hearings (BOH) (see Option 2), you should request your Appeal within twenty (20) calendar days. Requests received between days 21 and 30 will be treated as a standard Appeal by the BOH.

## **Option 2: request a hearing for a board of hearings appeal**

### *Steps to take*

You or your 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:

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1. You are dissatisfied with the Fallon's expedited (fast) Internal Appeal determination;
2. You are dissatisfied with the Fallon first-level standard Internal Appeal; or
3. If Fallon did not resolve your first level standard Internal Appeal, or did not resolve your expedited (fast) Internal Appeal within three (3) calendar days (or within fourteen (14) extra calendar days if there is an extension).

To do so, you need to complete the Fair Hearing Request form which you 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 100 Hancock St., Sixth floor Quincy, MA 02171 Or fax to 1-617-847-1204 You must file your Fair Hearing Request Form within 120 calendar days of Fallon's decision resolving your Internal Appeal unless you are requesting an expedited (fast) BOH appeal, as described below.

To ask for help with any of the Appeal process options, call the Fallon Member Appeals and Grievances Department at 1-800-333-2535 (TTY users please call TRS Relay 711). Board of hearings: expedited (fast) internal appeal If your Appeal was an expedited (fast) Internal Appeal and you want BOH to make an expedited (fast) decision too, you or your authorized Appeal Representative must request a BOH Appeal within twenty (20) calendar days of Fallon's decision resolving your expedited (fast) Internal Appeal. If BOH receives your request between days twenty-one (21) and one-hundred and twenty (120), your Appeal will be processed as a standard Appeal. You tell the BOH that you want a fast appeal by checking the appropriate space on the BOH form.

### ***How to receive continuing services***

If you want to receive continuing coverage of previously authorized services through the outcome of the BOH Appeal, your appeals request must be received by the BOH within ten (10) calendar days of Fallon's decision resolving your Internal Appeal. You also have the option of withdrawing your request for services. If you choose to receive continuing services through your Appeal and if the BOH upholds Fallon's original denial, you may be responsible for paying MassHealth back for the cost of the continuing services.

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## **Navicare HMO SNP members appeals and grievances rights**

### ***Making an appeal – Level 1***

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you appeal a decision for the first time, this is called a Level 1 Appeal.

In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, the member can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

Your doctor or other health care provider can make a request for you. For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 Appeal on your behalf.

If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf. To request any appeal after Level 2, you must name your doctor as your representative to act on your behalf. For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, you must name your doctor or other prescriber as your representative.

### ***Level 2***

If we say no to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare or MassHealth (Medicaid) or could be covered by both.

- If your problem is about a service or item that is usually covered by Medicare, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that is usually covered by MassHealth (Medicaid), you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be covered by both Medicare and MassHealth (Medicaid), you will automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

What to do if you have a problem or complaint (coverage decisions, appeals, complaints). If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to member handbook for information about continuing your benefits during Level 1 Appeals.

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- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that is usually covered by MassHealth (Medicaid), your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan's decision letter.

## ***Filing a Level 2 Appeal - MassHealth (Medicaid) Appeal***

If we say no to your Level 1 Appeal about a MassHealth Standard (Medicaid)-covered benefit, you may pursue an independent review by the MassHealth (Medicaid) Board of Hearings (BOH).

During the Level 2 Appeal, the BOH reviews our decision for your first appeal. They decide whether the decision we made should be changed.

**Step 1:** To make a Level 2 MassHealth (Medicaid) Appeal, you (or your representative or your doctor or other prescriber) must contact the Board of Hearings and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the BOH. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the BOH.
- If you choose to pursue an external appeal, you must submit your written hearing request to BOH within 120 calendar days from the date of mailing of the NaviCare SCO denial notice (or in the event that the plan did not resolve your appeal in a timely fashion, within 120 days of the date on which the plan's time frame for resolving that appeal has expired).

Our Member Appeals and Grievances may assist you with this process, but it is your (or your representative's) responsibility to submit the request and to do it within 120 calendar days from the date we mailed the denial notice. Hearing requests should be sent to: Executive Office of Health and Human Services Board of Hearings Office of Medicaid 100 Hancock Street, 6th floor Quincy, MA 02171 Or fax to 1-617-847-1204.

## ***Standard and fast deadlines***

Generally, we use the standard deadlines for giving you our decision. When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request for a medical item or service.

If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- For a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network health care providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) If your health requires it, ask us to give you a “fast coverage decision”
- A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours. o For a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network health care providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug. o If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints. We will call you as soon as we make the decision.
- To get a fast coverage decision, you must meet two requirements:
  1. You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.) o
  2. You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision. If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead). This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision. o The letter will also tell you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

## ***Filing a grievance***

How to make a complaint about quality of care, waiting times, customer service, or other concerns.

**Step 1:** Contact us promptly – either by phone or in writing.

- Usually, calling Enrollee Services is the first step. If there is anything else you need to do, Enrollee Services will let you know. Our Enrollee Services

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phone number is 1-877- 700-6996 (TRS 711). Hours are Monday–Friday, 8 a.m.–8 p.m. (Oct. 1–March 31, seven days a week).

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- To use the grievance procedure, you may file your grievance orally or in writing. Send your written grievance to Fallon Health Member Appeals and Grievances, 10 Chestnut St., Worcester, MA 01608. For oral grievances, call Fallon Health at 1-800-325-5669 (TRS 711), Monday–Friday, 8 a.m.–8 p.m. (Oct. 1–March 31, seven days a week) and ask them to file a grievance for you.

“Expedited” (“fast”) grievance requests can be made and are processed 24 hours a day, seven days a week by leaving a voice message at this number. You can also fax your grievance request to 1-508-755-7393. The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint.

We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. Whether you call or write, you should contact Enrollee Services right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.