Fallon Health Weinberg

Managed Long Term Care Plan Provider Manual

Table of Contents

Hours of Operation

Monday through Friday
8:30 a.m. to 5:00 p.m.

Contact Numbers

Fallon Health Customer Service	1-866-882-8185
Provider Relations Manager, Provider Relations	1 -855-827-2003 or 1-716-810-1893
Eligibility, Prior Authorizations and Benefits	1 -855-827-2003

FALLON HEALTH WEINBERG OVERVIEW

Fallon Health Weinberg is a New York State authorized and approved partially capitated Managed Long Term Care Program (MLTCP) established to coordinate healthcare services for chronically ill individuals 21 and older wishing to remain in their own home and communities as long as possible.

Each member's healthcare needs, both covered and non-covered, are coordinated by an assigned Care Manager in collaboration with Fallon Health Weinberg Participating Providers.

The services provided to individuals enrolled in Fallon Health Weinberg are considered to be Medicaid benefits.

Eligibility Criteria

To be enrolled in Fallon Health Weinberg members must meet the following eligibility criteria:

- Age 21 or older
- Live in Erie or Niagara County
- Be eligible for Medicaid
- Health care needs can be safely met in the home
- Determined eligible for MLTC using an eligibility assessment tool designated by New York State
- Require long term services for more than120 days from the date of enrollment

Service Area

Fallon Health Weinberg offers its benefit plan within Erie and Niagara Counties.

Fallon Health Weinberg Covered Services/Benefits

Fallon Health Weinberg Medicaid Benefits are community based services that would otherwise be covered in whole or part by Medicaid. These services are listed below:

Adult Day Health Care
Social Day Care including Medical Day Care
Hearing exams and hearing aides (including hearing aide batteries)
Home Health Care Services (Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Services, and Private Duty Nursing)
Personal Care
Chore Service and Housekeeping
Dental care
Durable Medical Equipment Medical and Surgical Supplies Meals (Home/Congregate)
Non-Emergency Transportation
Skilled Nursing Facility
Nutritional Counseling
Eye exams and Glasses
Rehabilitation therapies (PT, OT, ST) provided in settings other than the home
Podiatry

Personal Emergency Response System (PERS) Prosthetics/Orthotics
Respiratory Therapy and Oxygen
Social and Environmental Supports needed to safeguard health
Social Work Services
Consumer Directed Personal Assistance Program

There are no cost-sharing expenses for Fallon Health Weinberg members, including deductibles or copayments.

For more information, please call Fallon Health Weinberg Provider Relations at 1-855-827-2003 Monday through Friday, between 8:30 a.m. and 5:00 p.m.

Fallon Health Weinberg is always secondary payer to Medicare and other third party payers.

Fallon Health Weinberg Non-Covered Services

Services that a Fallon Health Weinberg member may require that are not covered by Fallon Health Weinberg but are billed directly by the provider to Medicaid, Medicare, or other third party payer may be included in the member's Fallon Health Weinberg Service Plan of Care and coordinated by the Care Manager in collaboration with the primary care physician and other providers involved in the member's care.

Non-covered services include:

- Physician Services
- Inpatient Hospital Stay
- Laboratory Services
- Imaging and Nuclear Medicine Services
- Emergency Transportation
- Chronic Renal Dialysis
- Hospice Services
- Alcohol and Substance Abuse Services
- Family Planning Services
- Prescription & Non Prescription Medications

Non-covered Mental Heath services include:

- Methadone maintenance treatment
- Intensive psychiatric rehabilitation treatment programs
- Day treatment

- Continuing day treatment
- Case management for seriously and persistently mentally ill
- Partial hospitalizations
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Rehabilitation services provided to residents of OMH Licensed Community Residences and Family Based Treatment Programs

Office of Mental Retardation and Developmental Disabilities (OMRDD) Services

AIDS Adult Day Health Care

If you have questions regarding eligible services, please call Provider Relations at 1-855-827-2003.

The Role of Fallon Health Weinberg Care Management

Care Manager/Interdisciplinary Team

Each member is assigned to a Care Manager/Interdisciplinary Team that will include health care professionals (nurses, social workers, and other professionals as appropriate) who have ongoing responsibility for coordinating, managing and authorizing all aspects of the delivery of care and services to members.

As the primary coordinator of care, the Care Manager's responsibilities include:

- Authorization and implementation of covered services outlined in the member's service plan
- Monitoring of all services for quality and effectiveness
- Integration of feedback, observations, and recommendations of other professionals involved in managing the care to the member, including network
- Coordinating care with the primary care physician, specialists and other providers of covered and non-covered services
- Assists in discharge planning from hospitals and nursing homes

Member Service Representative

Member service staff serves as liaison between the member and Care Manager, and assist the care management team by providing information about Fallon Health Weinberg policies, available services, and network providers to members; making and confirming service arrangements, issuing authorizations as directed by the Care Manager, and by answering questions and resolving problems presented by members and providers, as appropriate.

Coordination of Care and Provider Responsibilities

Fallon Health Weinberg is a New York State Managed Long Term Care program, responsible for providing long-term care and health services to its members. Because intensive care coordination and management is critical to the health and well-being of its membership, Fallon Health Weinberg participating providers agree, through the Fallon Health Weinberg Participating Provider Agreement to fully cooperate with Fallon Health Weinberg care management, even if the episode of care does not result in any payment by Fallon Health Weinberg to the participating provider because the provider's fee is covered entirely by a primary payer, such as Medicare. Specifically, it is not unusual for a Fallon Health Weinberg member to also be Medicare- eligible. In these cases, because Medicaid is always the payer of last resort and Medicare is the primary payer, under the Fallon Health Weinberg coordination of benefits procedure Fallon Health Weinberg may owe no secondary payments to the participating provider. This payment circumstance does not alter the responsibility of participating providers to cooperate with Fallon Health Weinberg care management.

Providers are responsible for effectively communicating with the Care Manager/ Interdisciplinary Team, along with the Member Services staff regardless of primary payer, in order to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, access appropriate reimbursement sources for services, increase continuity of care, and progress toward goal achievement.

As part of its role in managing a member's care, Fallon Health Weinberg authorizes services and provides the following information:

- Member demographics
- Physician information
- Description of requested service
- Clinical status as appropriate

Podiatry, Optometry, Dentistry and Audiology screening services provided by network providers do not require prior authorization; however, the above information must be available upon request. A member may refuse care that has been specified in the member's service plan. Fallon Health Weinberg will not place, or terminate, services that the member refuses after the member, their family, or representative has been fully informed of the health risks and consequences involved in such refusal, and the member, upon being fully informed, continues to refuse care. Providers must notify Fallon Health Weinberg immediately if an authorized or requested service is refused.

All providers are required to:

- Comply with all regulatory and professional standards of practice and are responsible to acquire physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or third party reimbursement. The Care Manager/Interdisciplinary Team may assist in obtaining orders if the provider has been unsuccessful.
- Notify Fallon Health Weinberg immediately whenever there is identification of a clinical issue of serious concern, change in member status, refusal of service, inability to access member's home, or inability to provide service for any reason.
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the member and the member's progress and status.
- Cooperate with Fallon Health Weinberg on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to Fallon Health Weinberg within 10 working days of request.
- Communicate to Fallon Health Weinberg any complaint made by or on behalf of the member.
- Cooperate with Fallon Health Weinberg's quality assurance programs as needed.
- Assure that all provider's employees and agents involved in direct contact with

members carry proper agency identification.

- Notify Fallon Health Weinberg of the provision of any unauthorized urgent services within 48 hours.

In addition, providers of home care services are responsible for:

- Obtaining physician orders.
- Developing the aide care plan for requested services.
- Ensuring that family members of Fallon Health Weinberg enrollees who are HHA/PCA are NOT assigned to handle the care of their family member.
- Notifying member of assigned staff name(s) in advance of care.
- Notify member in advance of need for replacements and name of replacement staff.
- Confirming aide daily attendance.

  To assure the safety of our members, Fallon Health Weinberg recommends that all HOME CARE providers implement an electronic attendance program in addition to other manual random verification. Agencies not utilizing electronic attendance programs must verify attendance daily for all Fallon Health Weinberg members for whom they serve. Agency protocols on aide attendance verification must be available to Fallon Health Weinberg Provider Relations upon request.
- Cooperate fully with Fallon Health Weinberg care management; communicate verbally or in writing regarding the member's progress even if the episode of care does not result in any payment by Fallon Health Weinberg to the participating provider.

Providers of residential health care (RHCF) are responsible for:

Short Term Stay (up to 6 months):

- Determining the type of health insurance coverage the prospective resident has and whether or not the RHCF is authorized to serve the member.
- Submitting progress notes to Fallon Health Weinberg
- Health Care Manager bi-weekly.

- Obtaining authorization for any covered service outside of daily rate.
- Assisting in the Medicaid recertification process.

Long Term Care:

- Determining eligibility for Institutional Medicaid and other Third Party Health Insurance and whether or not the RHCF is authorized to serve the member.
- Submitting Conversion applications for members placed for long term care.
- Identifying the admission as a Managed Long Term Care admission.
- Collecting the NAMI (NAMI will be deducted from payments).
- Submitting Resident Monthly Summaries to the Fallon Health Weinberg Care Manager.
- Including Fallon Health Weinberg Care Manager in care conferences.
- Obtaining authorization for any covered service outside of daily rate.
- Assisting in the Medicaid recertification process.

Note: Fallon Health Weinberg members must be eligible for Institutional Medicaid to remain in a skilled nursing facility for long term care.

Providers of DME and medical supplies are responsible for:

- Verifying primary payor coverage and eligibility prior to delivery.
- Acquiring physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3rd party reimbursement.
- Exhausting all other payment sources prior to billing Fallon Health Weinberg.
- Timely delivery of requested products.

Note: It is the responsibility of the provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the provider does not know if the service or item is covered, the provider must first submit a claim to Medicare, as Fallon Health Weinberg is always the payer of last resort. If the item is normally covered by Medicare but the provider has prior information that

Medicare will not reimburse due to duplicate or excessive deliveries, the information should be documented and communicated to the Fallon Health Weinberg Care Manager prior to delivery.

Providers of transportation are responsible for:

- Arriving within **30 minutes** of requested pick up time.
- Providing **all** requested transportation requests including special needs transports.
- Assuring that all transportation is to medical appointments unless specifically noted in the authorization.
- Notifying Fallon Health Weinberg when a requested trip is to a non-medical destination not noted in the authorization.
- Notifying Fallon Health Weinberg when a member cancels or does not show for a pick up.
- Notifying Fallon Health Weinberg when it is determined, upon arrival, that the driver is unable to transport a member safely.
- Obtaining documentation for **each** trip and providing the following:
    - Member's name and ID number
    - Date of transport
    - Pick-up address and time of pick-up
    - Drop-off address and time of drop-off
    - Vehicle license plate number
    - Full printed name of the driver

Fallon Health Weinberg requires that all Ambulette and Car Service participating providers follow the safety criteria in accordance with the TLC & Safety Emissions of New York when transporting members, including the following securement systems:

- Tie down straps: 4 tie down straps for each wheelchair position.

- Seat belts: A passenger seat belt and shoulder harness shall also be provided for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device which secures the mobility aid itself.

ADDITIONAL TRANSPORTATION REQUIREMENTS:

Each vehicle must be equipped (installed)as follows:

- Body Fluid/Spill Kit Reflector Triangle Kit (3 Triangles)
- First Aid Kit
- Fire Extinguisher

Authorization Requirements

Fallon Health Weinberg requires prior written authorization, except for in network optometry, podiatry, dentistry and audiology. Those services may be self-selected and self-scheduled by the member from the Provider Network for routine visits. Limitations of services are in accordance with Medicaid Management Information Systems (MMIS) guidelines.

The table on the following pages outlines the authorization requirements for Fallon Health Weinberg.

Unless otherwise noted, Fallon Health Weinberg authorizations and prior approvals are obtained from the **Fallon Health Weinberg Care Manager** at 1-855-665-1112

Covered Service	**Authorization/Prior Approval Required**
Adult Day Care	Yes
Ambulance - Emergency	Not Covered
Ambulance Non-emergent, medically necessary via ambulette, ambulance or taxi	Yes
Dental – Basic Services no auth needed, all other dental service requires auth.	Yes

Covered Service	**Authorization/Prior Approval Required**
Diabetes self- monitoring, management training and supplies, including glucose monitors, test strips and lancets.	Yes
Durable Medical Equipment (DME)	Yes
Medical and Surgical Supplies	Yes
Parenteral/Enteral Feeds	Yes
Audiology, Hearing Exams/Hearing Aids	Yes
Home Health Care (CHHA)	Yes
Meals on Wheels	Yes
Nutrition Therapy	Yes
Optometry Eye Exams, Eye Glasses, Contact Lenses; Low Vision Services	Yes
Orthopedic Footwear	Yes
Ostomy Supplies	Yes
Oxygen Therapy	Yes
Personal Care to remain in Home	Yes
Personal Emergency Response System (PERS)	Yes
Physical Therapy/Occupational Therapy/ Speech Language Pathology (PT/OT/ST) in outpatient setting	Yes
Podiatry/Foot Care	No
Private Duty Nursing	Yes
Prosthetics and Orthotics	Yes
Respite Care	Yes

Covered Service	**Authorization/Prior Approval Required**
Skilled Nursing Facility (SNF) Care	Yes
Social and Environmental Modifications	Yes
Social/Medical Day Care	Yes
Social Work Services	Yes
Transportation Non Emergent	Yes
Consumer Directed Personal Care	Yes

Service Standards for Providers

Providers participating in the Fallon Health Weinberg Provider Network shall provide service to members in accordance with the standards set by Fallon Health Weinberg. Unless otherwise noted, these standards are outlined below.

***** *Clinical notes should be submitted within 48 hours of assessment visit. Progress notes/summaries should be submitted every two (2) weeks thereafter unless otherwise requested or there is a decrease in member health status.*

Service:	**Standard (relative to requested start date):**
Adult Day Health Care	Placement must occur within 14 days
Audiology	Standard: Within 7 days Emergency: Within 48 business hours
Dentistry	Standard: Within 28 days Emergency: Within 24 business hours
DME/Supplies	Delivery must occur within 72 hours, unless custom order
Home Health Care	Initial visit***** must occur within 24 hours
Meals (Home/Congregate)	Date and time specified by Fallon Health Weinberg
Skilled Nursing Facility	Placement must occur as quickly as possible

Nutritional Counseling	Service must be provided within 14 days
Service:	**Standard (relative to requested start date):**
Optometry	Standard: Within 7 days Emergency: Within 24 business hours
Personal Care	Initial visit***** must occur on the date and time specified by Fallon Health Weinberg
Physical, Occupational & Speech Therapy (Not in home)	Initial visit***** within 7 days
Physical, Occupational &Speech Therapy (In home)	Initial visit***** must occur within 72 hours
Podiatry	Standard: Within 7 days Emergency: Within 24 business hours
Private Duty Nursing	Date and time specified by Fallon Health Weinberg
Prosthetics/Orthotics	Measurement within 14 days
Respiratory Therapy	Initial visit***** must occur within 24 hours
Social Day Care	Placement must occur within 14 days
Social and Environmental Supports	Delivery within 14 days unless custom ordered
Social Work Services	Service must be provided within 14 days
Transportation	Pick up within 30 minutes of scheduled time

Appeals of Denied Claims

All Claim inquiries and Appeals must be submitted within 120 days of receipt of claim determination by the Request for Claims Guidelines located on the fallonweinberg.org Provider site.

Claim Inquiry Contacts:

Claims Processing : 1-866-882-8185
Provider Relations: 1--855-827-2003
Member Services: 1-866-882-8185

Adverse Reimbursement Change

An adverse reimbursement change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional." A provider under this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.

Notice of adverse reimbursement change will be provided **at least 90 days prior to an adverse reimbursement change** to the provider contract. If the provider objects to the change that is the subject of the notice by Fallon Health Weinberg, the provider may, within thirty days of the date of the notice, give written notice to Fallon Health Weinberg to terminate the contract effective upon the implementation of the adverse reimbursement change.

Exceptions:

1. The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions.
2. The change is provided for in the contract between Fallon Health Weinberg and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a provider relative to this provision.

False Claims Act

Scope of the False Claims Act

The False Claims Act (FCA) is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term "knowingly" means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth. Knowingly submitting claims to (Fallon Health Weinberg) for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Submitting a claim for DME or supplies when delivery was refused by the member
- Submitting a claim for 2-man transportation, as authorized, but providing 1 man
- Submitting a claim for a service not provided

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include "treble damages" (damages equal to three times the amount of the false claim) and civil penalties of up to $11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

The FCA's Qui Tam Provisions

The FCA contains a qui tam, or whistleblower provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. Fallon Health Weinberg Heatlh's False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws punishing the submission of false claims and the making of false statements:

- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a

false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.

- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.

- Article 176 of the Penal Law makes it a misdemeanor to commit a "fraudulent insurance act," which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds $1,000 the crime is punishable as a felony.

- Article 177 of the Penal Law makes it a misdemeanor to engage in "health care fraud," which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds $3,000 the crime is punishable as a felony.

Medicaid Spend-down and Third Party Insurance

Fallon Health Weinberg assumes responsibility for billing Medicaid spend-down amounts for community based Fallon Health Weinberg members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Providers shall not bill or collect such amounts from the member.

For long term/permanent nursing home placement, the residential health care facility is responsible to collect the NAMI for members designated long term. A stay is considered short term for a maximum of six (6) months.

Providers are required to bill Medicare or any other third party insurance that is primary to Medicaid.

Medicare and other primary payor services

Fallon Health Weinberg members continue to access their services fully or partially covered by Medicare through fee for service Medicare or another Medicare product that the MLTCP member may be enrolled in. Participating providers may bill Fallon Health Weinberg for any required secondary payments not covered by other insurance as stipulated in the Provider Agreement. Fallon Health Weinberg members are not responsible for any deductibles or co-payments for covered services.

Referrals for services fully or partially covered by Medicare

Fallon Health Weinberg is payor of last resort. It is the provider's responsibility to determine primary coverage and eligibility. Co-insurance claims do not require authorization, except skilled nursing facilities. A copy of the primary and secondary insurers Evidence of Payment (EOP) must accompany all co-insurance claims.

Guidelines for Marketing

Fallon Health Weinberg Services

Providers may market Fallon Health Weinberg services under the following parameters:

- Providers may distribute brochures provided by Fallon Health Weinberg
- Fallon Health Weinberg may conduct marketing activities at the provider's site with the permission of the provider
- "Cold Call" telephoning and door-to-door distribution of material and solicitation is not permitted
- There is no offer of monetary incentives to Medicaid recipients to join the plan
- There is no offer of monetary incentives to providers to market Fallon Health Weinberg services or refer prospective members to Fallon Health Weinberg

Member Confidentiality

Providers shall ensure the confidentiality of all member related information by maintaining all member specific information and member records in accordance with New York State Public Health Law, the New York State Social Services Law and the Health Insurance Portability Accountability Act (HIPAA).

Member information shall be used or disclosed by a provider only with the member's consent unless otherwise required by law and only for purposes directly connected with provider's performance and obligations under Fallon Health Weinberg's Provider Agreement.

Provider will inform and train its employees and personnel to comply with the confidentiality and disclosure requirements of New York State statutes and HIPAA.

Member authorization is not required for access by:

- Medicare or CMS
- The New York State Department of Health
- Accreditation surveyors

- Federal, state and local government agencies authorized to conduct investigations of Medicaid Managed Long Term Care Programs

Member Rights

Providers will uphold the Member's rights and responsibilities as outlined below.
As a member of Fallon Health Weinberg, the member has the right to:

- Receive medically necessary care
- Privacy about the member's medical record and treatment
- Timely access to care and services
- Receive information on available treatment options and alternatives presented in a manner and language understood by member
- Receive information necessary to give informed consent before the start of treatment
- Be treated with respect and dignity
- Receive a copy of their medical records and ask that the records be amended or corrected
- Take part in decisions about their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion
- Be told where, when and how to receive the services they need from Fallon Health Weinberg, including how they can receive covered benefits from out-of-network providers if they are not available in the plan network
- Complain to Fallon Health Weinberg, the New York State Department of Health; the right to use the New York State Fair Hearing System or in some instances request a NYS External Appeal
- Appoint someone to speak for them about their care and treatment
- Make advance directives and plans about their care

Member Responsibilities

As a Fallon Health Weinberg member, the member is responsible to:

- Use network providers who work with Fallon Health Weinberg Health for eligible covered services
- Receive approval from their Care Manager or care management team before

receiving a covered service requiring such approval
- Inform Fallon Health Weinberg about their care needs and concerns and work with their Care Manager in addressing them
- Notify Fallon Health Weinberg when they go away or are out of town
- Make all required payments to Fallon Health Weinberg
- Cooperate with any requests for documentation related to maintaining Medicaid eligibility

Member Grievance Process

A grievance is any communication by a member to Fallon Health Weinberg about dissatisfaction with the care and treatment received from Fallon Health Weinberg staff or providers of covered services, which does not amount to a change in scope, amount, and duration of service or other actionable reason.

A member or a provider on the member's behalf may make a grievance verbally or in writing. Members are advised of their right to file a grievance at the time of enrollment (and are advised of their rights and responsibilities annually). Members are advised as to how to file a grievance, and of their ability to receive assistance from Fallon Health Weinberg staff, if necessary. All grievances will be resolved without disruption to the member's plan of care. Members will be free from coercion, discrimination or reprisal in response to a grievance.

All grievances are logged, tracked and reported. Fallon Health Weinberg will designate appropriate personnel who were not involved in the previous level of decision-making to review grievances in supervisory capacity and on grievance appeal. If the grievance relates to clinical matters, the personnel assigned will include duly registered health professionals to process both grievances and grievance appeals.

Grievances (non–same day resolution) are of two types: standard and expedited. Standard grievances, including both those reported verbally or written, are acknowledged in writing within 15 business days of receipt of grievance or less by the Quality Assurance Department or Care Management Department. Grievances are addressed as quickly as required by the member's condition. A standard determination is to be made within 45 calendar days of the receipt of all necessary information and no more than 60 calendar days from receipt of grievance. The standard grievance decision will be communicated by telephone and in writing within 3 business days of the decision. The review period for Fallon Health Weinberg's grievance determination can be increased by an additional 14 calendar days if it is in the member's best interest. The member, the provider on the member's behalf, or Fallon Health Weinberg may request the extension. The reason for the extension must be documented. When the extension is initiated by Fallon Health Weinberg, a notice will be sent to the member or the

provider advising of the extension, the reason for the extension and specify how it is in the best interest of the member. If a decision on the grievance is reached before the written acknowledgement was sent, Fallon Health Weinberg will send the written acknowledgement with the grievance determination. A Fallon Health Weinberg decision to initiate an extension is made by senior staff, i.e., supervisors or directors, when it is established that inadequate information is available to make an informed decision.

If the standard response time to the grievance would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, Fallon Health Weinberg will expedite the grievance. The member or the provider may request that a grievance be expedited. If Fallon Health Weinberg agrees to expedite the grievance, the expedited grievance determination will be made within 48 hours of receipt of all necessary information and no more than 7 calendar days from receipt of the grievance. The expedited grievance decision will be communicated by telephone and in writing within 3 business days of the decision.

If the expedited grievance decision is made before the written acknowledgement is sent, both the acknowledgement and expedited grievance decision will be combined. If the member or the provider on the member's behalf requests that the grievance be expedited and Fallon Health Weinberg does not agree, Fallon Health Weinberg will notify the member or the provider verbally within 2 days and in writing within 15 days, that the grievance decision was not expedited and the grievance will be handled within the standard grievance decision time frames.

Grievance data and its analysis are to be used to identify opportunities for program improvement. Fallon Health Weinberg senior staff will review the grievance data from several perspectives, including provider type, specific providers, and Fallon Health Weinberg staff identified as responsible parties in the grievance.

The Quality Assurance (QA) director is responsible for all internal management and external reports such as those to: the care management supervisors and directors, senior staff, the QA committee, the Fallon Health Weinberg governance and the New York State Department of Health.

Member Appeals of Grievances

A grievance appeal is a written communication from the member that the member disagrees with the decision of Fallon Health Weinberg in response to the grievance filed. Once a member files a grievance appeal, Fallon Health Weinberg must look again at the determination to decide if the decision was the correct one.

Members are instructed during enrollment of their right to appeal a grievance determination if the member is dissatisfied with the determination of a grievance.

Members are advised how to file a grievance appeal and if needed, told how to obtain assistance from Fallon Health Weinberg staff. Fallon Health Weinberg staff will review the grievance appeal with no disruption in the member's care and members will be free from coercion, discrimination or reprisal by the program.

The member has the right to present their reasons for the grievance appeal both in person and in writing during the grievance appeal process. The member has the right to examine all records that are part of the grievance appeal process. The member has the right to have a designated representative.

There are two (2) types of grievance appeal processes. They are:

a. Standard grievance appeal decisions are made within 30 business days of the date of receipt of necessary information.

b. Expedited grievance appeal decisions (if the member, provider on behalf of member or Fallon Health Weinberg feel that the time interval for a standard grievance appeals process could result in serious jeopardy to the member's health, life or ability to attain, maintain or regain maximum function) are made within 2 business days of receipt of all necessary information.

For both the standard and expedited process, the member must submit a written grievance appeal form request within 60 business days from the receipt of the initial grievance decision. The appeal request form is sent with all notices of action, denial of service requests or grievance determinations not made in the members favor. Members may request an appeal verbally and Fallon Health Weinberg staff will complete the appeal request form on the member's behalf and file with Quality Management.

Quality Initiatives

The goal of the Fallon Health Weinberg Quality Assurance/Performance Improvement (QAPI) program is to ensure an effective review mechanism for evaluating, maintaining, and improving the quality and appropriateness of services provided by Fallon Health Weinberg to its members through QAPI activities and utilization review.

Objectives for the QAPI program are to ensure member satisfaction; positive member outcomes and appropriate and efficient service utilization are the major goals of the QAPI program and utilization activities.

Plan objectives summarize these goals:

1. To assess and improve the quality of services delivered to members.

2. To assess and improve the effectiveness and efficiency of services in meeting member needs.
3. To identify and correct significant unfavorable trends.
4. To recommend and follow up on plans of action that will lead to improvement.

Authority and Responsibility
The board of directors of Fallon Health Weinberg has the full legal authority and responsibility for the quality assessment and performance improvement program. The Executive Director, Medical Director, and Quality Director have overall responsibility for the design and implementation of the QAPI program. They report to the Fallon Health Weinberg board of directors.

Scope
Performance improvement opportunities are identified through the analysis of data and trends and in response to Federal and State mandates. Other mechanisms to identify opportunities for improvement include:

- Recognition of themes across service areas.
- Examination of sentinel events (an unexpected occurrence) that caused a member's death or serious physical or psychological injury that included loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides.
- Tracking and trending of outcome measures identified in the annual work plan.
- Response to published innovative approaches to care and services.
- Response to staff recommendations.
- Response to member advisory council.

Quality Improvement Process
The Fallon Health Weinberg quality improvement process is a problem solving mechanism which finds a process to improve, organizes a team that knows the process, clarifies the current knowledge related to the process, uncovers root causes, and selects interventions to improve the process. The improvement cycle includes planning the improvement, collecting baseline data, implementation of interventions, measurement of the results of the interventions, and analysis of outcomes resulting in continuous improvement of the process.

Fallon Health Weinberg has adopted the PDSA (Plan, Do, Study Act) model for performance improvement:

Plan

- Find a process to improve
- Organize to improve it
- Clarify knowledge
- Understand variation
- Select and improve

Do

- Pilot the improvement

Study

- Evaluate the pilot

Act

- Standardize the improvement or start over
- Develop and implement mechanisms for sustaining the improvement with appropriate measurement

Provider Credentialing

Fallon Health Weinberg Credentials Department maintains credentialing files for each provider and ensures timely credentialing/recredentialing. Providers must submit information and documentation required by Fallon Health Weinberg to validate provider's qualifications to provide contracted services to Fallon Health Weinberg members.

Required documents include:

Completed and signed participating provider application
All regulatory licenses and certifications
Evidence of insurances:
(Fallon Health Weinberg must be included as certificate holder and additional insured)

- General Liability
- Professional Liability
- Worker's Compensation
- Automobile Insurance (as applicable)

NPI (National Provider Identification Number) Medicaid and Medicare provider numbers for all Medicaid/Medicare providers.

Provider information is forwarded to credentialing for verification and to check for any existing Medicaid or Medicare sanctions.

Renewed licenses and insurances must be submitted to Fallon Health Weinberg Credentialing within 7 business days of receipt.

Fallon Health Weinberg or its subcontractor will inform provider of any deficiencies or missing documents. If the provider cannot correct deficiencies or provide timely submission of documents, termination procedures will be initiated.

Fallon Health Weinberg may conduct a site survey of the provider's premises when services are to be rendered on-site at the provider's facility at the discretion of the Credentialing Manager. Fallon Health Weinberg will consider the results of the site survey in determining whether to contract with a provider, and in determining whether to renew a contract with a provider.

Recredentialing will be conducted every two (2) years.

Monitoring of Providers

Fallon Health Weinberg Health monitors provider performance on an ongoing basis as follows:

- Quality Assurance (QA) reviews member satisfaction surveys and member complaint logs
- QA and Provider Relations meet monthly to review member complaints
- Repeated complaints regarding a particular provider are followed up by Provider Relations
- Provider Relations contacts the provider to discuss complaints and request a plan of action
- If repeated issues cannot be remedied Provider Relations will commence contract termination procedures

Provider Audits

Fallon Health Weinberg Health will annually review a sampling of provider records documenting evidence of service delivery to determine accuracy and any patterns of error.

Documents collected and reviewed will include but not be limited to:

- Medical record notes
- Attendance sheets
- Activity records
- Time slips
- Sign in logs/attendance sheets
- DME delivery tickets
- Trip verification
- Monitoring reports from network providers

Audits will be based upon a sampling of paid claims for a specific time frame. Provider selection will be rotated based on highest utilization. No less than 100 claims will be reviewed.

Method:

1. Upon 30 days notice to provider, Fallon Health Weinberg Health will give the provider a list of invoice numbers, member names and service dates.

2. Provider will make available service rendered documents for Fallon Health Weinberg Health to review against the paid claims.
3. Fallon Health Weinberg Health will compile data into a report indicating number of providers audited, number of claims, and number of errors, if any, found.
4. Providers showing a pattern of errors (excess of 5%) will be notified and corrective action requested. Re-audits of these providers will be conducted quarterly.
5. If no corrective action is taken, Provider Relations will be notified and contract termination procedures will be initiated.

Provider Termination

Fallon Health Weinberg may terminate its contract with a Provider pursuant to the provisions of the Fallon Health Weinberg Provider Agreement.

Fallon Health Weinberg shall not terminate a contract with an individual health care provider except in compliance with the requirements of Section 4406-d of the New York Public Health Law. Under this policy, the term “health care professional” shall be defined in accordance with Section 4406-d of Public Health Law, as a health care professional licensed, registered or certified pursuant to Title Eight of the New York Education Law.

In accordance with the requirements of Section 4406-d, termination by Fallon Health Weinberg of a contract with a health care professional shall comply with the following:

a) Fallon Health Weinberg shall not terminate a contract with a health care professional unless Fallon Health Weinberg provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This provision shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.

b) The notice of the proposed contract termination provided by Fallon Health Weinberg to the health care professional shall include: (i) the reasons for the proposed action; (ii) notice that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by Fallon Health Weinberg; (iii) a time limit of not less than thirty (30) days within which a health care professional may request a hearing; and (iv) a time limit for a hearing date which must be held within thirty (30) days after the receipt of a request for a hearing.

c) The hearing panel shall be comprised of three persons appointed by Fallon

Health Weinberg. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on the panel shall constitute one third or more of the total membership of the panel.

d) The hearing panel shall render a decision on the proposed action in a timely manner.
Such decision shall include reinstatement of the health care professional by Fallon Health Weinberg, provisional reinstatement subject to conditions set forth by Fallon Health Weinberg, or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

e) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision; provided, however, that Section 4403(6)(e) of the New York Public Health Law, concerning members rights to continue an ongoing course of care, shall apply to such termination.

f) In no event shall termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

Updating Policies and Procedures

Updates and changes in policies and procedures related to provider services will be reviewed and distributed to providers at least thirty (60) days in advance of implementation.

Providers will be required to attend in-service and orientation programs, as requested.

461 John James Audubon Pkwy
Amherst NY 14304
Phone: 1-855-827-2003
TTY/TDD
Fax: (716-810-1903)
FallonWeinberg.org