

Member appeals and grievances

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Member appeals and grievances

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. Access for those who are hearing impaired is TRS 711. 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 have 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 Customer Service Department Representatives 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.

Representatives 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 Customer Service 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.

Member appeals and grievances

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 are 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 refers to the Member

Member appeals and grievances

Community Care Plan

Member appeal and grievance procedures

Filing an Internal Appeal:

- **Definition:** A request to overturn an adverse determination (e.g., denial, reduction, termination of coverage).
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1
Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m. to 6:00 p.m. or www.fallonhealth.org. 24/7.

Or call Appeal & Grievance Dept at 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:**
 - Must file within 180 calendar days of denial. If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken
 - Fallon acknowledges written/electronic appeals within 15 calendar days.
 - Oral appeals are documented and sent within 48 hours.
 - Final decision within 30 calendar days of receipt. May be extended.

Member appeals and grievances

Opportunity for Reconsideration

- Definition: A chance to reconsider a final adverse determination if relevant information was received too late or is expected to become available within a reasonable time period.
- Who Can File: Members or authorized representatives (family, friend, provider).
- Timeline: Must be agreed upon in writing; review completed within 30 days of agreement.

Expedited Review

- Definition: A fast-track appeal for urgently needed services.
- Who Can File: Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
 - **Provider Filing**: Treating physician must certify urgency.
- How to File: Same methods as **internal appeal** above.
- Timeline:
 - Inpatient Admission: Decision before discharge.
 - Urgent Services: A written decision will be issued within 48 hours if your treating physician confirms the service is medically necessary and that delaying it poses an immediate and serious health risk.
 - Durable Medical Equipment: For durable medical equipment, a written decision will be issued in less than 48 hours if your physician certifies medical necessity, immediate risk of serious harm without the equipment, and provides a specific timeframe for response.
 - Other Expedited Reviews: Response within 72 hours. May be extended.

Expedited Review for Terminally Ill Members

- Definition: Accelerated appeal process for terminally ill members.
- Who Can File: Terminally ill members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- Timeline:
 - Determination within 5 business days.
 - Optional conference within 10 days (or 5 days if urgent).
 - Coverage continues during review.

Member appeals and grievances

Expedited External Review

- **Definition:** If you're not satisfied with Fallon's final decision after an internal appeal, you may request an independent external review with Office of Patient Protection (OPP). This must be submitted in writing within four months of receiving the final determination.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
 - **Provider Filing:** Physician must certify urgency for expedited request.
- **How to File:**
 - **Mail:** Health Policy Commission, Office of Patient Protection, 50 Milk Street, 8th Floor, Boston, MA 02109
 - **Phone:** 1-800-436-7757
 - **Fax:** 1-617-624-5046
 - **Website:** masshpc.gov/OPP
- **Timeline:** Determination within 72 hours (standard) or 24 hours (expedited).

Filing a grievance

- **Definition:** A complaint about service quality, provider behavior, access issues, etc.
- **Who Can File:** Members or authorized representatives.
 - Providers may assist but do not file grievances directly.
- **How to File:** Same methods as **internal appeal** above.
- **Deadline:**
 - Must file within 180 calendar days.
- **Timeline:**
 - Oral grievance acknowledged within 24–48 hours.
 - Written grievance acknowledged within 15 calendar days.
 - Resolution contact within 30 business days.
- **Failure to Meet Time Limits:**
 - **Definition:** If Fallon fails to meet required timelines for an appeal. Time limits include any extensions made by mutual agreement between you or your authorized representative and the plan.
 - **Outcome:** The decision is automatically in favor of the member.

Member appeals and grievances

Fallon Medicare Plus Supplement Plan Member appeals and grievances rights

Filing an Internal Appeal

- **Definition:** A request to overturn an adverse determination (e.g., denial, reduction, termination of coverage).
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:**
 - **Write:** Fallon Health Member Appeals and Grievances Department
1 Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. Or at www.fallonhealth.org. 24/7.

Or 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health, 1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:**
 - Must file within 180 calendar days of denial. If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken
- **Timeline:**
 - Fallon acknowledges written/electronic appeals within 15 calendar days.
 - Oral appeals are documented and sent within 48 hours.
 - Final decision within 30 calendar days of receipt. May be extended.

Opportunity for Reconsideration

- **Definition:** A chance to reconsider a final adverse determination if relevant information was received too late or is expected to become available within a reasonable time period.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).

Member appeals and grievances

Fallon Medicare Plus Supplement Plan continued...

- **Timeline:**
 - Must be agreed upon in writing; review completed within 30 days of agreement.

Filing an Expedited External Review

- **Definition:** Independent review of a final adverse determination when urgent.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **Deadline:**
 - May be requested immediately after final internal decision.
 - If ongoing services are terminated, request continuation within 2 business days.

Oversight Agency:

- Massachusetts Division of Insurance, Bureau of Managed Care
 - Phone: 617-973-8787

Expedited Review for Terminally Ill Members

- **Definition:** Accelerated appeal process for terminally ill members.
- **Who Can File:** Terminally ill members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **Timeline:**
 - Determination within 5 business days.
 - Optional conference within 10 days (or 5 days if urgent).
 - Coverage continues during review.

Filing a Grievance

- **Definition:** A complaint about service quality, provider behavior, access issues, etc.
- **Who Can File:** Members or authorized representatives.
 - Providers may assist but do not file grievances directly.
- **How to File:** **Same methods as an *internal appeal* above.**
- **Deadline:**
 - Must file within 180 calendar days.
 - Oral grievance acknowledged within 24–48 hours.
 - Written grievance acknowledged within 15 calendar days.
 - Resolution contact within 30 business days.
- **Failure to Meet Time Limits**
 - **Definition:** If Fallon fails to meet required timelines for an appeal.
 - Time limits include any extensions made by mutual agreement between you or your authorized representative and the plan.
 - **Outcome:** The decision is automatically in favor of the member.

Member appeals and grievances

Fallon Medicare Plus Orange, Green and Blue HMO Plans Member appeals and grievances rights

Filing a Standard Internal Appeal (Medical Care, Part B, or Reimbursement)

- **Definition:** A formal request to review and change a coverage decision.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department
1 Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. or at www.fallonhealth.org. 24/7.

Or 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health 1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:**
 - Must file within 65 calendar days from the date on the written notice denial.
 - If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken
- **Timeline:**
 - Final decision for a standard appeal for Medical Care within 30 calendar days or 7 calendar days for Part B drugs.

If the plan includes Part D coverage-

Filing a Part D drug standard or fast appeal, or about payment for a drug

- **Definition:** A fast-tracked appeal when waiting could seriously jeopardize health or life.

Member appeals and grievances

- **Who Can File:** Members or authorized representatives (family member, friend, **Provider** or other prescriber can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1 Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. Or at www.fallonhealth.org. 24/7. Or call Appeals and Grievance Dept at 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:** Must file within 65 calendar days from the date on the written notice denial.
 - If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken
- **Timeline:**
 - Decision within 7 calendar days for a standard appeal, 72 hours for a fast appeal, and 14 calendar days for a payment appeal

Filing an appeal to change hospital discharge date

- **Definition:** To ask us to cover your inpatient hospital services for a longer time
- If you need help: Call Customer Service at 1-800-325-5669 (TTY: 711), or contact your State Health Insurance Assistance Program (SHIP) for personalized support.
 - In Massachusetts, SHIP is called SHINE (Serving the Health Insurance Needs of Everyone)—an independent organization not affiliated with this plan.
 - SHINE: 1-800-243-4636
 - TTY (Massachusetts only): 1-800-439-2370

Member appeals and grievances

Hospital Discharge Review

If you disagree with your planned discharge date, you can request an immediate review by your state's Quality Improvement Organization (QIO)—a group of independent health professionals paid by the federal government to ensure Medicare care quality. They are not affiliated with our plan.

- Step 1: Request an Immediate Review
 - Act quickly: Contact the QIO before you leave the hospital and no later than midnight on your discharge date.
 - If you meet the deadline, you can stay in the hospital without paying while waiting for the QIO's decision.
 - If you miss the deadline, contact us. You may be responsible for costs if you stay past your discharge date.
- How to contact the QIO:
 - Refer to your notice titled "An Important Message from Medicare About Your Rights".
- Step 2: QIO Review
 - The QIO will speak with you (or your representative), review your medical records, and consult your doctor and hospital.
 - By noon the day after the QIO contacts us, we'll send you a Detailed Notice of Discharge explaining why your discharge is considered medically appropriate.
- You can request a sample notice by calling:
 - Customer Service: 1-800-325-5669 (TTY: 711)
 - Medicare: 1-800-MEDICARE (TTY: 1-877-486-2048)
 - Or visit: CMS.gov
- Step 3: QIO Decision
 - Once the QIO has all necessary information, you'll receive a decision within one full day.

Requesting Extended Coverage for covered home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)

- **Definition:** To ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request
- **If you need help:** Call Customer Service at 1-800-325-5669 (TRS 711), or contact your State Health Insurance Assistance Program (SHIP) for personalized support.
 - In Massachusetts, SHIP is called SHINE (Serving the Health Insurance Needs of Everyone)—an independent organization not affiliated with this plan.
 - SHINE: 1-800-243-4636
 - TTY (Massachusetts only): 1-800-439-2370

Member appeals and grievances

If you believe your care should continue beyond the date our plan approved, you can file a Level 1 appeal through your state's Quality Improvement Organization (QIO) - an independent group of health professionals funded by the federal government. They are not part of our plan and review whether ending coverage is medically appropriate.

Step 1: Request a Fast-Track Appeal

- Act quickly: Contact the QIO by noon the day before the effective date listed on your Notice of Medicare Non-Coverage.
- This notice includes QIO contact details. You can also find them in Chapter 2 of your Evidence of Coverage.
- If you miss the deadline, you still have appeal rights—contact the QIO as soon as possible.

Step 2: Independent Review

- The QIO will speak with you (or your representative), review your medical records, consult your doctor, and consider information from our plan.
- By the end of the day the QIO informs us of your appeal, we'll send you a Detailed Explanation of Non-Coverage, outlining why coverage is ending.

Step 3: Appeal Decision

Once the QIO has all necessary information, you'll receive a decision within one full day.

Filing a grievance

- Definition: A complaint about service quality, provider behavior, access issues, etc.
- Who Can File: Members or authorized representatives.
 - **Providers** may assist but do not file grievances directly.
- How to File: Same methods as **internal appeal** above.
- Deadline: Must file within 60 calendar days from when you had the problem
 - Oral grievance acknowledged within 24–48 hours.
 - Written grievance acknowledged within 15 calendar days.
 - Resolution contact within 30 business days. May be extended.
- Timeline: Response typically within 30 calendar days
- Failure to Meet Time Limits:
 - Definition: If Fallon Health does not meet required timelines for an appeal, the case is automatically forwarded to the next level of review.
 - Implication: Member may receive automatic favorable decision or escalation to external review.

Member appeals and grievances

Fallon MassHealth Accountable Care Organization (ACO)

Member appeals and grievances rights - Fallon 365 Care, Berkshire Fallon Health Collaborative, and Fallon Health-Atrius Health Care Collaborative

Filing a Standard Internal Appeal

- **Definition:** A formal request to review and change an adverse action.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1
Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. or at www.fallonhealth.org. 24/7.

Or Call Appeals and Grievances at 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:** Must file within 60 calendar days from the date on the written notice denial. If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken
- **Timeline:** Resolution within 30 calendar days (may be extended).

If you disagree or are not satisfied with the outcome of the internal appeal you can appeal to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH).

Member appeals and grievances

Fallon MassHealth Accountable Care Organization (ACO) continued...

Filing an Expedited (Fast) Internal Review

- **Definition:** A fast-track appeal for urgently needed services.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1 Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. or at www.fallonhealth.org. 24/7.

Or call Appeals and Grievances at 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health 1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:** Must file within 60 calendar days from the date on the written notice denial.
- **Timeline:** Resolution within 72 hours. May be extended.

If you disagree or are not satisfied with the outcome of the expedited (fast) internal appeal, you can appeal to the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH)

Filing a grievance

- **Definition:** An expression of dissatisfaction you or your authorized appeal representative make about Fallon Health or one of our plan providers. For example, this would include concerns about your quality of care.
- **Who Can File:** Members or authorized representatives (family member, or friend can file on member's behalf).
 - Providers may assist but do not generally file grievances directly.
- **How to File:** Same methods as an **internal appeal above**.
- **Deadline:** Must file within 60 calendar days from when you had the problem
- **Timeline:** Grievance acknowledged within 1 business day.
- Resolution within 30 calendar days. May be extended.

Need Help? Call My Ombudsman at 1-855-781-9898 (MassRelay: 711 or VP: 339-224-6831). This service is independent and not connected to any health plan.

Member appeals and grievances

NaviCare® HMO SNP

Member appeals and grievances rights

Filing an Internal Appeal (Level 1 Appeal)

To request an appeal, a member, provider, or member's representative must contact us to ask for a standard or fast appeal by phone or in writing.

- **Definition:** A formal request to review a denied coverage decision.
- **Who Can File:** Members or authorized representatives (family member, friend or **Provider** can file on member's behalf).
- **How to File:** An *Internal Appeal (Level 1 Appeal)* you, your doctor, or your representative must contact us. You can ask for a standard or fast appeal by phone or in writing.
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1 Mercantile St., Ste. 400, Worcester, MA 01608
 - **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m to 6:00 p.m. or at www.fallonhealth.org. 24/7.

Or Call Appeals and Grievances Dept at 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
 - **Fax:** 1-508-755-7393
 - **In person:** Fallon Health1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadlines:** You must file your appeal within 65 calendar days of the date on our decision letter. If you file an appeal, be sure to give us all the following information:
 - The member's name
 - Member identification number
 - The facts of the request
 - The outcome that you are seeking
 - The name of any representative with whom you have spoken

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.

Member appeals and grievances

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 HMO SNP 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

Need Help?

- Call My Ombudsman at 1-855-781-9898 (MassRelay: 711 or VP: 339-224-6831). This service is independent and not connected to any health plan.
- Important Notes:
 - If your doctor wants to continue your care during the appeal, they may need to be named as your representative.
 - If someone else is appealing for you, submit an Appointment of Representative form. Get it at [CMS.gov](https://www.cms.gov) or fallonhealth.org/navicare.
- Timelines:
 - Standard: Decision within 30 days (services), 7 days (Medicare Part B drugs). May be extended except for Part B drugs.
 - Expedited: Decision within 72 hours. May be extended except for Part B drugs.

Filing a Part D drug standard or fast appeal, or about payment for a drug

- **Definition:** A fast-tracked appeal when waiting could seriously jeopardize health or life.
- **Who Can File:** Members or authorized representatives (family member, friend, **Provider** or other prescriber can file on member's behalf).
- **How to File:**
 - **Mail:** Fallon Health Member Appeals and Grievances Department 1 Mercantile St., Ste. 400, Worcester, MA 01608

Member appeals and grievances

- **Inquiries, appeals and grievances questions?** Contact Customer Service at 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8:00 a.m. to 6:00 p.m., Wednesday, 9:00 a.m. to 6:00 p.m. Or at www.fallonhealth.org. 24/7.

Or 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
- **Fax:** 1-508-755-7393
- **In person:** Fallon Health1 Mercantile St., Ste. 400, Worcester, MA 01608
- **Deadline:** Must file within 65 calendar days from the date on the written notice denial.
- **Timeline:** Decision within 7 calendar days for a standard appeal, 72 hours for a fast appeal, and 14 calendar days for a payment appeal

Disagree with a Payment Decision? File an Appeal

- **Definition:** If you believe we should have paid for a service, you can file an appeal.
- Follow the steps listed above on how to make a **level 1 appeal**
- **Timeline:** Once we receive your appeal, we'll respond within 30 calendar days. May be extended.

Filing an appeal to change hospital discharge date

- **Definition:** To ask us to cover your inpatient hospital services for a longer time,
- **If you need help:**
 - Call NaviCare Enrollee Services at 1-800-700-6996 (TRS 711), or contact your State Health Insurance Assistance Program (SHIP) for personalized support.
 - In Massachusetts, SHIP is called SHINE (Serving the Health Insurance Needs of Everyone)—an independent organization not affiliated with this plan.
 - SHINE: 1-800-243-4636
 - TTY (Massachusetts only): 1-800-439-2370

Hospital Discharge Review

If you disagree with your planned discharge date, you can request an immediate review by your state's Quality Improvement Organization (QIO)—a group of independent health professionals paid by the federal government to ensure Medicare care quality. They are not affiliated with our plan.

Step 1: Request an Immediate Review

- **Act quickly:** Contact the QIO before you leave the hospital and no later than midnight on your discharge date.
- If you meet the deadline, you can stay in the hospital without paying while waiting for the QIO's decision.

Member appeals and grievances

- If you miss the deadline, contact us. You may be responsible for costs if you stay past your discharge date.
- How to contact the QIO:
- Refer to your notice titled “An Important Message from Medicare About Your Rights”.

Step 2: QIO Review

- The QIO will speak with you (or your representative), review your medical records, and consult your doctor and hospital.
- By noon the day after the QIO contacts us, we’ll send you a Detailed Notice of Discharge explaining why your discharge is considered medically appropriate.
- You can request a sample notice by calling:
 - Enrollee Services: 1-800-700-6996 (TRS 711),
 - Medicare: 1-800-MEDICARE (TTY: 1-877-486-2048)
 - Or visit: CMS.gov

Step 3: QIO Decision

- Once the QIO has all necessary information, you’ll receive a decision within one full day.

Requesting Extended Coverage for covered home health services, skilled nursing care in a skilled nursing facility, or rehabilitation care as an outpatient at a Medicare approved CORF (Comprehensive Outpatient Rehabilitation Facility).

Filing an appeal to extend coverage

- Definition: To ask us to cover your care for a longer period of time, you’ll need to use the appeals process to make this request

If you need help:

- Call NaviCare Enrollee Services at 1-800-700-6996 (TRS 711), or contact your State Health Insurance Assistance Program (SHIP) for personalized support.
- In Massachusetts, SHIP is called SHINE (Serving the Health Insurance Needs of Everyone)—an independent organization not affiliated with this plan.
 - SHINE: 1-800-243-4636
 - TTY (Massachusetts only): 1-800-439-2370

If you believe your care should continue beyond the date our plan approved, you can file a Level 1 appeal through your state’s Quality Improvement Organization (QIO), an independent group of health professionals funded by the federal government. They are not part of our plan and review whether ending coverage is medically appropriate.

Step 1: Request a Fast-Track Appeal

- Act quickly: Contact the QIO by noon the day before the effective date listed on your Notice of Medicare Non-Coverage.

Member appeals and grievances

- This notice includes QIO contact details. You can also find them in Chapter 2 of your Evidence of Coverage.
- If you miss the deadline, you still have appeal rights—contact the QIO as soon as possible.

Step 2: Independent Review

- The QIO will speak with you (or your representative), review your medical records, consult your doctor, and consider information from our plan.
- By the end of the day the QIO informs us of your appeal, we'll send you a Detailed Explanation of Non-Coverage, outlining why coverage is ending.

Step 3: Appeal Decision

- Once the QIO has all necessary information, you'll receive a decision within one full day.

Filing a grievance

- Definition: A Complaint. Dissatisfaction with care, service, or plan operations.
- Who can file: Members or authorized representatives (family member, friend, caregiver file on member's behalf)
 - Providers may assist but do not generally file grievances directly.
- How to file:
 - Enrollee Services: 1-877-700-6996
 - Member Appeals & Grievances: 1-800-325-5669 (TRS 711) Available Mon–Fri, 8 a.m.–8 p.m. Oct 1–Mar 31: Available 7 days a week
 - Mail: Fallon Health Member Appeals and Grievances 1 Mercantile St., Suite 400 Worcester, MA 01608
 - Fax: 1-508-755-7393
- Deadline:
 - You can file a complaint anytime, unless it's about a Medicare Part D drug.
 - For Part D issues, you must file your complaint within 60 calendar days of the problem.

Grievances are resolved as quickly as your health requires, but no later than 30 days. We may extend the timeframe by up to 14 days if needed or requested.

Member appeals and grievances

External Complaint Options

Medicare: You can file a complaint directly with Medicare at [medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint).

- You don't need to contact NaviCare first.
- For help, call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048).

Office for Civil Rights (OCR)

If you feel you've been treated unfairly (e.g., due to disability or language access), contact the U.S. Department of Health and Human Services OCR:

- Phone: 1-800-368-1019 (TTY: 1-800-537-7697)
- Website: [hhs.gov/ocr](https://www.hhs.gov/ocr)
- Email: ocrmail@hhs.gov
- Local Office:

J.F. Kennedy Federal Building, Room 1875 Boston, MA 02203

Phone: 1-617-565-1340 | Fax: 1-617-565-3809 | TDD: 1-617-565-1343

Americans with Disabilities Act (ADA) Support

For help with disability-related concerns, contact My Ombudsman (advocate):

- Phone: 1-855-781-9898 (MassRelay: 711 or VP: 339-224-6831)
- Email: info@myombudsman.org

Quality of Care Complaints

You can report concerns about care quality to the Quality Improvement Organization (QIO). In Massachusetts, the QIO is Acentra Health: Phone: 1-888-319-8452

Member appeals and grievances

Members' Rights and Responsibilities statement

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

1. Be informed about Fallon Health and covered services.
2. Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
3. Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Health, including payment structure.
4. Choose a qualified contracted primary care physician and contracted hospital.
5. Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
6. Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.
7. Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
8. Enrollees have a right to receive a second opinion on a medical procedure from an in-plan Provider and have Fallon Health pay for the second opinion consultation. Ask your Primary Care Physician to refer you to an in network contracted provider for a second opinion consultation. Prior approval from Fallon Health is required when a second medical opinion is being requested to a provider who is not part of the Fallon Health provider network.
9. Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
10. Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.
11. Be treated with dignity and respect, and to have your privacy recognized.
12. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
13. Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).

Member appeals and grievances

14. Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.
15. If your grievance involved an adverse determination, and you are not satisfied with our final decision, you have the right to file an external review.
16. You may obtain the forms you need to file for an external review by calling the Department of Public Health Office of Patient Protection at 800-436-7757 or by accessing their website at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection/>.
17. Federal employees may ask the United States Office of Personnel Management for an external review by writing to: United States Office of Personnel Management Insurance Services Programs, Health Insurance Group 3 1900 E. Street, NW Washington, DC 20415-3630
18. Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Health and its contracted providers.
19. Make recommendations regarding Fallon Health's members' rights and responsibilities policies.

Member responsibilities:

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

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