Managing patient care

Medical Management overview

Fallon Health's care services program reviews and evaluates the health care members receive to make sure that member care is coordinated, and that appropriate levels of services are available to members. This includes prior authorization of select services, inpatient care services, care management including complex cases and disease management.

The Care Review Department is staffed by licensed registered nurse care reviewers and physician reviewers who are available to our network providers and physicians at least eight hours a day during normal business hours for inbound calls regarding utilization management and prior authorization issues. Incoming messages received after business hours and on weekends are returned the next business day. Fallon Health's Care Services uses national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by providers and physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

Fallon Health also develops in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from the Centers of Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts. Criteria are available upon request.

The Care Review Department provides physician support for services requiring prior authorization (see PCP referral and plan authorization process section).

Fallon Health provides all physicians with the opportunity to discuss any denial decision with a physician reviewer or to obtain information about the status or outcome of any utilization issue or review decision from the plan by contacting Care Services at our toll-free provider service line 1-866-275-3247, press 3 at prompt.

Availability of providers

When Fallon Health delegates quality services to a selected vendor, the delegated entity has responsibility to conduct performance assessment and report back to Fallon Health's Delegation Oversight Committee. Data analysis of availability of specialists, including behavioral health practitioners, must also be reported to the Delegation Oversight Committee using similar methodology approved by Fallon Health to ensure performance compliance with Fallon Health's standards.*

**Behavioral health access and availability is delegated to Carelon, an NCQA accredited MBHO. Carelon provides annual reports to Fallon Health's Delegation Oversight Committee.*

Primary Care Services

Accessibility of Service	Standard
1. Preventive and Primary Care – (Annual Physical or new patient examination)	Within 30 calendar days
2. Routine and Regular Care (Symptomatic Office Visit)	Within 48 hours
3. Urgent Symptomatic (Urgent Problem Visits)	Within 24 hours
4. Specialty Care	Within 14 calendar days
5. High Impact Specialty Care	Within 14 calendar days
6. Emergency Care*	Available 24 hours/day 7 days/week
7. After-Hours Care	24 hours/day
8. After-Hours Telephone	Within 2 hours for the return call

*Emergency care defined by the "Prudent Layperson" definition.

Primary Care Services
Medicaid Requirements

Medicaid ACO Accessibility of Service	Standard
1. Emergency Services	1. Immediately upon member presentation at the service delivery site (24 hour/day 7 days/week
2. Primary Care Services	2. Within 48 hours of member's request for urgent care; within 10 calendar days of member's request for non-urgent symptomatic care; and within 45 calendar days of member's request for non-symptomatic care.
3. Specialty Care Services	3. Within 48 hours of member's request for urgent care; within 30 calendar days of member's request for non-urgent symptomatic care; and within 60 calendar days of member's request for non-symptomatic care.
4. For members newly placed in care and custody of Department of Children and Families (DCF)	4. Best effort to provide DCF health care screening within 7 calendar days, and Initial Comprehensive Medical examination within 30 calendar days.
5. All other services	5. Usual and customary community standards.

Behavioral Health Services

Accessibility of Service	Standard
1. Life Threatening Emergency Needs	1. Immediately
2. Non-life-threatening Emergency	2. Within 6 hours
3. Routine or follow up Behavioral Health Appointment	3. Within 10 business days
4. Behavioral Health Urgent Appointment	4. Less than 48 hours

Behavioral Health Services
Medicaid Requirements

Medicaid Accessibility of Services	Standard
1. Emergency Services	1. Immediately (24 hours/day, 7 days/week)
2. Mobile Crisis Intervention - AMCI/YMCI *(Formerly known as Emergency Services Program (ESP))*	2. Immediately (24 hours/day, 7 days/week)
3. All other behavioral health services	3. Within 14 calendar days
4. Non-24-hour Diversionary Services	4. Within 2 calendar days of discharge
5. Medication Management	5. Within 14 calendar days of discharge
6. Other Outpatient Services	6. Within 7 calendar days
7. Intensive Care Coordination Services	7. No more than 14 days for 100% of the clients

Behavioral Health inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's discharge. The appointment date must be within the following time frames:

TYPE OF CARE	APPOINTMENT MUST BE OFFERED
Non-24 Hour Diversionary	Within 2 calendar days
Psychopharmacology Services/ Medication Management	Within 14 calendar days
All Other Outpatient Services	Within 7 calendar days
Intensive Care Coordination (ICC)	Within 3 calendar days

Providers are required to meet these standards, and to notify Carelon if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

Access standards for MassHealth ACO members
Geographic access standards

Under contract with the EOHHS, Fallon Health must ensure adequate access to covered services for all MassHealth ACO members and facilitate access to non-Fallon Health covered services. Adequate access shall include physical, telephone and geographic access including:

Primary Care Services
Geographic access standards
Medicaid Requirements

Type	Time (min)	Distance (miles)
Primary Care Services	30	15
Hospital (Acute Inpatient)	40	20
Urgent Care	30	15
Rehabilitation Hospital	60	30
All other services	Usual and customary community standards.	

Behavioral Health Services
Geographic access standards
Medicaid Requirements

Type	Time (min)	Distance (miles)
Inpatient Services	60	60
All other services	30	30

Customer Service Telephone Accessibility

The primary role of Fallon Health's call centers is to promptly respond to all external customers' inquiries and to appropriately refer calls for service requests. To this end, the call centers monitor incoming calls using an automated call tracking system which provides data on the time it takes to answer calls and on the percentage of calls abandoned. Fallon Health has established standards and monitors customer service performance and reports findings to the Customer Service Committee on a quarterly basis.

Customer Service Telephone Accessibility	Standard*
Abandonment Rate	<5%
% calls answered within 30 seconds for Community Care and FMP members only	80%
% calls answered within 30 seconds for ACO members only	90%
% calls answered within 20 seconds for SCO members only	90%
Behavioral Health (Delegated Vendor)	
% calls answered within 30 seconds (Behavioral Health)	90%
Abandonment Rate (Behavioral Health)	Within 5%

** Specific employer groups and government programs may require monitoring of different time intervals.*

Performance Assessment

Using an automated call center tracking system, the Customer Service department monitors its telephone performance. This includes telephone response times, call volume and abandonment rates. Findings are reported to the Customer Service Committee quarterly with evaluation of performance against the standards.

In addition, complaints about Customer Service performance are monitored continually and corrective action implemented when appropriate by the Committee.

When Fallon Health delegates quality services to a selected vendor, the delegated entity is responsible for monitoring customer services telephone accessibility and reporting it to Fallon Health. The Delegation Oversight Committee has responsibility for ensuring that the accessibility standards are met by all delegated vendors. Accessibility of behavioral health practitioners is conducted by Carelon, an NCQA accredited vendor.

Telephone Services and Office Wait Time Standards for Contracted Practitioners

Contracted practitioners are responsible for telephone coverage for the after-hours care and responsiveness of appointment telephone lines. The practitioners are responsible for arranging coverage for evenings and weekends. The plan standards for coverage are:

Physicians shall provide twenty-four-hour physician coverage with the availability of the covering physician to return members' calls within 2 hours of the call if medically necessary.

Physicians or their designees should return patients' calls.

received during routine business hours for active clinical problems, on a same day basis. Routine administrative requests for completion of forms, test reports, or chronic refills should generate a telephone response within one business day.

Fallon Health monitors this standard by soliciting feedback directly from members with a telephone survey conducted internally by the Department of Market Research and Product Development. Results of the survey are communicated to the Customer Service Committee to identify any opportunities and ensure that members receive appropriate coverage for after- hours care. In addition to the internal survey, the Committee monitors the CAHPS commercial survey Q 60 question which asks, "How long does it take for your doctor's office to return your call?" Results of the survey are also reviewed by the Customer Service Committee and any issues are addressed and forwarded to Provider Relations for follow up with the practitioners.

Admitting for inpatient stay

A Fallon Health utilization management (UM) nurse will perform clinical reviews for level of care on all inpatient admissions. All elective inpatient admissions must be authorized by Fallon Health's Prior Authorization (PA) Department prior to admission. (Refer to Elective admission procedure) The UM nurse will perform level of care clinical reviews for acute inpatient hospital admissions, Inpatient Rehabilitation Facility (IRF), Inpatient Skilled Nursing Facility (SNF) (with some exceptions), Long Term Acute Care Hospital (LTACH), and non-skilled facility admissions. Services must be authorized by Fallon Health prior to admission or upon notification the next business day when Fallon Health is closed.

Once a member is admitted, a UM nurse will perform a clinical review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. Fallon uses various coverage guidelines, including InterQual, the Medicare 2MN rule, and MassHealth coverage guidelines when making medical necessity determinations to authorize emergent hospital admissions.

Procedure:

Elective admissions

1. The admitting physician's office requests authorization for the admission by completing the Standard Prior Auth form and sending it to the Fallon Health Prior Authorization Department or by completing the request via the online provider portal. The organization makes decisions as expeditiously as the member's condition requires but no later than within 14 days of request. Expedited requests (when waiting for a decision may seriously jeopardize the life or health of the patient) are completed within 72 hours. The organization notifies practitioners of the decisions within one day of making the decision.

2. If authorized:

    a. The UM or PA staff provides the authorization number to the requesting provider office indicating that the referral is authorized.

    b. The requesting provider office /physician books the admission.

    c. The admitting physician performs the history and physical, completes all preadmission tests and obtains the member's written consent.

    d. The admitting physician forwards copies of the member consent and results from the history, physical and preadmission testing to the hospital prior to the admission, or otherwise complies with the hospital's admission policy.

3. If not authorized:

   Elective Pre-Service Admissions:

   a. The PA Department notifies the requesting provider's office to discuss if medical necessity criteria are not met. The provider is given the opportunity to discuss the denial decision with a physician.

   b. The PA Department sends the coverage determination letter, which includes all appeal rights, to the Member and/or Authorized Appeal Representative with a copy to the primary care physician.

   Pre-Service Post-Acute (SNF, Acute Rehab, LTACH, non-skilled facility) admissions:

   a. The UM department notifies the facility liaison and the hospital Case Manager to discuss if medical necessity criteria are not met. The provider is given the opportunity to discuss the UM denial decision with a physician.

   b. The UM department sends the coverage determination letter, which includes all appeal rights, to the Member and/or Authorized Appeal Representative with a copy to the primary care physician.

Procedure:

Emergency or Unplanned Admissions

Upon admission to the hospital, the facility is required to submit a notification of admission via authorization entry on the ProAuth portal (preferred method) or fax to 508-368-9175. Fallon Health requires that the hospital notify us within 24 hours of an emergency or unplanned hospital admission or transfer to a different acute facility.

Fallon Health will only pay for hospital days that are medically necessary, and which are called in or faxed to us within the notification time frame, 24 hours of admission. Please note: MassHealth ACO and NaviCare members cannot be held financially liable.

Post-acute admissions

The facility must submit a discharge planning request via fax to 508-368-9014 prior to admission to a SNF, Acute Rehab, or LTACH. We have a 24-hour TAT on these requests provided all documentation is submitted at the time of request. When we are closed, The Good Faith policy will be in effect- a post-acute provider can accept a member, who meets CMS and/or MassHealth coverage criteria, and notify the Fallon UM department the next business day by faxing clinical to 508-368-9014.

Discharge notification requirement for MassHealth ACO members:

Acute care facilities must provide a member's PCP with a discharge summary and relate documents within two business days of discharge; this applies to all MassHealth ACO members.

Advance directives

Our members have certain rights relating to advance directives. Advance directives are recognized under Massachusetts law to ensure a person who can't make and/or communicate a health care decision gets health care. If a member is no longer able to make decisions about their health care, having an advance directive in place can help. These written instructions tell providers what to do if their patients cannot make health care decisions. We have the authority to audit Fallon Health patients' records for the presence of advance directives at any time.

Providers must maintain written policies and procedures on Advance Directives as defined in the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The provider shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

- 42 CFR 489.100 defined: There are different types of advance directives, such as: "health care proxy," "living will" and "durable power of attorney for health care."

In all events, members who wish to execute one of below must be of at least 18 years of age.

Health Care Proxy

Member can use a health care proxy to choose someone they trust to make health care decisions for them (the "agent"). This person then will make health care decisions according to the instructions if for any reason the member becomes unable to make or communicate those decisions on their own. A health care proxy is legally binding in Massachusetts.

Living Will

This is a document in which a person specifies the kind of lifesaving and life-sustaining care and treatment they do or do not wish to receive in the event the person becomes both incapacitated and terminally ill. Massachusetts law considers the document good evidence of patient wishes; however, it is not legally binding in Massachusetts.

Durable Power of Attorney for Health Care

This is a legal document through which a person appoints someone else, an "attorney-in-fact," to act on the person's behalf in making medical treatment decisions in case of future incapacitation.

If a member decides they wish to have an any or all of the above, there are several ways to get these forms. These can be obtained from a lawyer, and forms may also be available at different healthcare providers, such as hospitals, skilled nursing facilities, etc.

Or visit the following online resources:

- Massachusetts law about health care proxy and living will on mass.gov
- Massachusetts Medical Society

Regardless of where the form is obtained, keep in mind that it is a very important document. A member may consider having a lawyer help prepare these; however, this is not necessary in the State of Massachusetts. It is important for the member to sign this form and keep a copy at home. They should also give a copy of the form to all their healthcare providers and to the person named on the form as the one to make decisions if they can't. It is also recommended that copies be given to close friends or family members. If a member knows ahead of time that they are going to be hospitalized, and have signed an advance directive, they should take a copy with them to the hospital.

If the member has not signed an advance directive form in advance but decides at the hospital that they want one, the hospital can provide the form to sign at that time. It is a member's right to fill out an advance directive at any time. According to law, no one can deny care or discriminate against a member based on whether they have signed an advance directive.

Additional member resources

Fallon Health website

Fallon Health's website, located at www.fallonhealth.org, contains information on Fallon Health's member benefits, services, and wellness programs.

Members may use the site to request information, consult our online provider directories, change plan options, change primary care physicians, with the *MyFallon* member portal. https://fallonhealth.org/en/members/myfallon

Learn more about each of the Fallon Health Plans, Benefits, Services, discounts, extras and more at: https://www.fallonhealth.org/en/members.

- *Fallon Health Plans*
  - Community Care members (commercial plans)
  - Fallon Medicare Plus/Fallon Medicare Plus Central (Medicare Advantage and Medicare Supplement)
  - NaviCare SCO and HMO-SNP
  - Berkshire Fallon Health Collaborative
  - Fallon 365 Care
  - Fallon Health-Atrius Health Care Collaborative
  - Summit ElderCare

Fallon Health member publications:

Fallon Medicare Plus (FMP), FMP Central, FMP Supplement, and NaviCare members receive *To Your Health* magazine. This is published at different times throughout the year, in English, Spanish and Portuguese. Articles on a wide array of health and wellness topics, fitness programs and community resources are designed to inform and reflect the health care concerns of our members.

Mass Health ACO members receive an annual mailer at the end of the year. The "Staying Healthy" mailer provides Information about their MassHealth ACO plan.

Healthwise Knowledgebase

Healthwise Knowledgebase is a free online resource designed to help people become informed about their health and health care and involved in an active partnership with their providers.

Healthwise contains more than 8,000 topics on health conditions, medical tests and procedures, medications, and everyday health and wellness issues. Every Healthwise topic is based on the most reliable and up-to-date medical research. By building self-care and shared decision-making skills, Healthwise helps people to triage symptoms, live a healthy lifestyle, understand treatment decisions on acute conditions, and manage

chronic diseases.

The entire database is in both Spanish and English and uses a combination of text, image, video, and interactive resources to make health education accessible and available.

Quit to Win: Fallon's tobacco treatment program

Fallon would like to help your patients quit smoking.

Our phone coaching program, *Quit to Win, is open to all Fallon members.* Participants will learn to create a quit plan that's right for them. The phone calls are facilitated by professional Quit Coaches.

Fallon also offers text support to its members. This includes text messages from our Quit Coaches to support and encourage those who are trying to quit smoking.

Fallon members can call us at 1-888-807-2908 or email us at QuitToWin@fallonhealth.org. Your office can also fax us at 1-508-798-8394, and we will contact your patient.

Naturally Well

Alternative and complementary health care discounts on acupuncture, chiropractic care and massage therapy.

Care Connect

24 hour, 7 days a week access to nurses who can answer health questions. They can also help you decide if you should go to the emergency room. Call Care Connect at 1-800-609-6175 (TDD/TTY: 1-800-848-0160). For more information see section about Care Connect.

Please visit the Fallon Health website for a much broader listing.

Behavioral health and substance use disorder services

Carelon's Provider Manual and Provider Directory:

- Provider Manual: https://www.carelonbehavioralhealth.com/providers/forms-and-guides/ma
- Provider Directory: https://plan.carelonbehavioralhealth.com/find-a-provider/

Carelon Managed Behavioral Health care Organization (MBHO) manages the behavioral health benefits (mental health and substance use) of Fallon Health members.

All Fallon members can self-refer for mental health or substance us disorder outpatient services by contacting a contracted provider. PCPs may also refer members directly to contracted providers. Members and PCPs may also contact Carelon at 888-421-8861, the number noted on member ID cards, for assistance in identifying contracted providers.

All members requiring inpatient or diversionary levels of care should contact Carelon at 888-421-8861 for triage and referral assistance. As with any emergent health situation, members experiencing a behavioral health emergency should be directed to the nearest emergency department, call 911, or call their local Emergency Services Program Provider.

Member calls are answered by a live voice within 30 seconds. On-call clinicians are available 24/7/365 for coverage of behavioral health emergent and urgent issues. The standard for returning calls by a Carelon clinician on weekends or after hours is 20 minutes. A Fallon MassHealth member can also access emergency behavioral health services 24 hours a day, seven days per week in any MA Emergency Department. Additionally, members can access these services through Community Behavioral Health Centers (CBHC). These services include: assessment, treatment, stabilization, mobile crisis intervention or a combination of these services for individuals having an emergency behavioral health crisis The CBHC network includes 29 centers throughout the state and contact information can be found at https://www.mass.gov/community-behavioral-health-centers Members can also access this information online through Carelon, at FallonHealth.org, and in Carelon's Provider Directory. Emergency Behavioral Health Services can also be accessed via the Behavioral Health Help Line at (833)-773-2445, or via web chat at masshelpline.com

Fallon Health PCPs and nurse practitioners may obtain a brief consultation regarding specific cases of behavioral health treatment being provided in the PCP setting by calling Carelon's provider hotline at (781) 944-7556 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday. This line is not for emergent, urgent or routine referral calls, rather it is provided as a short-term consultation for PCPs and prescribers to address concerns regarding members' behavioral health issues.

Managing patient care

Behavioral health providers are required to coordinate with state agencies, including but not limited to the Department of Children and Families (DCF), the Department of Youth Services (DYS), the Department of Mental Health (DMH), the Department of Transitional Assistance (DTA), the Department of Developmental Services (DDS), the Department of Corrections (DOC), Probation and Parole, the Executive Office of Elder Affairs (EOEA), State and Federal housing agencies, and local education authorities.

Carelon works with facilities to ensure those with existing state agency services are actively engaged in the treatment of the member as appropriate. This could include integrated team meetings in the inpatient setting. For members whose discharge is contingent on a state agency placement Carelon coordinates with the state agency on discharge planning and

they meet weekly with state agencies regarding members who are awaiting resolution of disposition. In addition, Carelon also coordinates with state agencies on members who are not inpatient and are boarding awaiting placement and collaborate on potential diversionary solutions.

Behavioral Health Providers and PCPs are required to coordinate member's care. Carelon Provider Manual and reference section 5.7. Coordination and Continuity of Care. Carelon and Fallon Health share a commitment to full integration of medical and behavioral health care services. Effective coordination improves the overall quality of both primary care and behavioral health services by:

- Support member access to needed medical and behavioral health services
- Reducing the occurrence of over- and under-utilization
- Increasing the early detection of medical and behavioral health problems
- Facilitating referrals for appropriate services

Maintaining continuity of care—Fallon and Carelon require PCPs and behavioral health providers to coordinate care through ongoing communication directly related to their patient's health status. With informed member consent, behavioral health providers are required to provide PCPs with information related to behavioral health treatment needs and current treatment plans of shared members. If a member is receiving treatment from more than one provider, the guidelines in this section apply to all providers.

Educate members and obtain member consent

Providers are expected to educate members about the benefits of care coordination and encourage them to grant consent for their clinical and environmental information to be shared among treatment providers. Notification requirements in this section can be fulfilled only with the member's consent

Communication between outpatient behavioral health providers, PCPs, and other treatment providers

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Behavioral health providers may use Carelon's Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health - PCP Communication Form for initial communication and subsequent updates, both available on the Carelon website, or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

Request for PCP response by fax or mail within three (3) business days of the request to include the following health information:

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information

Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.

Communication between inpatient/diversionary providers, PCPs, and other outpatient treatment providers

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within two days post-discharge: Date of discharge, Diagnosis, Medications, Discharge plan, and Aftercare services for each type, including name of provider, date of first appointment, recommended frequency of appointments, and treatment plan. Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Carelon's member record.

Behavioral Health Providers are required to follow protocols for transitioning Enrollees from one Behavioral Health Provider to another. Carelon Provider Manual and reference section 5.8. Transitioning Members from One Behavioral Health Provider to Another.

Additionally, Fallon MassHealth members under the age of 21, diagnosed with severe emotional disturbance, may have their behavioral health services coordinated through the services within the Children's Behavioral Health Initiative (CBHI). CBHI is an interagency undertaking by the Executive Office of Health and Human Services (EOHHS) and MassHealth whose mission is to strengthen, expand and integrate behavioral health services for Enrollees under the age of 21 into a comprehensive system of community-based, culturally competent care. Incorporated into the CBHI program is a network of Community Services Agencies (CSAs) to provide Intensive Care Coordination, Family Support and Training Services (Family Support Partner) services to Enrollees who are eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Care coordination for CSA services will be arranged by the member's behavioral health provider. Other services offered under CBHI include Mobile Crisis Intervention, Therapeutic Mentor, In Home Therapy, and In Home Behavioral Services.

- CBHI resources- Children's Behavioral Health Initiative (CBHI) | Mass.gov

Primary care settings are increasingly the first line of identification for behavioral health (BH) issues, especially for depression. As your patients' primary medical practitioner, you already know the large number of patients who present with both physical and behavioral health disorders. Carelon our behavioral health partner supports PCPs as the locus of treatment for a wide variety of BH diagnoses. To that end, a toolkit is available to help you with identification and next steps in treatment of BH conditions. We are committed to leading the integration of medical and BH services with the goal of improved patient outcomes.

- For more information on the PCP Toolkit, click here.
- For additional clinical resources, visit Carelon's clinical tools page.

Care Management programs

Fallon Health's Care Management Programs are staffed with a dedicated team of resources including but not limited to: Navigators, Nurse Case Managers (RNs), Social Workers, Behavioral Health Case Managers, Advanced Practice Clinicians (Nurse Practitioners), Pharmacists, Physicians, and Health Educators.

Care Management staff use motivational interviewing and coaching techniques with sensitivity to cultural disparities to better foster members' understanding of their health risks and empower them to make the lifestyle/behavioral changes required to reach their goals.

Interventions are Member-specific, focused, and strategic. They consist of live communications, telephonic and face-to-face interactions, as the individuals move along the health risk continuum.

Available Care Management programs and the referral criteria

To refer a Fallon Health member to any of these programs, access the referral form on fallonhealth.org and fax to 1-508-368-9030 OR call 1-508-799-2100 extension 78002, Monday through Friday, from 8:30 a.m. to 5:00 p.m. Provide the referral details including the member's full name, date of birth, member's preferred phone number, your name, your contact information and the date of the referral along with any additional pertinent details.

Enhanced Care Coordination: Members can receive enhanced care coordination supports from the ACO Nurse Case Managers and/or Behavioral Health team. Members in an enhanced care coordination program will have a multi-disciplinary Care Team in accordance with the needs and preferences of the Enrollee. Enrollees are encouraged to identify individuals to participate on their Care Team. These Enrollees have a comprehensive assessment completed along with a care plan that they approve. Outreach and engagement activities include but are not limited to telephonic communications, face-to-face visits with the Enrollee and coordination communications at time of transition and ongoing. There are 3 levels of care management in this program; Care Coordination, Care Management and Complex Care Management for enrollees with complex or chronic medical or behavioral health needs.

Care Coordination:	Fallon Health Navigators are experts in member benefits, network provider, community resources and coordinating care. Our Navigators work with member short term to ensure coordination needs are met.
Care Management:	Fallon Health Behavioral Health Care Team and/or Nurse Case Managers work with member who require a higher touch with a more episodic approach to assist the member in navigating medical conditions to ensure care needs are being met.
Complex Case Management:	Fallon Health Behavioral Health Case Managers and Nurse Case managers can provide long-term case management to our members that have highly complex medical and/or behavioral health needs. Each member receives an

individualized care plan, scheduled outreaches, regular collaboration with external providers and assistance in goal attainment to meet healthcare needs.

Our Enhanced Care Coordination program is designed to be tailored to each members individual needs with an interactive approach that encourages patient self-management. Our team strives to meet the holistic needs of members, to include social determinants of health, aiming to improve health outcomes, enhance quality of life and reduce healthcare costs.

Chronic Condition program

Fallon Health Nurse Case Managers and Health Educators work with the members and providers to educate members about their conditions and commonly work with members and their caregivers with the goal to develop a member approved care plan to meet their short- or long-term care needs.

Referral criteria:

- Two or more hospitalizations and/or ER visits for asthma, COPD, diabetes or cardiac conditions within the previous 12 months

Note: ANY Fallon Health Care Management, Disease Management, Pharmacy, Utilization Management staff may also refer members into this comprehensive complex case management program (NaviCare members do not qualify for this program secondary to their comprehensive Model of Care and Care Team structure). There are multiple avenues for members to be considered for this program including medical management program referrals, discharge planner referrals, member or caregiver referrals, and practitioner referrals.

Memory Specialist program

The Memory Specialist Program is a partnership with Fallon Health and the Alzheimer's Association of Massachusetts. Fallon's Memory Specialists are embedded at the Alzheimer's Association and are supported with their resources and expertise.

Referral Criteria:

- Members with a diagnosis of:
    - Dementia or Alzheimer's
    - Need for advanced planning
    - Need for member/family/caregiver education on the disease progression and community resources

Oncology (Cancer Support) Care Management program

Referral criteria:

- Two or more hospitalizations and /or ER visits for oncology concerns within the previous 12 months

- Presence of metastatic disease and multiple providers involved requiring care coordination and member case management support

Note: NaviCare members do not qualify for this program secondary to their comprehensive Model of Care and Care Team structure.

Palliative Care program

The Palliative Care Program focus is on care coordination for members in need.

Referral criteria:

- Presence of disease (acute or chronic life threatening or limiting conditions)

Pharmacy review

Fallon Health Pharmacists are available to assist providers and members with medication needs.

Referral criteria:

- Polypharmacy: more than 8 prescriptions
- High cost (more than $4,000 annually)
- Potential drug regimen adverse reactions/interactions

Special Deliveries High Risk Prenatal program

The program focus is on educating and empowering the member to seek timely prenatal care and together with the Navigator and Social Care Management staff the RN Case Managers work together with the prenatal providers to connect the member to care, services, and community resources such as transportation to meet their needs. The Program follows members throughout their pregnancy and post-partum time period up until the provider is seen for follow up care post-delivery. The Program also focuses on ensuring the newborn is connected with care and providers upon birth. The program is available for all pregnant members regardless of Fallon product membership.

Referral criteria:

- History of preterm delivery (less than 37 weeks)
- History or current PTL, PROM, abnormal bleeding, cerclage
- History or current PIH, preeclampsia, hyperemesis
- History of low birth weight infant (less than 2500 grams or 5 lbs., 8 0z.)
- Chronic health condition, i.e. diabetes or other chronic health condition
- Recent emergency room visit/hospitalization
- New pregnancy or fetal complication
- Previous and/or current behavioral health issues affecting pregnancy
- Previous and/or current substance abuse affecting pregnancy

- Socioeconomic concerns – unmet basis needs such as food, housing or transportation
- Unsafe living environment such as homelessness, violence or abuse

Renal program

The program focus is to assist End Stage Renal Disease (ESRD) members with network resources and benefit guidelines to manage their condition. Nurse Case Managers and Navigators are available to assist members.

Referral Criteria:

- ESRD, newly diagnosed
- ESRD, receiving dialysis

Social Care Management program

Fallon Health employs Social Care Managers to help members with housing, accessing community resources such as fuel assistance, SNAP benefits, Medicaid applications, work with other community organizations such as food pantry's, religious organizations, cultural organizations and others to fill needs and gaps with the overall goal to improve the member's health and reduce utilization of unnecessary health care services.

Referral Criteria:

- Socio-economic concerns
- Community resource needs
- Long-term placement
- Legal concerns
- Financial issues pertaining to prescription costs
- Other concerns impacting member's ability to receive care

Disease Management

Available Disease Management Programs and the referral criteria follows – to refer a Fallon Health member to any of these Programs, access the Referral Form(s) on fallonhealth.org and fax to 1-508-368-9030 OR call 1-508-799-2100 extension 78002 Monday through Friday from 8:30 am to 5:00 pm and provide the referral details including the member's full name, date of birth, member's preferred phone number, your name, your contact information and the date of the referral along with any additional pertinent details.

Asthma Management program

Fallon Health employs Nurse Case Managers and Health Educators with experience and expertise in asthma and are ready to work with members over the age of 5 and their families with the goal to educate the member/family on asthma, coordinate care with providers and work with community resources and partners with the goal for optimal management of the condition.

Referral criteria:

- Newly diagnosed with asthma
- Two or more hospitalizations and/or ER visits for asthma within the previous 12 months
- Has asthma and has needs related to:
    - Education about the disease
    - Self-management
    - Medication adherence

Cardiac Management program

Fallon Health employs Nurse Case Managers and Health Educators with experience and expertise in cardiac conditions and are ready to work with members over the age of 18 and their families with the goal to educate the member/family on cardiac conditions, coordinate care with providers and work with community resources and partners with the goal for optimal management of the condition.

Referral criteria:

Two or more hospitalizations and/or ER visits for cardiac disease within the

previous 12 months

- Has a recent cardiac event (CHF, CABG, MI, PT CA) and/or unstable angina
- Has a past cardiac event (CHF, CABG, MI, PTCA) and/or unstable angina and has needs related to:
    - Education about the disease and self-management
    - Medication adherence
- Has high blood pressure and has needs related to
    - Education about the disease and self-management
    - Medication adherence
- Has hyperlipidemia and has needs related to
    - Education about the disease and self-management
    - Medication adherence

COPD Management program

Fallon Health employs Nurse Case Managers and Health Educators with experience and expertise in COPD and are ready to work with members over the age of 18 and their families with the goal to educate the member/family on living with COPD, coordinate care with providers and work with community resources and partners with the goal for optimal management of the condition.

Referral criteria:

- Newly diagnosed with COPD
- Two or more hospitalizations and/or ER visits for COPD within the previous 12 months
- Member has COPD and has needs related to:
    - Education about the disease
    - Self-management
    - Medication adherence

Congestive Heart Failure (CHF) Management program

Fallon Health employs Nurse Case Managers and Health Educators with experience and expertise in CHF and are ready to work with members over the age of 18 and their families with the goal to educate the member/family on living with CHF, coordinate care with providers and work with community resources and partners with the goal for optimal management of the condition.

Referral criteria:

- Newly diagnosed with CHF
- Two or more hospitalizations and/or ER visits for heart failure within the previous 12 months
- Member has CHF and has needs related to:
    - Education about the disease
    - Self-management
    - Medication adherence

Diabetes Management program

Fallon Health employs Nurse Case Managers and Certified Diabetic Health Educators with experience and expertise in diabetes and are ready to work with members and their families with the goal to educate the member/family on living with diabetes, coordinate care with providers and work with community resources and partners with the goal for optimal management of the condition.

Referral criteria:

- Newly diagnosed with diabetes or pre-diabetes
- Two or more hospitalizations and/or ER visits for diabetes within the previous 12 months
- Member has diabetes and has needs related to:

- Education about the disease
- Self-management
- Medication adherence

Quit to Win (smoking cessation program)

Fallon Health employs Health Educators with experience and expertise in smoking cessation and are ready to work with members to help them stop smoking.

Referral criteria:

- Member is ready to quit and wants to start the program
- Member is interested in learning more about the program

Members are informed about the Clinical Integration Team Care Management Programs through the member magazine and on the Fallon Health website.

Satisfaction with Care Management and Disease Management programs

Fallon annually evaluates satisfaction with the various care management programs by obtaining feedback from members and analyzing member complaints and inquiries; identifying opportunities to improve satisfaction.

NaviCare

NaviCare® – Model of Care training

The main philosophy behind our NaviCare product is to assist our members in functioning at the safest level in the most appropriate setting, utilizing both Medicare and Medicaid covered benefits and services. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. NaviCare services every county in Massachusetts, with the exception of Nantucket and Dukes.

Every member has a customized member centric plan of care developed by their Care Team. The care plan contains details about the member's goals and the benefits that are part of their care plan. Benefits may include but are not limited to in-home supportive services such as homemakers, the Personal Care Attendant (PCA) Program, Adult Day Health Care, Group Adult and Adult Foster Care. Each member's care plan is unique to meet their needs.

Note: NaviCare benefits may change annually – to see the most current benefits for the appropriate calendar year, check out fallonhealth.org/navicare.

NaviCare members get an entire Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as a coordinated care plan to reference and other Care Team members to communicate with to have the best information possible for each NaviCare patient.

Managing patient care

Care Team members and their roles include:

Navigator

- Educates patients about benefits and services
- Educates patients about—and obtains their approval for—their care plan
- Assists in developing patient's care plan
- Helps patients make medical appointments and access services
- Informs Care Team when patient has a care transition

Nurse Case Manager or Advanced Practitioner

- Assesses clinical and daily needs
- Teaches about conditions and medications
- Helps patients get the care they need after they're discharged from a medical facility

Primary Care Provider (PCP)

- Provides overall clinical direction
- Provides primary medical services including acute and preventive care
- Orders prescriptions, supplies, equipment and home services
- Documents and complies with advance directives about the patient's wishes for future treatment and health care decisions
- Receives patient's care plan and provides input when needed

Geriatric Support Service Coordinator employed by local Aging Service Access Points (ASAPs) *(if patient is living in own home)*

- Evaluates need for services to help patients remain at home and coordinates those services
- Helps patients with MassHealth paperwork
- Connects patients with helpful resources

Behavioral Health Case Manager (as needed)

- Identifies and coordinates services to support patients' emotional health and well-being
- Supports your patients through transition to older adulthood
- Helps connect patients with their Care Team and patients' mental health providers and substance- use counselors, if present

Clinical pharmacist (as needed)

- Visits patients after care transition to perform a medication reconciliation and teaches them proper medication use

Managing patient care

Providing input to your patient's care plan and working with us

PCPs are welcome to provide input to their patient's care plan at any time by contacting the NaviCare Enrollee Service Line at 1-877-700-6996 or by speaking directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you are interested in having a Navigator and/or Nurse Case Manager embedded in your practice, please contact us at the above phone number.

To refer a patient to NaviCare or learn more about eligibility criteria, contact a Representative at the NaviCare Marketing Line 1-877-255-7108.

Communication and coordination protocols of the Interdisciplinary Care Team (ICT)

The following are protocols for communication and coordination between Members of the Enrollee's ICT, including access to electronic health records or care management portals:

Fallon Health, in partnership with our contracted primary care providers for the Senior Care Options (SCO) product demonstrate compliance to the following subset of elements from the Massachusetts Executive Office of Health and Human Services (EOHHS) SCO Contract.

Fallon Health supports primary care providers in their role on the ICT. To accomplish this, Fallon Health will dedicate employed clinical care team staff to document in the provider's electronic medical record (EMR) and will adhere to security protocols as mutually agreed upon.

Fallon Health's I.T. Team will partner with the provider organization's I.T. Team to develop and implement interoperability protocols and data sharing for simplification and efficiencies.

The provider organization will ensure Fallon Health care team staff are only able to view and edit in the records of Fallon Health SCO member files according to mutually agreed upon security protocols.

Fallon Health care team staff will document in the EMR the following at minimum (and/or will develop in partnership with the provider's I.T. Team interoperability to accomplish such) and will mutually develop documentation protocols for these elements with the provider partner designee.

- Member's initial and ongoing Comprehensive Assessment results (or at mutually agreed upon frequencies)
- Member's care plans at time of initial development and ongoing updates (or at mutually agreed upon frequencies)
- Notification about member emergency room and inpatient admissions and discharge follow needs and plans

Fallon Health requests the ability to set tasks and send messages to primary care providers in their EMR and will also dedicate resources, to receive and manage tasks and messages from primary care providers associated with the member care coordination needs. Primary care providers may provide input to the member's care plan at any time.

Managing patient care

Fallon Health care team staff will access the EMR to obtain data as required for HEDIS reporting.

Primary Care Providers (PCPs) are required to share clinical data on Enrollees with the Fallon Health, including but not limited to data to support the Quality Measure reporting requirements subject to all applicable laws and regulations, as further specified by EOHHS.

Primary Care Providers (PCPs) are required to document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions.

Primary Care Providers (PCPs), as part of the ICT, must document in the EMR all notifications they receive from the hospital on Enrollee’s Emergency Department (ED) services, Hospital admission and discharge information.

Emergency Department (ED) services

- The hospital shall notify the Enrollee’s PCP, and/or Care Team within one business day of the Enrollee’s presentation at a hospital’s ED. Notification may include a secure electronic notification of the visit.

Hospital services

- The hospital shall ensure that the hospital’s discharge summary is sent to the Enrollee’s PCP, and/or Care Team within two business days of the discharge. The discharge summary shall include a copy of the hospital’s discharge instructions that were provided to the Enrollee and include details on the Enrollee’s diagnosis and treatment.

- The hospital shall notify the Enrollee’s PCP and the Contractor in order to ensure that appropriate parties are included in Discharge Planning. Such parties may include care coordinators, case managers, caregivers, and other critical supports for the Enrollee.

Centralized Enrollee Record

- To coordinate care, the Fallon Health care team staff shall maintain a single, centralized, comprehensive electronic record that documents the Enrollee's medical, prescription, functional, and social status. The Fallon Health care team staff shall ensure that the PCP and all Members of the ICT, including the GSSC Coordinator, as well as any other appropriate providers, make appropriate and timely entries describing the care provided, clinical assessments, diagnoses determined, medications prescribed, treatment plans, treatment services provided, treatment goals and outcomes, and pharmacy records.

CareConnect (formerly called Nurse Connect)

Fallon Health offers members access to registered nurses who serve as health coaches 24 hours a day, seven days a week, 365 days a year. A health coach can provide:

- Personal education and support
- Information to help your patients make health decisions
- Educational materials relevant to a diagnosis or condition (mailed right to their home)
- Assistance with finding additional health information online

Community Care, MassHealth ACO and Fallon Medicare Plus members can call

800-609-6175 (TDD/TTY: 1-800-848-0160)

NaviCare members can call 877-700-6996 (TDD/TTY: 1-800-848-0160)

Dental benefits for MassHealth ACO members

MassHealth dental benefit

Fallon Health's contract with MassHealth only provides coverage for emergency dental services and oral surgery performed in an outpatient setting which is medically necessary to treat a medical condition. All other dental services/procedures are covered by MassHealth. For questions related to Fallon Health MassHealth ACO dental benefits, please contact Fallon Health MassHealth ACO Customer Service at 800-341-4848. MassHealth benefits are not administered by Fallon Health. MassHealth provides dental coverage and is contracted with Dental Service of Massachusetts, Inc. (DSM) to manage the MassHealth dental program. DSM and its subcontractor, DentaQuest, referred to as Dental Customer Service, specialize in dental services for MassHealth members. They are available to answer questions about MassHealth dental coverage and help in finding a dentist and intervention services for both members and providers.

For eligible adults, MassHealth covers medically necessary dental services including check-ups, x-rays, cleanings, fillings, certain endodontic services (for example, root canals), and dentures. Some of the services need prior approval.

For a listing of dental providers, visit the web at masshealth-dental.net or call 1-800-207-5019 between the hours of 8:00 a.m. and 6:00 p.m.

Dental screenings and cleanings are available for children, adolescents and young adults under age 21. The child's PCP will check the child's oral health and, if the child is three years old or older, will recommend a visit to a dentist at least twice a year. No referral is required for an appointment with a MassHealth dentist. MassHealth recommends a dental checkup once per year starting at age three; and

- a dental cleaning every six (6) months starting at age three; and
- any other dental treatments needed, even before age three, if the child's primary care provider or dentist detects problems with the child's teeth or oral health.

MassHealth requires that the child's annual dental checkup should include: a complete dental exam, teeth cleaning and fluoride treatment.

Fluoride varnish coverage for Fallon Health MassHealth ACO members

Physicians and other qualified health care professionals* now may apply fluoride varnish to eligible Fallon Health MassHealth members under age 21. It's expected that this procedure would occur during a pediatric preventive care visit. The goal is to increase access to preventive dental treatment in an effort to prevent early childhood cavities in children at moderate to high risk for dental decay.

Eligible members

Members must meet the following three criteria to be eligible:

1. The member is under the age of 21;
2. The member is eligible for dental services; and
3. The service is medically necessary as determined by a Caries Assessment Tool.

Providers must bill Fallon Health with CDT code D1206 on the CMS 1500 form.

Please refer any MassHealth ACO member who is without a dental provider to an appropriate dental service provider for ongoing preventive care. Please call us at the number below if you need assistance in locating a dental provider.

Required training:

We've approved the following training programs for providers who want to apply fluoride varnish to our eligible members. You may self-administer either the American Association of Pediatric Oral Health Group's online training on Cavity Risk Assessment at http://www.aap.org/commpeds/dochs/oralhealth/cme or the Smile for Life program at http://www.stfm.org/oralhealth. Providers must maintain proof of their completed training and provide Fallon Health with documentation upon request.

** Physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses who complete the required training.*

Dental benefits for NaviCare, Fallon Medicare Plus, Community Care

Effective January 1, 2024, DentaQuest is the dental benefit administrator and utilization manager for Fallon Health eligible members.

DentaQuest is the largest, multi-product dental administrator in the country. Their experience provides the ability to leverage their knowledge gained from over 40 years managing dental programs across the country. DentaQuest is a valued partner in supporting dental benefit administration, exceeding network adequacy and access requirements and providing clinical expertise and utilization management support.

DentaQuest: https://www.dentaquest.com/en/providers/massachusetts

Dental benefit for eligible members: Eligible members have access to dental benefits through the DentaQuest network of dental providers.

This applies to the following products:

- Fallon Medicare Plus (FMP) - *excluding FMP Supplement and FMP Super Saver*
- NaviCare HMO SNP and SCO
- Community Care - pediatric only

DentaQuest covers preventive dental care including exams, cleanings, and X-rays (limited to twice a year), and minor and major restorative dental services. Certain dental services require prior authorization. Refer to the member's benefits and DentaQuest for approval.

Members can find contacted providers online at our website fallonhealth.org/findphysician.

Provider information: providers can contact DentaQuest directly for information on the network, authorizations, claims and provider enrollment.

For contracted Providers-
Provider Portal: https://govservices.dentaquest.com/
Provider Services: 1- 844-234-9829

For non-contracted Providers-
https://www.dentaquest.com/en/providers/massachusetts
Provider Recruitment: 1-855-873-1283; NetworkDevelopment@dentaquest.com

Claims and related provider appeals should be sent to DentaQuest:
DentaQuest accepts dental claims in these formats:

- Electronic claims via DentaQuest's Portal.
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File
- Paper claims mailed to: DentaQuest of Washington, LLC PO Box 2906 Milwaukee, WI 53201-2906

Emergency care and urgent care

Directing and monitoring emergency care

The plan covers emergency care worldwide. Members with an emergency medical condition should go to the nearest emergency room for care or call the local emergency communications system (e.g., police, fire department or 911) to request ambulance transportation.

Please note: For all Behavioral Health (mental health and substance abuse) emergency care, please refer to the Behavioral Health (mental health and substance abuse) section.

An emergency health condition is a condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual (or unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency services do not require prior authorization. The PCP should be notified to ensure coordination of any needed follow-up care. Follow-up care in an emergency room often will not meet a prudent layperson definition and most emergency room follow-up care can be provided in another setting.

In out-of-area emergencies the member is instructed to call the local communication system (e.g., police, fire department or 911) or go to the nearest medical facility for care. Within 48 hours after receiving emergency care the member or someone on their behalf should notify the plan and contact their PCP for follow-up assistance. Once stabilized a member should return to the service area for follow-up care.

Emergency Department (ED) Services

a) The hospital shall notify the member's Primary Care Physician (PCP), Community Partner (CP), ACO Care Management program, and/or Care Team within one business day of the Enrollee's presentation at a hospital's ED. Notification may include a secure electronic notification of the visit.

b) The hospital shall offer Emergency Service Program (ESP) Services to all members presenting with a behavioral health crisis in the ED.

c) The hospital shall offer substance use evaluations, treatment, and notification in the ED in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

Urgent care

The member is instructed to call the PCP before seeking urgently needed services. Urgently needed services are those services needed immediately as a result of an unforeseen illness, injury or condition. The PCP should ensure that the member is seen in the PCP's office or hospital courtesy room whenever appropriate. The hospital Emergency Department should be recommended only when the PCP determines that the office is an inappropriate place for treatment. If out-of-area and a member requires urgent care, they are instructed to call their PCP first, if possible, before going to the nearest medical facility.

Note: Some IPA/PHO provider network agreements differ from the procedure described below. When applicable, please defer to the IPA/PHO procedures.

Procedure:

In-area care

If the member calls the physician prior to treatment, the physician:

- Recommends the most appropriate plan of treatment.
- Advises the member where to go for treatment.
- Calls the hospital Emergency Department to advise of referral, if appropriate.

If the member does not call the physician until after receiving emergency department treatment, the physician obtains information on the service and arranges follow-up care.

The physician follows the member to ensure that Emergency Department care and any subsequent admission is appropriate and managed properly.

Follow-up for out-of-area care

The member calls the PCP to arrange for any follow-up care. The PCP follows referral procedures in order to authorize follow-up care with any other provider. Follow-up care should be provided in the PCP's office when appropriate.

Emergency Department Based Behavioral Health Crisis Evaluations

Medicaid ACO members

For dates of service on or after January 3, 2023, Fallon Health will reimburse hospitals for behavioral health crisis evaluations provided to members in the emergency department pursuant to MCE Bulletin 93.

All claims for these services should be billed to Fallon Health

- S9485 (Crisis intervention mental health services, per diem)

The code may be billed once per member for each visit the member makes to the emergency department. The code and related rate include the initial evaluation, triage, and disposition planning that generally occurs on the first day and isn't intended to reimburse for members awaiting inpatient placement. Hospitals are expected to deliver emergency department-based behavioral health crisis evaluations in accordance with the standards set forth in Appendix I of the MassHealth Acute Hospital RFA.

Community Care members

For dates of service on or after November 1, 2022, Fallon Health will reimburse hospitals for behavioral health services provided to Community Care patients awaiting inpatient psychiatric admissions pursuant to Massachusetts Division of Insurance Bulletin 2022-08.

All claims for these services should be billed to Fallon Health

- S9485 (Crisis intervention mental health services, per diem) with modifiers TG, TF, ET
- T1004 (Services of a qualified nursing aide, up to 15 minutes)

Responsibilities of Fallon Health providers defined

We want to make it easy for you to serve and provide the highest quality care possible to your Fallon Health patients. With this goal in mind, we will keep you informed of Fallon Health policies and procedures as well as your responsibilities as a participating Fallon Health provider.

As a Fallon Health Provider you MUST:

- Adhere to all Fallon Health policies and procedures as outlined in the *Provider Manual* or other appropriate channels.
- Accept and treat your Fallon Health patients in an identical manner to all other patients in your practice.
- Participate in discharge planning and follow-up.
- Support members experiencing—or at risk of—homelessness in discharge planning. Please notify Fallon Health of MassHealth ACO, NaviCare, and Summit ElderCare members who are inpatient and homeless/housing insecure by emailing HomelessHelpline@fallonhealth.org
- Ensure you are responsive to your Fallon Health patients' linguistic, cultural, ethnic, or other unique needs of members of minority groups, members experiencing homelessness, members with disabilities, and other special populations.
- When necessary, have the capacity to communicate with Fallon Health members in languages other than English, and communicate with individuals who are deaf, hard-of-hearing, or deaf blind.
- Accept and treat all members regardless of race/ethnicity, age, English proficiency, sexual orientation, gender identity, health status or disability.
- Not engage in any practice with respect to any Member that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and pursuant to Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections, Section 10.5.2.
- Help your non-English speaking members get interpreter services if necessary. For more information see Interpreter Services.
- Provide Advance Directive information according to health plan and regulatory requirements. For more information see Advance Directives
- Provide or coordinate all age-specific Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services according to health plan requirements. https://www.mass.gov/service-details/epsdt-and-pphsd-information-and-resources

- Meet regulatory requirements.
    - Adhere to the Standard for Privacy of Individually Identifiable Health Information.
    - Use Health Insurance Portability and Accountability Act (HIPAA) compliant practices.
    - Report mandatory findings to local health departments and notify us as appropriate.
- **Primary Care Provider (PCP) responsibilities**. Each Fallon Health member selects a PCP (internal medicine, family practice, pediatrics or adolescent medicine) from the list of Fallon Health providers. A Medicaid ACO member may choose an Ob/Gyn as a primary care provider. The PCP has the primary responsibility for managing and monitoring overall care and providing the continuity of care for each member in their panel. The primary care provider's role includes the following responsibilities:
    - Provide primary care, including preventive care, diagnosis and treatment of illness and injury, and office laboratory and diagnostic services, as available.
    - Provide medical care in the hospital or skilled nursing facility as appropriate, following procedures for "Admitting for Inpatient Stay or Same-Day Surgery."
    - Refer member for specialty care when appropriate, following procedures for PCP Referral and Plan Prior Authorization Processes.
    - Additionally, as part of the NaviCare Interdisciplinary Care Team (ICT), the role of the PCP is:
        - To work with the team (and the enrollee) to develop/reassess the Individualized Plan of Care (IPC) to ensure the enrollee receives the care they need. The PCP receives patients' care plan and provides input when needed.
        - To follow *Communication and coordination protocols* as described in the *Care Management* section of this provider manual.

      For more information about NaviCare visit: https://fallonhealth.org/en/find-insurance/navicare/About-NaviCare,
- Comply with medical and behavioral record standards as outlined in Medical and Behavioral Record Standards
- Notify a patient's PCP about any services and/or treatment you provide, if you are not the patient's PCP.
- Make covered health services available to all members.
- Discuss all treatment options with your patients, regardless of cost or benefit coverage.

- Cooperate with Fallon Health's quality improvement (QI) activities to improve the quality of care services and member experience including the collection and evaluation of data and participation in Fallon Health's QI programs as outlined in the Quality Programs section of this manual.
- Keep your information current with Fallon Health. Log into CAQH Proview (https://proview.caqh.org/Login) to review and/or update your information. Verify and attest to data quarterly in CAQH.
- Providers cannot charge a Fallon Health member for any service that is not medically necessary or not a covered service if you did not explain this and explain that other services may meet the member's needs. Providers also need to explain to the member that they would have to pay for such services and the expected cost. Providers will need to document that they have notified the member and have the member sign a waiver.
- Assist with case management by referring members and by participating in multidisciplinary case management teams.
- Provide coverage on 24-hour basis, direct member to appropriate place of treatment and monitor initial and follow-up treatment for member emergent/urgent conditions. Advise emergency room care as appropriate according to procedures.
- Ensure office hours of operation are consistent across all patients.
- Providers are expected to support the rights of Fallon Health members including but not limited to those listed below. Members are allowed to exercise such rights without any adverse impact on their treatment. If a member is dissatisfied with the provider or action of the plan, they may file a grievance or appeal. See Member Appeals and Grievances section of this manual for details.
    - The right to receive the information required pursuant to the Fallon Health contract.
    - The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
    - The right to freely exercise their rights without adversely affecting the way the plan and its providers treat the Member.
    - The right to request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526; and the right to be furnished covered services.
- Ensure that services are provided to children in the care or custody of DCF, and youth affiliated with DYS (either detained or committed), as follows:
    - Ensure that providers make best efforts to provide the 7-day medical screenings and 30-day comprehensive medical evaluations, which shall include the EPSDT screens appropriate for the child's age, for their Enrollees who are taken into DCF custody.

- In addition to the Continuity of Care requirement, cover primary care services when provided by out-of-network providers for 30 days after a member is taken into DCF custody, without requiring any prior approval or permission to see such out-of-network provider.

- Make best efforts to provide foster parents with current medical information about the Enrollees placed in their care in a timely manner.
- Ensure that providers make best efforts to communicate with the DCF caseworker(s) assigned to Enrollees in DCF care or custody and inform them of services provided through Fallon Health's MassHealth ACO plans.
- Ensure that providers make best efforts to communicate with the DYS caseworker(s) assigned to Enrollees in DYS and inform them of services provided through Fallon Health MassHealth ACO plans.

- In accordance with 42 USC 1396u-2(b)(3) and 42 CFR 438.102, Fallon Health may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is their patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment; and
  - The member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- In accordance with the Fallon Health Contract.
  The Physician Organization (PO) shall have a process in place for ensuring that all Plan correspondence is received by Plan Members who are inpatients at the facility on the date of delivery of said correspondence. The receipt of such correspondence shall be documented. The PO shall notify the Plan if they are unable to deliver such correspondence to the Plan Member.

  The PO shall provide information to Plan Members regarding treatment options, including those Plan Members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities in a culturally competent manner. The PO shall ensure that Plan Members with disabilities have effective communication with Providers in making decisions regarding treatment options.

The PO shall educate Plan Members regarding their health needs, share findings of history and physical examinations, side effects of treatment, management of symptoms and recognize that the Plan Member shall determine the final course of action among clinically acceptable choices.

Marketing activity guidelines

All Marketing activities must be done in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Provider promotional activities & communications with Fallon Medicare Plus (FMP) Medicare Advantage members on behalf of Fallon Health:

Contact your provider relations representative in the event you would like to develop informational materials for FMP members or other Medicare beneficiaries. Such communications are subject to CMS review and approval in accordance with, Medicare Communications and Marketing Guidelines (MCMG) 42 CFR §422.2260 -422.2276.

If you have any questions regarding the following activities, please call your provider relations representative to discuss the guidance provided in the current version of the Medicare Marketing Guidelines.

- § 422.2266 (A-F) Activities with healthcare providers or in the healthcare setting.

Provider promotional activities & communications with Fallon Medicare Plus (FMP) Medicare Supplement members on behalf of Fallon Health:

Contact your provider relations representative in the event you would like to develop informational materials for Medicare Supplement members or engage in any other promotional or marketing activities. Health plans selling these types of products are subject to state regulatory guidelines around marketing activities.

Provider promotional activities & communications with NaviCare SCO and HMO SNP members on behalf of Fallon Health:

Contact your provider relations representative in the event you would like to develop informational materials for NaviCare members. Such communications are subject to CMS review and approval in accordance with, Medicare Communications and Marketing Guidelines (MCMG) 42 CFR §422.2260 -422.2276.

If you have any questions regarding the following activities, please call your provider relations representative to discuss the guidance provided in the current version of the Medicare Marketing Guidelines.

- § 422.2266 (A-F) Activities with healthcare providers or in the healthcare setting.
- All permissible marketing activities and materials must be submitted and approved by EOHHS prior to distribution.

Provider promotional activities & communications with Community Care members on behalf of Fallon Health:

Contact your provider relations representative in the event you would like to develop informational materials for Community Care members or engage in any other promotional or marketing activities. Health plans selling these types of products are subject to state regulatory guidelines around marketing activities.

Marketing Activities Requirements for Fallon Health MassHealth ACO plans:

General requirements:

Fallon Health and Fallon Health providers must meet the following requirements for any Marketing activities described herein:

- Ensure that all Marketing Materials regarding Fallon Health MassHealth ACO plans clearly state that information regarding all MassHealth Managed Care enrollment options including, but not limited to, Fallon Health MassHealth ACO plans, are available from the MassHealth Customer Service Center. Fallon Health shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for Fallon Health's customer service center. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by Fallon Health.
- Comply with all applicable information requirements set forth in 42 CFR 438.10 when conducting Marketing activities and preparing Marketing Materials.
- Submit all Marketing Materials to EOHHS for approval prior to distribution. Fallon Health shall submit Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible.
- Comply with any requirement imposed by EOHHS.
- Distribute and/or publish marketing materials throughout Fallon Health's service area(s), unless Fallon Health submits a written request which is approved by EOHHS to implement a targeted marketing campaign. A targeted marketing campaign involves distributing and/or publishing materials (1) to a part of the Fallon Health's service area(s) or (2) where the campaign relates to a local event (such as a health fair) or to a single provider (such as a hospital or clinic), to a certain zip code or zip codes; and
- Provide EOHHS with a copy of all press releases pertaining to Fallon Health's MassHealth line of business for prior review and approval.

Permissible Marketing Activities:

Fallon Health and Fallon Health providers may engage in only the following marketing activities, in accordance with the requirements stated above.

- A health fair or community activity sponsored by Fallon Health or Fallon Health provider provided that the Fallon Health or provider shall notify all MassHealth-

contracted Accountable Care Partnership Plans or MCOs within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted Accountable Care Partnership plans or MCOs choose to participate in a Fallon Health or Fallon Health provider sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted Accountable Care Partnership Plans and MCOs. Fallon Health or Fallon Health provider may conduct or participate in marketing at Fallon Health or non-Fallon Health sponsored health fairs and other community activities only if:

  - Any marketing materials Fallon Health distributes have been pre-approved by EOHHS; and
  - Any free samples and gifts offered by Fallon Health or Fallon Health provider are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in Fallon Health's Plan.
- Fallon Health may participate in Health Benefit Fairs sponsored by EOHHS.
- Fallon Health may market Fallon Health's Plan to members in accordance with the rules stated above, by distributing and/or publishing marketing materials throughout the Fallon Health's service area(s) or implementing a targeted marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing marketing materials may include:
  - Posting written marketing materials that have been pre-approved by EOHHS at Provider sites and other locations; and posting written promotional marketing Materials at Network Provider and other sites throughout Fallon Health's service area.
  - Initiating mailing campaigns that have been pre-approved by EOHHS, where Fallon Health distributes marketing materials by mail; and
  - Television, radio, newspaper, website postings, and other audio or visual advertising.

Prohibitions on marketing and enrollment activities:

Fallon Health and Fallon Health providers shall not:

- Distribute any marketing material that has not been pre-approved by EOHHS.
- Distribute any marketing material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the marketing material, including but not limited to, any assertion or statement, whether written or oral, that:
  - The recipient of the marketing material must enroll in Fallon Health's plan in order to obtain benefits or in order to not lose benefits; or
  - Fallon Health is endorsed by CMS, the federal or state government or similar entity.
- Seek to influence a member's enrollment in Fallon Health's Plan in conjunction with the sale or offering of any private or non-health insurance products (e.g., life insurance);

- Seek to influence a member's enrollment into Fallon Health's Plan in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts.
- Directly or indirectly, engage in door-to-door, telephonic, email, texting, or any other cold-call marketing activities.
- Engage in any Marketing activities which could mislead, confuse or defraud Members or Enrollees, or misrepresent MassHealth, EOHHS, the Contractor or CMS.
- Conduct any Provider site Marketing, except as described above.
- Engage in marketing activities which target members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

Marketing plan and schedules:

- Fallon Health shall make available to EOHHS, upon request, for review and approval:
    - A comprehensive marketing plan including proposed marketing approaches to groups and individuals in Fallon Health's service area(s); and
    - Current schedules of all Marketing activities, including the methods, modes, and media through which marketing materials will be distributed.
- As requested by EOHHS, Fallon Health shall present its marketing plan in person to EOHHS for review and approval.
- As requested by EOHHS, Fallon Health shall submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud members or the state.

Information to enrollees:

Nothing herein shall be deemed to prohibit Fallon Health and Fallon Health providers from providing non-Marketing information to members consistent with their contract, regarding new services, personnel, member education materials, care management programs and provider sites.

MassHealth Benefit Request and Eligibility Redetermination Assistance:

- As directed by EOHHS, Fallon Health or provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:
    - Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants.
    - Assist MassHealth applicants in completing and submitting MBRs.
    - Offer to assist members with completion of the annual ERV form; and
    - Refer MassHealth applicants to the MassHealth Customer Service Center.

Home Care, Hospitalization and Skilled Nursing Facility admissions

Home Care Services

Home health care services (skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work, and home health aide services) are provided to members in their home by certified home health care agencies and are considered skilled when they can only be safely and effectively provided by and/or under the supervision of a licensed clinician. Home health care services must be ordered by a licensed physician or other allowed practitioner.

A Fallon Health Prior Authorization (PA) Nurse will perform initial and concurrent review on all home health care admissions. Once a member is admitted, the PA nurse will perform concurrent review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. Fallon Health uses nationally recognized criteria for review such as CMS and MassHealth.

Procedure

1. Services must be ordered by a licensed physician (MD, DO, DPM) or other allowed practitioner who is working in collaboration with a licensed physician. Beginning March 2020, other allowed practitioners include:
   - A nurse practitioner collaborating with a physician
   - A clinical nurse specialist collaborating with a physician
   - A physician assistant working in accordance with state law

   For MassHealth ACO members, a certified nurse midwife is also allowed to order home health services.
2. The member must be under a plan of treatment established and periodically reviewed by a licensed physician. Beginning March 1, 2020, the allowed practitioners listed above may establish and review home health plans of care for commercial and Medicare members.
3. Commercial and Medicare Advantage plan members must be homebound (not able to leave the home without a taxing effort). For products with MassHealth enrollment (inclusive of dual-enrolled programs NaviCare, PACE) there is no specific requirement to be homebound.
4. The member must have a clinical need for part-time, intermittent skilled services, which include at least one of the following disciplines: Skilled nursing (RN), physical therapy, occupational therapy, or speech therapy. In order to qualify for a medical social worker or a home health aide to assist with personal care, the member must also have the clinical need for at least one of the skilled services listed above.

5. There must be an end point to the services based on medical necessity.
6. MassHealth defines the below clinical, in addition to the above, as clinical criteria for nursing services:
    - Medication Administration Visit. A skilled nursing visit for the sole purpose of administering medication may be considered medically necessary when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task of the administration of medication, including the route of administration, requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication.
7. All requests must be submitted on the Universal Health Plan/Home Health Authorization Form – March 1, 2006, version.
    1. If a member needs additional skilled home health care services following the initial 30-day period, Fallon Health will consider authorizing subsequent services for up to a 30-day period.
    2. If the member needs ongoing home health care services, the Home Health Agency would submit the request for consideration. Based upon the member's clinical needs, Fallon Health may authorize services for up to a 30-day period. Monthly vitamin B12 injections and Foley catheter changes for homebound members may be approved for up to a 60-day period.
    3. Upon completion of all home health care services, the Agency must notify Fallon Health in writing of the discharge utilizing the appropriate discharge section of the Universal Health Plan/Home Health Authorization Form. Fallon Health must be notified of the Agency discharge prior to, or on the day of, the last skilled discipline visit.
    4. In addition, for all Fallon Health Medicare Plus, including NaviCare HMO SNP members, a copy of the Notice of Medicare Non-Coverage (NOMNC) letter must be faxed to Fallon Health at the time of discharge.
8. Fallon Health reserves the right to deny authorization requests for visits which have already been provided and not previously authorized.
9. Fallon Health notification to members of pre-authorization, concurrent authorization, reduction of services, termination of services and the appeals/grievance process will meet the requirements of Medicare, MassHeatlh, the Managed Care Act, and the Plan.
10. For prompt payment, the Agency must indicate the correct "start of care date" on the request form.

Hospital admissions

When a Fallon Health member is admitted to an acute care hospital, the hospital must notify the Fallon Health Utilization Management (UM) Department by submitting notification for admission through the ProAuth online portal (preferred method) or faxing notification of admission to 508-368-9175 within 24 business hours of admission. Once the notification is received, the Fallon Health (or designated UM nurse reviewer) Utilization Management (UM) Nurse will conduct an admission review to determine the medical necessity of the admission. All reviews (in-area and out-of-area) will be conducted telephonically, via review of faxed clinical documentation, or via review of the hospital's electronic medical record. Written documentation from the medical record will be requested when verbal and faxed information is inadequate. Reviews must include the following information:

- The date and time of admission
- Type of admission (emergent or elective)
- Service the member was admitted to
- Admitting diagnosis
- Co-morbid diagnoses
- Clinical status
- Functional status
- Prescribed medical treatment
- Residence of the member (their own home, long-term care facility, assistive living, etc.)
- Name, address and phone number of the responsible party or legal guardian
- Estimated length of stay

Admission and length of stay are based on medical necessity and the appropriateness of the level of care. Fallon Health physician medical review is available to consult with the UM nurse and attending physician regarding medical necessity and level of care issues as they arise. The UM nurse works collaboratively with the physician and hospital staff to assist with and promote a timely discharge.

Discharge Notification requirement for MassHealth ACO members:

Acute care facilities must provide a member's PCP with a discharge summary and relate documents within 2 business days of discharge; this applies to all MassHealth ACO members.

Fallon Health Standard Response Times

Product	Type of Request (Inpatient and Outpatient)	Response Time
Community Care ACO, Fallon Medicare Plus, NaviCare	Pre-Service Non-Urgent Approval	Determination is made within two working days of obtaining all necessary information Determination is made as expeditiously as possible, not to exceed 14 calendar days of receipt of request *All provider and member notifications are sent within regulatory timeframes
Community Care ACO, Fallon Medicare Plus, NaviCare	Pre-Service Urgent Approval	Determination is made within two working days of obtaining all necessary information Determination is made within 72 hours of the request *All provider and member notifications are sent within regulatory timeframes

Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Urgent Concurrent Approval	Decision is made within one working day of obtaining all necessary information. Determination is made within 72 hours of the request *All provider and member notifications are sent within regulatory timeframes
Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Non-Urgent Concurrent Approval	Decision is made within one working day of obtaining all necessary information Decision is made as expeditiously as member's clinical condition requires, not to exceed 14 calendar days. *All provider and member notifications are sent within regulatory timeframes
Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Urgent Pre-Service Denial	Decision is made within 24 hours of obtaining all necessary information Determination is made within 72 hours of the request *All provider and member notifications are sent within regulatory timeframes

Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Non-Urgent Pre-Service Denial	Decision is made within 48 hours of obtaining all necessary information Determination is made as expeditiously as possible, not to exceed 14 calendar days of receipt of request *All provider and member notifications are sent within regulatory timeframes
Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Urgent Concurrent Denial	Decision is made within 24 hours of obtaining all necessary information Determination is made within 72 hours of the request *All provider and member notifications are sent within regulatory timeframes
Exchange (Community Care) ACO, Fallon Medicare Plus, and NaviCare plans	Non-Urgent Concurrent Denial	Decision is made within two working days of obtaining all necessary information Determination is made as expeditiously as possible, not to exceed 14 calendar days of receipt of request *All provider and member notifications are sent within regulatory timeframes

	Reconsideration	
Exchange (Community Care) and (MassHealth ACO)		Provider can request reconsideration at notification of denial with decision made within 7 days of denial. Request may be in the form of additional clinical documentation or a request for peer to peer (P2P). Oral notification given within one day of determination.
Fallon Medicare Plus and NaviCare		Provider can request reconsideration at notification of denial Reconsiderations by CMS definitions are initial appeals after initial denials Request is forwarded to the Member Appeals Department
	Post-Service Review Process	
Exchange (Community Care)		Determination is made within 30 calendar days from receipt of request.
MassHealth ACO, Fallon Medicare Plus, and NaviCare plans		Determination is made within 14 calendar days from receipt of request. *All provider and member notifications are sent within regulatory timeframes

Notification of Birth form submission

Starting January 1, 2021, MassHealth will require acute inpatient hospitals to use an updated paper or electronic Notification of Birth (referred to as the "NOB-1" form and "eNOB" respectively, but as "NOB" collectively in All Provider Bulletin 305.

The Notification of Birth (NOB-1) form must be completed by hospitals and other providers to facilitate eligibility determinations and health-plan enrollment for newborns of Fallon Health Accountable Care Organizations (ACO) (MassHealth ACO eligible members). The completed NOB forms should be submitted to MassHealth no later than 10 days after birth whenever possible. Providers should note that NOB forms with "Baby Boy" or "Baby Girl" in place of the child's name will not be processed after January 1, 2021. If a newborn's medical condition is such that the parent/guardian has not been able to name the baby within the 10-day NOB submission timeframe, hospitals should email NewbornAdd@mass.gov for instructions on how to establish eligibility for the newborn or contact a MassHealth Enrollment Center. For more details and a sample of the form, see All Provider Bulletin 305. You may also contact the Fallon Health Provider Relations Department at 1-866-275-3247, prompt 4 or MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

High risk screening

At the time of discharge the UM nurse may identify a member at high risk for complications following discharge. The UM nurse may refer the member to outpatient case management who may contact the member by telephone within 48 hours of discharge from the hospital. A telephonic assessment is conducted to determine if the member is receiving prescribed home care.

Retrospective reviews for hospital and post-acute facility admissions (SNF, AR, LTACH)

For acute hospital, Skilled Nursing Facility (SNF), Acute Rehabilitation (AR), and Long-Term Acute Care Hospital (LTACH) admissions, clinical reviews will be performed against Fallon Health Criteria which may include InterQual, Medicare, and MassHealth criteria. If the admission is approved, the standard process of notification will occur. If the admission is denied, an outreach is made by the UM nurse to the facility case management staff to notify them of the denial. Written notifications are generated for all determinations.

Post-Acute care facilities such as Skilled nursing facilities (SNF), Acute Rehabilitation Facilities (ARF), and Long-Term Acute Care Hospitals (LTACH) that have admissions occurring over weekends and holidays must notify UM by faxing clinical documentation to 508-368-9014 on the first regular business day following the admission. The initial clinical review performed by the UM nurse will allow approved coverage of the weekend and/or holiday days. Clinical criteria from a national set of criteria that incorporates Centers for Medicaid and Medicare (CMS) and/or MassHealth guidelines will be applied to all days going forward. Notifications of determinations will follow the standard process of oral and/or written notifications.

Admission to a post-acute care facility

All scheduled admissions to a post-acute care facility (SNF, AR, LTACH) must be approved by the Fallon Health (or delegated entity) UM nurse prior to admission. This can be done by faxing the request, including clinical documentation to the UM SNF line 508-368-9014. Providers may use the Skilled Nursing Facility Admission Review Request form, or the Standard Prior Authorization Request Form.

The level of service and number of covered days that the member is admitted to the facility of admission will be based upon the medical necessity of the condition as determined by applying appropriate benefit and clinical coverage criteria. Concurrent reviews will be done on an ongoing regular basis to allow for appropriate level of care and adequate, comprehensive discharge planning.

Skilled Nursing Facility level of care:

Fallon Health follows a national set of criteria that incorporates the Centers for Medicaid & Medicare Services (CMS) Criteria for Skilled Nursing Facility Coverage of Services (CMS Program Manuals— Skilled Nursing Facility), and/or MassHealth Nursing Facility Coverage Criteria. Care in an SNF will be covered if all of the following four factors are met:

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician.
2. The patient requires these skilled services on a daily basis (see §30.6); and
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (see §30.7).
4. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

The UM nurse reviews the request for pre-admission and notifies the requestor, member, authorized representative, and hospital staff, if needed, of the determination, which may include applicable appeal rights for adverse determinations.

Concurrent review is conducted at designated times based on the clinical condition of the member, and in conjunction with the facility staff.

Acute inpatient rehabilitation facility:

Fallon Health uses CMS criteria for inpatient rehabilitation facility (IRF) stays, with clarifications based on evidence-based medicine.

1. The member must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

2. The member must generally require an intensive rehabilitation therapy program, generally consisting of at least 15 hours of therapy per week.

3. The member must reasonably be expected to actively participate in and benefit significantly from the intensive rehabilitation therapy program at the time of admission to the IRF. The member can only be expected to benefit significantly from the intensive rehabilitation therapy program if the member's condition and functional status are such that the member can reasonably be expected to make measurable improvement (that will be of practical value to improve the member's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time. The member need not be expected to achieve complete independence in the domain of self-care nor be expected to return to their prior level of functioning in order to meet this standard

4. The member must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the member at least 3 days per week throughout the member's stay in the IRF to assess the member both medically and functionally, as well as to modify the course of treatment as needed to maximize the member's capacity to benefit from the rehabilitation process.

5. The member must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Concurrent review is conducted at designated times based on the clinical condition of the member, and in conjunction with the facility staff.

Long-Term Acute Care Hospital (LTACH)

Fallon Health uses CMS criteria for LTACH coverage. Criteria includes:

1. The member's medical needs are complex and require extensive nursing and rehabilitation (e.g., ventilator weaning, multiple IV therapies)
2. The member requires greater than 6.5 hours of nursing interventions and treatments each day.
3. If the member's condition allows it is expected the member participate in 1 to 3 hours of skilled rehabilitation services 5 days a week
4. The member requires and receives daily direct physician interventions

Concurrent review is conducted at designated times based on the clinical condition of the member, and in conjunction with the facility staff.

Fallon Health Accountable Care Organization (ACO) Standard/CommonHealth members –

Skilled Nursing Facility, Chronic or Rehabilitation Hospital Services – services, for all levels of care, provided at a nursing facility, chronic or rehabilitation hospital, or any combination thereof, 100 days per Contract Year per Enrollee. The contract year will then run every year following from January 1st through December 31st. The 100-day limitation shall not apply to Enrollees receiving Hospice services and we will not request disenrollment of Enrollees receiving Hospice services based on the length of time in a skilled nursing facility. We shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital, rehabilitation hospital and nursing facility, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts the 100-day limitation at either a nursing facility, chronic or rehabilitation hospital for that Contract Year.

For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410 and 435.408, 435.409 and 435.410 (rehabilitation hospitals). We will ensure that our contracted facilities establish and follow a written policy regarding its bed-hold period, consistent with the MassHealth bed-hold policy. For applicable criteria, see 130 CMR 456.425.

For MassHealth ACO Family Assistance Members, only the Chronic or Rehabilitation Hospital Services apply.

MassHealth Basic and Essential enrollees do not have this benefit.

Denial process:
If the member does not meet post-acute skilled care criteria or care can be provided in a less restrictive setting (including the home), the request for admission will be reviewed with the medical director and the member will be notified of the decision. If admission is denied, the member will be issued a of denial of medical coverage letter.

If a member requests admission to a non-contracted facility, the request will be reviewed, and the member will be notified of the decision. (It is at the sole discretion of the plan to authorize a non-contracted admission for any Fallon Health members). In addition, Fallon Medicare Plus beneficiaries are entitled to a home SNF benefit as described in 42 CFR §422.133. Under this SNF home benefit, a member may elect to receive post-hospital services through the following facilities:

- The SNF in which the enrollee resided at the time of admission.
- The SNF that provided services through a continuing care retirement community that provided residence to the enrollee at the time of admission to a hospital.
- The SNF in which the spouse of the enrollee is residing at the time an enrollee is discharged from the hospital.

A Fallon Medicare plus, including Fallon HMO SNP enrollee may elect to receive services through one of these facilities only if the facility has agreed to be treated in a substantially similar manner as a Fallon Health contracted SNF.

Concurrent review:

Upon admission to a post-acute facility, it is the responsibility of the designated staff at the facility to contact the Fallon Health UM nurse of the admission as soon as possible on the day of admission, and on the next regular business day after a weekend or holiday

Admission:

Once a member is admitted to a post-acute facility, the UM nurse conducts a clinical review and collaborates with the treatment team for discharge planning.

Length of stay in a post-acute facility will be based on the member meeting skilled care criteria and individual care needs. The post-acute facility shall designate a case management contact that will be responsible for providing the Fallon Health UM nurse with regularly scheduled updates on the member's clinical and functional status. The facility must contact the assigned Fallon Health UM nurse within two business days after admission with the supporting clinical information. Information must include the member's functional status, skilled qualifiers, types and frequency of the therapies, attending physician notes, discharge planning documentation, information regarding the discharge site, family involvement and education required, discharge dates, and changes in the member's level of care.

Managing patient care

At a minimum, the Fallon Health UM nurse will conduct weekly updates by review of medical records, and telephonic review. The UM nurse may request medical records to review clinical information in addition to the information requested by fax. The facility is responsible for providing medical records upon request by the Fallon Health UM nurse.

When the member's status changes from skilled to non-skilled, the facility case manager must notify the Fallon Health UM nurse as soon as this level of care change is anticipated. The member's medical record must be sent via fax to the UM nurse for review by the medical director. If the decision is made to deny further skilled services, the member will be provided with the applicable notice of termination of skilled services (i.e.: NOMNC, Inpatient Denial, Coverage Decision letter, etc. with applicable appeal rights). We require that all contracted facilities provide the decision letters to the member/authorized representative upon request. Length of stay in the skilled post-acute facility will be based on the existence of skilled criteria, the ability of the member to achieve realistic goals and the progress of the member. Post-Acute facilities are responsible for proactive discharge planning, following through on discharge plans, education of the patient/family and facilitating application for financial assistance based upon member needs and future plans.

The post-acute facility shall be responsible for notifying the Fallon UM nurse within one week prior to a planned discharge to prevent fragmentation of health care delivery and to ensure follow through on the discharge plan. The post-acute facility is responsible for notifying the Fallon Health UM nurse when the member's condition requires a change in the level of care, within 24 hours of the change.

Lack of notification by the post-acute facility to the Fallon Health UM nurse when the member's level of care changes or the member no longer requires skilled services will become the facility's financial responsibility until the Fallon Health UM nurse is notified.

If the member requires long-term care after they no longer qualify for a skilled level of care, the member may select a nursing home of choice.

Interpreter services

Fallon Health offers free audio translation services for our non-English speaking members in over 350 languages. If a member needs translation assistance including an interpreter to be present during their health care visit, or translation for any written Fallon Health materials, contact Fallon Health's Customer Service Department at 1-800-868-5200, and for Fallon Health MassHealth ACO members call the Fallon Health MassHealth ACO Customer Service Line at 1-800-341-4848. (711 TRS/Telecommunications Relay Service). Monday, Tuesday, Thursday and Friday 8 a.m. to 6 p.m., and Wednesday 10 a.m. to 6 p.m.

Providers shall make interpreter services available to Enrollees, providers shall not allow family members or other caregivers to serve as the interpreter except in instances of an emergency or if the provider will have to deny care. If the provider allows a family member or other caregiver to serve as the interpreter the provider shall document, it in the record as well as the reason an interpreter was not available.

All written materials are available in Spanish, large print, and other alternate formats like Braille. Fallon Health will translate written materials into other languages over the phone.

Please see the next page for available languages. Languages listed may belong to a language family and all languages, dialects, or spellings may not be listed.

**On-demand languages of limited diffusion. Please anticipate longer wait times to connect (5-10 minutes).*

***Languages of very limited diffusion. While attempting to connect on-demand is possible, please anticipate much longer wait times. It is strongly recommended to schedule these languages in advance rather than attempting to connect on-demand. This list may not be comprehensive of all languages and dialects we serve. Please reach out to us for any language needs you have.*

Acehnese**
Achi (K'iche')**
Acholi **
Afar**
Afghani
Afrikaans**
Akan**
Akateco**
Albanian
Amharic
Amoy (Xiamen Hokkien)**
Anuak **
Apache**
Arabic
Arabic (Algerian)
Arabic (Egyptian)
Arabic (Hassaniya)**
Arabic (Jordinian)
Arabic (Levantine)
Arabic (Moroccan)
Arabic (Sudanese)
Arabic (Tunisian)
Arabic (Yemeni)
Arakanese**
Aramaic
Armenian
Asanti (Twi)**
ASL
Azeri (Azerbaijani)**
Badini**
Bahasa (Melayu)**
Bajuni (Tikulu/Swahili)
Bambara**
Bashkir**
Basque**
Bassa**
Belarusian**
Belize Creole English**
Bemba*
Bengali
Berber**
Bini (Edo)**
Bisaya (Visaya)**

Bosnian
Brazilian Portuguese
Bulgarian
Burmese
Calabrese**
Cambodian (Khmer)
Canadian French
Cantonese
Cape Verde Creole
Carolinian**
Castellano (Castilian)
Catalan**
Cebuano**
Central Khmer
Chaldean (Neo-Aramaic)**
Chamorro**
Chao-Chow**
Cherokee**
Chichewa**
Chin
Chin (Falam)
Chin (Hakha)
Chin (Lai)
Chin (Lautu)**
Chin (Mizo)
Chin (Tedim)
Chin (Zo, Zomi)**
Chin (Zophei/Zyphe)**
Chinese (Cantonese)
Chinese (Chaozhounese/ Choujo/Teochew)**
Chinese (Fukienese/Min Nan/Hokkien)**
Chinese (Fuzhounese/ Min Dong)**
Chinese (Hainanese)**

Chinese (Hakka/Kejia)**
Chinese (Hokkien)**
Chinese (Lanyin/ Lanzhounese)**
Chinese (Mandarin)
Chinese (Puxian)**
Chinese (Shanghainese)**
Chinese (Sichuanese)**
Chinese (Taishanese/ Toisanese)**
Chinese (Taiwanese/ Mandarin/Hokkien/ Hakka**)
Chinn Matu**
Choujo **
Chuj**
Chuukese (Trukese/ Carolinian)**
Cotocoli (Tem)**
Creole
Croatian
Cupik**
Czech
Danish*
Dari
Dinka **
Dioula (Dyula/Jula)**
Dutch
Edo**
Egyptian (Arabic)
Esparanto
Estonian**
Ethiopian
Ewe**
Falam
Fanti**
Farsi
Filipino
Finnish**
Flemish**
Fon**
French
French Canadian
French Creole
Fujian
Fukienese**
Fulani (Fula/Pulaar)**
Fulde**
Fur
Fuzhou**
Ga **
Ganda (Luganda)**
Garre**
Georgian**
German
Gheg**
Goya **
Greek
Guarani**
Guere**
Guinea-Bissau Creole**
Gujarati
Gusii (Ekegusii)**
Hainanese**
Haitian Creole
Hakha Chin
Hakka-Chinese
Harari**
Hassaniya**
Hausa**
Hazaragi**
Hebrew*
Hiligaynon (Ilonggo)**
Hindi
Hindko **
Hmong
Hokkien**
Hunan **
Hungarian*
Ibanag
Ibo
Icelandic**
Igbo**
Ilocano (Iloko/Filipino)**
Ilonggo (Hiligaynon)**
Inabu Arabuc
Indonesian
Iranian Farsi
Italian
Ixil**

Jamaican (Patois)
Jamaican Creole
Japanese
Jarai**
Javanese
Jiangsu**
Jordanian Arabic
Jula
K'iche (Quiche)**
Kabye**
Kachin**
Kamba**
Kandahari**
Kanjobal (Q'anjob'al)**
Kannada**
Kapampangan**
Kaqchikel**
Karen
Karenni (Kayah/Red Karen)**
Kayah**
Kazak**
Kazakh**
Kejia
Khmer (Cambodian)
Kikuyu (Gikuyu)**
Kinyarwanda (Kinyamulenge)
Kirghiz
Kirundi**
Kisii**
Kiswahili
Kituba**
Kizigua (Kizigula/ Mushunguli)**
Kongo (Kikongo)**
Konkani**
Korean
Kosraean**
Kotokoli**
Kpelle**
Krahn**
Krio (Sierra Leone Creole)**
Kunama**
Kurdish
Kurdish
Kurmanji
Kurdish Sorani
Kyrgyz**
Lanzhou**
Lao (Laotian)
Latvian*
Lautu (Chin)**
Levantine (Arabic)
Lingala*
Lithuanian*
Lorma (Loma)**
Luganda (Ganda)**
Luhya
Luo**
Maay Maay (Mai Mai)
Macedonian*
Mai Mai
Malagasy**
Malayalam
Malaysian (Bahasa Melayu/Indonesian)**
Malinke**
Mam**
Manado Malay**
Mandarin
Mandinka (Mandingo)**
Mara**
Marathi**
Marshallese*
Masalit**
Matu**
Mbay**
Mende**
Mien**
Mina (Hina)**
Minangkabau**
Mirpuri**
Mixteco Alto**
Mixteco Bajo**
Mizo**
Moldovan**
Mon**
Mongolian**
Montenegrin **
Moore**
Mushunguli**

Navajo**
Neapolitan**
Neo-Aramaic (Assyrian/Chaldean)**
Nepali
Newari**
Nigerian (Pidgin)**
Norwegian**
Nuer**
Oromifa
Oromo
Pahari**
Pampangan
Pashto
Patois (Jamaican)
Persian
Pidgin (Cameroonian)**
Pidgin (Nigerian)**
Polish
Ponapean/Pohnpeian**
Popti**
Portuguese (Brazilian)
Portuguese (European)
Portuguese Creole
Pothwari**
Pulaar**
Punjabi
Puxian**
Qeqchi**
Quechua**
Quiche**
Rohingya

Romanian
Runyankore**
Russian
Samoan*
Sango**
Sarahuli
Saraiki**
Sarikoli**
Senthang**
Serbian
Serbo-Croatian
Shan**
Shona**
Sicilian**
Sinhalese**
Sizang
(Siyin)**
Slovak**
Slovene**
Somali
Soninke
(Sarahuli)**
Sorani**
Spanish
Susu**
Swahili
(Kiswahili)
Swedish
Sylheti**
Tagalog
(Filipino)
Taiwanese
Tajik**
Tamil**
Telugu
Temne**
Teochew**
Tetum**
Thai
Tibetan**
Tigre**
Tigrinya
Tongan
Tosk**
Trukese**
Tshiluba**
Tunisian
Turkish
Turkmen**
Twi (Asanti)**
Ukrainian*
Urdu
Uspanteko**
Uyghur**
Uzbek*
Vietnamese
Visaya
(Bisaya)**
Wolof**
Xhosa**
Yiddish**
Yoruba*
Yup'ik**
Zapotec**
Zo, Zomi**
Zophei/Zyphe**
Zulu**

Network providers

Locating a network provider

At Fallon Health we make finding a network provider easy.

Fallon Health members will need to choose a primary care provider (PCP) who is affiliated with Fallon Health and is within their network. If they do not pick a PCP, Fallon Health will choose one for them. Members can contact Fallon Health customer service at any time to assist with this process.

Whenever possible, a PCP should refer to a specialist who is in the member's network. In some cases, such as when the type of specialty that a condition requires is not available from a Fallon Health network provider, the PCP will need to request an authorization from Fallon Health for the member to see a provider outside of their Fallon Health network. See *PCP referrals and plan prior authorization process* section to learn more about services that require a referral or prior authorization.

To assist members with choosing a network provider, please refer to the online provider look up tool found at fallonhealth.org/FindPhysician/search.aspx

You will be able to search by product network, provider name, location, specialty or language. You do not need a username of password to use this online tool.

Please call 1-866-275-3247 if you have questions.

Oral surgery

Policy

Fallon Health covers the following oral surgery services. All services must be provided by a plan contracted oral surgeon or physician. This does not include plan dentists.

Note for Fallon Health MassHealth ACO members:
Fallon Health provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition, all other dental procedures are covered by MassHealth. The MassHealth ACO member should be referred to the MassHealth Dental Customer Service Center at 1-800-207-5019.

Please note: All members (except ACO, see above) may self-refer to a Fallon Health plan contracted oral surgeon for the removal or exposure of impacted teeth and emergency medical care. For any other oral surgery procedure, plan authorization is required. The provider should verify eligibility prior to performing the procedure at 866-275-3247, press 1.

Oral surgery service

1. Oral examination and subsequent extraction of teeth for the following:
    a) Suspected infection in those at risk for developing bacterial endocarditis.
    b) Preparation for radiation treatment of the head or neck.
2. Removal or exposure of impacted teeth, including both hard and soft tissue impactions (except ACO, see above).
3. Surgical removal of benign or malignant lesions (includes cysts) affecting the intraoral cavity.
    a) Reconstruction of a ridge is covered when performed as a result of and at the same time as the surgical removal of a tumor.
4. Surgery related to the jaw, or any structure connected to the jaw, including structures of the facial area below the eyes. This includes:
    a) Reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances if used for this purpose.
    b) Wiring of teeth when performed in connection with the reduction of a jaw fracture.
    c) Removal of a torus palatinus (a bony protuberance of the hard palate) if the procedure is not performed to prepare the mouth for dentures.
    d) Lingual frenectomy
    e) Insertion of metallic implants if the implants are used to assist in or enhance the

retention of a dental prosthetic because of a covered procedure.

5. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues when provided as soon as medically possible after the injury. This does not include restorative or other dental services.
6. Oral examination to detect infection prior to kidney transplantation.

Procedure for referring to oral surgeons:

The primary care provider (PCP) should follow the appropriate referral process for the member's plan. Commercial plans follow the PCP/NPI process. Medicare, NaviCare and MassHealth ACO plans follow the ProAuth entry process. There is no referral required for extraction of impacted teeth by a plan-contracted provider (see ACO information above).

All subsequent visits for these services require preauthorization by the servicing provider.

The oral surgeon must submit a Request for Prior Authorization via ProAuth or a completed Standardized Prior Auth request Form for all subsequent oral surgery services and treatment to the Fallon Health Care Review Department at 508-368-9700.

All services are subject to coverage, benefit, network and contract policies and exclusions.

Out of area care

Members are covered for emergency services, post-stabilization services and urgent care services, such as injuries and sudden illnesses, wherever they travel, even when outside of Fallon Health's service area. If a member becomes seriously sick or hurt while out of area, they should be instructed to go to the nearest doctor or emergency room or call 911. Members are instructed to call their PCP within 48 hours of receiving health care while traveling.

Routine health care is not covered outside of Fallon Health's service area.
The following are examples of care that is NOT covered while a member is traveling:

- Tests or treatment that a PCP requested before the member traveled
- Routine care or care that can wait until the member returns home (for example, physical exams or immunizations)
- Routine care that can be anticipated as a need before traveling (for example, routine prenatal care)
- Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition at a non-Medicare approved facility)
- Elective procedures
- Transportation back to Massachusetts from another country or state

As a provider you may ask a member (excluding MassHealth ACO members) to pay for care received outside of Fallon Health's service area at the time of emergency or urgent care service. The Commonwealth of Massachusetts Executive Office of Health and Human Services precludes billing MassHealth ACO members. It is preferred that Fallon Health be contacted directly for payment by calling Fallon Health's Customer Service Department at 1-800-868-5200 and for MassHealth ACO members call Fallon Health's MassHealth Customer Service line at 1-800-341-4848 (TRS 711), Monday through Friday, 8 a.m. to 6 p.m.

PCP referral and plan prior authorization process

Fallon Health's referral and prior authorization process is outlined in the following pages. A grid is provided to describe the Primary Care Provider (PCP) referral, prior authorization, and notification policies and procedures. The type of service, services included, and referral process are outlined within the grid.

The following are important reminders about Fallon Health's referral and prior authorization process:

- PCP coordination of care is the foundation for care delivery.
- All specialty visits, initial and follow up, must be coordinated by the PCP. Specialists cannot refer to other specialists.
- Specialty visits that occur without PCP coordination will not be reimbursed. Any exceptions to this rule, e.g., member self-referrals, are specifically noted below.
- Office-based procedures: Use the procedure code look up at https://www.fchp.org/providertools/ProcedureCodeLookup/ to check if a procedure requires a prior authorization.
- PCPs are allowed to direct for specific types of specialty services for eligible health plan members who are being referred within the members' network.
    - Prior authorization is required for **non-covered benefits**, **or services provided by non-contracted provider**s, a PCP's referral is void, as these situations require plan prior authorization.
    - Please note that if non-covered or out-of-network services are not specifically prior authorized by the plan, reimbursement to these providers will not occur.

PCP referrals

Referrals for specialty care are required for all members.

PCP referral process for Fallon Medicare Plus, NaviCare, and MassHealth ACO members.

1. The PCP refers the member to a specialist within the plan's network for medically necessary care and enters a referral into the ProAuth system.

   To sign up for ProAuth:
   https://www.fchp.org/Providertools/ProAuthRegistration/ProAuthRegContacts/Create

If the PCP cannot enter the referral through the ProAuth system, a standardized prior authorization form can be faxed to Fallon Health's Care Services at 1-508-368-9700. https://fallonhealth.org/en/providers/forms.

2. The specialist verifies member's eligibility through the Fallon Health online eligibility tool, POS device or by contacting Fallon Health at 866- 275-3247, option 1, Monday through Friday from 8:00 a.m. to 5:00 p.m., or through the eligibility verification Provider Tool.

3. The specialist treats the member according to the PCP's request and exchanges clinical information with the member's PCP.

Retroactive referrals may be submitted as follows:

Product	Timeline
Fallon Medicare Plus	Up to 90 days after Date of Service
NaviCare	Up to 90 days after Date of Service
Berkshire Fallon Care Collaborative Medicaid ACO	Up to 30 days after Date of Service
Fallon 365 Care	Up to 30 days after Date of Service
Fallon Health-Atrius Health Care Collaborative	Up to 90 days after Date of Service

PCP referral process for Community Care:

1. The PCP refers the member to a specialist within the member's product for medically necessary care.

2. PCP contacts the specialist by telephone, fax, mail, or script and provides the PCP's name, their NPI number, the reason for the referral and number of visits approved.

3. Referral should be documented in member's medical records for both PCP & specialist. Fallon Health reserves the right to audit medical records to ensure specialty referral was obtained. Lack of proof of referral may result in claims retractions.

4. The specialist verifies member's eligibility through the Fallon Health online eligibility tool, POS device or by contacting Fallon Health at 866- 275-3247, option 1, Monday through Friday from 8:00 a.m. to 5:00 p.m., or through the eligibility verification Provider Tool

5. The specialist treats the member according to the PCP's request and exchanges clinical information with the member's PCP.

6. The specialist places the PCP's NPI number in the appropriate field on their claim when submitting to Fallon Health.

Retroactive referrals for Community Care may be submitted up to 120 days after the date of service.

Prior authorizations

Prior authorization process for all plans:
(with the exception of Summit ElderCare)

The prospective or concurrent review process used by Fallon Health to determine coverage of a particular medical service. Prior authorization involves the review of eligibility, level of benefits, servicing provider's participating status and medical necessity. Depending on the contract, some groups for some product lines might be delegated for this process. If this is a question, contact your Provider Relations Representative.

For services that require prior authorization, all contracted providers are responsible for ensuring that the appropriate authorization is in place prior to services being rendered. If medically necessary services are rendered to an eligible plan member and there is no prior authorization, the provider will not be reimbursed for related charges and the member cannot be billed.

To submit a prior authorization request, please enter the request into ProAuth.

- To sign up for ProAauth
  https://www.fchp.org/Providertools/ProAuthRegistration/ProAuthRegContacts/Create

Or submit a Standardized Prior Authorization Request form
https://fallonhealth.org/en/providers/forms

Fallon Health will not accept retroactive authorization requests effective 1/1/2025.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
Primary care	Family practice Internal medicine Pediatrics A MassHealth ACO Member may choose an OB/Gyn as their Primary Care Provider.	Member self-referral
Specialty services	Specialty visits Specialty visits—all out of network or noncontracted providers	PCP Referral MassHealth ACO- PCP Referral for ACO affiliate providers Plan prior authorization requested by PCP
Specialty services	Annual GYN (one visit) Other GYN	Member self-referral within product Member self-referral within product
	Chiropractors	Calendar Year benefit For a referral to a participating chiropractor, the PCP must provide the member and/or the chiropractor with a written prescription. The chiropractor needs to submit a copy of the prescription to American Specialty Health Network when submitting the initial claim.
	Infertility/Assisted Reproductive Technology (ART)	Plan prior authorization requested by PCP or specialist. NOTE: These services are not covered for Fallon Health MassHealth ACO members.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
	Obstetrics (prenatal and maternity)	Member self-referral within product
	Oral surgery (impacted teeth)	Member self-referral within product for impacted wisdom teeth NOTE: Fallon Health MassHealth ACO members- Fallon Health provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition, all other dental procedures are covered by MassHealth. The MassHealth ACO member should be referred to the MassHealth Dental Customer Service Center 1-800-207-5019
	Oral surgeon consultation * See benefit coverage for Fallon Health MassHealth ACO members above	PCP referral within product. For additional information, please refer to Oral Surgery section of Managing Patient Care
	Oral surgery services and treatment * See benefit coverage for Fallon MassHealth ACO members above	Plan prior authorization requested by specialty (for office or facility-based services) for procedures specified on the https://www.fchp.org/providertools/ProcedureCodeLookup/
	Plastic reconstructive surgeon consultation	PCP referral
	Plastic reconstructive surgery and treatment	Plan preauthorization requested by specialist (for office or facility-based services) for procedures specified on the https://www.fchp.org/providertools/ProcedureCodeLookup/
	Podiatry services	See Podiatry payment policy https://fallonhealth.org/providers/criteria-policies-guidelines/payment-policies and procedure code look up tool https://www.fchp.org/providertools/ProcedureCodeLookup/

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
Specialty services	Transplant evaluation	Plan prior authorization requested by PCP or specialist.
Office-based procedures	For all office-based procedures identified https://www.fchp.org/providertools/ProcedureCodeLookup/, the PCP or specialist must obtain plan prior authorization.	
Other professional services	Abortion Neuropsychological testing	Member self-referral in network (Coverage based on member's benefit) Plan prior authorization requested by PCP or specialist (CPT codes 96115 and 96117).
	Nutrition	PCP referral
	Pain clinic	PCP referral
	Preventive dental For Fallon Health MassHealth members (age 21 and under) fluoride varnish treatments can be provided by a primary care provider. Refer to the MassHealth Dental Benefit section for full description.	Member self-referral NOTE: Fallon Health MassHealth ACO members dental benefits are provided by MassHealth. Dental screenings and cleanings are available for children, adolescents, and young adults under the age of 21. The enrollee should be referred to MassHealth Dental Customer Service Center 1-800-207-5019.
	Routine eye exam	Member self-referral
	Physical, occupational or speech therapy	Covered physical therapy and occupational therapy do not require a PCP referral or prior authorization by the plan. A physician prescription is required, and therapists must be contracted by Fallon Health. Members will be covered up to their benefit maximum. Speech therapy requires plan prior authorization by the plan.
	All unlisted CPT-4 codes and all unspecified HCPCS	Plan prior authorization requested by PCP or specialist.

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
Other professional services	Genetic testing	PCP referral to specialist required for initial consultation. Plan prior authorization requested by PCP or specialist needed for subsequent testing.
Outpatient diagnostic tests	PET scans	Plan prior authorization requested by PCP or specialist submitted to eviCore For Summit ElderCare submit to Fallon Health
Hospital/facility	Elective hospital/facility same-day surgery and ambulatory procedures	For all facility-based services identified on https://www.fchp.org/providertools/ProcedureCodeLookup/ the PCP or specialist must obtain plan prior authorization
	All elective inpatient admissions	Plan prior authorization requested by PCP or specialist
DME	DME	Plan prior authorization is required for certain DME services. For additional information, see the DME Payment policy https://fallonhealth.org/providers/criteria-policies-guidelines/payment-policies
Nutritional supplements	Nutritional supplements for which coverage is mandated by law are supplied through contracted pharmacies	Plan prior authorization is required. Provider submits an order to the DME vendor. NOTE: For Fallon Health MassHealth ACO members, nutritional supplements may also be obtained through a contracted pharmacy with a physician script.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
Hospice	Hospice	Plan prior authorization is required.
Oxygen	Oxygen	Plan prior authorization is required.
Prosthetics and orthotics	Prosthetics and orthotics	Plan prior authorization is required.
Nonemergency ambulance	Nonemergency ambulance	Plan prior authorization is required for the following HCPCS codes: A0420, A0426, A0428, A0999, A0130, S0209, S0215
Fallon Health MassHealth ACO Plans, Standard/ members only: **Transportation non-emergent *out-of-state location*** **Not covered by either Fallon Health or MassHealth for MassHealth ACO Family Assistance enrollees.**	Fallon Health covers non-emergency transportation by ambulance and other common carriers that generally are pre-arranged to transport a member to a service that is located outside a 50-mile radius of the MA border.	Plan prior authorization is required.
Transportation non-emergent, to in-state	Fallon Health can coordinate this service, but generally the MassHealth ACO member contacts his/her physician who will complete and send the PT- 1 form requesting the non-	PT-1 Form Required.

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Preauthorization
location or location within 50 miles of the Massachusetts border **Note: Not covered by MassHealth for Family Assistance**	emergent transportation to MassHealth. MassHealth provides coverage for ambulance (land), chair car, taxi, and common carriers that generally are pre-arranged to transport an Enrollee to a covered service that is located in-state or within a 50-mile radius of the Massachusetts border.	
Behavioral health	Outpatient mental health and outpatient substance use disorder	Member self-referral by calling Carelon at 888-421-8861.
Please note this is not a comprehensive list of all Fallon Health Covered Services. Please refer to the Explanation of Benefits for the Fallon Health product in question and for Fallon Health MassHealth ACO members, please refer to the Fallon Health MassHealth ACO Covered Services lists.		

Fallon Health standard response times

* All unlisted/unspecified CPT/HCPCS codes require preauthorization.

Product	Type of Request	FH will respond within:
MassHealth, Medicare Plans and NaviCare SCO and SNP Plans	• **Pre-Service Non-urgent (routine) Approvals and Denials**	• Determination made as expeditiously as possible but not to exceed 14 calendar days of receipt of request. • Written notice is sent to member and provider within the timeframe allotted for determinations (14 calendar days).
MassHealth, Medicare Plans and NaviCare SCO and SNP Plans	• **Pre-Service Urgent/Expedited Approvals and Denials**	• Determination is made within 72 hours from receipt of request. • Oral notification to member or provider within 24 hours of decision, but not to exceed 72-hour timeframe. Verbal notification requires communication with a live person; the organization may not leave a voicemail. • Written notice is sent to member and provider within the timeframe allotted for determinations (72 hours). If successful oral notification made to member or provider, the letter can be mailed within 3 days of notification.
MassHealth, Medicare Plans and NaviCare SCO and SNP Plans	• **Pre-Service Non-urgent and Urgent/Expedited Extensions**	• If the member or provider requests an extension or if the plan feels this is in the best interest of the member, a 14-calendar day extension can be taken. This must be taken before expiration of timeframe (72 hours (expedited/Urgent or 14 days (standard).

		• Written notification must be sent to member advising of extension. • Written notification of decision must be sent within the expiration of timeframe plus applicable extension (17 days for urgent and 28 days for standard).
Community Care (Exchange)	• **Urgent Concurrent**	• Electronic or written notification of the decision to member and practitioners within 24 hours of the request
Community Care (Exchange)	• **Pre-Service Non-urgent (Standard) Approval**	• Determination is made as expeditiously as possible (within 2 days of receipt of all information) not to exceed 14 calendar days of receipt of request. • Electronic notice is sent to the provider within 1 business day after determination of approvals.
Community Care (Exchange)	• **Pre-Service Non-urgent (Standard) Denial**	• Determination is made as expeditiously as possible (within 2 days of receipt of all information) not to exceed 14 calendar days of receipt of request. • Electronic notice is sent to the provider within 1 business day after determination of approvals.
Community Care (Exchange)	**Pre-Service Urgent/Expedited Approval and Denial**	• Determination is made within 72 hours from receipt of request. • Oral notice is given to member and provider day of determination not to exceed 72 hours of receipt of request. Verbal notification requires communication with a live person; the organization may not leave a voicemail. • Electronic notification is sent to provider within one business day after determination

		• Written notice sent to member and practitioner within 3 calendar days of the determination.
Community Care (Exchange)	• **Concurrent Urgent/ Expedited Extension**	• Request must be made less than 24 hours prior to the expiration of the previously approved time period/number of treatments • Determination must be made within 72 hours • Notification **Approval**: o Electronic notification is sent to provider within one business day after determination o Written notice sent to member and practitioner within 3 calendar days of the determination. **Denial**: o Electronic notification is sent to provider within one business day after determination • Written notice sent to member/practitioner within 3 calendar days of the request.
Community Care (Exchange)	• **Pre-Service Urgent/ Expedited Extension**	• Determination time frame is extended once up to 48 hours if unable to make determination due to lack of necessary information • Determination must be made within 48 hours of receiving the information, or by the end of 48- hour period given the member to supply the information, whichever is earlier • Determination must be made even if information is incomplete or was not received within this period

		• Written notification must be sent to member within 24 hours of the request to extend the decision time frame regarding specific information to make the determination • Member has 48 hours to provide the specified information
Community Care (Exchange)	• **Post-Service Review Process**	• Determination is made within 30 calendar days from receipt of request • Electronic notification of the determination sent to provider within 1 business day after determination • Written notification sent to member and provider within 30 calendar days of receipt of request
Community Care (Exchange), *Medicaid Plans*	• **Reconsideration**	• Provider can request reconsideration of denial within one week of determination • Reconsideration is done through peer-to-peer discussion or receipt of additional or new information • Oral notification given within 1 business day • No written notification is required for this level of review's determination

The following services do not require an additional PCP referral or plan prior authorization when provided by a contracted, in-network provider and within the member network option:

- Allergy injections
- Cardiac rehabilitation outpatient
- Chemotherapy outpatient, depending on the J-Code (drug being administered)
- Diabetes education
- Dialysis
- EMG/NCV
- Interventional cardiology (cardiac catheterization, angiography, PTCA, electronic pacing study)
- Pacemaker/defibrillator check
- Pulmonary rehabilitation outpatient
- PUVA
- Radiation therapy outpatient

Treatment of a minor without parental consent

A minor is any individual 18 years of age or younger. In general, a minor cannot consent to treatment, and the parent or guardian must be notified of the treatment.

A minor may give consent for treatment under the following circumstances:

1. If the minor is married, widowed, divorced;
2. If the minor is a parent of a child (in such an instance the minor is also the legal guardian of their own child);
3. If the minor is a member of the armed forces;
4. If the minor is pregnant or believes themselves to be pregnant;
5. If the minor is seeking family planning/birth control services;
6. Minors 16 and above may consent to their own abortion services;
7. If the minor is living separate and apart from their parent or legal guardian; or
8. If the minor believes they are suffering from a disease dangerous to the public health (as defined from time to time by the Massachusetts Department of Health), to the extent of treatment for that disease.

A minor who is 16 years of age or older may consent to admit themselves to a mental health treatment facility. There are some instances in which a minor under the age of 16 may consent to their own mental health counseling; this must be assessed on a case-by-case basis. A minor who is 12 years or older, and who is found to be drug dependent by two or more physicians may give consent for care and treatment related to the drug dependency.

Quality programs and utilization statement

Providers compliance with quality activities

Collaboration is key to delivering exceptional care for our members and measuring performance of the care delivered. Fallon Health requires medical records from time to time for review to document these performance measures. Obtaining these medical records is vital to accurate reporting and true reflection of practice performance.

To ensure that data is reported accurately for all quality activities including but not limited to the National Committee for Quality Assurance (NCQA), Health Effectiveness and Data Information Set (HEDIS)® Medicare 5 Star measures, Medicaid Accountable Care Organization (ACO) measures, and state and federal requirements.

Fallon Health requires practice cooperation and access to medical records as stated in the Quality and Utilization Management section of the executed contract:

"The Contracted Provider agrees to participate in and cooperate with the Plan's Quality Management and Utilization Management Programs which include, provision of data and access to medical records for the Plan's quality management, Healthcare Effectiveness Data and Information Set (HEDIS) and NCQA studies."

Treatment options

Fallon Health supports providers, acting within the lawful scope of practice, to advise and advocate on behalf of an individual who is a member of Fallon Health regarding the following:

- The medical care or treatment options (including any alternative treatments that may be self- administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future decisions
- The member's health status

Managing patient care

Fallon Health contracted providers are required to provide information regarding treatment options for the member's condition regardless of the cost or benefit coverage, including the option of no treatment, to Fallon Health members, including those with limited English proficiency or reading skills, diverse cultural backgrounds and physical or mental disabilities, in a culturally competent manner.

The provider shall ensure that individuals with disabilities have effective communication with participants through the plan in making decisions regarding treatment options. The provider shall educate patients regarding their health needs, share findings of history and physical examinations, side effects of treatment, management of symptoms and recognize the patient has the final course of action among clinically acceptable choices.

Quality Programs

The Quality Programs department supports the Fallon Health Performance Improvement programs. We may use practitioner performance data for quality improvement activities.

Our responsibilities:

1. Conducts medical record reviews for all member complaints related to medical treatment received by the Member Relations Department and the tracking and trending of the outcomes of these peer review proceedings.

2. Routinely monitors sentinel events resulting from outpatient care and major adverse events from inpatient care, referred by clinicians, case managers, and other appropriate staff.

3. Maintains confidential record keeping of case reviews related to complaints and adverse events; ensures follow up to cases reviewed by the Peer Review Committee and documents corrective actions.

4. Submits peer reviewed quality information to the Credentialing Department for individual practitioner's review during the re-credentialing process.

5. Performs data collection for contractual reporting for the various product lines, such as Medicare and Medicaid agency requirements.

6. Responsible for HEDIS® (Healthcare Effectiveness Data and Information Set) reporting requirements, including the audit for the measurement system, interpretation of the technical specifications and the accuracy of information submitted to the external agencies and public reporting.

7. Supports the Clinical Quality Improvement Program by coordinating the Clinical Quality Improvement Committee and Quality workgroups assisting with minute taking, documentation, data collection and analyses, and trending of information.

8. Responsible for the implementation of the annual work plan and the completion of tasks assigned to the department. Conducts an annual evaluation of the work plan, analyses those results and adjusts resources as needed.

9. Coordinates the requirements for employer requests related to quality management.

10. Champions the organizations' compliance to external accrediting agencies along with federal and state regulations.

11. Responsible for supporting the organization's initiatives related to the quality improvement and patient safety by collecting and analyzing data, implementing interventions, and ensuring follow up and re-measurement of the process.

12. Develops organization-wide policies and procedures related to Quality Programs.

13. Provide oversight to assigned entities to which Fallon has delegated responsibility for any areas within the scope of Quality Programs, including credentialing of providers, quality and utilization management, and Complex Case Management.

Utilization statement

Utilization decision-making is based on appropriateness of care and service and existence of coverage. Fallon Health does not specifically reward practitioners or other individuals for issuing denials of coverage for service or care. The plan does not provide financial incentives for utilization decision makers that encourage decisions that result in underutilization.