



## FCHP MassHealth Appeals Policies and Procedures

### Definitions

The following definitions apply to the MassHealth Appeals policy and procedure:

<b>Adverse Action</b>	<p>The following actions or inactions by FCHP:</p> <ul style="list-style-type: none"> <li>(1) the failure to provide Covered Services in a timely manner in accordance with the MassHealth waiting time standards in Section 2.6.B of the contract with EOHHS;</li> <li>(2) the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;</li> <li>(3) the reduction, suspension, or termination of a previous authorization for a service;</li> <li>(4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:             <ul style="list-style-type: none"> <li>(i) failure to follow prior authorization procedures;</li> <li>(ii) failure to follow referral rules;</li> <li>(iii) failure to file a timely claim;</li> </ul> </li> <li>(5) the failure to act within the timeframes in Section 2.4.B.4 of the contract with EOHHS for making authorization decisions. Also referred to as an "Initial Determination."; and</li> <li>(6) the failure to act within the timeframes specified in Section 2.9.B.4.a for reviewing an Internal Appeal and issuing a decision.</li> </ul> <p>It is not necessary to receive an Adverse Action notice to appeal. It is only necessary that an Adverse Action has taken place. For those adverse actions where notice is not possible or was not provided for any reason, the Member must appeal within 30 calendar days from the day the Adverse Action occurred.</p>
<b>Authorized Appeal Representative</b>	<p>Any individual that has been designated by the Member in writing to represent the member with respect to a Grievance, an Internal Appeal or BOH Hearing Appeal. FCHP must allow the Member to give a standing authorization to an Appeal Representative to act on his/her behalf for all Grievances and Internal Appeals. A standard authorization must be done in writing and may be revoked by the Enrollee at anytime. Appeal Representatives may include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>a. Physician;</li> <li>b. Family Member;</li> <li>c. Legal Counsel;</li> </ul> <p style="text-align: center;">(Refer Appeal information to FCHP legal counsel where</p>



	<p>appropriate.)</p> <ul style="list-style-type: none"> <li>d. Guardian;</li> <li>e. Conservator;</li> <li>f. Holder of Power of Attorney;</li> <li>g. Health care agent; or</li> <li>h. Community Advocacy Group.</li> </ul>
<b>Board of Hearings (BOH)</b>	The Board of Hearings within the Executive Office of Health and Human Services' Office of Medicaid.
<b>Continuing Services</b>	Managed Care Organization (MCO) Covered Services that were previously authorized by FCHP and are the subject of an Internal Appeal and BOH Appeal, if applicable, involving a decision by FCHP to terminate, suspend, or reduce the previous authorization and which are provided by FCHP pending the resolution of the Internal Appeal and BOH Appeal, if applicable.
<b>Database</b>	The system in which appeals data is accumulated: data captured includes Member demographics and case specific appeal type, outcome and turn around times.
<b>Designated Reviewer</b>	Health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action.
<b>Executive Office of Health and Human Services (EOHHS)</b>	The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.
<b>Expedited Internal Appeal</b>	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for review of an Adverse Action, which is processed within 3 business days (unless there is an extension). This fast appeal process is available to members who believe that their health or ability to function could be seriously harmed by waiting 20 calendar days for an appeal determination, which is the timeframe for the Standard first level Internal Appeal process (unless there is an extension).
<b>External Appeal</b>	A written request to the BOH, made by a Member or an Authorized Appeal Representative on behalf of a Member to review a Final Standard Internal Appeal decision by FCHP or an Expedited Internal Appeal.
<b>First Level Review</b>	A review conducted during the First Level Internal Appeal by an FCHP Medical Director or a health care professional who has the appropriate clinical expertise in treating the medical condition,



	performing the procedure, or providing the treatment that is the subject of the Adverse Action.
<b>Final Standard Internal Appeal</b>	The second-level review of an Internal Appeal or, for the member who waives the second level Internal Appeal, the first-level review of an Internal Appeal.
<b>Grievance</b>	Any expression of dissatisfaction by a Member or Authorized Appeal Representative about any action or inaction by FCHP other than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of FCHP, or failure to respect the Member's rights. Also the decision to extend the timeframes for deciding an Internal Appeal or authorization request, and the decision to deny a request that an Internal Appeal be considered as an Expedited Internal Appeal.
<b>Grievance regarding Quality of Care</b>	A Member's or an Authorized Appeal Representative's Grievance that involves the clinical care or medical treatment delivered to a Member ( <i>with no associated service denial</i> ), based on the Member's perception of the delivery of care.
<b>Internal Appeal</b>	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for review of an Adverse Action
<b>Inquiry</b>	Any oral or written question by a Member received by FCHP regarding any aspect of FCHP operations that does not express dissatisfaction about FCHP.
<b>Second Level Review</b>	A review conducted during the Second Level Appeal Committee hearing by an FCHP Medical Director or a health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action. (and who have not been involved in any prior review or determination in the Internal Appeal)
<b>Standard Second Level Appeal Request</b>	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for a Second Level Review by the Second Level Appeal Committee of the First Level Adverse Action, which is processed within 20 calendar days (unless there is an extension).
<b>Standard First Level Appeal Request</b>	A request made by a Member or an Authorized Appeal Representative on behalf of a Member for a First Level Review of an Adverse Action, which is processed within 20 calendar days (unless there is an extension).





## I. Mass Health Appeal Processing Procedure

### A. APPEAL CASE RECEIVED VIA TELEPHONE CALL OR IN PERSON

1. Any FCHP Department with direct Member contact is instructed to immediately direct all Member requests for an Appeal to the Member Relations Department. The Member Relations Administrative Assistant screens the calls to determine:
  - a) If the Member calling has an open Appeal case, then transfers the call to the Member Relations Coordinator assigned to that Appeal.
  - b) If the Member is requesting an Expedited (fast) Appeal, then transfers the call to the next available Member Relations Coordinator.

For Standard Appeal requests, the Member Relations Administrative Assistant describes the Appeal rights and process for requesting an Appeal to the Member. The Member is informed that the appeal must be filed within 30 days from the notice of Adverse Action or if no notice was issued, within 30 days from the day the Adverse Action itself occurred. Procedural denials that are not Adverse Actions and for which notices are not issued, include:

- ◇ failure to follow prior authorization procedures,
- ◇ failure to follow referral rules,
- ◇ failure to file a timely claim,
- ◇ failure to provide services in a timely manner unless FCHP is aware of the failure,
- ◇ failure to resolve an Internal Appeal within the timeframes,
- ◇ failure to act within the timeframes for making authorization decisions

In addition, the Member is informed of the following:

- ◇ interpreter services that are available through FCHP free of charge.
- ◇ any correspondence relating to the Member's Appeal is available in Spanish and in large print upon request by the Enrollee.
- ◇ Member Relations availability to assist with filing an Appeal or completing any necessary form.
- ◇ if his/her appeal involves a FCHP decision to reduce, suspend, or terminate a previous authorization for a service, s/he may receive Continuing Services for previously authorized services from FCHP pending the outcome of an Appeal as long as the Member's Appeal request is submitted within 10 calendar days of the notice of the Adverse Action date. The date on the notice of action is considered the mailing date.
- ◇ if s/he chooses to receive continuing services during the appeal, and if we uphold our original denial, the Member may be responsible for paying MassHealth back for the cost of the continuing services. The Member has an option of canceling these services.

2. If the Member is willing to submit correspondence, the written Appeal request, when received, is time and date stamped using the Member Relations Department Electronic Date/Time Stamper and handled according to **Section B** (*"Case Received Via Member Correspondence, Fax, or Electronically"*) of this policy.



3. If the Member is unwilling to submit correspondence to the Member Relations Department, the Administrative Assistant or the Member Relations Coordinator will reduce the Member's request to writing noting the date and time of receipt of the request on the *Documentation of Oral Appeal Request Form* and forward a copy of the request to the Member within 1 business day of the telephone call along with the acknowledgement letter and *Personal Representative Authorization Form* as necessary.
4. If the Administrative Assistant cannot determine the nature of the inquiry, the call is transferred to an available Member Relations Coordinator. The Member Relations Coordinator receiving the call is responsible to identify whether the request involves an Appeal.
5. If the inquiry does not involve an Appeal request, the Member Relations Coordinator or the Member Relations Administrative Assistant directs the inquiry to the appropriate area as follows:
  - a) Requests for payment or service for which there has been no Initial Determination of Adverse Action, except of those services related to access issues, are directed to the FCHP Customer Service Research Unit as appropriate.
  - b) Inquiries that do not express dissatisfaction, for example regarding benefits, information, FCHP policies, etc., are directed to the appropriate FCHP Department. Grievances regarding quality of care or quality of service are processed by the Member Relations Coordinator. (See Grievance Policy.)

## **B. APPEAL CASE RECEIVED VIA MEMBER CORRESPONDENCE, FAX, OR ELECTRONICALLY**

Upon receipt of Member correspondence, the Member Relations Administrative Assistant is responsible for the following:

- a) Sorting, opening and date-stamping all correspondence addressed to the Member Relations Department, which is not designated as *Personal or Confidential*.
- b) Checking the fax machine and distributing faxes to appropriate staff at least every hour.
- c) Reviewing the correspondence and identifying whether it involves an Appeal request.
- d) Forwarding the Appeal related correspondence to the Member Relations Triage Analyst for processing and documenting receipt of such Appeal correspondence in the Customer Services database.
- d) Directing Member correspondence, if the correspondence does not involve a new Appeal request, to the appropriate area as follows:
  - ◇ Correspondence relevant to an existing Appeal case is directed to the appropriate Member Relations Coordinator.
  - ◇ Correspondence relevant to a request for payment or service for which there has been no Initial Determination with Adverse Action, is directed to Claims or Care Services as appropriate.



- ◇ Correspondence relevant to inquiries that do not express dissatisfaction, for example regarding benefits, information, FCHP policies, and complaints, are redirected to the appropriate FCHP Department.
  - ◇ Correspondence relevant to an existing Grievance case is directed to the appropriate Member Relations Coordinator.
  - ◇ Correspondence relevant to a procedural payment denial is directed to Customer Service. The Administrative Assistant enters the case information into the Customer Service database.
- e) Correspondence relevant to situations where a provider received payment from a Member for any service payable under MassHealth without knowing that the Member was enrolled in the MassHealth Program at the time the service was provided should be directed to Customer Service Representative, who will coordinate with the provider to ensure that provider immediately returns all sums solicited, charged, received, or accepted with respect to such service.
- f) Filing the completed cases numerically in hanging files by case number labeled with the Member's Last Name, First Name. The files are maintained by year of their final resolution
- g) Maintaining the central e-filing folder located on the G drive.

### C. TRIAGING OF APPEAL CASES

1. Member Relations Triage Analyst or the Administrative Assistant determines if the Appeal is filed within 30 calendar days of the notice of Adverse Action or the date of the Adverse Action occurrence. In such process, the following steps are taking:
  - a) Determining if the Appeal request has been filed within 30 days from the notice of Adverse Action.
  - b) Dismissing the appeal, if it is filed beyond the 30 days time period, by issuing a letter to the Member or Authorized Appeal Representative. The letter must state the reason for the dismissal and inform the Member or Authorized Appeal Representative that s/he can request the dismissal be vacated by submitting a written request. Such request must be received within 10 calendar days of the date of the FCHP letter.
  - c) Reviewing all Member or Authorized Appeal Representative's requests to vacate a dismissal for late filing with the Member Relations Manager who may decide to either:
    - ◇ Issue a final dismissal letter informing the Member of the right to appeal to BOH if the Member raises a dispute about whether he/she in fact requested an Internal Appeal within the 30 day time period; or
    - ◇ Vacate the dismissal and proceed with the Internal Appeal.

**The only ground to vacate the dismissal is that the appeal was in fact filed on time and not that there is an excuse for late-filing**



d) If the Member files an Appeal for which an Adverse Action notice (denial letter) was not issued, the Administrative Assistant or the Triage Analyst determines if the Member's request is eligible for Appeal in accordance with the definition of Adverse Action. If confirmed, then the Triage Analyst/ Administrative Assistant reviews the request and conducts a manual review to determine if the appeal is filed within 30 calendar days from the date of Adverse Action occurrence. Such review may involve:

- ◇ **For the failure to act within the timeframes for making authorization decisions** – establishment of the actual date of the prior authorization determination and the date the determination should have been issued under the following MassHealth contract requirements:
  - For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action
  - For standard service authorization decisions that deny or provide limited authorization for requested services, as expeditiously as the Member's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days
  - For expedited service authorization decisions that deny or provide limited authorization for requested services, as expeditiously as the Member's health requires but no later than 3 business days after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days.
- ◇ **For the failure to follow prior authorization procedures** – review and identification of the circumstances when the prior authorization procedures were not properly followed and establishment of dates of such procedural failure
- ◇ **For the failure to follow referral rules**- review and identification of the circumstances when the referral rules were not properly followed and establishment of dates of such procedural failure
- ◇ **For the failure to file a timely claim** - review of the claim filing process for the claim in question and determination of the date of failure to file a timely claim
- ◇ **For the failure to resolve an Internal Appeal within the timeframes**- identification of the date where the failure to timely resolve the Internal Appeal occurred
- ◇ **For the failure to provide services in a timely manner** - review of the circumstances relating to the failure to provide timely services and identification of the date the failure occurred.

2. The Triage Analyst determines if the Appeal case involves Continuing Services. The Triage Analyst reviews the Member's prior authorization history in the FCHP computer system to determine if:
  - ◇ the Member was previously authorized by FCHP to receive the services under the Appeal
  - ◇ Appeal request is filed within 10 days of the notice of the Adverse Action. If confirmed then the Triage Analyst notifies the Member Relations Coordinator to whom the case is assigned.



3. The Member Relations Triage Analyst identifies if the Appeal request is initiated by a third party (an individual acting on behalf of the Member). The Triage Analyst issues an acknowledgment letter along with the *Personal Representative Authorization form* to the Member and assigns the case to the Member Relations Coordinator for processing.

The third party who may file an appeal on the Member's behalf includes:

- ◇ The Member (including his or her representative);
- ◇ The legal representative of a deceased Member's estate; or
- ◇ A provider determined to have an appealable interest in the proceeding.
- ◇ In cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent them, without parental/guardian consent.

**If a provider files an expedited appeal on the behalf of the member, the appeal is accepted and processed without a written authorization from the member.**

All written Member requests to vacate a dismissal for failure to authorize an Authorized Appeal Representative are received by the Triage Analyst and reviewed with the Member Relations Coordinator who may decide to either:

- ◇ send a final dismissal informing the Member of the right to appeal to BOH if the Member raises a dispute about whether he/she in fact authorized the Appeal Representative in writing before the time for resolving the Internal Appeal expired;
  - or
  - ◇ vacate the dismissal and proceed with the Internal Appeal.
4. The Member Relations Triage Analyst identifies if the case involves a request for an Expedited Appeal. The Triage Analyst immediately assigns the Expedited Appeal case to the next available Member Relations Coordinator. If a Standard Appeal is received the Triage Analyst assigns it to the Member Relations Coordinators on a rotational basis.
  5. The Member Relations Triage Analyst contacts the appropriate department to acquire the denial letter (which is the Adverse Action notice issued by Claims Department, Care Review Services, etc.). The Adverse Action notice remains as a permanent part in the Appeal case file.
  6. The Member Relations Triage Analyst issues acknowledgment letters to the Member or the Authorized Appeal Representative. The following is a list of possible Acknowledgement Letters:
    - ◇ Acknowledgment letter only
    - ◇ Acknowledgment letter and *Personal Representative Authorization Form* – sent if the Appeal is filed by someone who is not yet been authorized in writing to serve as the Member's Authorized Appeal Representative.



The Triage Analyst signs the *Acknowledgment Letter* with the name of the Member Relations Coordinator to whom the case is assigned and initials the signature. Mails the original letter and inserts a copy of it in the case file.

7. The Member Relations Triage Analyst creates a new case folder with Member's name and inserts the following documents:
  - ◇ a copy of the acknowledgment letter,
  - ◇ a copy of the Personal Representative Authorization form, if applicable
  - ◇ the documented request for appeal based on the telephonic conversation or a written Appeal letter received from the Member or his/her Authorized Appeal Representative
  - ◇ the Member Relations Case Summary form (generated from the Member Relations database)
    - ◇ a copy of the organization determination
    - ◇ a copy of the information used by the Care Review Department to render the organization determination, if applicable
    - ◇ a *Case Summary Sheet* from the Database
    - ◇ a copy of Customer Service case if applicable
8. The Member Relations Triage Analyst completes a deadline sheet that includes dates upon which each step of the process is to be completed.
9. The Member Relations Triage Analyst reviews the Weekly Case Distribution log to determine to which Member Relations Coordinator the Appeal should be assigned.
10. The Member Relations Triage Analyst assigns the case file to the Member Relations Coordinator the same day as receipt of the Appeal request.
11. The Member Relations Triage Analyst enters Member's demographic information in the Member Relations database, including, but not limited to:
  - ◇ IDX medical record number (which pulls the demographic information from the IDX system)
  - ◇ Group Number
  - ◇ Last FCHP effective date prior to a break in coverage.
  - ◇ FCHP Plan option under which the services named in the Appeal were received
  - ◇ Indicate the Member Relations Coordinator to whom case is assigned
  - ◇ Categorization
  - ◇ Case classification
  - ◇ Provider relationship to FCHP
  - ◇ Claim information, if relevant
  - ◇ Member Relations Coordinator name to whom the case is assigned
12. The Member Relations Triage Analyst identifies the financially liable party for the services at issue. If the provider is financially liable and the Member has no financial liability for the services as stated above, the Member is notified in writing within 2



business days. Please note: MassHealth Members have no financial liability for covered services.

13. If the Appeal relates to a service denial, the Member Relations Triage Analyst updates the status of the referral in question to reflect that it is pending appeal resolution.

#### **D. INTERPRETER SERVICES/AVAILABILITY OF MEMBER MATERIALS IN ALTERNATIVE FORMATS**

If the Member requests interpreter services the Member Relation staff follow the following process:

- ◇ Use conference Hold to place the non-English speaker on hold.
- ◇ Dial one of the following Language Line Services number:
  - 1-800-523-1786 for emergencies or
  - 1-800-874-9426 for routine calls.
- ◇ Inform the Language Line Representative of the type of language needed by the Member
- ◇ Enter the FCHP client number, which is 226353.
  - ◇ Enter the company name (FCHP) and the Member Relations staff person personal code. The personal code consists of the initials of the FCHP employee's first and last name along with the extension number.
  - ◇ The interpreter is placed on the line to discuss the Member's issue.
  - ◇ Once the interpretation is completed, Member Relations staff must state "end of call" to terminate the call.

If the Member requests that all Appeal related correspondence is sent to him/her in the Spanish language, the Member Relations staff accommodate such request by having the letter translated by the bi-lingual FCHP staff. If such staff is not available, the Member Relations staff may;

- ◇ Contact the FCHP Communications Department for assistance
- ◇ Access Ectaco - On Line Dictionary by clicking on the following link  
<http://online-old.ectaco.com/online/diction.php3?refid=316&pagelang=23&word=harmless&direction=1&lang=12>

If the Member requests Appeal related correspondence in a large print, the Member Relations staff accommodate such request by printing the relevant documents in font size 14.

#### **E. FIRST LEVEL STANDARD INTERNAL APPEAL PROCEDURE**

1. Throughout the Appeal process, the Member Relations Coordinator identifies Appeal requests that may require processing sooner than departmental or regulatory time frames due to the Member's health status. Evidence of the Member's health status may be demonstrated by indications obtained from the treating provider, from the Member's medical record, or test results. The Member Relations Coordinator



immediately reviews any Appeal with the FCHP Medical Director or designated reviewer whenever it is thought that the Member's health may be jeopardized by a delay in receipt of health care services.

2. The Member Relations Coordinator updates the *Intake Information/Processing Deadline and File Completion Checklist* as the Appeal progresses.
3. The Member Relations Coordinator begins to document the case in the *Case Narrative Form*.
4. The Member or the Authorized Appeal Representative has the opportunity to submit evidence and allegations of fact or law, in person or in writing, to the Member Relations Coordinator, in support of the Appeal request. This information must be provided prior to the review of the Appeal. In addition, the Member may request to review the case file, before and during the Appeals process, including medical records, and any other documentation and records considered during the Appeal process.
5. The Member Relations Coordinator identifies whether the Appeal request also raises a Grievance regarding Quality of Care (QC) or whether the member is dissatisfied that FCHP has taken an extension for making appeal decisions or for the fact that an expedited appeal request was not approved and is being treated as a standard internal appeal.
  - a) If no QC component is identified, proceed with the Appeal procedure.
  - b) If a QC component is present, address the Appeal request through the Appeals Process while the QC component is addressed through the Grievance process concurrently. Appropriate correspondence is sent to the Member upon resolution of both components.
  - c) If it is determined that the member is dissatisfied that FCHP has taken an extension for making appeal decisions or for the fact that an expedited appeal request was not approved and is being treated as a standard internal appeal, the Member Relations Coordinator addresses any of these components through the Grievance process while the Appeal is conducted via the Appeal process. Appropriate correspondence is sent to the Member upon resolution of both components.
7. FCHP has a **20 calendar day turnaround time** for the First Level Internal Appeal process, unless the time is extended. The Member or Authorized Appeal Representative may request a 5 calendar day extension. FCHP can also take a 5 calendar day extension if FCHP can justify to EOHHS, upon their request, that:
  - a. the extension is in the Member's interest; and
  - b. there is a need for additional information where:
    - ◇ There is a reasonable likelihood that receipt of such information would lead to approval of the request; and
    - ◇ Such outstanding information is reasonably expected to be received within 5 days.

If FCHP elects to take the extension, a letter must be issued to the Member advising the following:



- a) the reason for the extension;
  - b) the Grievance procedure in the event the Member disagrees with the extension. The Member Relations Coordinator documents the justification for the extension in the *Case Narrative* Form.
8. When prepared, the case is reviewed with a FCHP Medical Director or other appropriate health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action.
- If the FCHP Medical Director or any other FCHP medical reviewer had prior involvement in the case, the review is conducted with another FCHP Medical Director or other appropriate physician reviewer who has appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action. **All individuals who make decisions on internal appeals may not have any prior involvement in review of such case.**
- If the appeal request is not a matter of medical necessity, but rather, relates to a benefit issue, the request will be reviewed by a designated health care professional, who typically reviews such requests. Example: non-emergency travel expenses are not a covered benefit. Clinical review relating to medical necessity is not appropriate as regardless of medical necessity, this is not a covered benefit. (Only bright line cases could be reviewed by non-doctors i.e.: if the benefit is clearly excluded by statute or regulation or clearly qualifies as an excluded service. These may involve services/benefits included in the MassHealth Excluded List of Services in the Contract – Appendix C, Exhibit 6. However, certain items on Appendix C Exhibit 6 do require medical necessity review, i.e., experimental treatment or cosmetic surgery.)
9. The Medical Director/Appeal Reviewer documents the determination on the Member Relations Reconsideration Documentation Form.
  10. The Member Relations Coordinator documents the outcome of the review and the determination in the Case Narrative Form.
  11. Overturned cases may require a corrective action plan, which is documented on the *Case Narrative* and/or the Member Relations Reconsideration Documentation Forms. The documentation includes staff involved in corrective action. Recommendations are communicated as appropriate to the involved clinical or administrative area (including executive level staff) for review and/or implementation.
  12. The Member Relations Coordinator notifies the Member in writing of the determination as expeditiously as the Member's health requires but not to exceed 20 calendar days from receiving the Appeal request or the expiration of the extension.
  13. If the Adverse Action is overturned, the Member is notified in writing within the same day of completion of the review. The provider may also be notified of any overturned



decisions relating to payment of claims [If coverage of the service is at issue, payment can be involved and it would be an Adverse Action. If coverage of service is not at issue, this would be an administrative appeal] or authorization of services.

14. If the Adverse Action is upheld, the written notification to the Member must include
  - a) The appeal determination and the effective date of the decision.
  - b) An explanation that the Member has the right to file either a Second Level Internal Appeal with FCHP or an External Appeal with the Board of Hearings.
  - c) Instructions for how to file a Second Level Internal Appeal with FCHP. The request for a Second Level Internal Appeal must be received by FCHP within 30 calendar days from the date of the notice. The Member can file the Second Level Internal Appeal orally, in writing, or in person.
  - d) Instructions for filing an External Appeal with the Board of Hearing (BOH) within 30 calendar days of the denial notice. A Fair Hearings Request form and any other instructive materials and forms provided to FCHP by EOHHS that are required for the Member to request an External Appeal with the Board of Hearings, are enclosed in the letter.
  - e) A statement informing the Member that, if applicable, coverage for Continuing Services will be provided by FCHP as long as the Member's request for a Second Level Internal Appeal hearing or the BOH request is submitted within 10 calendar days of date of this notice. The date on the notice of action is considered the mailing date. If the Member chooses to receive continuing services through the Appeal and if the BOH or the Second Level Internal Appeal Committee upholds the original denial, the Member may be responsible for paying MassHealth back for the cost of the continuing services.
  - f) Information relating to FCHP toll-free number with TDD/TYY services
  - g) A statement informing the Member of the right to request a copy of the documents that were submitted in the course of making the appeal determination.
  
15. If the Member requests a Second Level Internal Appeal, the case is referred to the Second Level Appeal Coordinator (SLAC) using the *Request for SLAC Hearing Form*.



16. FCHP shall notify MassHealth within one business day of learning that a Member's First Level Internal Appeal in which an Adverse Action is upheld will not be going to a Second Level Internal Appeal and thus may be proceeding to the BOH.
  - a) FCHP will provide MassHealth with a copy of the First Level Internal Appeal decision within 1 business day of issuing the notice.
  - b) FCHP will provide MassHealth with all necessary information to assist with MassHealth's review of FCHP's decision. This shall include:
    - ◇ letters that are sent when FCHP fails to act within the time frames for reviewing Internal Appeals, and
    - ◇ letters sent issuing a decision, including all upheld First Level appeals that FCHP knows or reasonably believes will be appealed at the Board of Hearings.
  - c) FCHP shall provide MassHealth with all necessary information to assist with MassHealth review of FCHP's determination. For decisions involving Behavioral Health Services, MassHealth will consult with the MassHealth Behavioral Health Unit in its review of FCHP's decision.

The Member Relations Coordinator shall comply with any MassHealth directive to reevaluate the basis of its decision in a manner that is consistent with MassHealth's interpretation of any statute, regulation, and contractual provision and sub-regulatory authority, i.e. clinical guidelines that relate to the decision. When BOH notifies FCHP of the date of the fair hearing, FCHP will then notify MassHealth immediately and include the names of FCHP clinical and other staff who will be attending the BOH hearing. In addition, FCHP shall provide MassHealth, upon request, any other documents, records, studies, or other information relating to the Internal Appeal and FCHP decision resolving the Internal Appeal.

17. The Member Relations Coordinator completes the case documentation on the *Case Narrative Form*.
18. The Member Relations Coordinator completes the *Intake Information/Processing Deadline and File Completion Checklist* for Standard Appeal.
19. For a completely overturned First Level Internal Appeal regarding a request for service, which may have not yet been furnished or may have been received while the appeal was pending, the Member Relations Coordinator facilitates authorization or provision of the service under dispute as expeditiously as the Member's health requires, but no later than 20 calendar days after the date FCHP receives the request for Appeal and updates the referral in question in the FCHP computer system. If the Appeal involved a claim denial, the Member Relations Coordinator facilitates authorizations of such claim by requesting payment through the Claims Adjustment Department.
20. The Member Relations Coordinator completes the *Case Summary Sheet* and returns it to Member Relations Administrative Assistant to update and close the First Level Internal Appeal case file in the Appeals Database.



21. The Member Relations Coordinator organizes all documentation relevant to the First Level Internal Appeal request in the Appeal case file. Documentation contained in the Appeal case file includes:
  - a) *Case Summary Sheet* (2 pages);
  - b) *Case Narrative Form*;
  - c) *Medical Director Review Form*;
  - d) Member (or Authorized Appeal Representative) written Appeal request;
  - e) The FCHP initial Adverse Action notice;
  - f) Signed *Personal Representative Authorization Form* (where necessary);
  - g) Internal Appeal determination letter and other correspondence relating to the Internal Appeal;
  - h) Medical Records; and
  - i) Other FCHP documentation (Referral information, etc.).
22. The Member Relations Department maintains Appeal case file documentation for 10 years following the final resolution of the Appeal.
23. The Member Relations Department provides information regarding coverage and payment issues relevant to the Appeal to the Member upon request.
24. The Appeals Administrative Assistant files the cases numerically in hanging files by case number labeled with the Member's Last Name, First Name. The files are maintained by year of the final resolution.

#### D. EXPEDITED INTERNAL APPEAL REQUEST

1. An Expedited (fast) Internal Appeal request may be submitted orally, in writing or in person, directly to FCHP by a Member or Authorized Appeal Representative. The physician/treating provider can file an expedited appeal on the behalf of the Member and act as Member's Authorized Appeal Representative without a written authorization from the member so as not to hold up an expedited appeal request, but FCHP may request a copy of the authorization form from the provider after the fact.

If the physician/treating provider support the request that the appeal be expedited, FCHP can only refuse to expedite the appeal if the request is totally unrelated to the Member's health status.

2. For Appeals filed orally or in person, the Member Relations Coordinator will reduce the Member's request to writing on *Documentation of Oral Appeal Form* and forward a copy of the request to the Member within 1 business day of receipt along with the *Acknowledgement Letter* and *Personal Representative Authorization Form* as necessary.
3. Upon receipt of a request for an Expedited Internal Appeal, the date and time of receipt of the appeal request is recorded.



- a) For written requests, the Administrative Assistant time and date stamps the correspondence using the Member Relations Department Electronic Date/Time Stamper.
  - b) For oral requests, the Appeal Coordinator documents the Member request noting the date and time of receipt of the request on the *Documentation of Oral Appeal Request Form*.
4. FCHP staff is on call after business hours and on weekends and holidays.
- a) If the request is received after normal business hours, refer to the *Protocol for After Hours Expedited Appeal Requests*.
  - b) For weekend and holiday requests, a Member Relations Coordinator is on-call.
5. If the request for an Expedited Internal Appeal is initiated by someone other than the Member, and the Member has not returned the signed *Personal Representative Authorization Form* within 24 hours from the time the Expedited Internal Appeal was filed, the Member Relations Coordinator contacts the Member by phone.

If the Member has not returned the *Personal Representative Authorization Form* within 3 business days from the date the Expedited Internal Appeal was filed, the Appeal request is dismissed and the Member notified of the dismissal in writing. This notice informs the Member that he/she can request that the dismissal be vacated by submitting a request to vacate in writing within 10 calendar days of the date of the FCHP letter. All Member or Authorized Appeal Representative's requests to vacate a dismissal for failure to authorize an Appeal Representative in writing are received and reviewed with the Member Relations Manager who may decide to either:

- a) send a final dismissal informing the Member of the right to appeal to BOH if the Member raises a dispute about whether he/she in fact authorized the Appeal Representative in writing before the time for resolving the Internal Appeal expired;  
or
- b) vacate the dismissal and proceed with the Internal Appeal.

**The only ground to vacate the dismissal is that the appeal was in fact filed on time and not that there is an excuse for late-filing**

6. If any physician requests, on behalf of the Member, that an Appeal be treated as an Expedited Internal Appeal, the Member Relations Coordinator presents the request to the FCHP Medical Director, who will grant the request unless it is unrelated to the Member's health condition. A request for an Expedited Internal Appeal will be granted to all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.
7. If the person requesting that an Appeal be treated as an Expedited Internal Appeal is not a physician, the Member Relations Coordinator may contact the Member's Primary Care Physician or treating specialist to gather information for the FCHP Medical



Director to determine if the request meets Expedited Internal Appeal criteria. The FCHP Medical Director or designated reviewer will grant a request for an Expedited Internal Appeal if it is determined that applying the standard time frame for reconsidering a determination could seriously jeopardize the life or health of the Member.

8. The Member Relations Coordinator initiates the *Intake Information/Processing Deadline and File Completion Checklist* for the Expedited Internal Appeal and submits it to the Member Relations Department Triage Analyst for entry into the Appeals Database. The Analyst compiles the case file and issues the appropriate letters, which includes the Acknowledgement Letter and/or an Appeal Representative Authorization form, if required, via facsimile, if possible, to the Member, Authorized Appeal Representative or provider the same day the Expedited Internal Appeal information from the Member Relations Coordinator was received.
9. The Triage Analyst obtains the initial Adverse Action notice from the appropriate department (Care Services, Care Review, etc.).
10. If the request does not meet Expedited Internal Appeal criteria, refer immediately to *AP-1.0, I,C ("First Level Standard Appeal Procedure")*.
11. If FCHP denies a request that an Appeal be treated as an Expedited Internal Appeal, the Member Relations Coordinator makes reasonable efforts to give the Member or the Authorized Appeal Representative prompt oral notice of the denial and sends a written notice within 2 calendar days. Written notification will:
  - a) Explain that FCHP will process the request using the 20 calendar day timeframe for a Standard First Level Appeal;
  - b) Inform the Member or the Authorized Appeal Representative of the right to file a Grievance if he/she disagrees with FCHP's decision not to expedite; and
  - c) Provide instructions about the Grievance process and its timeframes.
12. The Member or the Authorized Appeal Representative has the opportunity to submit evidence and allegations of fact or law, in person or in writing, to the Member Relations Coordinator, in support of the Appeal request. This information must be provided prior to the review of the appeal. In addition, the Member may request to review the case file, before and during the appeals process, including medical records, and any other documentation and records considered during the Appeal process.
13. The Member Relations Coordinator or Triage Analyst identifies whether the Appeal request also raises a Grievance regarding Quality of Care (QC) or whether the member is dissatisfied that FCHP is taking an extension for making appeal decisions or for the fact that an expedited appeal request was not approved and is being treated as a standard internal appeal..
  - a) If no QC component is identified, proceed with the Appeal Procedure.



- b) If a QC component is present, address the Appeal request through the Member Relations Appeals Process and the QC component is addressed through the Member Relations Grievance process concurrently. Appropriate correspondence is sent to the Member upon resolution of both components.
- c) If it is determined that the member is dissatisfied that FCHP is taking an extension for making appeal decisions or for the fact that an expedited appeal request was not approved and is being treated as a standard internal appeal, the Member Relations Coordinator addresses any of these components through the Grievance process while the Appeal is conducted via the Appeal process. Appropriate correspondence is sent to the Member upon resolution of both components.

14. FCHP has a 3 business day turnaround time for the Expedited Appeal process unless the time is extended. The Member or Authorized Appeal Representative may request a 14 calendar day extension. FCHP can also take a 14 calendar day extension if FCHP can justify to EOHHS, upon their request, that:

- a) the extension is in the Member's interest; and
- b) there is a need for additional information where:
  - ◇ there is a reasonable likelihood that receipt of such information would lead to approval of the request; and
  - ◇ such outstanding information is reasonably expected to be received within 14 days.

If FCHP elects to take the extension, the Member Relations Coordinator issues a written notice to the Member advising of the following:

- a) the reason for taking the extension; and
- b) the Grievance procedure, in the event the Member disagrees with the extension decision by FCHP.

The Member Relations Coordinator documents the justification for the extension in the *Case Narrative Form*.

15. The Member Relations Coordinator compiles the case and reviews it with a FCHP Medical Director or health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure or providing the treatment that is the subject of the Adverse Action, as expeditiously as the Member's health requires but not exceeding 3 business days of receipt of the Member Appeal request or expiration of the extension.

If the FCHP Medical Director or any other FCHP medical reviewer had prior involvement in case, the review is with another FCHP Medical Director or other appropriate physician reviewer who has appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action. **All individuals who make decisions on internal appeals may not have any prior involvement in review of such case.**

If the appeal request is not a matter of medical necessity, but rather, relates to a benefit issue, the request will be reviewed by a designated health care professional,



who typically reviews such requests. Example: non-emergency travel expenses are not a covered benefit. Clinical review, relating to medical necessity, is not appropriate as regardless of medical necessity, this is not a covered benefit.

16. The Medical Director/Appeal Reviewer documents the determination on the *Member Relations Reconsideration Documentation Form*.
17. Overturned cases may require a corrective action plan, which is documented on the *Case Narrative* and/or the *Member Relations Reconsideration Documentation Forms*. Recommendations are communicated as appropriate to the involved clinical or administrative area for implementations.
18. The Member Relations Coordinator notifies the Member orally and in writing of FCHP's determination as expeditiously as the Member's health requires, but not to exceed 3 business days from receiving the Appeal request or expiration of the extension.
  - ◇ If the Adverse Action is overturned the Member is notified in writing within the same day of completion of the review. The provider may also be notified of any overturned decisions relating to payment of claims or authorization of services.
  - ◇ For a completely overturned First Level Internal Appeal regarding a request for service, which may have not yet been furnished or may have been received while the appeal was pending, the Member Relations Coordinator facilitates authorization or provision of the service under dispute as expeditiously as the Member's health requires, but no later than 20 calendar days after the date FCHP receives the request for Appeal and updates the referral in question in the FCHP computer system. If the Appeal involved a claim denial, the Member Relations Coordinator facilitates authorizations of such claim by requesting payment through the Claims Adjustment Department.
19. If the Adverse Action is upheld, Written notification to the Member must include:
  - a) The results of the resolution process and the effective date of the decision.
  - b) An explanation that the Member has the right to file an External Appeal with the Board of Hearings.
  - c) Instructions for filing an External Appeal with the Board of Hearing. The Member must file a Fair Hearing Request form with the Board of Hearings within 20 calendar days of this notice for an expedited BOH hearing but may receive a standard BOH hearing if the Fair Hearing Request form is filed between 21 and 30 days of this notice.
  - d) A copy of the Fair Hearing form and any other instructive materials and forms provided to FCHP by EOHHS that are required for the Member to request an External Appeal with the Board of Hearings.
  - e) A statement informing the Member that, if applicable, coverage for Continuing Services will be provided by FCHP as long as the Member's request for a BOH appeal is submitted within 10 calendar days of this notice. The date on the notice of action is considered the mailing date. If the Member



- chooses to receive continuing services through the Appeal and if the BOH or the Second Level Internal Appeal Committee upholds the original denial, the Member may be responsible for paying MassHealth back for the cost of the continuing services.
- f) Information relating to FCHP toll-free number with TDD/TYY services.
20. FCHP shall notify MassHealth within 1 business day of upholding an Expedited Internal Appeal decision and thus may be proceeding to the BOH.
- ◇ FCHP will provide MassHealth with a copy of the Expedited Internal Appeal decision within 1 business day of issuing the notice.
  - ◇ FCHP will provide MassHealth with all necessary information to assist with MassHealth's review of FCHP's decision. This shall include letters that are sent when FCHP fails to act within the time frames for reviewing Internal Appeals, and letters sent issuing a decision, including all upheld First Level appeals that FCHP knows or reasonably believes will be appealed at the Board of Hearings.
  - ◇ FCHP shall provide MassHealth with all necessary information to assist with MassHealth review of FCHP's determination. For decisions involving Behavioral Health Services, MassHealth will consult with the Deputy Commissioner of the Department of Mental Health in its review of FCHP's decision.

The Member Relations Coordinator shall comply with any MassHealth directive to reevaluate the basis of its decision in a manner that is consistent with the MassHealth's interpretation of any statute, regulation, and contractual provision and sub-regulatory authority, i.e. clinical guidelines that relates to the decision. When BOH notifies FCHP of date of the fair hearing, FCHP will then notify MassHealth immediately and include the names of FCHP clinical and other staff who will be attending the BOH hearing. In addition, FCHP shall provide MassHealth, upon request, any other documents, records, studies, or other information relating to the Internal Appeal and FCHP decision resolving the Internal Appeal.

21. The Member Relations Coordinator will make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Member and FCHP within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing.
22. The Member Relations Coordinator completes the *Intake Information/Processing Deadline and File Completion Checklist* for Expedited Appeal.
23. For a completely overturned Expedited Internal Appeal decision regarding a request for service, the Member Relations Coordinator facilitates authorization of the service under dispute as expeditiously as the Member's health requires, but no later than 3



business days after the date FCHP receives the reconsideration determination, and completes the *Case Summary Sheet* and returns it to the Administrative Assistant to update and closes the Expedited Internal Appeal case file in the Appeals Database.

24. The Member Relations Coordinator organizes all documentation relevant to the Appeal request in the Appeal case file. Documentation contained in the Appeal case file includes:
  - a) *Case Summary Sheet* (2 pages);
  - b) *Case Narrative Form*;
  - c) *Medical Director Review Form*;
  - d) Member (or Authorized Appeal Representative) Appeal request;
  - e) Adverse Action notice;
  - f) Signed *Personal Representative Authorization Form* (where necessary);
  - g) Expedited Internal Appeal determination letter and other correspondence relating to the Internal Appeal;
  - h) Medical Records; and
  - i) Other FCHP documentation and correspondence (Referral information, etc.).
  
25. The Member Relations Department maintains Appeal case file documentation for 10 years following the final resolution of the Appeal. The Member Relations Department provides information regarding coverage and payment issues relevant to the Appeal to the Member upon request.
  
26. The Member Relations Department Administrative Assistant files the cases numerically in hanging files by case number labeled with the Member's Last Name, First Name. The files are maintained by year of the final resolution.

#### **E. SECOND LEVEL INTERNAL APPEAL PROCEDURE: SLAC REVIEW**

1. Requests for Second Level Internal Appeal review by a Second Level Appeal Committee (SLAC) must be received from the Member or the Authorized Appeal Representative within 30 calendar days of the First Level Internal Appeal decision to uphold an Adverse Action.
  
2. Upon receipt of a request for a Second Level Appeal Committee Hearing, the date and time of receipt of the appeal request is recorded by the Member Relations Coordinator in the Case Narrative Form.
  
3. The Member or the Authorized Appeal Representative has the opportunity to submit evidence and allegations of fact or law, in person or in writing, to the Member Relations Coordinator, in support of the Appeal request. This information must be provided prior to the review of the Appeal. In addition, the Member may request to review the case file, before and during the Appeals process, including medical records, and any other documentation and records considered during the Appeal process.



4. Once the SLAC hearing is scheduled, a letter is issued to the Member or the Authorized Appeal Representative to confirm the date and time of the hearing.
5. The following time frames apply to processing and resolution of Second Level Internal Appeal requests. FCHP has a **20 calendar day turnaround time** from the receipt of Second Level Internal Appeal request from the Member or Authorized Appeal Representative to conduct the Second Level Review and notify the Member or Appeal Representative of the determination unless this time period is extended. The Member or Authorized Appeal Representative may request a 5 calendar day extension. FCHP can also take a 5 calendar day extension.

**Note:** A 5 **calendar day** extension period can be taken by FCHP only if an extension **was not** taken at the First Level Internal Appeal. (The Member or the Authorized Appeal Representative may request a 5 calendar day extension at both the First Level and Second Level Internal Appeals.)

FCHP can take an extension only if FCHP can justify to EOHHS, upon their request, that:

- a) the extension is in the Member's interest; and
- b) there is a need for additional information where:
  - ◇ there is a reasonable likelihood that receipt of such information would lead to approval of the request; and
  - ◇ such outstanding information is reasonably expected to be received within 5 days.

If FCHP elects to take the extension, a letter must be issued to the Member advising the following:

- a) the reason for the extension;
- b) the Grievance procedure in the event the Member disagrees with the extension.

The Member Relations Coordinator documents the justification for the extension in the *Case Narrative* Form.

**Note:** The Member and the Authorized Appeal Representative (if appropriate) will be notified of the SLAC decision within 5 calendar days from date of SLAC review, not exceeding the final completion timeframe.

6. MassHealth Members may elect to bypass SLAC and proceed to an External Appeal at the Board of Hearings.
7. The Member Relations Department under the direction of the FCHP Medical Director appoints the SLAC.
8. The SLAC is comprised of FCHP Management or Director level staff and FCHP physicians and/or their designees.
  - a) The Coordinator selects the FCHP administrative staff and one FCHP physician to attend the hearing.



- b) The Coordinator selects the physician participants from a list of FCHP Medical Directors or designees. A physician reviewer who is a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue may participate in the SLAC or provide a written assessment, prior to the SLAC.

**All reviewers, with the exception of the Member Relations Coordinator, who participate in the SLAC may not have any prior involvement in review of such case.**

9. If the appeal request is not a matter of medical necessity, but rather, relates to a benefit issue, the request will be reviewed by a designated health care professional, who typically reviews such requests. A medical specialty reviewer will not be required. Example: travel expenses are not a covered benefit. Clinical review, relating to medical necessity, is not appropriate as regardless of medical necessity, this is not a covered benefit.
10. No member of the SLAC may have been involved in the Adverse Action or the First Level Internal Appeal.
11. The Coordinator completes the *Request for SLAC Hearing* and gives it to the Member Relations Department Administrative Assistant. The Administrative Assistant is responsible for arranging the SLAC hearing within **15 Calendar days** of the request for the hearing. The Member is verbally notified of the date and time of the SLAC Review and is offered the opportunity to participate in the SLAC Review session.
  - a) The Member or Authorized Appeal Representative may participate by telephone conference call or other appropriate technology if unable to attend the hearing in person.
  - b) The Member may participate in person and may be accompanied to the SLAC hearing by a friend, relative, physician or other clinical provider, or by legal counsel. (NCQA Standard RR 3.3.3.2)  
**Note:** Refer the case to FCHP's legal counsel if the Member's legal counsel is expected to attend the hearing.
  - c) Any additional information submitted by the Member or Authorized Appeal Representative to be considered at the hearing should be received by the Coordinator at least 1 day prior to the hearing date.
12. The Member Relations Department Administrative Assistant generates the confirmation letters that indicate the date and time of the SLAC hearing, and includes travel directions, if the Member is attending the hearing. Where time permits, the Member or Authorized Appeal Representative is notified in writing at least 3 business days prior to the date of hearing for a SLAC hearing.
13. The FCHP physician and administrative staff are notified in writing of a SLAC hearing at least 2 business days prior to the date of the hearing.



14. At least 1 business day prior to the SLAC Review, the Coordinator provides physician participant with information relevant to the case, including but not limited to a summary of the Member's First and Second Level Internal Appeal requests, relevant medical records and FCHP documents, applicable coverage criteria, clinical practice guidelines, etc.
15. If the Member calls to cancel attendance, he/she will be offered a 5 calendar day extension and he/she will be given an opportunity to designate an Authorized Appeal Representative to attend on his/her behalf. If the member decides to take the extension, then the SLAC will be scheduled within 25 calendar days of the initial request for the Second Level Internal Appeal. If the extension is refused, the hearing will commence, as scheduled.
16. At the SLAC Review, the case file including the *Case Narrative* and medical records are available for review. If present, the Member or Authorized Appeal Representative is given the opportunity to present additional information he/she feels is relevant to the Appeal. The SLAC participants are given the opportunity to ask questions of the Member or Authorized Appeal Representative or of the Member Relations Coordinator or SLAC.
17. The Member or Authorized Appeal Representative is dismissed from the SLAC Review prior to any discussion or determination made by the Committee.
18. The SLAC hearing is tape-recorded. The tape is filed in the appeal file.
19. The SLAC deliberates the facts of the case and provides a determination to the Member Relations Coordinator at the conclusion of the review session.
20. The Member Relations Coordinator notifies the Member or Authorized Appeal Representative of the SLAC's decision in writing as expeditiously as the Member's health requires but not to exceed the 20 calendar day timeframe, unless a 5 calendar day extension is taken.
21. If the Adverse Action is overturned the Member is notified in writing within the same day of completion of the review. The provider may also be notified of any overturned decisions relating to payment of claims or authorization of services.

Additionally, the Member Relations Coordinator facilitates authorization or provision of the service under dispute as expeditiously as the Member's health requires, but no later than 20 calendar days after the date FCHP receives the request for Appeal, unless a 5 calendar day extension was taken.

For a completely overturned First Level Internal Appeal regarding a request for service, which may have not yet been furnished or may have been received while the appeal was pending, the Member Relations Coordinator facilitates authorization or provision of the service under dispute as expeditiously as the Member's health requires,



but no later than 20 calendar days after the date FCHP receives the request for Appeal and updates the referral in question in the FCHP computer system. If the Appeal involved a claim denial, the Member Relations Coordinator facilitates authorizations of such claim by requesting payment through the Claims Adjustment Department.

22. If the Adverse Action is upheld, the notification must include the following:
  - a) Determination
  - b) If denied, the reason for the denial;
  - c) Instructions for filing an External Appeal with the Board of Hearing (BOH). The member must file a Fair Hearings Request Form with the Board of Hearings within 30 calendar days of this notice;
  - d) Copy of Fair Request Hearing form and any other instructive materials and forms provided to FCHP by MassHealth that are required for the Member to request a Board of Hearings Appeal;
  - e) Description of alternative covered treatment, services, or supplies, if applicable;
  - f) If applicable, a statement informing the Member that coverage for Continuing Services will cease unless the Member submits a request for an External Appeal to BOH within 10 calendar days of the date of this notice. The date on the notice of action is considered the mailing date
  
23. If the determination is upheld, the Member Relations Coordinator provides MassHealth with a copy of the decision sent to the Member within 1 business day of issuing the decision. FCHP will provide MassHealth with all necessary information to assist with MassHealth's review of FCHP's decision. In addition, upon request from MassHealth, the Member Relations Coordinator provides any other documents, records, studies, or other information relating to the Second Level Internal Appeal decision. The Member Relations Coordinator shall comply with any MassHealth directive to reevaluate the basis of its decision in a manner that is consistent with MassHealth's interpretation of any statute, regulation, and contractual provision and sub-regulatory authority, i.e. clinical guidelines that relates to the decision. When the BOH notifies FCHP of date of the fair hearing, FCHP will notify MassHealth immediately.
  
24. For a Second Level Review that completely overturns an Adverse Action, the Member Relations Coordinator facilitates authorization or provision of the service under dispute as expeditiously as the Member's health requires, but no later than 20 calendar days after the date FCHP receives the request for Appeal, unless a 5 calendar day extension was taken.
  
25. The Member Relations Coordinator updates the *Case Summary Sheet* and submits it to the Member Relations Department Administrative Assistant for update and case closure in the Appeals Database and the. The Member Relations Coordinator updates the *Case Narrative* Form documenting all actions taken and the outcome of the hearing.
  
26. The Member Relations Department maintains Appeal case file documentation for 10 years following the final resolution of the Appeal. The Member Relations Department



provides information regarding coverage and payment issues relevant to the Appeal to the Member upon request.

27. The Member Relations Department Administrative Assistant files the cases alphabetically in hanging files labeled with the Member's Last Name, First Name. The files are maintained by year of the final resolution.

## F. EXTERNAL REVIEW APPEAL PROCEDURE: STEP 3

1. If the Member is dissatisfied with the final disposition of the Final Standard Internal Appeal or Expedited Internal Appeal, he/she may request a fair hearing through the Office of Medicaid's (MassHealth) Board of Hearings (BOH) under 130 CMR 508.006(B).

**NOTE:** MassHealth Members may elect to bypass SLAC and proceed to external review by the Board of Hearings.

2. For all Second Level Internal Appeals and Expedited Internal Appeals in which an Adverse Action is upheld, FCHP will provide MassHealth with a copy of the decision sent to the Member within 1 business day of issuing the decision. In addition, FCHP will notify MassHealth within 1 business day of learning that a Member's First Level Internal Appeal in which an Adverse Action is upheld will not be going to a Second Level Internal Appeal and thus may be proceeding to the BOH and will provide MassHealth with a copy of all such First Level Internal Appeal decisions. If FCHP learns of a scheduled BOH hearing, FCHP will provide MassHealth with all necessary information to assist with MassHealth's review of FCHP's determination. In addition the Member Relations Coordinator shall provide MassHealth upon request, any other documents, records, studies, or other information relating to the Appeal decision. The Member Relations Coordinator shall comply with any MassHealth directive to reevaluate the basis of its decision in a manner that is consistent with the MassHealth's interpretation of any statute, regulation, and contractual provision that relates to the decision.
3. For any Final Internal Appeal being appealed to the BOH, the Member must request an External Appeal within 30 calendar days of the receipt of the Final Internal Appeal resolution notice.

**Note:** If the Board of Hearings receives the Member's External Appeal request within 10 calendar days of the mailing of the decision of the Final Internal Appeal, the Member will be provided Continuing Services, if applicable. This will continue until the Board of Hearings makes a determination, unless the Member opts to not receive Continuing Services. The Board of Hearings will notify the Second Level Appeal Coordinator upon receipt of a request for an External Appeal so the service will continue. FCHP will notify MassHealth about the date and time of the External Appeal.



4. For any Expedited Internal Appeal being appealed to the BOH, the Member must request an External Appeal within 20 calendar days of the receipt of Expedited Internal Appeal resolution notice for the Board of Hearing process to be expedited. If the Member submits a request to the Board of Hearings to appeal an Expedited Internal Appeal between 21 and 30 calendar days of receipt of the Expedited Internal Appeal resolution notice, the Board of Hearings will apply standard timeframes.

**Note:** If the Board of Hearings receives the Member's External Appeal request within 10 calendar days of the mailing of the decision of the Expedited Internal Appeal, the Member will be provided Continuing Services until the Board of Hearings makes a determination, unless the Member opts to not receive Continuing Services. The date on the decision is considered the mailing date

The Board of Hearings will notify the Member Relations Coordinator upon receipt of a timely BOH appeal so the service will continue. FCHP will notify MassHealth about the date and time of the External Appeal.

5. The BOH will consider all, but not limited to the following information:
  - a) Written documents submitted by the Member or the Authorized Appeal Representative;
  - b) Copy of the FCHP internal appeal file.
  - c) Additional information from the parties to the Appeal or outside sources that are deemed necessary or relevant.
6. The Member Relations Coordinator must prepare and forward all applicable information to the BOH and the Member within five (5) business days prior to the date of the hearing, or if the case is expedited within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of:
  - a) The original notice of Adverse Action;
  - b) The Member's request(s) for Appeal;
  - c) Copies of decision letters from each level of internal appeal;
  - d) All pertinent documents relied on by FCHP in rendering the Initial Determination and in deciding the Internal Appeal and all documents that will be relied upon at the hearing; and
  - e) Chronology of events.
7. The Member or the Authorized Appeal Representative has the opportunity to submit evidence and allegations of fact or law, in person or in writing, to the Member Relations Coordinator, in support of the Appeal request. This information must be provided prior to the review of the Appeal. In addition, the Member may request to review the case file, before and during the Appeals process, including medical records, and any other documentation and records considered during the Appeal process.
8. FCHP allows Members and their Appeal Representatives access to files during the Internal Appeal process and during the BOH appeals process.



9. The BOH issues a determination notice to the Member and FCHP within 45 days of receipt of the External Appeal request.
  - a) At the discretion of the BOH, additional time may be taken if the Member delays the submission of evidence; the hearing is rescheduled or continued for the Member's benefit; or a delay occurs due to an act of God or serious illness of the hearing officer, the BOH will notify FCHP and the Member of the extension.
  - b) Immediately upon receipt of the notice indicating that the BOH overturns the FCHP determination, the Member Relations Coordinator facilitates authorization or provision of the services. The Member Relations Coordinator sends a written confirmation to EOHHS within 30 calendar days of the receipt of the BOH decision indicating that the decision has been effectuated.
  - c) In the event that the Member appeals a decision of the BOH, FCHP will comply with and implement the decisions of any court of competent jurisdiction.
  
10. The Member Relations Coordinator acts as a liaison between FCHP, MassHealth and the BOH to:
  - a) Determine whether each Member who requests a BOH Appeal has exhausted the Internal Appeals process;
  - b) If requested by the Member, assist the Member to complete a request for a BOH Appeal;
  - c) Receive notice from the BOH that the Member has requested a BOH appeal, track the status of all pending BOH Appeals, notify the FCHP Senior Manager of MassHealth Program of the date, time and place of the BOH appeal, and notify MassHealth immediately of the date, time and place of the BOH appeal;
  - d) Notify EOHHS immediately upon notification by BOH of BOH's decision;
  - e) Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH was timely received as follows:
    - while a BOH Appeal is pending, unless the Member specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service.
    - until one of the following occurs:
      - The Member withdraws the BOH Appeal; or
      - The BOH issues a decision adverse to the Member;
  - f) Instruct Members for whom an Adjustment (compromise between the Member and FCHP) is made about the process informing BOH in writing of all Adjustments and, upon request, assist the Member to complete any necessary documentation to alert BOH about the Adjustment and withdraw the BOH Appeal;
  - g) Ensure that the case folder and/or pertinent data screens are physically present at each hearing;
  - h) Ensure that appropriate FCHP staff attend the BOH hearings;
  - i) Coordinate with BOH requests to reschedule hearings and ensure that FCHP requests to reschedule hearings only for good cause;
  - j) Ensure that FCHP implements BOH decisions upon receipt;
  - k) Report to the FCHP Senior Program Manager for MassHealth within 30 calendar days of receipt of the BOH decision that such decision was implemented;



- ◇ If FCHP or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Appeal or BOH Appeal were pending,
  - ◇ FCHP shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires.
  - ◇ If FCHP or BOH reverses an Adverse Action to deny, limit, or delay services and the Member received Continuing Services while the Appeal or BOH Appeal were pending, FCHP shall pay for such services.
- l) Coordinate with the BOH as directed by MassHealth; and
  - m) Ensure that appropriate FCHP staff attends BOH Appeals training organized by MassHealth.
11. The BOH's determination is final and binding to FCHP with 2 exceptions:
- a) Judicial review pursuant to G.L. c. 30A.
  - b) Remand
12. The Member Relations Coordinator reviews the BOH's determination with the FCHP Medical Director to determine the appropriate corrective action, if any.
13. The Member Relations Coordinator closes the case file and submits the completed *Case Summary Sheet* along with the SLAC determination to the Member Relations Department *Administrative Assistant* for update and closure of the Appeal in the Appeals Database.
14. The Member Relations Coordinator organizes all documentation relevant to the reconsideration as follows:
- a) Affixes the FCHP case file to the inside front cover of the SLAC case file with a binder clip.
  - b) Affixes correspondence between the SLAC and FCHP relevant to the case to the back cover with a binder clip, with the SLAC determination on top.
  - c) Sends a copy of all Final Internal Appeal decisions and Expedited Internal Appeal decisions to the FCHP MassHealth Liaison to forward to MassHealth within 24 hours of notifying the Member.
15. The Member Relations Department maintains Appeal case file documentation for 10 years following the final resolution of the Appeals. The Member Relations Department provides information regarding coverage and payment issues relevant to the Appeal to the Member upon request.
16. The Member Relations Department Administrative Assistant files the cases alphabetically in hanging files labeled with the Member's Last Name, First Name. The files are maintained by year of the final resolution.



## G. APPEALS CASE TRACKING POLICY

### I. TRACKING/TRENDING OF APPEALS

1. The Member Relations Triage Analyst enters Appeal case categorization information into the Member Relations database.
2. The Member Relations Management compiles information from the Member Relations database on a monthly, quarterly, semi-annual and annual basis.
3. Member Relations Management identifies trends and establishes corrective action plans where necessary. The Management distributes information relevant to identified trends and corrective action plans to the appropriate administrative personnel. The aggregate Appeals information is considered for the FCHP quality assurance initiatives that are performed by the FCHP Appeals Work Group as necessary.
4. The Management presents this information to the FCHP Customer Service Committee and the Performance Improvement Committee (PIC)

### II. CATEGORIZATION

1. The Member Relations Management is available to review Member issues with the department Coordinators for the purpose of providing direction on an as needed basis.
2. The Administrative Assistant provides Management with detailed summary reports of each department Coordinator's case volume/activity on a monthly basis.
  - a) The Member Relations Administrative Assistant generates categorization reports from the database.
  - b) The Management reviews categorization reports for the purpose of verifying the appropriateness of category assignment and ensuring timeliness of resolution.
  - c) The Management discusses any questions relevant to the appropriateness of categorization or timeliness of resolution with the department Coordinator by whom the case was documented.

### III. CASE NARRATIVE DOCUMENTATION

1. The Management is available to review Member issues with the department Coordinators for the purpose of providing direction on an as needed basis.
2. The Management reviews a random sampling of completed cases from the department central file on a monthly basis.



3. The Management reviews case narrative documentation for: accuracy of categorization; timeliness of resolution; completeness; and compliance with Member rights and regulatory requirements.
4. At the discretion of the Management, noted deficiencies are subject to corrective measures and/or disciplinary action as necessary.

#### IV. OPEN CASE TRACKING REPORT

1. The Administrative Assistant provides a weekly report of all open cases for each Member Relations Coordinator to the respective coordinator and to the Management. Reports are designed to list open cases from oldest to newest.
2. The Member Relations Coordinators are responsible to monitor timeliness of case completion based on open case tracking report.
3. The Member Relations Management reviews the open case tracking report on a weekly basis to monitor timeliness of case completion.
4. The Management meets with Coordinators regarding all cases that have been open in excess of 15 business days to monitor and assist where necessary with case completion within the 30 calendar day time standard.
5. All Appeal files are maintained for ten (10) years.

#### G. REPORTING REQUIREMENTS

All required reporting for First and Second Level Internal Appeals, Expedited Internal Appeals, and BOH Appeals will be provided on a semi-annual basis to EOHHS. Required reporting includes the following components:

- a) the number and type of each clinical Appeal received from Members or his/her Authorized Appeal Representatives.
- b) FCHP's decision for each such Appeal (overturned/upheld).
- c) the time frame for resolution of each Appeal.

#### H. MAINTENANCE OF THE POLICY

The Manager of the Member Relations Department reviews the Appeals Policy and Procedure at least annually to amend and improve it. Copies of any amendments will be forwarded to EOHHS 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS.