

Additional information about our health plan benefits and policies

Utilization and care services

The Fallon Health Utilization and Care Services Program serves to ensure that appropriate, high-quality and cost-effective utilization of health care resources is available to all members. The utilization and care management process provides a system that ensures equitable access to high-quality health care across the network of providers for all eligible members.

Depending upon the type of service and the involved member's clinical condition, the Utilization and Care Services Program includes pre-service, concurrent and post-service review components. These services are reviewed and coordinated by nurses in collaboration with Fallon's medical directors.

Pre-service review

Pre-service review for preauthorization includes initial determination of requests for certain services and for continuation of these services. Preauthorization is required for services such as elective inpatient admissions, elective same-day surgery, select radiological services (outpatient CT, MR and/or PET scans), genetic testing, neuropsychological testing related to medical conditions, plastic and reconstructive consultations and services, selected prosthetics and orthotics, transplant evaluation, tertiary practitioner/facility service, out-of-network/out-of-area services (with the exception of urgent/emergent care and out-of-area dialysis), some oral surgery services, non-emergent ambulance services, and certain durable medical equipment. Pre-service procedures are established to allow prospective evaluation of the proposed service to determine if it is medically necessary, covered by the member's benefit plan, provided by a contracted provider and provided in the most appropriate setting.

Pre-service decisions include urgent and non-urgent requests for initial determination as well as requests for continuation of services. For our commercial plan members, pre-service non-urgent authorization decisions are made within two business days of obtaining all necessary information and within 72 hours of receipt of request for urgent/expedited requests.

Concurrent review

All concurrent reviews are treated as urgent and handled within 24 hours of receipt of the request after the member's admission to hospitals, rehabilitation units, or skilled nursing facilities. A licensed registered nurse conducts on-site or telephonic concurrent review of the member's admission, and continued periodic reviews throughout the continued stay to monitor for medical necessity, level of care, discharge planning, case management and disease management, and to coordinate alternatives to inpatient care.

Discharge planning

Discharge planning begins prior to or at admission, and reviews are conducted throughout the stay to ensure that patients are discharged only when they are medically stable. Plans are designed to identify ongoing needs for case management. Nurse care specialists collaborate with internal and external staff, practitioners and their representatives to ensure that discharge needs are met in a timely manner, and continuity of care is provided.

Post-service review

Post-service review is a process to evaluate inpatient and outpatient facility and professional claims to ensure appropriate resource utilization. Post-service review includes out-of-area services and cases that did not receive pre-service authorization. Post-service reviews are conducted within 30 calendar days of receipt of request.

Appeals

An adverse determination means that Fallon made a decision, based on the review of information provided, that denies, reduces, modifies or terminates coverage for health care services because the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. If you disagree with an adverse determination about coverage related to your care, you may file an appeal. An appeal is a request to change a previous decision made by Fallon.

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

Case management

The case management component of the Utilization/Care Services Program is designed to identify members frequently during the care continuum through predefined triggers for screening, health risk appraisals and referrals received from all internal Fallon departments, such as inpatient nurse care specialists, Disease Management, Member Services, Provider Services, and Member Relations. In case management (CM), the outpatient nurse case manager works with the member/family and/or authorized representative, physician(s) and/or provider health care team to facilitate a plan of care. This includes efforts to maximize the member's benefit plan design and facilitate the availability of alternative community resources.

Fallon's case management program includes acute case management, complex case management and case management of members identified as high-risk for disease management. Our outpatient nurse case managers partner with contracted providers and the member and/or authorized representative to assess, plan, implement, coordinate, monitor and procure multidisciplinary health care services. We emphasize the use of alternative resources and improving the member's clinical and functional status.

After the initial screening of member data, outpatient nurse case managers perform an assessment through telephone interviews with the member/family and/or authorized representative, and interface with contracted providers and facilities. Assessment information includes past medical history and psychosocial and functional health status. The nurse case managers then enroll the members in the program by developing and implementing individualized care plans to meet the identified members' needs.

Disease Management

Fallon has several in-house, internally developed disease management programs designed to empower members with chronic health conditions to self-manage their disease and achieve optimum control. The purpose of the Disease Management program is to slow disease progression, prolong periods of health and improve quality of life by focusing on healthier living.

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease Management supports the member-practitioner relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based guidelines that serve as the clinical basis for these programs and member empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

Identification of members begins upon enrollment in Fallon with member-reported information, including, but not limited to, Health Risk Assessment and medical and pharmacy claims data. Other means of identification may include provider referral, Customer Service referral, self-referral, Case Management referral and laboratory data.

Condition-specific educational materials are provided to all members enrolled in the program. Health Educators and nurses provide telephonic outreach to those members deemed to be “moderate risk.” They use a “coaching” model to move members through lifestyle behavior change, which addresses diet, exercise, stress management and tobacco cessation, to name a few. Disease specific self-management is also addressed and includes medication adherence, biometric tracking and follow-up medical care. Content for all disease management programs is based on nationally recognized standards of care.

Behavioral health services

Beacon Health Options (Beacon) is Fallon’s behavioral health care partner and provides behavioral health services to all Fallon members. Fallon and Beacon collaborate to provide integrated management across medical and behavioral health levels of care. Beacon’s utilization management program encompasses pre-service, concurrent, and post-service review for inpatient, diversionary and outpatient care of Fallon’s members.

Confidentiality of member information

In support of our commitment to protect our members’ privacy, Fallon has in place a comprehensive, corporate-wide privacy and security program. The ultimate goal of Fallon’s privacy and security programs is to safeguard our members’ protected health information (PHI) from inappropriate access, use and disclosure, while permitting appropriate access in order to provide the highest quality health care coverage for our members.

Our numerous privacy and security policies and procedures address the protection of PHI in all forms—oral, written, and electronic—across the organization. We define the appropriate uses and disclosures of information, such as members have the right to authorize the disclosure of PHI for certain non-routine uses and disclosure, and employers can access PHI for enrollment and disenrollment purposes and under other limited circumstances. Our policies and procedures also address the rights members have with respect to their PHI. For example, members have the right to access most PHI that Fallon has about them.

You can be confident that all of us at Fallon are committed to safeguarding the privacy and security of our members’ PHI. If you have questions or would like more detailed information about our privacy practices, you can review our Notice of Privacy Practices at fallonhealth.org (keyword: “policies”), or, for a printed copy, call our Customer Service Department at 1-800-868-5200 (TRS 711). They are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m., and Wednesday from 10 a.m. to 6 p.m.

Program eligibility and benefits may vary by employer, plan and product.

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