Appeal Rights

What is an appeal?
An **appeal** is the participant's action taken in response to the PACE organization's non-coverage or non-payment for a service. If you wish to challenge a decision, you have the right to appeal. These may include denials and reductions or termination of services.
For example, if Fallon Health:

- Has not paid all or part of a bill for services
- Will not approve care you think it should cover
- Is stopping or reducing care you believe you need

If you choose to appeal, please submit your appeal request orally or in writing within 60 calendar days of receiving the denial notice from Fallon. Additional time may be granted for extenuating circumstances, which should be explained in your appeal request.

Any service(s) you are currently receiving that may be in dispute will continue to be provided upon request until there is a final determination. However, if the result of the appeal is not in your favor, you will be financially liable for the cost of the contested services.

Who may file an appeal?

- The participant
- The participant's appointed personal representative
- A court-appointed guardian or an agent under a health care proxy to the extent provided under state law
- Prescriber for Part D

There are two kinds of appeals you can file:
A *standard 30-day appeal*: You will receive a decision no later than 30 calendar days after we receive your appeal.

An *expedited (72-hour) appeal*: You can request an expedited appeal for denied services or those that are being stopped or reduced for situations in which you believe your life, health or ability to regain or maintain maximum function could be seriously jeopardized, if you do not receive the service in dispute.

We will give you a decision on an expedited appeal no later than 72 hours after we receive your appeal. We may extend this time by up to 14 days if requested by you or if we need additional information and the delay would be in your best interest.

What do I include with my appeal?
You should include your name, address, member ID number, reasons for appealing and any evidence you wish to attach. You may mail, fax or email this information or present it in person.

How do I file an appeal?

For a standard 30-day appeal: You, your authorized representative or prescriber should either:

- Call Member Appeals and Grievances at: 1-800-333-2535, ext. 69950 (TRS 711), or

- Mail, fax, email or deliver your written appeal request to:

  Fallon Health
  Member Appeals and Grievances
  10 Chestnut St.
  Worcester, MA 01608

- Fax: 1-508-755-7393

- Email: grievance@fallonhealth.org

For an expedited appeal: You, your authorized representative or prescriber should contact Member Appeals and Grievances by:

- Phone: 1-800-333-2535, ext. 69950 (TRS 711)

- Fax: 1-508-755-7393

- Email: grievance@fallonhealth.org

If calling after normal business hours to request an appeal, contact your Summit ElderCare® PACE Center to reach a provider on call. Requests for expedited appeals that are left via voicemail to the phone number above will be retrieved each weekday morning. If calling during the weekend, or on a holiday, you will be connected to our on-call staff member, who will be able to assist you with your urgent needs.

Please note, information transmitted by you via email is unencrypted and as such is not secure. If you choose to send information via email, you understand and acknowledge that it may be possible for others to intercept the information sent and received.

If after filing an expedited appeal you want to request a 14-day extension, the request must be put in writing and sent to the address above.

What happens next?
Member Appeals and Grievances will facilitate a review of the Summit ElderCare Care Team decision.

- If the outcome of the review is in your favor, you will be notified. The Summit ElderCare site will also be notified and will provide the services or make the claim payments under dispute.
- If the outcome of the review is not fully in your favor, you will be advised. If you are not satisfied, you have additional rights for an independent external review of your appeal.

If you decide to use these additional rights and appeal to an outside independent external review agency, you should contact Member Appeals and Grievances or a member of the Summit ElderCare team. They will assist you in the process.

These rights may be under Medicare or Medicaid managed care or both. A Member Appeals and Grievances Representative, in consultation with the Summit ElderCare PACE Center, will assist you in determining which appeal route is most appropriate to your request, if both are applicable.

Medicare beneficiaries have access to an Independent Review Entity (IRE) for external appeals:

- The independent agency, MAXIMUS Federal Services, Inc., has been designated by the Centers for Medicare & Medicaid Services (CMS) to review Medicare appeals, and may review your case.

- If your appeal is forwarded to MAXIMUS by Fallon, you have the right to send additional information about your appeal. That information should be sent to:

  MAXIMUS Federal Services
  Medicare Managed Care & PACE Reconsideration Project
  3750 Monroe Ave., Suite 702
  Pittsford, NY 14534-1302
  Fax: 1-585-425-5292

- If the IRE decision is not in your favor, you may then request the Member Appeals Representative to forward the appeal to an Administrative Law Judge, provided that the dollar value of the services in the appeal is $170 or more.

Medicaid beneficiaries have access to an external appeals route:

- The Office of Medicaid Board of Hearings may review your request. This review is called a Fair Hearing. To ask for a Fair Hearing, you must complete the Fair Hearing Request form that you received with the denial. A Summit ElderCare staff person can assist you with this process. The form should be mailed or faxed to:

  Board of Hearings Office of Medicaid
  100 Hancock St., 6th floor
  Quincy, MA 02171

  Fax: 1-617-847-1204

If you do not have Medicare or Medicaid, Fallon will contact the State Administering Agency, which is the Executive Office of Elder Affairs, to help determine which appeals route you should follow.

If you choose to pursue an appeal with the Board of Hearings, you have 120 days to request a hearing once this notice is received. Member Appeals and Grievances will assist you with this process.

If the outcome of the external review is not in your favor, you will be financially responsible for the services provided.

Grievance Rights

What is a grievance?

A **grievance** is a complaint, written or oral, expressing dissatisfaction with the delivery of service or the quality of care furnished by Summit ElderCare® or one of our contracted providers.

How do I file a grievance?

There are several ways to file a grievance including:

- Orally to any staff member
- By sending a letter that includes all the details of your grievance to:

  Summit ElderCare
  Senior Director, Nursing and Quality
  10 Chestnut St.
  Worcester, MA 01608

- By calling the Site Director at the PACE center you attend, Monday–Friday, 8 a.m.–5 p.m.
- By calling the Summit ElderCare Senior Director, Nursing and Quality at 1-508-414-8525 (TRS 711)
- By sending a fax to the Summit ElderCare Senior Director, Nursing and Quality at 1-508-368-9981

We will acknowledge your grievance in writing within 72 business hours of receipt. Every reasonable attempt will be made to resolve your grievance within 30 calendar days of receipt. We will provide both oral and written notice of the resolution of your grievance.

All grievances are handled in a confidential manner.

For more information about your appeal and grievance rights, see your Summit ElderCare Enrollment Agreement or call your Site Director.

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