

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 Health's medical directors.

Pre-service review

Pre-service review for preauthorization includes initial determination of requests for certain services and requests 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, 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 Health 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 health care 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 Health.

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 Health'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 Health 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/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

Carelon Behavioral Health is Fallon Health’s behavioral health care partner and provides behavioral health services to all Fallon Health members. Fallon Health and Carelon collaborate to provide integrated management across medical and behavioral health levels of care. Carelon’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 Health has in place a comprehensive, corporate-wide privacy and security program. The ultimate goal of Fallon Health’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 Health has about them.

You can be confident that all of us at Fallon Health 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 online at our member website 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.

Prescription drug benefit

The Department of Pharmacy Services of Fallon Health is committed to managed care. Managed care means managing existing resources effectively and efficiently while ensuring quality care. The goal is that care provided is both medically necessary and demonstrates an appropriate use of resources.

Pharmaceutical management tools

Fallon Health uses criteria based on current standards, evidence-based medicine, outcome studies, established compendia, peer review articles, quality of life studies, and other types of reproducible peer reviewed papers to assess clinical safety and efficacy in order to create pharmaceutical management tools and procedures.

Approved criteria also includes reviews of any known drug-to-drug interactions, drug-disease state interactions, dosing parameters, side effect issues, age-related problems and any information necessary for effectiveness and safety.

Fallon Health reviews pharmaceutical management procedures as new pharmaceutical information becomes available.

Generic substitution

The state of Massachusetts mandates that all prescriptions written, unless specified by the prescribing provider, will be dispensed as the generic form. Fallon Health upholds the law by mandating all prescriptions filled for Fallon Health members are filled as generic unless specified by the prescribing practitioner.

Therapeutic substitution

Therapeutic substitution is not employed as a Fallon Health strategy.

Quantity, duration of use limits, step therapy and age restrictions

Fallon Health has established quantity and duration limits, step therapy and age restrictions for a specific list of medications. Determinations regarding which medications are included on this list and the number of doses the member is able to receive are made annually and submitted to the Pharmacy & Therapeutics (P&T) Committee for review and approval. If a practitioner would like an exception to this rule for a specific member, he/she can submit a completed prior authorization request form to the Department of Pharmacy Services. This form must state the medical reason why the management tool would be inappropriate for the member.

New-to-market medication evaluation

Fallon Health follows a new-to-market medication evaluation policy and usage determination for medications newly approved by the FDA. Fallon has a waiting period (moratorium) of up to 180 calendar days for all new medications, in order to ensure enough time to determine true dosing parameters, side effect profiles, drug- drug interactions, drug-disease state interactions, and age-related issues. During this period, a practitioner can request the medication via the prior authorization process.

Prior authorization

Prior authorization guidelines, based on medical necessity, are developed using clinical evidence from appropriate external organizations and are approved by the P&T Committee. Revisions to guidelines are made in response to new information derived from reviews of medical literature, guidelines from national medical organizations, new legislative or regulatory mandates and appeal trends and utilization patterns. Revisions to policies and guidelines are presented to the P&T Committee for comment, input and approval. Prior authorization criteria are reviewed annually as new pharmaceutical information becomes available. Fallon Health provides information about the pharmaceutical management procedures and formulary lists to practitioners on the Fallon website. This information may include copayment information, list of formularies, prior authorization criteria, prior authorization forms and procedures for submitting a prior authorization request.

Requests for medically necessary pharmaceuticals

All information regarding medical necessity is obtained from prescribing practitioners via the prescription prior authorization form. The information is reviewed in conjunction with the guidelines by appropriate pharmacists and practitioners. Routine requests are processed within three days from the date of request. Urgent/emergency requests are processed within one day of the date of request. Requests are reviewed in the order of arrival, with the exception of emergency medications, which are reviewed according to the urgency of the clinical situation. Emergency medications are noted to be: antibiotic medications, antipsychotic medications and pain medications. Only a clinical pharmacist or medical director can deny a request for authorization based on medical necessity.

Approval notification

Notification of approval is made to the requesting practitioner by fax. At the same time, a letter is sent to the member stating the medication name, dose, quantity approved and the start and end date of the approval.

Adverse determination notification

Determinations to not authorize are based on benefits, Fallon criteria, guidelines and protocols, as applicable. The reviewing pharmacist or physician may consult with the requesting practitioner prior to issuing an adverse determination in order to clarify clinical questions and to arrange appropriate alternative medications when necessary.

Notification of adverse determination based on medical necessity is made to the practitioner first by phone, followed by fax. At the same time a letter is sent to the member citing determination reasons in easily understandable language, alternative medications if indicated, and a reference to the guideline, protocol or other similar criterion on which the decision is based. Included is information on the appeal process that contains a description of the appeal rights, right to submit written comments, documents or other information relevant to the appeal, an explanation of the appeal process, including the right to member representation and time frames for deciding appeals and a description of the expedited appeal process for urgent requests. A final inclusion is the contact information in the event that the practitioner or member wants to discuss the rationale for the adverse determination. Clinical review criteria are available to all members and practitioners upon request. Adverse benefit determinations are based upon policies covered in member coverage communications including the *Member Handbook*.

Notification of adverse determination based on benefit determination is made to the practitioner by fax. At the same time a letter is sent to the member explaining the determination reasons and possible alternative therapies if available. Included is information on the appeal process that contains a description of the appeal rights, right to submit written comments, documents or other information relevant to the appeal, an explanation of the appeal process, including the right to member representation and time frames for deciding appeals, and a description of the expedited appeal process for urgent requests. A final inclusion is the contact information in the event that the practitioner or member wants to discuss the rationale for the adverse determination. All adverse determinations of medications are subject to a reconsideration process. All reconsiderations follow Appeals and Grievance Policies and Procedures.

Requests for use of FDA approved medication for a non-FDA approved condition

If a practitioner requests an FDA approved medication for a non-FDA approved disease state/condition, the criteria for its use will be based upon standard criteria for non-FDA approved medications. If the use of the medication does not meet any of the above requirements and if not medically indicated, Fallon Health's Department of Pharmacy Services generally will make an adverse determination decision.

Formulary drug list

Fallon Health has developed a Formulary Drug List that includes medications from every drug class except for those medications specified in the evidence of coverage document.

The formulary drug list is reviewed annually, or more frequently if the current standard of care changes. It will be modified in a timely manner to reflect any changes.

Major changes to the Formulary Drug List, for reasons such as newly approved medications, new evidence of efficacy or safety and cost will occur at a minimum of four times per year.

Information about the Formulary Drug List and other pharmaceutical management tools and criteria is communicated to practitioners, members and pharmacists by way of the Fallon website. A hard copy is provided upon request.

Fallon Health also notifies practitioners whenever there is a change in the formulary. Formulary changes include additions to, removal from or any change in the preferred tier cost sharing status of any drug on the Fallon Health formulary. These notifications are by direct mailings, practitioner's manuals and newsletters.

Patient safety and drug utilization review

Pharmaceutical patient safety is monitored with the Pharmacy Benefit Manager with procedures in place for point of dispensing communications to identify and classify patient safety issues. Procedures include notification to dispensing providers of specific drug safety issues when they meet the organization's severity threshold. These include:

- Possible medication errors
- Duplicate drugs treating same condition
- Age-gender related issues
- Drug-drug interactions
- Drug-disease state interactions
- Drug allergies
- Drug dosage errors
- Over-usage of narcotic drugs
- Acetaminophen high dose edit

Fallon Health sets the thresholds for point of dispensing communications to identify drug-to-drug interactions by severity. When the dispensing pharmacy tries to adjudicate a claim for a medication that meets the drug-to-drug threshold, the claim is rejected and not allowed to process, therefore, disrupting the dispensing of the medication. This rejection triggers the point of dispensing provider to notify and resolve any drug-to-drug interaction issues. Only upon resolving any potential interactions is the pharmacy able to dispense the drug.

A prospective drug utilization review in accordance with the state Omnibus Budget Reconciliation Act (OBRA) regulations includes a review of the patient's drug profile for drug-to-drug interactions and resolution. When a dispensing pharmacist discovers a drug-to-drug interaction, the pharmacist may contact the prescribing practitioner to notify and resolve any issues. Only upon resolving any potential interactions is the pharmacist able to dispense the drug.

Members and practitioners are also notified when FDA-required or voluntary drug withdrawals from the market occur. Screening of new drugs occurs through Fallon's P&T Committee, with input from national guidelines and research consortia.

Voluntary and FDA-required recalled medications are classified according to the degree of hazard presented by the product. Class I recalls are those that cause serious or fatal consequences. Class II recalls may cause serious but reversible health effects. Class III recalls are not likely to cause adverse health consequences. If a medication is recalled, or if there is new pertinent information regarding a medication, Fallon Health will identify and notify applicable members and their practitioners according to the pharmacy communication process.

This process is followed for Class I, II and III recalls. The first step is to identify members who have been dispensed the recalled medication within the last year and practitioners who have prescribed the recalled medication to the identified members. The second step is for the Pharmacy Services Department to create appropriate letters for the members and practitioners. These letters are sent within 24 - 48 hours of notification by the FDA of the recall. Lastly, in concurrence with the letters, the practitioners and members are contacted by telephone. Each step of the communications process is documented in the Pharmacy Communication Log. All documentation is kept by Pharmacy Services.