TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472-1508
tuftshealthplan.com

TUFTS HEALTH DIRECT
MEMBER APPEALS PROCESS

Your rights to appeal
As a Tufts Health Plan member, you or your Authorized Representative, if you identify one, has the right to request an Internal Appeal for us to review an Adverse Determination.

How to request an Internal Appeal
You or your Authorized Representative may request an Internal Appeal within **180 calendar days** of an Adverse Determination in the following ways:

- **Telephone** — call us at **888-257-1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays (we offer translation services in more than 200 languages)
- **TTY/TTD** — people with hearing loss can call our TTY line at 888-391-5535, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail** — request an Internal Appeal by mail, by sending a copy of the notice of Adverse Determination and any additional information about the Internal Appeal to Tufts Health Plan, Attn: Appeal and Grievance Team, P.O. Box 9194, Watertown, MA 02472-9194
- **Email** — request an Internal Appeal by email via the "Contact us" section of our website at tuftshealthplan.com
- **Fax** — request an Internal Appeal by faxing us at 781-393-2643
- **In person** — visit our 705 Mount Auburn Street (Watertown, Mass.) address, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

Although you have **180 calendar days** to request an Internal Appeal, we encourage you to act as soon as possible.

We will let you and your Authorized Representative know we got your Internal Appeal request by sending you a written notice within **one business day**, **or 48 hours**, whichever is less.

Other people who can request an Internal Appeal for you
Your Authorized Representative, if you identify one, can request an Internal Appeal for you. You need to tell us in writing if your Authorized Representative will be requesting an Internal Appeal for you. You can appoint an Authorized Representative by sending us a signed Authorized Representative Form. You can get this form by calling our member services team or our appeal and grievance team at **888-257-1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. You can also find this form on our website at tuftshealthplan.com.

Please note: *If someone tries to request an Internal Appeal, including an Expedited* (*fast*) *Appeal, for you and you did not already send us an Authorized Representative Form for that person*, *we will tell you in writing that a request has been made and will send you a copy of the Authorized Representative Form to sign and return to us*. *We will take no further action until we get the signed Authorized Representative Form*. *If you don't send the form* ***within 30 calendar days***, *we will dismiss the request unless it is an Expedited Appeal requested by a provider*.

Continuation of services during the appeals process
If you have been getting a covered service and we stop covering that service, we will continue the disputed coverage at our expense through the end of the appeals process, as long as you or your Authorized Representative, if you identify one, requests the Internal

Appeal in a timely manner. Ongoing coverage or service includes only medical services that we authorized.

Standard Internal Appeal time frame
We will review and make a decision about your Internal Appeal request within **30 calendar days** from the date we get your request.

Please note: *Any Internal Appeal*, *including an Expedited Appeal, not properly acted on by us within the time limits specified will be decided in your favor. Time limits include any extensions made by mutual written agreement between you or your Authorized Representative and Tufts Health Plan.*

Reviewing medical records as part of the Internal Appeal
You may send us written comments, documents, or other information relating to your Internal Appeal. If we need to review additional medical records, the standard Internal Appeal period of **30 calendar days** begins when you or your Authorized Representative, if you identify one, sends us a signed authorization for release of medical records and treatment information, as required. If you do not provide this authorization within **30 calendar days** of our getting the Internal Appeal request, we may issue a decision on the Internal Appeal without reviewing some or all of the medical records. You have the right to review your case file, which includes information like medical records and other documents we considered during the appeals process. We will provide this to you free of charge, upon request.

How to request an Expedited (fast) Appeal
If a provider thinks that our standard time frame of **30 calendar days** could seriously harm your life, health, or ability to get back to maximum function, or if it will cause you severe pain that cannot be adequately managed without the requested service, then you or your Authorized Representative, if you identify one, may request an Expedited Appeal. You or your Authorized Representative may request an Expedited Appeal from us orally, in writing, or in person, in place of a standard Internal Appeal. You or your Authorized Representative may also request an expedited External Review from the Office of Patient Protection (OPP) at the same time you request an Expedited Appeal. For more information, please see the following section on expedited External Reviews.

There are three situations when we may review an Internal Appeal in a fast manner, and each has a certain time requirement in which we must decide the Internal Appeal:

- When you are a patient in a hospital, we must issue a decision before you are discharged.
- When a provider tells us in writing that a delay in getting the requested service or supply would result in risk of substantial harm to you, we must issue a decision within **72 hours**.
- If you are terminally ill, we must issue a decision within **72 hours**.

We will issue a decision within **72 hours** or less for durable medical equipment when the provider specifies a reasonable time. If the Expedited Appeal upholds the denial of coverage or treatment regarding terminal illness, we will allow you or your Authorized Representative to ask for a conference. We will schedule the conference within **10 calendar days** of getting a request. The conference will be held within **five calendar days** of the request if the treating provider determines, after consulting with a Tufts Health Plan medical director, that the effectiveness of the proposed treatment or supplies, or any alternative treatment or supplies, would be greatly reduced if not provided

at the earliest possible date. You or your Authorized Representative can attend the conference.

Please note: *Any Internal Appeal, including an Expedited Appeal, not properly acted on by us within the time limits specified will be decided in your favor. Time limits include any extensions made by mutual written agreement between you or your Authorized Representative and Tufts Health Plan*.

Written notice of Internal Appeal decision
We will tell you or your Authorized Representative, if you identify one, our Internal Appeal decision in writing. For Adverse Determinations, this notice will include a clinical explanation for the decision and will:

- Give specific information upon which we based an Adverse Determination
- Discuss your symptoms or condition, diagnosis, and the specific reasons why the evidence submitted does not meet the relevant medical review criteria, if that is the case
- Specify alternate treatment options we cover
- Reference and include applicable clinical practice guidelines and review criteria
- Let you or your Authorized Representative know your options to further appeal our decision, including procedures for requesting an External Review or an expedited External Review

External Review process
If you get a Final Adverse Determination from us, you have the opportunity to request an External Review from the OPP.

You or your Authorized Representative, if you identify one, is responsible for starting the External Review process. We will enclose an External Review Form anytime we issue a Final Adverse Determination. To start the review, send the required form to the OPP within **four months** of getting our final decision. The OPP's address is:

Health Policy Commission
Office of Patient Protection
50 Milk Street, Eighth Floor
Boston, MA 02109

If you have been getting a covered service and we end coverage of that service, the disputed coverage will continue at our expense through the end of the appeals process, as long as you request an External Review by the end of the **second business day** after receiving your Final Adverse Determination. If the External Review agency decides you should keep getting the service because there could be substantial harm to you if the service ends, we will keep covering the service until the External Review is decided, no matter what the final External Review decision is.

The OPP will screen all requests for External Reviews to see if they:

- Meet the requirements of the External Review Form
- Do not involve a service or benefit we specify in our *Member Handbook* that we exclude from coverage
- Result from our issuing of a Final Adverse Determination (you will not need a Final Adverse Determination from us if we fail to act within the time frame for the Internal Appeal)

If your case is eligible for External Review, you will get a written decision from the External Review agency within **45 calendar days**.

Expedited (**fast**) **External Reviews**
You or your Authorized Representative, if you identify one, may request an expedited External Review if your provider tells the OPP in writing that a delay in care would result in a serious threat to your health. Expedited External Reviews are resolved within **72 hours** from when the External Review agency gets the referral from the OPP. You or your Authorized Representative may request an expedited External Review at the same time you request an Expedited Appeal from us.

When your External Review involves a decision by us to end previously authorized services
If the External Review involves ending ongoing coverage of services, you may apply to the OPP to keep getting the services during the External Review. You need to make the request before the end of the **second business day** after you get our Final Adverse Determination. If the External Review agency decides you should keep getting the services because there could be substantial harm to you if the services end, we will keep covering the services until the External Review is decided, no matter what the final External Review decision is.

How to contact the Office of Patient Protection (OPP)
If you have questions about your rights as a member, or questions about the External Review process, you can contact the OPP by phone at 800-436-7757 or by fax at 617-624-5046, or visit the OPP's website at mass.gov/hpc/opp. You may also email the OPP at HPC-OPP@state.ma.us.

The consumer assistance program in Massachusetts can help you file your appeal:

Health Care for All
One Federal Street
Boston, MA 02110
800-272-4232
hcfama.org/helpline