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Welcome to Fidelis Care at Home

We are pleased to provide you with your Fidelis Care at Home Member Handbook. The Handbook covers important information for you to know, such as how to access services - including urgent and emergency care.

Always remember to contact your Fidelis Care at Home Nurse Care Manager whenever you need health care services or if you have any questions.

You can reach your Fidelis Care at Home Nurse Care Manager or another Fidelis Care at Home Representative 24 hours a day by calling 1-800-688-7422.

If you ever have a medical emergency, please go directly to the nearest hospital or call 911. Bring your Medicare and/or Medicaid cards and any other health insurance card with you.

Carry your Fidelis Care at Home member identification card, which will be sent to you separately, at all times. Keep your Fidelis Care at Home card with your Medicare and/or Medicaid cards and any other health insurance card, and show them to your health care providers as described on the back of the Fidelis Care at Home card.

We look forward to helping you achieve your health goals and ensuring that you have the care and services you need.
What is Fidelis Care at Home?

Fidelis Care at Home is approved by the New York State Department of Health as a managed long term care program for individuals who need long term care services and who are eligible for Medicaid. Fidelis Care at Home provides long term care and other health-related services to members. Fidelis Care at Home gives you the flexibility and freedom you need to make the right choices that will help you achieve your best possible state of health.

Managed long term care means that a coordinated Plan of Care and coordinated services are provided to individuals who are eligible for nursing home level of care, but choose to enroll in Fidelis Care at Home and live in their own homes for as long as possible. The primary care physician and/or the Fidelis Care at Home Nurse Care Manager must order these services. Members obtain these services through a network of Fidelis Care at Home participating health care providers. Members can continue to use their own primary care physician, as long as the physician is willing to work with Fidelis Care at Home. Your Medicare and/or Medicaid benefits remain intact.

You must use a provider listed in Fidelis Care at Home’s Provider Directory when receiving any of Fidelis Care at Home’s covered services. Your Nurse Care Manager can choose or assist you in choosing the providers that meet your needs. If a service is also covered by Medicare, you are free to choose any non-Fidelis Care at Home health care provider who accepts Medicare. However, we encourage you to choose Fidelis Care at Home providers so that you would not have to change providers later - for example, if your treatment exceeds Medicare’s coverage limits.

Membership in Fidelis Care at Home is voluntary. You can decide on your own, or with Fidelis Care at Home’s help, whether or not to enroll in Fidelis Care at Home, or to disenroll for any reason.

Fidelis Care at Home makes every effort to be responsive to cultural diversity and communication needs in all of its operations. You have the right to obtain any information from Fidelis Care at Home translated into another language if you are not an English speaker. Written materials can be provided in prevalent languages such as Spanish. As many participating providers speak languages other than English, please refer to our Directory or call Fidelis Care at Home to obtain the most current provider information. If you wish, Fidelis Care at Home can also provide specific staff members to assist you. For example, staff members are available to orally translate materials to you on the telephone.

Plan documents can be provided in alternate formats as well. Staff members are happy to read Plan information to individuals who are visually impaired. Large-type documents such as this Handbook can be provided. The Plan can also arrange for the services of a professional sign language interpreter on request for individuals who are hearing impaired, and TTY phone service is available at 1-800-695-8544.
How do I enroll?

To be eligible to enroll you must be:

- 18 years of age or older.
- Eligible for Medicaid, as determined and approved by your Local Department of Social Services (LDSS) or Human Resources Administration (HRA).

We will gather this information by telephone before a visit is arranged. A visit will not occur if you are ineligible for any of these 3 reasons (see also p. 6, Denial of Enrollment).

You must also be:

- For non-mandatory counties: You must be eligible for nursing home level of care as of the time of Fidelis Care at Home’s enrollment assessment.
- Capable of returning to or remaining in your home and community without jeopardy to your health and safety.
- Expected to be in need of long term care services and care management from Fidelis Care at Home for at least 120 days from the date of enrollment. Long term care services include nursing services, therapies, home health or personal care aide services, adult day health care, or social day care if used as a substitute for in-home personal care aide.

An intake/assessment nurse will arrange to visit you to discuss Fidelis Care at Home, to assist you with the details of applying for enrollment, and to gather information about and assess your health and long term care needs.

During this visit, she/he will complete a comprehensive clinical/functional assessment using New York State-approved forms, and will discuss an initial Plan of Care with you. She/he will also review your Medicaid information if applicable and will discuss and provide information about Advance Directives, how to access covered and non-covered services, and your rights as a Fidelis Care at Home member. The Nurse Care Manager is responsible for coordinating, arranging, and authorizing Fidelis Care at Home payment to providers for your medically necessary covered services. Covered services are provided to you through a network of Fidelis Care at Home participating health care providers as listed in our Provider Directory. She/he will give you a copy of this Handbook and Provider Directory, and will explain the forms you are
required to sign for enrollment: an enrollment agreement/attestation form, an authorization for release of medical information, and a notice of HIPAA privacy practices.

If the Local Department of Social Services (LDSS)/New York Medicaid Choice (NYMC) receives a complete package of enrollment material by the 20th of the month, your membership will usually begin on the 1st day of the next month. For example, if the LDSS/NYMC receives the enrollment package by August 20th, enrollment will usually begin on September 1. If the LDSS/NYMC receives a complete enrollment package after the 20th of the month, enrollment will usually begin on the 1st day of the month following the next month. For example, if the LDSS/NYMC receives the enrollment package on August 24, enrollment will usually begin on October 1.

If you are enrolled for the 1st day of the month, your services will begin according to your Plan of Care. Your Nurse Care Manager may need to make a second visit to review your Plan of Care and the service authorization process.

Applications for enrollment may be accepted for otherwise eligible inpatients or residents of hospitals or residential facilities operated under the auspices of the State Office of Mental Health (OMH), State Office of Alcohol and Substance Abuse Services (OASAS), or State Office for People with Developmental Disabilities (OPWDD), but enrollment may only begin upon discharge to the applicant’s home in the community.

An applicant who is enrolled in another managed care plan capitated by Medicaid, a Home and Community Based waiver program, or a Comprehensive Medicaid Case Management program (CMCM) or OPWDD day treatment program or who is receiving inpatient hospice services may be enrolled in Fidelis Care at Home only upon termination from the other program.

Withdrawal of Enrollment

You may withdraw your application at any time during the enrollment process. You may elect to withdraw your enrollment application prior to enrollment by advising us orally or in writing, and we will confirm your withdrawal in writing.

Denial of Enrollment

Enrollment will be denied if, after assessment by Fidelis Care at Home, you do not meet these criteria:

1. Eligible for nursing home level of care as of the time of the enrollment assessment.

2. Capable of returning to or remaining in your home and community without jeopardy to your health and safety.

3. Expected to be in need of long term care services and care management from Fidelis Care at Home for at least 120 days from the date of enrollment.
4. Your primary care physician does not wish to collaborate with Fidelis Care at Home on developing a Plan of Care for you or writing orders for covered services from network providers, and you do not want to change physicians.

Enrollment will be denied by the LDSS/HRA or NYMC if, after assessment by Fidelis Care at Home, you do not meet these criteria.

If you do not meet the eligibility criteria for age, county of residence, and Medicaid, you will not have been assessed for enrollment. If you choose to pursue enrollment despite a lack of eligibility, we will send this information to your LDSS/NYMC/HRA for review and eligibility determination.

Can I continue to use my own physician?

Yes, with Fidelis Care at Home, you choose your own physician. Your Nurse Care Manager will work closely with your physician to arrange the services you need, as long as your physician agrees to work with Fidelis Care at Home. She/he will also work with both network and non-network providers to coordinate all of your health care services.

If you do not currently have a primary care physician, or would like to change your physician, or if your physician does not wish to work with Fidelis Care at Home, your Nurse Care Manager can help you locate a primary care physician in your area. She/he can also assist you with obtaining specialty physician services if needed.

Medicare

If you have Medicare and/or Medicare Supplementary coverage and benefits, they do not change when you join Fidelis Care at Home, and you are free to choose Medicare providers for Fidelis Care at Home-covered services and non-Fidelis Care at Home covered services. To the extent that both Medicare and Fidelis Care at Home cover a service, Medicare will be billed first. If Medicare doesn’t cover the service and Fidelis Care at Home does, these services will be billed directly to Fidelis Care at Home for services from Fidelis Care at Home’s provider network. If a provider is not in the provider network, you should contact your Care Manager prior to using that provider to avoid getting billed for unauthorized services after your Medicare coverage has been exhausted.

If Medicare does not cover the entire cost of a service that is also within Fidelis Care at Home’s list of covered services, any Medicare Supplement or other health insurance coverage you have primary to Fidelis Care at Home will be billed for any deductibles or coinsurance prior to payment by Fidelis Care at Home.

Should your Medicare or related coverage become exhausted and the provider is not a part of Fidelis Care at Home’s provider network, you will need to change to providers in Fidelis Care at Home’s provider network.
What Services are Included in Fidelis Care at Home?

Below is the list of services covered by Fidelis Care at Home. Your care must be “medically necessary” as determined by your physician and your Nurse Care Manager. This means that the services you receive are needed to prevent, diagnose, correct, or cure any conditions that you might have that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant disability.

The services covered by Fidelis Care at Home include:

- Care Management
- Home health care
  - Nursing
  - Home health aide
  - Physical therapy
  - Occupational therapy
  - Speech pathology
- Medical social services
- Adult day health care
- Personal care aides
- Durable medical equipment and oxygen (Compression stockings will only be covered when used in treatment of open venous stasis ulcer.
- Medical and surgical supplies
- Prosthetics and orthotics (Prescription footwear is limited to treatment of diabetics or when a shoe is part of a leg brace (orthotics) or for foot complications in children under 21.)
- Personal emergency response system
- Non-emergency transportation
- Podiatry
- Dentistry
- Optometry/eyeglasses
- Audiology/hearing aids and hearing aid batteries
- Home delivered or congregate meals
- Social day care
- Respiratory therapy
- Nutrition
- Social and environmental supports
- Outpatient Rehabilitation (Physical, Occupational and Speech therapy is limited to twenty (20) visits per therapy per year, except for children under age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.)
Nursing Home care (Please note that if you have Medicaid but are not eligible for “Institutional Medicaid,” you will be disenrolled from Fidelis Care at Home if you require such care).

Definitions of Covered Services and Ordering Guidelines:

**Care Management:**

**Coverage:** Care Management is a process that helps Enrollees access necessary covered services as identified in the Plan of Care. It also provides referral and coordination of other services in support of the Plan of Care. Care management services will help Enrollees obtain needed medical, social, education, psychosocial, financial, and other services in support of the Plan of Care irrespective of whether the needed services are covered under the capitation payment of this Agreement.

**Home Health Care (includes Nursing Services, Personal Care Services, Nutritional Services, Social Work Services, Physical, Occupational, Speech or Respiratory Therapy Services)**

**Coverage:**
Home Care includes the following services which are of a preventive, therapeutic rehabilitative, health guidance, and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, respiratory therapy, occupational therapy, and speech/language pathology.

Community members who require skilled services will be followed by a Certified Home Health Agency for the skilled nursing/therapy monitoring. All home care services require physician orders for treatment modality. The Fidelis Care at Home Nurse Care Manager is responsible for coordinating care with the applicable discipline.

**Nursing Services** include intermittent, part-time, and continuous nursing services provided in accordance with an ordering physician’s treatment plan as outlined in the physician’s recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing Services include care rendered directly to the individual and instructions to his family or caretaker in the procedures necessary for the patient’s treatment or maintenance.

**Ordering Guidelines:**
The physician will order the skilled nursing services needed for treatment of an illness, disease, or injury. The frequency of the nursing visits will be determined in collaboration with the physician and the Nurse Care Manager. Examples of skilled nursing services include: Wound care, medication pre-pours, administration of medications, ostomy care, and client teaching of diet regime, disease process, and drug therapy.

**Exclusions:** Members Residing in a Skilled Nursing Facility.
Home Health Aide or Personal Care Aide is a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping, and other related supportive tasks to the Member with health care needs in his/her home.

Ordering Guidelines:
Home health aide hours or Personal Care hours are determined after care planning with the member and caregiver, if applicable, and the Fidelis Care at Home Nurse Care Manager and/or designee. A Nurse assesses the member’s needs using the UAS tool and Time Task tool if applicable, and discusses the number of hours for the Plan of Care. After the member and /or caregiver verbalize approval, the request for aide hours is faxed to all licensed agencies with a start date. Fidelis Care at Home encourages the involvement of informal supports in the member’s care as much as possible - especially if they were previously involved and active with the member on a frequent basis. Fidelis Care at Home promotes their continued involvement to maintain consistency for the member’s quality of life and home stability. Fidelis Care at Home modifies Plans of Care based on the level of involvement from the caregiver and informal supports. In regard to 24 hour care, Fidelis Care at Home offers 24 live-in based on clinical need or seek SNF coverage on a long term basis - especially when 24 live-in is difficult to secure in more rural service areas.

Nutritional Services: means the assessment of nutritional needs and food patterns, or the planning for the provision of food and drink appropriate for the member's physical and medical needs and environmental conditions, or the provision of nutrition counseling to meet normal and therapeutic needs. The services must be provided by a qualified nutritionist and include the following: assessment of the member’s nutritional status and food preferences, planning for provision of appropriate dietary intake within the member’s home environment and cultural considerations, nutritional education regarding therapeutic diets, development of a nutritional treatment plan, evaluation and revision of treatment plans, provision of in-service education to staff as well as consultation for a specific dietary problem, and nutrition teaching to members and their families.

Ordering Guidelines:
Nutrition services are indicated for assessing a member’s risk for and treatment of malnutrition, eating disorders, weight management, or dietary restrictions. These services are also considered for promotion of healing and to complement the treatment of clinical conditions such as diabetes, renal disease, and cardiovascular disease. The nutritionist will determine the appropriate number of follow-up visits needed based on the assessment, and will submit a treatment plan for authorization. The Nurse Care Manager will coordinate care and receive the physician’s order for nutritional services.

Social Work Services are information, referral, and assistance with obtaining or maintaining benefits that include financial assistance, medical assistance, food stamps or other support programs provided by the Local Department of Social Services, HRA, Social Security Administration, and other sources. Social Work services also involves providing supports and
addressing problems in a member's living environment, as well as activities of daily living to help the member remain in the community.

**Ordering Guidelines**
The Social Worker will receive referrals from the Care Manager and act as a member of the interdisciplinary team to help the member. The Social Worker will meet with the member upon request by the Care Manager, and help the member on an ongoing basis with: Medicaid recertification, food stamp applications, navigating through the local Department of Social Services, HRA, Medicare Part D education, housing applications, monthly budgeting, emotional support for long term care needs, and dealing with disease and the aging process. The Nurse Care Manager will conference with the Social Worker at least monthly.

Respiratory Therapy is performed by a qualified respiratory therapist. It includes the preventive, maintenance, and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients, and the provision of consultation to other health personnel. The respiratory therapist will go to the member’s home and provide treatment as ordered by the member’s physician.

Physical Therapy includes rehabilitative services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her optimum functional level. Physical therapy includes examination and diagnosis and treatment of musculoskeletal and neuromuscular problems.

**Ordering Guidelines**
Services can be provided in a rehabilitation facility or at the member’s home. This will be based on the member’s functional level, whether homebound or not. The therapist evaluates the member and begins treatment as ordered by the physician. (Certain restrictions and limitations apply as per Medicaid guidelines.)

Occupational Therapy includes rehabilitative services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her optimum functional level. Occupational therapy includes evaluation of performance, skills assessment, and treatment customized to improve ability to perform activities of daily living independently.

**Ordering Guidelines**
Services can be provided in a rehabilitation facility or at the member’s home. This will be based on the member’s functional level, whether homebound or not. The therapist evaluates the member and begins treatment as ordered by the physician.

Speech-Language Pathology is performed by a licensed and registered speech-language pathologist who provides rehabilitative services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her optimum functional
level. Speech therapy includes evaluation and treatment of speech and language disorders that result in communication difficulties or feeding/swallowing disorders due to neurological or anatomical deficits.

**Ordering Guidelines**
Services can be provided in a rehabilitation facility or at the member's home. This will be based on the member’s functional level, whether homebound or not. The therapist evaluates the member and begins treatment as ordered by the physician.

**Private Duty Nursing Services** is performed by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services can be provided through an approved certified home health agency or a private practitioner.

**Ordering Guidelines**
The location of nursing services may be in the member's home. Services will be based on the member's functional status and skilled nursing needs. The Nurse Care Manager will evaluate the need and determine the frequency and duration for private duty nursing.

**Adult Day Health Care**

**Coverage:**
Adult Day Health Care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

**Ordering Guidelines:**
Adult Day Health Care (medical model programs) requires a physician’s order and prior authorization from the Fidelis Care at Home Nurse Care Manager/Designee. Arrangements for service will be coordinated through the Fidelis Care at Home Care Manager/Designee, and the Fidelis Care at Home Transportation Coordinator, member, the ADHC Director, and the member's physician. Fidelis Care at Home will help the member complete any necessary admission paperwork for Adult Day Health Care, including arranging for a health history and physical exam by the primary care provider, and a tuberculosis test.

The Adult Day Health Care Director will complete an RAI (Resident Assessment Instrument) to determine the member’s appropriateness for ADHC. If the member doesn’t require skilled or medical care, he or she will be referred to Social Day Care.
Exclusions:
Members will not be approved for ADHC for socialization and recreational purposes only.

Social Day Care

Coverage:
Social Day Care is a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, and personal care and nutrition in a protective setting during any part of the day, but less than a 24-hour period.

Ordering Guidelines:
Fidelis Care at Home members are encouraged to attend Social Day Care as often as they would like to promote their socialization and level of activity.

No physician’s order is necessary; however Fidelis Care at Home must authorize this service. Fidelis Care at Home will assist with arranging and coordinating home care schedules of the nurses and aides to accommodate the member’s attendance and participation in Social Day Care.

The member and his or her family may request this service at time of enrollment or any time thereafter.

The Fidelis Care at Home Nurse Care Manager/Designee will authorize service and arrange for the delivery of this service through coordination between the Care Manager, Transportation Coordinator, and member.

Exclusion:
Members who require medically necessary skilled services and/or rehabilitation services throughout the day are excluded from the social model, but can receive the necessary services from Adult Day Health Care.

Durable Medical Equipment / Medical Supplies
Prosthetics and Orthotics

Coverage:
Durable Medical Equipment (DME) is devices and equipment that are ordered by a practitioner and have the following characteristics:
- can withstand repeated use for a protracted period of time,
- are primarily and customarily used for medical purposes,
- are generally not useful in the absence of an illness or injury, and
- are not usually fitted, designed, or fashioned for a particular individual's use.

Medical/Surgical Supplies are items for medical use that have been ordered by a practitioner to treat a specific medical condition. They are usually:
- consumable,
- non-reusable
o disposable, and
o for a specific purpose and generally have no salvageable value.

Prosthetic appliances and devices are appliances and devices that replace a missing body part - excluding artificial eyes and dental prostheses.

Orthotic appliances and devices are appliances and devices used to support a weak or deformed part of the body, or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic footwear are shoes, shoe modifications, or shoe additions that are used to correct, accommodate, or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot, or to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.

Ordering Guidelines:
Durable Medical Equipment, Medical/Surgical Supplies, (including enteral/parenteral nutritional supplements), Prosthetic and Orthotic appliances, and Orthopedic footwear require both a physician’s order and prior authorization from Fidelis Care at Home. (Certain restrictions and limitations apply as per Medicaid guidelines.)

Fidelis Care at Home will follow the guidelines in the fee-for-service New York State Medicaid Program using the MMIS Provider Manual to determine coverage of service items and frequency guidelines.

Fidelis Care at Home will cover at a minimum no less than that which is covered in the Medicaid fee-for-service system as outlined in the MMIS Provider Manual, and follow the same frequency guidelines. The list below includes a few examples of commonly requested items and the frequencies allowed under the NYS Medicaid System and Fidelis Care at Home. However, all DME, prosthetics, and orthotics will be arranged through Fidelis Care at Home following the NYS Medicaid guidelines. A physician’s order and prior authorization from the Fidelis Care at Home Nurse Care Manager/Designee are required for all equipment, devices, orthotics, and prosthetics. Arrangements for ordering and delivery will be made through the Fidelis Care at Home Nurse Care Manager/Designee.

o Hospital bed=once/5 years
o Mattress=once/2 years
o Gel or air pressure mattress=once/year (gel mattress is once a year, air pressure is once every 5 years)
o Oxygen equipment system=once/month
o Nebulizer=once/year
o CPAP device=once/5 years
o Walker= twice/lifetime Walkers can be received once every 5 years, as long as another mobile device such as a wheelchair is not being used
o Standard Wheelchair=once every 2 years 5 years (depending on the type of wheelchair it is once either every 3 or 5 years)
○ Motorized Wheelchair=once/5 years
○ Commode=once/ 5 years
○ Raised toilet seat=once/5 years
○ Tub bench=once/5 years
○ Hoyer lift=once/lifetime
○ Breast Prosthesis, mastectomy bra=two/year
○ Elastic Stockings= Medicaid coverage limits and restrictions apply. (follows NYS Medicaid guidelines) (one pair per year)
○ Prescription orthopedic footwear=Medicaid coverage and restrictions apply. (follows NYS Medicaid guidelines) (2 per year)

Personal Emergency Response System

Coverage:
A Personal Emergency Response System (PERS) is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency.

Ordering Guidelines:
All members, at the time of intake and enrollment, will be offered a personal emergency response system. If a member refuses the unit or a member resides with his or her family and the family declines the unit, then Fidelis Care at Home abides by their wishes. This service requires the prior authorization of the Fidelis Care at Home Nurse Care Manager/Designee. A physician’s order is not required, and the delivery of this service is arranged and coordinated by the Fidelis Care at Home Nurse Care Manager. Members and/or families may accept this service at time of enrollment or request this service at any time thereafter.

Exclusions:
None - all members are offered the PERS.

Non-Emergent Transportation

Coverage:
Non-emergent transportation is provided by ambulance, ambulette, and taxi or livery service as appropriate for the member’s condition. This is used to transport members to medical appointments or adult or social day program activities that are part of the member’s Plan of Care.

Ordering Guidelines:
Transportation does not require a physician’s order, but prior authorization is required from Fidelis Care at Home. Requests are communicated via phone to Fidelis Care at Home Member Services, which then arranges the trip through a Fidelis Care at Home network provider.

All transportation requests for medical appointments, day center attendance, and other approved non-emergency trips (routine requests) must be arranged and have prior
authorization through **Fidelis Care at Home** at least 48 hours in advance. Non-routine transportation requests (for example: same day medical appointments, same day requests for day care centers, etc...) will be accommodated whenever possible. Medical appointments will be given priority, but there is no guarantee that the transportation vendor will be able to accommodate the request on such short notice.

**Fidelis Care at Home** will only pay for authorized and approved trips. If a member elects to arrange for transportation privately and does not receive authorization or approval from the **Fidelis Care at Home** Nurse Care Manager, the member will be responsible for payment to the vendor they selected.

**Exclusions:**
Emergent transports (Emergency transportation is transportation by ambulance as a result of an emergency condition)
Non-medical related transports (i.e. shopping, errands, etc...)
Non-authorized and approved trips will be excluded

**Podiatry Services**

**Coverage:**
Podiatry Services are by a podiatrist who must include routine foot care when the member’s physical condition poses a hazard due to the presence of localized illness, injury, or symptoms involving the foot. They are performed as an integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.

**Ordering Guidelines:**
Podiatry Services is a preventive health service and does not require a physician order or prior authorization from **Fidelis Care at Home**.

**Dental Services:**

**Coverage:**
**Fidelis Care at Home** will provide adequate coverage of dentists and will maintain current updated listings for members. **Fidelis Care at Home**, at a minimum, will cover no less than that which is covered in the Medicaid fee-for-service schedule. This includes preventive, prophylactic, and other dental care, services and supplies, routine exams, X-rays, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances.

**Ordering Guidelines:**
A member does not require a physician’s order or prior authorization from **Fidelis Care at Home** for a routine dental exam/evaluation. After the routine exam/evaluation, prior authorization is required from **Fidelis Care at Home** for all dental procedures.
If a member has broken or lost their prosthetic appliances, such as complete or partial dentures, **Fidelis Care at Home** will approve and pay for new ones only when existing prostheses are not serviceable or cannot be relined or rebased.

**Vision Care/Optometry/Eyeglasses**

**Coverage:**
Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes, and low vision aids.

The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member’s condition. Exams that include refraction are limited to every two years unless otherwise justified as medically necessary. An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist, as well as supplies, eyeglasses, or other vision aids upon the order of a qualified practitioner.

**Ordering Guidelines:**
Vision care is a preventive health service and does not require a physician’s order or prior authorization from **Fidelis Care at Home** except for ocular prosthetics which require **Fidelis Care at Home**’s prior authorization.

Eye exams by an optometrist are limited to one visit per year and the dispensing of eyeglasses is one pair per year.

If eyeglasses are lost or broken within the year, **Fidelis Care at Home** will approve another eye exam if indicated, and replace and/or pay for the repair of the eyeglasses.

**Audiology Services (including hearing aids)**

**Coverage:**
Audiology services include audiometric exams and testing, hearing aid evaluation, conformity evaluation, and hearing aid prescription or recommendation if indicated. Hearing aid services include: selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing, and hearing aid repairs. Products include hearing aids, earmolds, batteries, special fittings, and replacement parts.

**Ordering Guidelines:**
A member does not require a physician’s order or prior authorization from **Fidelis Care at Home** for audiology services (exams and evaluations). Hearing aid services require prior authorization from **Fidelis Care at Home**.
Hearing aids will be replaced based upon the findings of a hearing aid evaluation test performed at either a New York State-approved Speech and Hearing Center or by a Fidelis Care at Home network provider.

If a hearing aid is lost or broken, Fidelis Care at Home will be responsible for replacing and/or paying for the repair of the appliance.

Prior authorization from the Fidelis Care at Home Nurse Care Manager/Designee is required for the approval and reimbursement of hearing aids. Fidelis Care at Home will follow the same Hearing Aid Coverage Criterion as per the New York State Medicaid guidelines.

**Nursing Home Care**

**Coverage:**
Nursing Home care is care provided to members by a licensed skilled nursing facility for short term rehabilitation and long term placement.

**Ordering Guidelines:**
If a member requires Nursing Home Care (SNF placement – short- or long-term), the Nurse Care Manager will arrange and coordinate this covered service through one of the Fidelis Care at Home network providers and the member’s physician. Prior authorization is required from the Fidelis Care at Home Care Manager/Designee before a member is admitted to any nursing home (in or out of network).

For short term post-acute and rehabilitation: The member must have a 3-day qualifying stay at a hospital within 30 days of the admission to the skilled nursing facility. Necessary paperwork and required SNF assessments will be completed by the hospital case manager if the member is in an acute hospital setting, and will be completed by the Fidelis Care at Home Nurse Care Manager if the member is being admitted from the home setting.

For long term placement: prior approval is needed by Fidelis Care at Home. The Fidelis Care at Home Nurse Care Manager will complete and/or assist the member and his or her caregiver in filling out all necessary admission paperwork for the Skilled Nursing Facility, if the member is in the community setting.

**Exclusions:**
Out-of-network providers

**Home Delivered Meals**

**Coverage:**
Home-delivered meals are for members who need help with meal preparation.

**Ordering Guidelines:**
Through the intake process (UAS and interview), the assessment by the Nurse Care Manager, (nutritional risk assessment), and sometimes a Social Worker evaluation, a determination is made that the member is no longer able to prepare meals, use an oven or stove safely, or is not
eating nutritionally balanced meals, and would benefit from home-delivered meals. All members at the time of intake and enrollment will be assessed for the need for home-delivered meals. Prior authorization is required for this service from the Fidelis Care at Home Nurse Care Manager/Designee, and a physician’s order is not required. Arrangements for the delivery of this service are coordinated by the Fidelis Care at Home Nurse Care Manager. Requests for home-delivered meals can be made at any time after enrollment into Fidelis Care at Home.

Social and Environmental Supports

Coverage:
Social and environmental supports are services and items that support the medical needs of the member and are included in the member’s Plan of Care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

Ordering Guidelines:
All requests for social and environmental supports require prior authorization from the Fidelis Care at Home Nurse Care Manager/Designee but do not require a physician’s order. All requests will be reviewed for necessity, and if the service is authorized and approved, Fidelis Care at Home will arrange the delivery of this service and coordinate it through the appropriate vendors and/or providers.

Exclusions:
Social and environmental supports requested for convenience only.

Physical Therapy, Occupational Therapy, Speech Therapy, or other therapies provided in a setting other than in your home

Coverage:
Ordering Guidelines:
Fidelis Care at Home is responsible for coordinating, arranging, and authorizing Fidelis Care at Home payment to providers for the member’s medically necessary covered services. Covered services are provided to members through a network of Fidelis Care at Home participating health care providers as listed in our Provider Directory, which is updated and given to each member at least annually.

What services will not be covered by Fidelis Care at Home?
Below is a list of the services that Fidelis Care at Home does not cover, but which you can still receive. Medicare and/or Medicaid may cover these or any other non-Fidelis Care at Home service that a member needs, on a fee-for-service basis from a provider who accepts Medicare and/or Medicaid. Although members can obtain these services without Fidelis Care at Home authorization by using a Medicare or Medicaid provider, Fidelis Care at Home may assist
members in obtaining these services and in making appointments and arranging non-
emergency transportation and follow-up care if needed:

- Inpatient hospital services
- Outpatient hospital services
- Physician services including services provided in an office setting, a clinic, a facility, or in the home (includes nurse practitioners and physicians' assistants acting as "physician extenders")
- Laboratory services
- Radiology and radioisotope services
- Emergency transportation
- Rural health clinic services
- Chronic renal dialysis
- Prescription and non-prescription medication
- Mental Health services
- Alcohol and Substance Abuse services
- Mental Retardation or Developmental Disabilities services provided
- Family Planning services

**Do I have to pay to receive services?**

If you are eligible for full Medicaid benefits, there are no charges to you for Fidelis Care at Home covered services. Providers of the covered services are paid on a “fee-for-service” basis by Fidelis Care at Home, after they have rendered care. If Medicare or other insurance covers the services you are receiving, these payers may be billed by the providers first. As you are not liable for the cost of covered services, if a provider should accidentally bill you directly, please send the bill to Fidelis Care at Home.

If you are required to pay a monthly "spenddown" in order to receive Medicaid benefits, the Local Department of Social Services will determine the spenddown amount to be paid by you to Fidelis Care at Home. If you have a spenddown (or a “NAMI,” Net Available Monthly Income calculation as a nursing home resident), a bill will be sent to you each month as needed, requesting payment. If not paid on time, Fidelis Care at Home will make an effort to collect payment by sending the member another copy of the bill and making a follow-up call. If these efforts fail, you will receive a letter letting you know that you may no longer be able to be enrolled in Fidelis Care at Home.

Your spenddown payment, by check or money order, should be sent to the following address:

**Fidelis Care at Home**
P O Box 347724
Pittsburgh, PA 15251-4724

If payment cannot be sent by mail, please contact us Monday through Friday 8:30 AM to 5 PM at 1-800-688-7422 (or TTY at 1–800-695-8544) so that other arrangements can be made.
Your Care Team

When you join Fidelis Care at Home, you will be assigned a Nurse Care Manager and Service Coordinator who will assist you in accessing the services that you need in order to remain as independent and as healthy as possible. She/he will also:

- Call you and your family or other individuals who may be assisting you on a regular basis to assure that you are satisfied with the care and services you are receiving.
- Work with your primary care physician to obtain the medical orders needed for covered services in your Plan of Care.
- Authorize covered services for you based on medical necessity.
- Talk to your primary care physician about changes or updates to your Plan of Care.
- Arrange and coordinate services that are covered by Fidelis Care at Home.
- Help arrange for services that you need but which are not covered by Fidelis Care at Home or are not available within Fidelis Care at Home’s existing network.
- Be available to you, or provide coverage by another Nurse Care Manager, 24 hours a day to assist you with urgent care or other issues.

Transitional Care

New enrollees who have a life-threatening disease or condition or a degenerative or disabling condition may continue an ongoing course of treatment with a non-network health care provider for up to 90 days after enrollment. The provider must accept payment at the Fidelis Care at Home rate, adhere to Fidelis Care at Home quality assurance and other policies and procedures, and provide Fidelis Care at Home and your primary care physician with medical information about your care. Fidelis Care at Home’s Medical Director may review these circumstances.

Your Plan of Care

You, your family, your physician, and the intake/assessment nurse will work together to develop a Plan of Care that meets your needs. The Plan of Care is a written description, including the amounts, frequency, and duration of all the services you need. It is based on Fidelis Care at Home’s assessment of your health and preferences, and the recommendations and medical orders of your physicians and other caregivers. Your Nurse Care Manager will authorize services and payment to network providers.

You will receive a copy of your Plan of Care. As your needs change, you may require different services or a change in the amount of services you receive. Your Nurse Care Manager and your network providers will work together and implement any changes to your Plan of Care. They will periodically evaluate it with you to ensure that the services you are receiving continue to meet your needs.
You are an important member of the health care team, so it is important for you to talk with your physician and Nurse Care Manager if you have a need for any service you are not receiving or wish to change your Plan of Care in any way (for example, you may request to be seen by a Physical Therapist more often than was authorized originally, or you may be receiving services that you feel you no longer need). Also, please let your Nurse Care Manager know if you are not taking your prescribed medications or have made any medication changes on your own.

Service Authorizations

_Fidelis Care at Home_ Nurse Care Managers authorize your covered services for specific amounts and periods of time based on your needs and requests or the requests of your network providers.

A request from you or from your provider on your behalf for authority for a new service in an existing authorization period or for a new authorization period is called_Prior Authorization_. It can also be a request to change a service in your Plan of Care for a new authorization period. A _Concurrent Review_ is a request by a _Fidelis Care at Home_ member or provider on the member’s behalf for additional service (more of the same) that are currently authorized in the Plan of Care. You may also request that _Fidelis Care at Home_ expedite the decision about a change in your Plan of Care.

_Fidelis Care at Home_ must decide whether to make the requested changes and must notify you by phone and in writing as fast as your condition requires but no more than the below timeframes. If the provider indicates or _Fidelis Care at Home_ determines that a delay would seriously jeopardize your life or health or your ability to attain, maintain, or regain maximum function, we will Expedite the review. Should we deny the request from you to Expedite our review, we will notify you and will handle it as a standard review.

For Prior Authorizations, we will decide and notify you as fast as your condition requires or within 3 business days after we receive the necessary information, but in no more than 14 days after we receive the request for services. If Expedited, we will decide and notify you as fast as your condition requires or within 3 business days after we receive the request.

For Concurrent Reviews, we will decide and notify you as fast as your condition requires or within 1 business day after we receive the necessary information, but in no more than 14 days after we receive the request for services. If Expedited, we will decide and notify you as fast as your condition requires or within 1 business day after we receive the necessary information, but in no more than 3 business days after we receive the request.

You or your provider may request an extension of up to 14 calendar days. _Fidelis Care at Home_ may initiate an extension of up to 14 calendar days if the reason is in your interest and well documented and justified.

If your Nurse Care Manager agrees with the request for a new service or change in service, we will change your Plan of Care. Should _Fidelis Care at Home_ refuse to authorize a service or
intend to reduce, suspend, or terminate an authorized service, we will advise you in writing and you or your provider may file an appeal of the denial. Any decision that denies any part of a service requested by you or your providers is an Action. You or your provider may appeal an Action. Please review the section starting on page 29 regarding filing an appeal.

**Identification Card**

After you enroll, your **Fidelis Care at Home** identification card should arrive within 14 to 30 days. Remember to carry your identification cards at all times, including your **Fidelis Care at Home** ID card and your Medicare and/or Medicaid cards and any other health insurance card, and show them when you go for care. The **Fidelis Care at Home** ID card is effective from the first day of your membership, and will help your health care providers to bill correctly for covered services. If you need care before you receive your card, or if you lose your ID card, or need to change or correct information on your card, contact **Fidelis Care at Home** Member Services.

**Provider Network**

When you require covered services, your Nurse Care Manager will select or assist you in selecting providers from **Fidelis Care at Home’s** Provider Directory and will make and/or assist you with the arrangements, including transportation, for you to receive the needed services. She/he will also offer to coordinate any non-covered services. If you are dissatisfied with a specific provider, you may call your Nurse Care Manager and request a change and she/he will help you select a new provider in time for your next scheduled or requested appointment.

**Out-of-Network Care**

You may receive services from a health care provider outside of **Fidelis Care at Home’s** network when it is determined that you require a service that a provider in our network cannot provide. Your Nurse Care Manager will coordinate these arrangements in the same manner as with a network provider, and if the out of network service is normally a **Fidelis Care at Home**-covered service, Medicare and/or **Fidelis Care at Home** will pay for the service and request the provider to join the network if quality and credentialing criteria are met.
Transitional Care from Network Providers

Should your Fidelis Care at Home network provider leave Fidelis Care at Home during an ongoing course of treatment, your Nurse Care Manager can arrange payment for the continuation of medically necessary treatment from this provider for a transitional period of up to 90 days. We will ensure that you are kept updated on new service providers and their availability by issuing new listings or updates yearly or more often as needed.

Advance Directives

You have the right to let us and your family know how you would want to be taken care of if you became seriously ill or injured and couldn’t communicate with your physician. Your instructions can be stated in a document called an "Advance Directive.” Fidelis Care at Home encourages you to think about this now before an extreme situation occurs, and to speak with us and get information about how to formulate your Advance Directives.

Examples of such documents include a signed and witnessed statement with your instructions called a Living Will, a DNR order, or a form called a Health Care Proxy. New York State has a law that allows you to appoint a Proxy - someone you trust, for example a family member or close friend, as your Health Care Agent to decide about your treatment if you lose the ability to decide for yourself. You must be sure to state what you would want your physician and/or Proxy to do or not to do for you, in accordance with your wishes. You may also use the NYS Health Care Proxy form we can give you to indicate your wishes regarding organ donation in the event of your death.

Confidentiality

Fidelis Care at Home is committed to respecting your privacy. We keep your health records confidential, making them accessible only to appropriate health professionals, health care providers, and authorized personnel as is necessary for your proper care as a member of Fidelis Care at Home. All of Fidelis Care at Home’s procedures are in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Emergency Care

An emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy.
- Serious impairment to such person’s bodily functions.
- Serious dysfunction of any bodily organ or part of such person.
- Serious disfigurement of such person.

Emergency services are services needed to evaluate or stabilize an emergency medical condition, and are not subject to prior authorization by Fidelis Care at Home.

If you have an emergency:
- Call 911, or
- Go to the nearest emergency facility, and show them your Medicare and/or Medicaid card(s), and any other health insurance card.

You or someone on your behalf should notify Fidelis Care at Home and your physician as soon as possible afterward so that we and/or your physician can provide or help you obtain any services you may need after your condition is stabilized.

Out-of-Area Care

If you plan to be away from home or outside the service area, please notify your Nurse Care Manager as early as possible so that she/he can help arrange any appropriate services that you may need in the area you will be visiting. Fidelis Care at Home will work with you to plan for your needs and will continue to provide non-emergency covered services to the extent that they can be arranged with the area providers. You can use your Medicare or Medicaid card or any other health insurance card to access non-covered services in the service area and outside of the service area if the health care provider accepts Medicare or New York State Medicaid.

If you are out of the area and have an emergency, go to the nearest emergency facility.

You or someone on your behalf should notify Fidelis Care at Home as soon as possible afterward.

An urgent medical or behavioral condition happens unexpectedly and usually care or services are needed within 24 to 48 hours. If you are outside the service area and become ill and it is urgent but not an emergency, please telephone Fidelis Care at Home for guidance or seek the care you need and notify Fidelis Care at Home as soon as possible afterward. This will enable your Nurse Care Manager to change your Plan of Care if necessary, arrange follow-up care if needed, and coordinate services for you.

Member Rights

Your Member Rights include the following specifics, and you have the ability to exercise your rights and be free from retaliation.
- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand and you can get oral translation services free of charge.
- You have the right to receive from your providers the information necessary to give informed consent before the start of any procedure or treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion.
- You have the right to be told where, when, and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if the services are not available in Fidelis Care at Home's provider network.
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services, and the right to use the NYS Fair Hearing System or in some instances request a NYS External Appeal.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to make advance directives and plans about your care.
Member Responsibilities

1. Provide accurate and complete health information regarding past illnesses, hospitalizations, medications taken, allergies, and other details as needed.

2. Work with the people who take care of you in developing and carrying out your Plan of Care. If you have questions or concerns about your Plan of Care, you should discuss them with your health care providers and your Nurse Care Manager.

3. Receive all of your covered services through Fidelis Care at Home’s Provider Network, and obtain authorization from your Nurse Care Manager for each of these medically necessary services.

4. Notify Fidelis Care at Home of changes in your condition.

5. Notify Fidelis Care at Home if you move.

6. Notify Fidelis Care at Home as soon as possible when you need to change an appointment.

7. Use the health care providers listed in Fidelis Care at Home’s Provider Directory for covered services.

8. Pay your monthly spenddown or NAMI amount, if any, as determined by LDSS/HRA, to Fidelis Care at Home in a timely manner.

9. Be cooperative with the people that are providing you with care.

Disenrollment

Voluntary Disenrollment

You may request to voluntarily leave Fidelis Care at Home at any time for any reason by letting Fidelis Care at Home know orally or in writing. This request starts the process to leave Fidelis Care at Home and arrange care through the LDSS/HRA. Voluntary disenrollment requests are sent to LDSS/HRA/ New York State Medicaid Choice (Maximus) for processing.

Call Fidelis Care at Home at 1-800-688-7422 and your Nurse Care Manager will assist you in completing any necessary documents, arranging care for you, and obtaining LDSS/HRA/New York State Medicaid Choice (Maximus) approval.
Involuntary Disenrollment

Involuntary disenrollment means that Fidelis Care at Home has assessed you as no longer being eligible for community-based long term care services. There are circumstances under which Fidelis Care at Home must disenroll you, and other circumstances under which Fidelis Care at Home may disenroll you. Fidelis Care at Home will not discriminate based on health status or change in health status, or the need for or cost of covered services.

Fidelis Care at Home must disenroll you if:

1. Fidelis Care at Home is aware that you no longer live in the service area;
2. You leave the service area for any reason for more than 30 consecutive days;
3. You lose your Medicaid eligibility;
4. You are hospitalized or enter an OMH, OPWDD, or OASAS residential program for 45 days or longer;
5. You are assessed as no longer eligible for nursing home level of care as determined at the last comprehensive assessment of the calendar year using the NYS required assessment tool, unless Fidelis Care at Home and the LDSS/HRA agree that your disenrollment and therefore termination of services provided by Fidelis Care at Home could reasonably be expected to result in your again becoming eligible for nursing home level of care within six months;
6. You clinically require nursing home placement but do not qualify under Medicaid rules.
7. You are homeless.

Fidelis Care at Home may disenroll you if:

1. You fail to pay for or make arrangements with Fidelis Care at Home to pay any amount owed, for example a Medicaid spenddown, within 30 days after the amount first becomes due;
2. You or your family/caregiver or others in your home engage in conduct or behavior that seriously impairs Fidelis Care at Home’s ability to provide services to you or to other members, and we have made and documented reasonable efforts to resolve the situation (unless the conduct or behavior is related to an adverse change in your health status or service usage, diminished mental capacity, or a result of your special needs);
3. You knowingly fail to complete and submit any necessary consent or release which is reasonably requested by Fidelis Care at Home to obtain covered services;
4. You provide false information, deceive, or defraud Fidelis Care at Home;
5. Your physician refuses to collaborate with **Fidelis Care at Home** on developing and implementing your Plan of Care and you do not wish to change physicians. “Collaborate” means being willing to refer to network providers or write orders for covered services.

Involuntary disenrollment requests are sent to the LDSS/HRA/New York Medicaid Choice (Maximus) for review and approval.

**When does a disenrollment become effective?**

If you have Medicaid, the effective date of disenrollment from **Fidelis Care at Home** will be the first day of the month following the month in which the disenrollment request is received and is processed by the LDSS/HRA. Generally, a signed request form must be received by **Fidelis Care at Home** by the 15th of the month for a disenrollment to become effective the next month. For example, if a form is received on May 3rd you would be disenrolled June 1st; if a form is received May 20th you would be disenrolled on July 1st. This applies to both voluntary and involuntary disenrollments. **Fidelis Care at Home** will provide services until the effective disenrollment date. **Fidelis Care at Home** will also assist you by making referrals and helping you arrange for services through the LDSS/HRA with other providers available in the community.

**How to File a Grievance or Appeal**

**Fidelis Care at Home** will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by **Fidelis Care at Home** staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone, for example a relative or friend or a provider, to act for you.

To file a grievance or to appeal a plan action, please call 1-800-688-7422 or write to Fidelis Care at Home, 95-25 Queens Boulevard, Rego Park, New York 11374. When you contact us, you will need to give us your name, address, telephone number, and the details of the problem.

**What is a Grievance?**

A grievance is any communication by you or by a provider on your behalf to us of dissatisfaction about the care and treatment you receive through **Fidelis Care at Home** which does not amount to a change in the scope, amount, or duration of service. For example, if someone was rude to you or you do not like the quality of care or services you have received, you can file a grievance with us.
The Grievance Process

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate Fidelis Care at Home staff will oversee the review of the grievance. If we are not able to immediately decide the grievance to your satisfaction, we will send you a letter within 15 business days telling you that we received your grievance and a describing our review process. We will review your grievance and give you a written answer as fast as your condition requires but within no more than one of two timeframes:

1. If you request, we determine, or the provider indicates that a delay would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum functions, we will expedite the grievance and decide within 48 hours after receipt of necessary information, and in no more than 7 days from our receipt of the grievance;

2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

How Do I Appeal a Grievance Decision?

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address, and telephone number of the individual we designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When Fidelis Care at Home denies or limits services requested by you or your provider, denies a request for a referral, decides that a requested service is not a covered benefit,
reduces, suspends or terminates services that we already authorized, denies payment for services, doesn’t provide timely services, or doesn’t make grievance or appeal determinations within the required timeframes, those are considered plan “actions.” An action is subject to appeal. (See p.22 for a description of the Service Authorization process. See also How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action
If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend, or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action
Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us, including whether you may also have a right to the State’s external appeal process;
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up, i.e. “expedite,” our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medial necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are reducing, suspending, or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?
If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking, such as denying or limiting services or not paying for services, you must file your appeal request within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

How do I Contact my Plan to file an Appeal?
You can reach us by calling 1-800-688-7422 or by writing to Fidelis Care at Home, 95-25 Queens Boulevard, Rego Park, New York 11374. (Please also contact us, or have someone on
your behalf contact us, if you need assistance with speech, hearing, or language issues). The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter within 15 days of our receipt telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff members who were not involved in the plan’s initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than 10 days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section on page 33).

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest. During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

In some cases, you may request an “expedited” appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action.
We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

**If the Plan Denies My Appeal, What Can I Do?**

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Hearing, who can appear at the Hearing on your behalf, and, for some appeals, your right to request to receive services while the Hearing is pending and how to make the request. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an ‘external appeal’ of our decision.

**State Fair Hearings**

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.
Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Hearing is not decided in your favor, you may be responsible for paying for the services that were subject of the Fair Hearing.

**State External Appeals**

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within 45 days from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time, up to 5 business days, may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your physician can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the one that counts.

**Filing Complaints with the NYS Department of Health**

If at any time you are dissatisfied with how Fidelis Care at Home has treated you or how we have handled your grievance or appeal, you may contact the Department of Health directly at:

New York State Department of Health  
Bureau of Continuing Care Initiatives  
Corning Tower, Room 2084  
Empire State Plaza  
Albany NY 12237  
Telephone #: 1-866-712-7197

**Surveys and Member Input**

Fidelis Care at Home is committed to providing the best possible service and care to our members, and your input will help us in our efforts to continually develop and improve the program. We may ask for your participation in Fidelis Care at Home Board or Quality Management committee meetings. You will also periodically receive a written Member Satisfaction Survey from Fidelis Care at Home requesting that you rate our performance and
that you provide your comments and suggestions about Fidelis Care at Home. You can also call us at any time with your comments.

Additional Information Available to Members Upon Written Request

Names, business addresses, and official positions of Board members, officers, controlling persons, owners or partners of Fidelis Care at Home.

Most recent yearly certified financial statement of Fidelis Care at Home, including balance sheet and summary of moneys received and paid out.

Fidelis Care at Home’s procedures for protecting the confidentiality of medical records and other member information.

Procedures Fidelis Care at Home uses to make decisions about experimental or investigational services, medical devices, or treatments in clinical trials.

Written description of the organizational arrangements and ongoing procedures of the quality management and performance improvement program.

Written descriptions of the criteria relating to a particular condition or disease used to determine whether or not Fidelis Care at Home will authorize a service, and other clinical information which Fidelis Care at Home might consider in its authorization process.

Written application procedures and the qualifications which health care providers must present in order to be considered for participation in Fidelis Care at Home.

Copies of the Ethical and Religious Directives for Catholic Health Care Services, in accordance with which Fidelis Care at Home functions.

Consumer Directed Services
As part of your managed long term care services, you may be eligible to self direct your care. Consumer Directed Personal Assistance Services (CDPAS) is a specialized program where a member or a person acting on a member’s behalf known as a designated representative, self directs and manages the member’s personal care and other authorized services.

CDPAS members have greater flexibility and freedom in choosing their personal aide services, home health services and/or skilled nursing services that they are eligible to receive. The member and/or designated representative is responsible for hiring, training, supervising and if necessary terminating the employment of his/her aide.

To learn more about CDPAS, including eligibility for this program, contact your Nurse Care Manager.