Organization/Coverage Decisions, Appeals and Grievances

The process for organization/coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Organization/Coverage Decisions

An organization/coverage decision is a decision given in writing that we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We and/or your doctor make an organization/coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for an organization/coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make an organization/coverage decision for you.

To request an organization/coverage decision, you or your provider should contact us:

For Medical Determinations (Part B Benefit):

- **Mail:** Submit a written request to Integra Managed Care, 1981 Marcus Avenue, Suite 100, Lake Success, NY 11042
- **Fax:** Fax your written request to 1-516-321-4639
- **Phone:** Call Customer Service at 1-877-388-5195 (TTY: 711)

For Pharmacy Determinations (Part D Benefit):

- **Mail:** Submit a written request to Elixir, Attn: Coverage Determinations Department, 2181 East Aurora Road, Ste. 201, Twinsburg, OH 44087
- **Fax:** Fax your written request to 1-877-503-7321
- **Phone:** Call Elixir Customer Service at 1-833-459-4422 (TTY: 711)
- **Web:** **https://www.covermymeds.com/main/prior-authorization-forms/elixirsolutions/**

We make an organization/coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we will decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this organization/coverage decision, you can make an appeal.

Generally, for a standard decision, we will give you our answer within 14 days of receiving your request. We can take up to 14 more days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If you believe we should not take extra days, you can file an "expedited complaint" about our decision to take extra days. When you file an expedited complaint, we will give you an answer to your complaint within 24 hours. If we do not give you our answer within 14 days (or if there is an extended period, by the end of that period), you have the right to appeal.

You can ask our plan to make an "expedited decision" if your health needs a quick response. To get an expedited decision, you must meet two requirements:

- Requested medical care has not yet been received. You cannot get an expedited decision if your request is about payment for medical care you have already received.
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

Appeals

An appeal is a complaint you make when you want us to change a decision we made about your care. An appeal is a request from you, your member designee or non-contracted provider to reverse or modify an initial determination to deny, reduce or discontinue services or the denial of payment for medical care. The time frame for filing an appeal is 60 calendar days from the date of the notice of the adverse determination. You can file one when we:

- Deny or limit a service request.
- Reduce or stop services you have been getting.
- Refuse to pay for services that you think should be covered.
- Fail to give services in the required timeframe.
- Fail to decide an appeal in the required timeframe.

You or your doctor can ask for an expedited appeal. We will give you an expedited appeal if your doctor says waiting could seriously harm your health. You may ask for an expedited appeal without a doctor's help. We will decide if you need an expedited decision.

To File a Medical Appeal *(Part B Benefit):*

- **Mail:** Submit a written request to Integra Managed Care, 1981 Marcus Avenue, Suite 100, Lake Success, NY 11042
- **Fax:** Fax your written request to 1-516-321-4639
- **Phone:** Call Customer Service at 1-877-388-5195 (TTY: 711)

To File a Pharmacy Appeal *(Part D Benefit):*

- **Mail:** Submit a written request to Elixir, Attn: Coverage Determinations Department, 2181 East Aurora Road, Ste. 201, Twinsburg, OH 44087
- **Fax:** Fax your written request to 1-877-503-7321
- **Phone:** Call Elixir Customer Service at 1-833-459-4422 (TTY: 711)

If your request was filed verbally, written notice is not needed. For expedited appeals, we will call you. We will send a letter with the appeal decision within 72 hours.

If you ask for an expedited appeal and we decide that one is not needed, we will:

- Transfer the appeal to the timeframe for standard resolution.
- Make reasonable efforts to try to call you.
- Follow up within two days of written notice.
- Inform you verbally and in writing that you may file a grievance about the denial of the expedited process.

Integra Managed Care must make its reconsidered determination as quickly as the member's health condition requires, but no later than 30 calendar days from the date we receive the request for a standard appeal. The time frame will be extended by up to 14 calendar days by Integra Managed Care if you request the extension, or also may be extended by up to 14 calendar days if Integra Managed Care justifies a need for additional information and documents how the delay is in your best interest.

When Integra Managed Care extends the time frame, we will notify you in writing of the reasons for the delay and inform you of the right to file an expedited grievance if you disagree with Integra Managed Care's decision to grant itself an extension. For appeals related for a request for reimbursement (services that have already been received and you have paid for), Integra Managed Care must make its reconsidered determination no later than 60 calendar days from the date we receive the request.

Grievances

A grievance is any complaint other than one that involves a coverage determination. A grievance can be about administrative issues, such as Integra Managed Care staff or doctors' attitudes and/or their interactions with you. Grievances may include complaints about the timeliness, appropriateness, access to and/or setting of a provided health service, procedure, or item. For example, a grievance could be about dissatisfaction with wait times when filling a prescription or the cleanliness or condition of a network facility or provider office. You as a member or your representative must file a grievance no later than 60 days after the event or incident that caused the grievance. The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day timeframe.

If a request to have a coverage decision, coverage determination, reconsideration or coverage re-determination expedited is denied, you can file an expedited grievance.

You or someone that you appoint to act on your behalf can represent you and can file a grievance. (Appoint a Representative Form) Someone you appoint can be a relative, friend, advocate, attorney, physician or other prescriber. If you wish to appoint a representative, you can use the form or you can send a written statement with the following information included:

- Your name, address, and telephone number
- Your Medicare number (this is the number on the red, white, and blue Medicare ID card)
- Name, address, and telephone number of the individual being appointed
- A statement that you authorize the person to act on your behalf and permit us to disclose identifying information
- Signed and dated by you
- Signed and dated by your representative and the individual's statement that they accept being your representative

To File an Organizational Grievance *(Part B Benefit):*

- **Mail:** Submit a written request to Integra Managed Care, 1981 Marcus Avenue, Suite 100, Lake Success, NY 11042
- **Fax:** Fax your written request to 1-516-321-4639
- **Phone:** Call Customer Service at 1-877-388-5195 (TTY: 711)

To File a Pharmacy Grievance *(Part D Benefit):*

- **Mail:** Submit a written request to Elixir, Attn: Coverage Determinations Department, 2181 East Aurora Road, Ste. 201, Twinsburg, OH 44087
- **Fax:** Fax your written request to 1-877-503-7321
- **Phone:** Call Elixir Customer Service at 1-833-459-4422 (TTY: 711)

You can also submit a complaint directly to Medicare at Medicare.gov or by calling 1-800-Medicare.

To view the formal Appeals and Grievance Processes, please review Chapter 9 of the Evidence of Coverage:

- 2021 Integra Harmony (HMO SNP) Evidence of Coverage
- 2021 Integra Harmony (HMO SNP) Evidence of Coverage (Spanish)
- 2021 Integra Synergy MAP (HMO SNP) Evidence of Coverage
- 2021 Integra Synergy MAP (HMO SNP) Evidence of Coverage (Spanish)

To obtain an aggregate number of grievances, appeals and exceptions filed with the plan, please contact us:

- **Mail:** Submit a written request to Integra Managed Care, 1981 Marcus Avenue, Suite 100, Lake Success, NY 11042
- **Fax:** Fax your written request to 1-516-321-4639
- **Phone:** Call Customer Service at 1-877-388-5195 (TTY: 711)