Appeals & Grievances

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

- 2019 Harmony Evidence of Coverage

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, 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. 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 HICN number (this is your Medicare number on the red, white and blue Medicare ID card)
- Name, address and telephone number of the individual being appointed
- Contain a statement that you are authorizing the representative to act on your behalf, and a statement authorizing disclosure of identifying information to the representative
- Signed and dated by you
- Signed and dated by the individual being appointed as your representative, and the individual's 877- statement that they accept being your representative

To appoint a representative or to start the Grievance process, we are available Monday to Friday 8 a.m. to 8 p.m.

You can write to us at

Integra Managed Care
Attn: Appeals & Grievances Department
1981 Marcus Avenue, Suite 100 | Lake Success, New York 11042

Or fax Medical Grievances to 1-516-321-4639

Or fax Part D Grievances to 516-321-4640

Grievances can be submitted either orally or in writing. You are able to communicate with us by calling 1-877-388-5195 or for Part D grievance 1-833-459-4422. You can also submit a complaint at Medicare.gov or call 1-800-Medicare.

Appeal

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 will get a letter from us when any of these actions occur. This is called a “Notice of Action.” You can file an appeal if you think that the action was made in error.

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.

You or your provider must call or fax us to ask for an expedited appeal.

Call 1-877-388-5195 (TTY 1-800-662-1220) | Fax to 1-516-321-4639 or Fax Part D Appeals to 516-321-4640.

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 three days.

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 the member requests 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 the best interest of the member.

When Integra Managed Care extends the time frame, we will notify the member in writing of the reasons for the delay, and inform the member of the right to file an expedited grievance if the member disagrees 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.

In some cases, you may be able to continue receiving the services while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for this:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received. If we deny your appeal and you are not satisfied, you can appeal further using the fair hearing process or external appeals.

To obtain an aggregate number of grievances, appeals and exceptions filed with the plan, please call us at 1-877-388-5195, Monday through Friday, 8:00am-8:00pm (TTY/TDD users: 711). Interpreter services are also available. or reach us by mail at:

Integra Managed Care
Appeals and Grievances Department
1981Marcus Avenue. Suite M100
Lake Success, NY 11042

Organization Determinations

An organization determination is a decision we make about your benefits and coverage or about the amount we will pay for your medical or Part D services.

For example, your plan network doctor makes a (favorable) organizational decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure if we will cover a particular medical service or refuses to provide medical care you think that you need.

If you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare or Medicaid. If you disagree with this 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 a coverage decision on the medical care you are requesting. If your health needs a quick response, you should ask us to make an "expedited decision."

To get an expedited decision, you must meet two requirements:

- You can get an expedited decision only if you are asking for coverage for medical care you have not yet received. You cannot get an expedited decision if your request is about payment for medical care you have already received.
- You can get an expedited decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

To request a Coverage Determination, you or your provider must call or fax us: Call: 1-877-388-5195 (TTY 711) | Fax to 1-516-321-4639.

Or you can write to us at:

Integra Managed Care
Attn: Appeals & Grievances Department
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