No. GA-001	**Appeals and Grievances**	
Effective Date: 4/26/2018	**POLICY AND PROCEDURE**	
Previous Versions: see revision history on last page		
DMHC TAG: Grievance and Appeals **NCQA: UM 8**		

APPEALS AND GRIEVANCES POLICY

Where Canopy Health is not delegated to manage grievances and appeals for members of its Health Plans, the member and/or provider initiating the appeal or grievance are redirected to the Health Plan.

"Appeal, complaint or grievance" means any dissatisfaction expressed by a member or member's representative concerning a problem with Canopy Health, the Health Plan, a medical provider or coverage under the member's Evidence Of Coverage (EOC), including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by Canopy Health's affiliated medical groups or IPAs or the Health Plan to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on any of the following:

- An individual is no longer eligible with a Canopy Health parent health plan;
- A benefit is not covered; or
- A benefit is experimental, investigational, or not medically necessary or appropriate

Members may take the following steps to initiate an appeal or grievance depending on what type of service is in dispute, specified below:

1. **Medical services**

Canopy Health members who wish to initiate an appeal or grievance about medical services should contact their Health Plan. The Health Plan's EOC specifies details about how the Plan addresses appeals and grievances and communicates with members.
If the member informs the medical group, IPA or Canopy Health directly about an appeal or grievance in writing, the IPA or Canopy Health will forward that written communication to the health plan for processing, within one hour of receipt. If a health plan contracted with Canopy Health has its own Grievance Form, it will be posted on the member and provider portals of the medical group/IPA and Canopy Health. Medical group and Canopy Health staff will make that form available to members who wish to use it to file a grievance with their health plan. If the Health Plan requests clinical information when reviewing the member's appeal, the medical

group will provide this within the following timeframes, which apply to every calendar day of the year: within 24 hours for standard appeals, or within two hours for expedited appeals.

If the member calls the medical group, IPA, or Canopy Health directly about an appeal or grievance, the group, IPA or Canopy Health representative will instruct the member to contact the Health Plan's member services number or else will transfer the member to that number directly. The representative will also make the Health Plan's Grievance Form available to the member. If the member wishes to file concerns in writing. Members will continue to have coverage for all medically necessary covered services, pending results of an appeal.

2. **Mental health, substance abuse, chiropractic, or acupuncture services**

Canopy Health members with an appeal or grievance about mental health and substance abuse, chiropractic, or acupuncture should review their Health Plan's EOC documents for contact information.

3. **Clinical trial or investigational/experimental treatment outside clinical trials**

Canopy Health members with an appeal or grievance about denial of treatment offered only through a clinical trial or deemed to be investigational or experimental outside of a clinical trial may pursue either of these options:

- Use the medical appeals and grievance process with their Health Plan as noted above; or
- Request an independent medical review (IMR) of the denial through the California Department of Managed Health Care (DMHC): (1-888-HMO-2219) or TDD line (1-877-688-9891) or through its web site: http://www.hmohelp.ca.gov

Binding Arbitration

Members who continue to be dissatisfied after the grievance procedure has been completed through the Health Plan or DMHC may contact the DMHC for assistance or to initiate binding arbitration through their Health Plan. Binding arbitration is the final process for the resolution of disputes. Members should read their Health Plan EOC for more details.

Revision History:

Version Date	Edited By	Reason for Change
7/28/16	M. Durbin	Creation date
3/14/18	A. Kmetz	Revised to include medical group to health plan timeframes per UHC review.
4/18/2018	M Durbin	Added language about clinical trial appeals or grievances