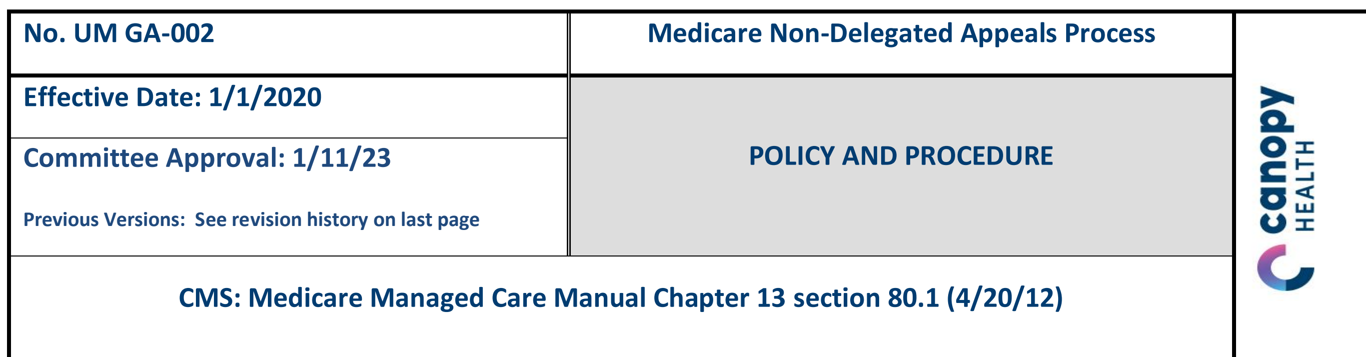

No. UM GA-002	Medicare Non-Delegated Appeals Process
Effective Date: 1/1/2020	POLICY AND PROCEDURE
Committee Approval: 1/11/23 Previous Versions: See revision history on last page	
CMS: Medicare Managed Care Manual Chapter 13 section 80.1 (4/20/12)	

Medicare Non-Delegated Appeals Process

Canopy Health is not delegated to manage grievances and appeals for Medicare members of its Health Plans. The member, the member's representative and/or the provider initiating the appeal or grievance is redirected to the Health Plan.

Canopy Health may receive an appeal request from a Medicare member or member's representative. The member's representative may include the practitioner who requested the service and is submitting an appeal on behalf of the member.

If the appeal is written, immediately upon receipt Canopy Health notifies the Health Plan and faxes the appeal. If the appeal is received via a phone call, the call should be warm transferred directly to the Health Plan member services number on the enrollee's card and the Canopy Health representative informs the Plan's Member Services of the exact date and time the call was received.

The Medicare member will have continued coverage for covered services, pending the outcome of the appeal. This applies to denial, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved. Canopy Health allows continued coverage pending the outcome of an internal appeal of a concurrent care decision until the end of the approved treatment period or determination of the appeal, subject to regulatory and contractual obligations.

If a Canopy Health Medical Group/IPA receives a Medicare member grievance or appeal (complaints, appeal, quality of care/service concern, whether oral or written), immediately, within one hour of receipt, forward to the Health Plan for processing:

For Medicare Advantage members:

UnitedHealthcare Appeals and Grievances Department
MS: CA 124-0157
P.O. Box 6106
Cypress, CA 90630
Fax: 888-517-7113
Website: myuhc.com

For pharmacy:
Medicare Part D Appeals & Grievances Department
Fax: 866-308-6296

Any clinical information requested by the Health Plan, such as the complete UM file, when the Health Plan has received an appeal request regarding an adverse organization determination or Notice of Medicare Non-Coverage (NOMNC) must be provided within two hours for expedited requests or within 24 hours for standard requests (See UM-012 Medicare Consistency and Timeliness for UM Decisions).

Revision History:

Version Date	Edited By	Reason for Change
1/1/2020	**R. Scott**	**Create new MA policy.**