SummaCare

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Policy Number: CSCL0028
Manual Name: SMSO Policy Manual
Policy Name: Medicare Explanation of Benefits and Denial Notices
Approved By: Stephen Adamson
Last Revised: 07/09/2019

SMSO Policy Manual
MEDICARE EXPLANATION OF BENEFITS AND DENIAL NOTICES

Executive Sponsor:	Stephen Adamson, Chief Operations Officer
Issuing Department:	Claim
Gate Keeper:	Melissa Rusk, Director Claims

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Health Management Company
- ☐ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☐ Commercial Groups
- ☐ Medicare Supplemental
- ☐ Off-Exchange
- ☒ Medicare
- ☐ On-Exchange
- ☐ Self-Funded

1.0 Purpose:

1.1 To ensure that an explanation of benefits (EOB) is generated and mailed to beneficiaries for claims finalized after 4/1/2014 and to provide detailed explanation when member liability exists.

2.0 Policy:

2.1 The Company generates weekly EOBs (ad hoc) for each member with claims processed in a given week, along with appeal rights. For claims where the member has financial liability beyond usual cost-sharing, the Company also sends the Integrated Denial Notice wording on the EOB. The Company generates CMS approved model Part C EOBs on a quarterly basis beginning April 2014.

3.0 Procedure:

3.1 EOB Procedure

3.1.1 Beneficiaries may opt out of weekly and quarterly EOB mailings via Plan Central. EOBs will still be available for beneficiaries in Plan Central but will no longer be mailed.

3.2 The Integrated Denial Notice (denial letter) is generated with the weekly EOB for the following denials:

3.2.1 FR (services provided are not considered medically necessary)

3.2.2 FS (service is not a covered benefit, bill patient)

3.2.3 FT (services have exceeded benefit limits of plan)

3.2.4 WZ (deny opt out of Medicare Physicians and Practitioners)

3.2.5 LK(submit to workers comp)

3.2.6 90 (billed as maintenance care – not a covered benefit)

3.2.7 SU(subrogation claim – third party responsible)

3.2.8 GY(services available in-network)

3.3 The weekly Medicare EOBs also includes appeals language, and 1557 (taglines and notice) as well as the out-of-pocket maximum for the year and the amount applied towards that maximum

3.4 Melissa Rusk, Director, Claims & BPO Operations has the authority and responsibility for the activities in this policy or procedure.

3.5 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.5.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 MMCM Chapter 4, Section 190

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 Approved Appeal Rights

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 None

6.0 Key Words or Aliases (Optional):

6.1 Medicare, EOB, Denial Notice, IDN, Explanation of Benefits

ORIGINAL *EFFECTIVE DATE*:	4/1/2014
REVIEWED:	1/20/2016; 2/8/2016; 7/12/2016; 3/13/2018; 4/2/2019
REVISED:	11/25/2014; 1/20/2016; 2/8/2016; 7/12/2016; 2/16/17; 4/2/2019; 7/9/2019 (format)