1979 - 2024 Celebrating our 45th Anniversary! Helping people on Medicare OFFICE of the INSURANCE COMMISSIONER SHIBA WASHINGTON STATE First in the nation

How to read Medicare Summary Notices and Explanation of Benefits

OFFICE of the INSURANCE COMMISSIONER SHIBA WASHINGTON STATE

Revised – Jan. 23, 2024

SHIBA mission

SHIBA provides **free, unbiased information** about **health care coverage and access** to help improve the lives of all Washington state residents. We cultivate community commitment through partnership, service and volunteering.

SHIBA celebrates 45 years

SHIBA celebrates 45 years of helping people on Medicare!

- In 1976, a small group of volunteers, known as Health Insurance Referral Services, were part of a pilot program in Mount Vernon. They helped counsel senior citizens on health insurance, Medicare and Medicaid.
- In 1978, the OIC's Consumer Protection Deputy Commissioner helped the group become SHIBA, which then stood for Senior Health Insurance Benefits Advisors.
- In 1979, the state's Insurance Commissioner Dick Marquardt, officially endorsed SHIBA as a statewide project with the Office of the Insurance Commissioner.
- Later on, SHIBA inspired the federal government in 1990 to create a model, called the national State Health Insurance Programs (SHIPs).
- Today, there are SHIPs in all 50 states, plus Puerto Rico, Guam, the District of Columbia and the US Virgin Islands.

The Senior Medicare Patrol (SMP) mission

The SMP mission:

Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling and education.

Today's overview

- Make sense of your Medicare Summary Notices (MSNs) from Medicare.
- Make sense of your Explanation of Benefits (EOBs) from your Medicare Advantage (MA) or drug plan.
- Helpful information about Medicare coverage.
- Find out about volunteer opportunities.
- We'll wrap up.

Important terms

Appeal: a formal request to Medicare, an MA or RX plan, to review a service or item coverage decision.

Coinsurance/Copayment: The amount you must pay for each service or item. Coinsurance is a percentage of the total cost. A copayment or copay is a fixed amount.

Deductible: The amount you must spend on health care or drugs before your insurance begins to pay.

Medicare Summary Notice (MSN)

What is an MSN?

- It's not a bill.
- It's a notice that people with Original Medicare get in the mail every 3 months for their Medicare Part A- and B-covered services.
- The MSN shows:
  - All your services or supplies that providers and suppliers bill to Medicare during the 3-month period.
  - What Medicare paid.
  - The maximum amount you may owe the provider.
- If Original Medicare will not pay for care you received, you will find this out when you receive your Medicare Summary Notice (MSN).

Tips for understanding your MSN

- You can also view your MSNs online at medicare.gov when you open an account.
- Read the definitions and descriptions of services carefully.
- Review the Notes section where Medicare explains its payment decision or gives other important information.
- If Medicare rejects a covered service you received, you should appeal.
- See the “Where to go for Help” section on the last page.

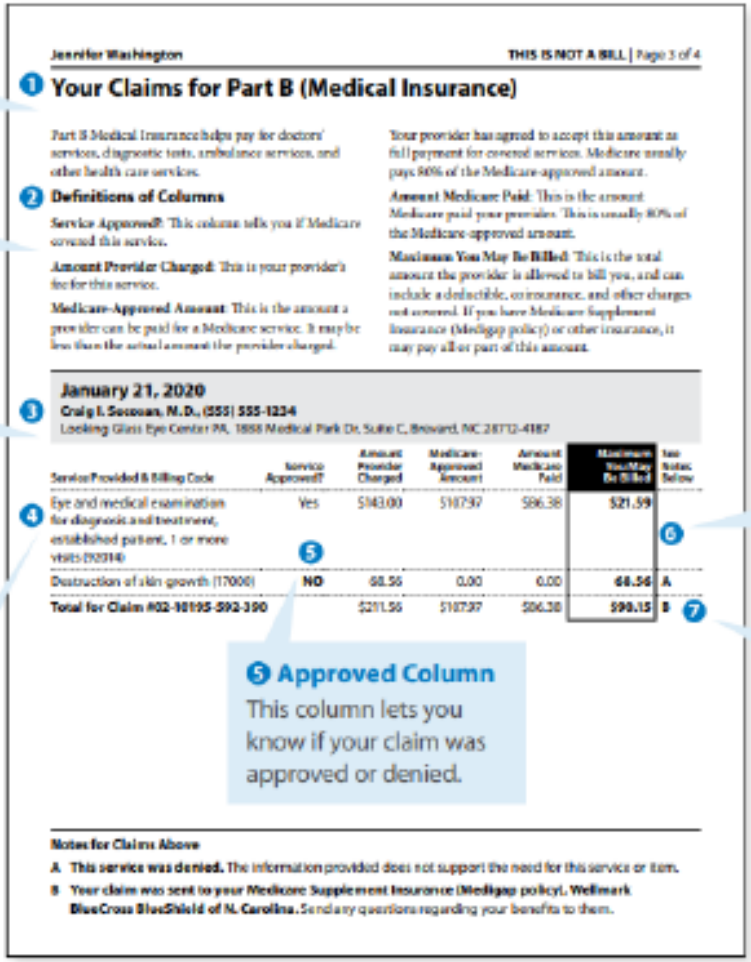
Sample MSN

❶ Type of Claim
Claims can either be assigned or unassigned.

❷ Definitions
Don't know what some of the words on your MSN mean? Read the definitions to find out more.

❸ Your Visit
This is the date you went to your doctor. Keep your bills and compare them to your notice to be sure you got all the services listed.

❹ Service Descriptions
User-friendly service descriptions will make it easier for you to know what you were treated for.



Jennifer Washington — THIS IS NOT A BILL | Page 3 of 4

❶ **Your Claims for Part B (Medical Insurance)**

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

❷ **Definitions of Columns**

Service Approved?: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

❸ **January 21, 2020**
Craig I. Sorensen, M.D., (555) 555-1234
Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
❹ Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	$143.00	$107.97	$86.38	**$21.59**	❻
Destruction of skin growth (17000)	**NO** ❺	68.56	0.00	0.00	**68.56**	A
Total for Claim #02-18195-592-390		$211.56	$107.97	$86.38	**$90.15**	B ❼

❺ **Approved Column**
This column lets you know if your claim was approved or denied.

Notes for Claims Above

A **This service was denied.** The information provided does not support the need for this service or item.

B **Your claim was sent to your Medicare Supplement Insurance (Medigap policy). Wellmark BlueCross BlueShield of N. Carolina.** Send any questions regarding your benefits to them.

❻ Max You May Be Billed
This is the total amount the provider is able to bill you. It's highlighted and in bold for easy reading.

❼ Notes
Refer to the bottom of the page for explanations of the services you got.

How to handle denied claims

Before starting, check to make sure the denial is not an error:

- Sometimes, the bill the provider sends to Medicare is incorrectly filed, which results in a denial of service.
- The provider's office can correct the error by contacting the company that processed the Medicare claim.

How to handle denied claims

Start the appeal by filling out the shaded area on the last page of the MSN.

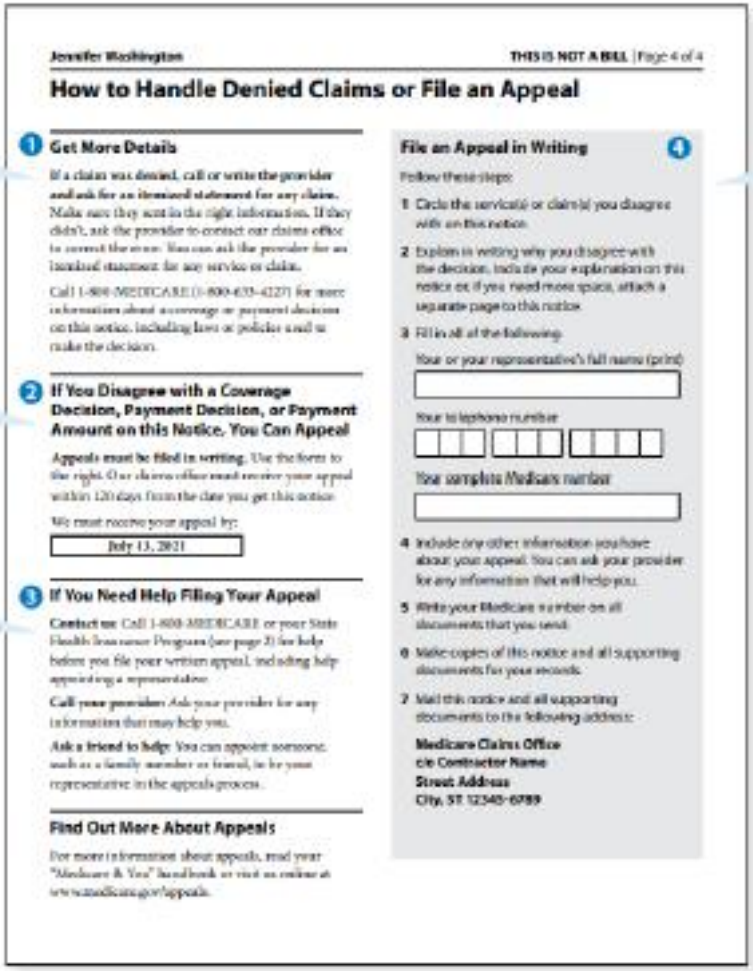
- Ask your provider to write a letter of support that explains why you need the care and addresses the plan's denial reason.
- Send copies of letters - do NOT send originals.
- Mail copies to the address by the date indicated on the last page.

How to handle denied claims

1 Get More Details
Find out your options on what to do about denied claims.

2 If You Decide to Appeal
You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

3 If You Need Help
Helpful tips to guide you through filing an appeal.



Jennifer Washington — THIS IS NOT A BILL | Page 4 of 4

How to Handle Denied Claims or File an Appeal

1 Get More Details

If a claim was denied, call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

2 If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

July 13, 2021

3 If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

File an Appeal in Writing 4

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

4 Appeals Form
You must file an appeal in writing. Follow the step-by-step directions when filling out the form.

How to handle denied claims

You can appeal Medicare's decision to deny coverage.

- There are multiple levels to the appeal process.
- If an appeal is denied, you can appeal to the next level.
- You can request a good cause extension if you miss the appeal deadline (file as normal with an explanation).

Explanation of Benefits (EOBs)

What is an EOB?

- You only receive an EOB if you have an MA plan or a Medicare Part D drug plan.
- It's not a bill.
- It's a summary of the services or items you have received and how much you may owe for them.
- It tells you:
  - How much your provider billed.
  - The approved amount your plan will pay.
  - How much you have to pay.

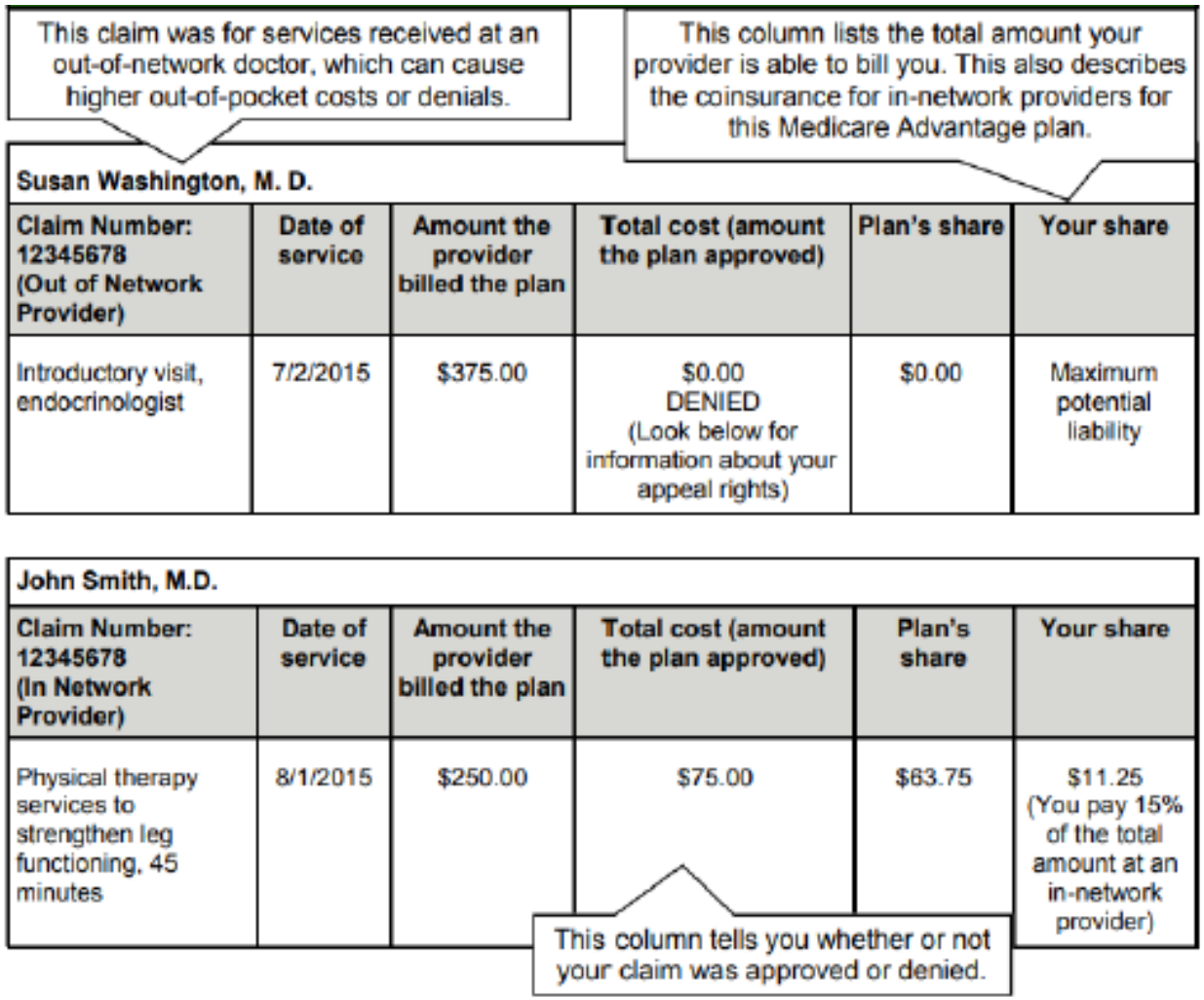
Tips for understanding your EOB

- If you have an MA plan or Medicare Part D drug plan, your plan will send you your EOBs monthly.
- You'll only receive an EOB if you received service.
- Each insurance plan has its own format, but should include information such as claim number, date of service, amount the provider billed the plan, etc.

Tips for understanding your EOB

- Read the definitions and descriptions of services carefully.
- Review the Notes section, including any footnotes where the plan explains its payment decision.
- If an MA or Medicare Part D plan rejects a covered service or prescription drug you received, you should appeal.
- See the “Where to go for Help” section on the last page of your EOB.

Sample EOBs



This claim was for services received at an out-of-network doctor, which can cause higher out-of-pocket costs or denials.

This column lists the total amount your provider is able to bill you. This also describes the coinsurance for in-network providers for this Medicare Advantage plan.

Susan Washington, M. D.

Claim Number: 12345678 (Out of Network Provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Introductory visit, endocrinologist	7/2/2015	$375.00	$0.00 DENIED (Look below for information about your appeal rights)	$0.00	Maximum potential liability

John Smith, M.D.

Claim Number: 12345678 (In Network Provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Physical therapy services to strengthen leg functioning, 45 minutes	8/1/2015	$250.00	$75.00	$63.75	$11.25 (You pay 15% of the total amount at an in-network provider)

This column tells you whether or not your claim was approved or denied.

How to handle denied claims

Before starting, check to make sure the denial is not an error:

- Sometimes, the bill the provider sends to your MA plan is filed incorrectly, resulting in a denial of service.
- The provider's office can correct the error by contacting the company that processed the claim.

How to handle denied claims

Start an appeal by sending a letter to the plan's grievances and appeals department that explains why you need the service or item.

- Ask the doctor to write a letter of support that explains why you need the care and addresses the plan's denial reason.
- Send copies of letters - do NOT send originals.

How to handle denied claims

You can appeal the MA or drug plan's decision to deny coverage.

- There are multiple levels to the appeal process.
- If an appeal is denied, you can appeal to the next level.
- You can request a good cause extension if you miss the appeal deadline (file as normal with an explanation).

What else you need to know

Learn about Medicare's coverage rules

To learn more about Original Medicare's coverage of a service:

- Call 1-800-MEDICARE (1-800-633-4227).
- Visit Medicare.gov.
- Read the relevant sections in the Medicare & You handbook.
- Contact your local SHIBA office at 1-800-562-6900.

Where to go for help

- For questions about your MSN, call: 1-800-MEDICARE (1-800-633-4227).
- For questions about your EOB, call: Your insurance plan - the phone number is located on the back of your plan's insurance card.
- If you do not think you received the service, item or medication outlined on your MSN or EOB, contact your provider to inquire about a possible error.

Volunteer for SHIBA!

Do you want to help explain health care benefits or options to:

- Friends?
- Neighbors?
- You community?
- Help people become better informed consumers?

Become a volunteer! Call: **1-800-562-6900**

Need help with other insurance questions?

The Office of the Insurance Commissioner can also help you with questions, information and complaints about all types of insurance, such as:

- Homeowner
- Auto
- Life
- Annuities
- Health
- And more!

Call our Insurance Consumer Hotline:

1-800-562-6900

On the web at: **www.insurance.wa.gov**