Explanation of Benefit (EOB) Case Study

Mario calls because he wants help with his appeal. He is 70 years old and has a Medicare Advantage Plan. He received a screening for abdominal aortic aneurysm (AAA) a couple months ago because his doctor recommended it. He just received something in the mail from his plan. It listed the AAA screening and said that he owes the full amount for the cost of the service. Mario wants to know why his plan did not pay anything.

Here is Mario's EOB:

Provider: Alex Brown, MD			**Claim Number:** 87765		**Patient Account Number:** 25303540			
Date of service	**Type of service**	**Notes**	**Amount billed**	**Your Plan Paid**	Deductible	Copay	Non-covered	Your Share
5/16/20	Abdominal aortic aneurysm screening	A2	$650	$0.00	$0.00	$0.00	$650	$650

A2: The information provided does not support the need for this service or item.

(Note: All billing codes and dollar amounts are examples and do not reflect actual Medicare billing codes or costs.)

How can you help Mario?

1. Determine why Mario owes the full amount for his AAA screening.

When someone appears to owe the full amount of the cost of a service, two common reasons include:

- The individual has not met their deductible yet
- The individual's plan did not cover the service

You can use Mario's EOB to learn more about why he owes $650 for the AAA screening. Notice that on the right side of the EOB it shows that zero dollars count toward the deductible and that there is a $650 charge in the "Non-covered" column. Since there is an amount listed in the non-covered column, this means that the plan did not cover the screening.

This project was supported in part by grant 90MINC0001-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services. Points of view or opinions do not necessarily represent official ACL policy.

Next, take a look at the “Notes” column, which directs you to a footnote A2. EOBs may be designed differently, so look for this information at the bottom of the page or directly beneath the claims information.

Note A2 indicates " The information provided does not support the need for this service or item.” This means that there was not enough information for the plan to determine if the screening was medically necessary.

2. Inform Mario about the steps he should take to file an appeal.

Now that you and Mario know that his AAA screening was not covered, Mario can begin an appeal. The EOB should include instructions on how to begin the first level of appeal, known as plan reconsideration.

In order to file an appeal, Mario should follow the instructions on his EOB within 60 days of the day that he receives it. The last page of his EOB should have instructions for filing the appeal, including an address for the plan’s Appeals and Grievances Department to which Mario should send his appeal documents.

Tell Mario that in appealing this decision, he should address the specific reason that the plan is not covering the service he needed. In the case of AAA screenings, Medicare Part B covers a one-time AAA ultrasound if someone is at risk for AAA and has received a referral from their provider. Medicare considers someone at risk for AAA if they have a family history of AAA or if they are a man age 65-75 and have smoked 100 or more cigarettes in their lifetime.
Mario should contact his doctor, if he has not already, and ask for his doctor’s assistance with the appeal. He should ask his doctor to address the specific reasons that the AAA screening was denied. It is possible that the plan is unaware of Medicare’s coverage rules for AAA screenings, in which case Marcus or his doctor can also include information from www.medicare.gov that explains the coverage rules.

For example, if Mario told his doctor that he has smoked more than 100 cigarettes in his life, the screening should have been covered for him (since he is a 70-year-old man age). It is possible that his doctor will need to provide the plan with documentation of Mario’s personal or family medical history.

Emphasize the importance of following the instructions on the EOB. This includes following the deadlines indicated, calling the listed numbers with questions, and sending paperwork to the appropriate address. Additionally, tell Mario that he should save copies of everything that he

This project was supported in part by grant 90MINC0001-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services. Points of view or opinions do not necessarily represent official ACL policy.

sends and receives, for his own records. After Mario sends his request for plan reconsideration, he should contact his plan to make sure that they have received it.

3. Tell Mario what will happen next.

During the plan reconsideration level of appeal, plan employees who were not involved in making the initial organization determination will reconsider the service denial. The plan should issue a decision within 60 days of receiving Mario's appeal.

If the decision is favorable, the plan should pay for the AAA screening.

If the decision is unfavorable, Mario's plan will automatically forward the case file to the second level, the Independent Review Entity (IRE). The IRE is contracted by Medicare to reconsider Medicare Advantage appeal cases at the second level. At this level of appeal, the IRE reviews the organization determination and the initial reconsideration decision and decides whether the plan should cover the service or item. The IRE must issue a decision within 30 days of getting the appeal from the plan, although it may extend the deadline up to 14 days if an extended deadline will help the beneficiary's case.

If the IRE's decision is favorable, Mario's plan should pay for his AAA screening. If the decision is not favorable, Mario will have the option of moving to further levels of appeal, beginning with sending the appeal to the Office of Medicare Hearings and Appeals (OMHA). The instructions on appealing to OMHA will appear on the denial notice from the IRE.

This project was supported in part by grant 90MINC0001-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services. Points of view or opinions do not necessarily represent official ACL policy.