View this email in your browser

Dear Provider,

We are writing to provide clarification regarding the relationship between prior authorization determinations and claims payment.

A prior authorization decision confirms that a service meets medical necessity criteria based on the information submitted at the time of review. However, prior authorization does not guarantee payment. All claims are processed in accordance with applicable benefit plan provisions, member eligibility and standard claims processing edits, including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

Claims submitted with services governed by LCD or NCD guidelines are processed based on established clinical criteria edits and may result in denial when services do not meet established coverage guidelines, regardless of prior authorization status. This information is also indicated in the prior authorization approval letter which states:

“SummaCare is required to follow all federal, state and CMS requirements for payment. This authorization is in place for members who are active with SummaCare and have not exhausted any benefit limits on or by the date the service is received. This authorization may be subject to claims edits and is only valid and applicable for the specific services requested. Members are responsible for payment for applicable deductible, coinsurance or any other services or items not covered by their plan.”

billing and coding articles, which are available through the CMS Medicare Coverage Database.

If you have questions, please contact Provider Support Services at 330.996.8400 or email Provider Engagement at providerengagement@summacare.com.

Sincerely,

Provider Support Services
