MATRIX
ABSENCE MANAGEMENT
A MEMBER OF THE TOKIO MARINE GROUP

2021

Disability Claims and Appeal Decision Guidelines

These Disability Claims and Appeals Decisions Guidelines reflect common steps in Matrix's review of claims for disability benefits. However, the facts and circumstances of each claim or appeal vary and as a result, Matrix's handling of each claim or appeal may vary. Matrix's goal on every claim and appeal is to provide a full and fair review of the claim and all relevant information and to make a determination in compliance with the terms of the disability plan or policy.

I. Eligibility Review for all claim types – STD and LTD

1. Claim received

    a. Notice sent to employee and employer
    b. Medical reach outs completed on all new claims
    c. Claim set up in Matrix claims system

2. Verify correct Plan at hand

3. Eligibility determination – verify against Plan provisions:

    a. Employee is employee of Matrix client (client data feed)
    b. Employee's dates of service
    c. Gaps in employment that affect eligibility
    d. Service waiting period met

4. Review circumstances of the claim – is it covered by the Plan?

    a. Did the employee meet the claim waiting period?
    b. Is there continuous lost time?
    c. If not, does the Plan cover part-time work loss?
    d. Is the employee covered under the Plan for the initial date of disability?
    e. Is the diagnosis or circumstances of the claim excluded by the Plan? Examples: cosmetic surgery, occupational injuries.
    f. Is the treating provider(s) as defined under the Plan per the physician definition? Examples: a physician, surgeon, dentist, podiatrist, practitioner, psychologist or other Health Care Professional, who is duly licensed and acting within the scope of his or her practice

5. If employee eligible under the Plan, continue the claim process; if not, see Section II.

6. Medical Records Not Received

    a. Send employee letter on business day eleven from date claim received to advise Matrix has not received required medical records

        i. Medical records are defined as:
            1. All chart notes,
            2. Narrative reports,
            3. Diagnostic testing and

        ii. The disability form.
            1. The disability form states the first date the employee was taken off of work and the estimated return to work date.
            2. It also outlines treatment dates – past and future, diagnosis(es) and diagnosis codes

7. Examiner sets task for 30 calendar day follow up to evaluate if decision can be made or determine if a status letter to the employee is required

8. Calendar day 30 after claim filed – examiner calls the employee and advises what documents are missing and the deadline for receipt

    a. The deadline for receipt is 15 additional days pending any differing plan language
    b. Status letter sent confirming the information provided in the phone call (missing information and due date)

9. If no clinical information (medical records) has been received by calendar day 45 from receipt of the claim the claim is reviewed for denial on day 46 based on plan requirements

10. Calendar day 60 after claim filed – if a claim decision has not been made by this day the claim is again evaluated for documents that may be missing and a second status letter may be sent

a. The examiner calls the employee to discuss what documents are missing and why
b. If appropriate, prior to calendar day 45, the examiner extends the time frame and advises the employee of the new due date
c. This is based on plan language and extenuating circumstances
d. A second delay letter is sent

11. Calendar day 90 after claim filed:

a. If a claim decision has not been made at this time and all clinical information or other information required to make a claim decision has not been received the examiner reviews and documents the claim to recommend denial
b. The claim decision is finalized before calendar day 105
c. The claim decision letter is mailed before calendar day 105

12. Upon receipt of medical records:

a. Examiner reviews medical records
b. Future actions are determined and documented
c. Future actions may consist of request for additional medical the employee has identified; this may involve calling the employee to ask for assistance in obtaining these records and/or checking with the provider and sending a written request
d. Future actions may also consist of checking with the employee and provider for a new medical exam coming up in the next week
e. If all medical records are received the claim is reviewed in order to make a claim determination
    i. Approval
    ii. Denial

II. Employee Not Eligible under the Plan

1. Stop medical reach out process, if previously initiated

2. Draft denial letter – required contents:

    1. Introduction

2. Claim History
3. Plan Provisions
4. File Information Reviewed
5. Claim Decision Rationale
6. Appeal Rights
7. What is Needed to Perfect Your Claim for Benefits
8. Copies of Documents and Disability Claims and Appeals Handling Guidelines
9. Closing Paragraphs – Conclusion

3. Draft plan of action for file documentation for recommendation to deny the claim and submit to supervisor

    a. Plan of action (POA) based on circumstances of the file using the following format:
    b. S.O.A.P. notes
        i. Subjective
        ii. Objective
        iii. Assessment
        iv. Plan – what we are doing and why

4. Supervisor reviews draft letter for:

    a. Agreement with decision to deny
    b. Appropriate content
    c. Required ERISA content*
    d. If the supervisor requests clarification of any claim facts for the letter, the examiner to obtain and submit recommendation back to supervisor for final review before the letter can be mailed (recommendation back to supervisor documented in PACS?)

* If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request

2. If supervisor agrees with denial:

    a. Letter mailed
    b. Employee called to advise of denial

III. Employee Not Due Benefits per Plan Provisions – all other denial types

Denial type:

a. Medical records not received
b. Medical records do not support

    i. Medical records are defined as:
        1. All chart notes,
        2. Narrative reports,
        3. Diagnostic testing and

    ii. The disability form.
        1. The disability form states the first date the employee was taken off of work and the estimated return to work date.
        2. It also outlines treatment dates – past and future, diagnosis(es) and diagnosis codes

1. Stop medical reach out process, if previously initiated

2. Draft denial letter – required contents:

    1. Introduction
    2. Claim History
    3. Plan Provisions
    4. Medical and File Information Reviewed
    5. Clinical Judgment or Rationale
    6. Conflicting Disability Opinions
    7. Social Security Administration Determination
    8. Appeal Rights
    9. What is Needed to Perfect Your Claim for Benefits

10. Copies of Documents and Disability Claims and Appeals Handling Guidelines
11. Closing Paragraphs – Conclusion

3. Draft plan of action for file documentation for recommendation to deny the claim and submit to supervisor with draft denial letter

    a. Plan of action (POA) based on circumstances of the file using the following format:
    b. S.O.A.P. notes
    c. Subjective
    d. Objective
    e. Assessment
    f. Plan – what we are doing and why

4. Supervisor reviews draft letter for:

    a. Agreement with decision to deny
    b. Appropriate content
    c. Required ERISA content, including language regarding experimental treatment*
    d. Plan language
    e. Steps taken
    f. Medical records reviewed
    g. Should the supervisor request clarification of any claim facts for the letter the examiner to obtain and submit recommendation back to supervisor for final review before the letter can be mailed
    h. Examiner documents next and final steps in claim system

* If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request

5. If supervisor agrees with denial:

    a. Letter mailed
    b. Employee called to advise of denial

IV. Appeals – all claim types – STD and LTD – Self Funded Programs

1. Appeal received:

    a. Appeals can be verbal; written confirmation is required
    b. Appeals are accepted by fax, in writing through the mail or by email

2. Notice sent to employer and employee

3. Appeal set up in Matrix claim system

4. Appeals are reviewed by Matrix staff that did not review the original denial in the claims team.

    a. The Matrix appeal staff is separate from operations
    b. Appeals are reviewed under a *de novo* review
    c. *De novo* is defined as: complete and new review of all materials from the start, without any deference to the prior review or determination

5. Initial review:

    a. Was the appeal timely per Plan language
    b. Verify the correct plan is in the claim file
    c. If appeal is timely continue appeal review
    d. Determine type of denial - appeal
        i. Eligibility under the plan
        ii. Employee not due benefits per Plan provisions – all other appeal types

6. Contact employee by phone or email per employee's stated request at Intake

    a. Confirm employee's appeal information outlined in appeal request
        i. Is there additional information to be sent?
        ii. If so, confirm time frame the new information is to be sent
    b. Advice the employee Matrix will reach out one time for missing medical information
    c. Confirm all diagnoses the employee feels is disabling
    d. Confirm work status

e. Confirm all providers and medication
f. Confirm next medical appointments

7. Send out requests for medical records after discussion with employee if appeal activity to continue

8. Eligibility determination – verify against Plan provisions:

a. Employee is employee of Matrix client (client data feed)
b. Employee's dates of service
c. Gaps in employment that affect eligibility
d. Service waiting period met

9. Review circumstances of the appeal – is it covered by the Plan?

a. Did the employee meet the claim waiting period?
b. Is there continuous lost time?
c. If not, does the Plan cover part-time work loss?
d. Is the employee covered under the Plan for the initial date of disability?
e. Is the diagnosis or circumstances of the claim excluded by the Plan? Examples: cosmetic surgery, occupational injuries.
f. Is the treating provider(s) as defined under the Plan per the physician definition? Examples: a physician, surgeon, dentist, podiatrist, practitioner, psychologist or other Health Care Professional, who is duly licensed and acting within the scope of his or her practice.
g. If employee eligible under the Plan, continue the appeal process
h. If not eligible under the plan, review for uphold of the prior denial
i. If claim initially denied for no medical received, see Section VI.

10. If appeal is late per Plan language:

a. Are there extenuating circumstances allowed by the plan?
    i. Contact employer if required to clarify any information
    ii. Check the due date of the appeal compared to national holidays where the post office may be closed
b. If there are extenuating circumstances, continue appeal review
c. If no extenuating circumstances, review for uphold of the prior denial

11. Complete initial appeal plan of action for file documentation

    a. Plan of action (POA) based on circumstances of the claim file and appeal using the following format:

        i. Subjective
        ii. Objective
        iii. Assessment
        iv. Plan – what we are doing and why

12. Set system tasks for appeal follow up activities

    a. Task for anticipated receipt of new information – 14 calendar days from request
    b. Task around next medical appointment – next business day after the medical appointment
    c. Task for appeal due date – one week before due date
        i. Appeal due date based on plan language and/or
        ii. ERISA guidelines

V. Employee Not Eligible under the Plan – Claim Decision Upheld in Appeal Review

1. Stop medical reach out process, if previously initiated

2. Draft uphold letter – required contents:

    1. Introduction
    2. Claim and Appeal History
    3. Plan Provisions
    4. File Information Reviewed
    5. Appeal Decision Rationale
    6. Appeal Rights if the Plan allows for a second level of appeal
    7. What is Needed to Perfect Your Claim for Benefits if the Plan allows for a second level of appeal
    8. Copies of Documents and Disability Claims and Appeals Handling Guidelines
    9. Closing Paragraphs – Conclusion

3. Draft plan of action for file documentation for recommendation to deny the claim in appeal review and submit to supervisor or sr. appeals specialist as back up

    a. Plan of action (POA) based on circumstances of the file using the following format:

        i. S.O.A.P. notes
            1. Subjective
            2. Objective
            3. Assessment
            4. Plan – what we are doing and why

4. Supervisor reviews draft letter for:

    a. Agreement with decision to uphold prior denial
    b. Appropriate content
    c. Required ERISA content*
    d. If the supervisor requests clarification of any appeal facts for the letter, the examiner to obtain and submit recommendation back to supervisor for final review before the letter can be mailed

* If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request

5. If supervisor agrees with uphold:

    a. Letter mailed
    b. Employee called to advise of uphold in appeal review

VI. Appeal Reconsideration Review – New Medical Received

1. If the claim was denied due to no medical having been received at all and the employee appeals and sends in the missing medical, or the employee only sends in the missing medical with no appeal:

a. The appeal is reviewed for reconsideration review and sent back to the claims team
b. If after the claims team completes the review and the claim is denied the employee will be given new appeal rights and the process starts over
c. If the medical comes in to the claims team first and is new information with no appeal the claims team can review and if appropriate approve the claim;

    i. If new medical received with no appeal the claims team calls the employee to advise the medical was received, ask if that represents the appeal or if the employee would like to have the claims team review the medical first to see if benefits may now be appropriate
    ii. If the employee indicates it is his/her appeal during this discussion the claims team will ask the employee to confirm their appeal in writing
    iii. Verbal appeals are accepted with written confirmation required

2. Notice of new or additional evidence or rationales before appeal adjudication

    a. An employee must be notified of and provided an opportunity to respond to any new evidence or rationales developed by the Plan during the review of the appeal

        i. Internal or external medical review
        ii. Matrix clinical team including the Matrix Medical Director
        iii. External Peer Reviews
        iv. External Independent Medical Examinations (IME's)

    b. The appeal decision will be tolled – in other words the due date for the appeal decision will temporarily be suspended while the employee is allowed to review the new information or medical opinion developed during the appeal review

    c. The employee will be given up to fourteen (14) calendar days to complete the review or supply new information to rebut the findings of any new evidence
        i. On calendar Day 15, if no additional evidence submitted, the appeal decision will be finalized

        ii. On calendar Day 15, if additional evidence submitted, tolling will be removed

1. Matrix will send a letter at the 15 calendar days to advise the employee the status of their appeal as well as the new, revised appeal decision due date
2. The information submitted by the employee will be reviewed to determine next steps which may include another medical review.
3. Another 14 day tolling period maybe applicable for the employee to review additional findings

VII. **Next Steps – Medical Records and any Other Information Obtained or Sent with the Appeal Reviewed**

1. Ongoing Appeal Review

    a. All information is not received by due date

        i. Appeal specialist makes one follow-up call to employee
        ii. Pending extenuating circumstances employee may be given additional time to submit medical if the plan allows for it

2. All information received:

    a. Assess for medical review
    b. If it appears the medical supports appeal specialist can make decision using Official Disability Guidelines (ODG) guidelines as a resource or complete Matrix clinical walkup review pending clinical availability
    c. Many claim denials are round tabled with the Matrix medical director who therefore cannot be involved in appeal reviews per Matrix best practice and ERISA guidelines
    d. Appeal specialist staffs with direct manager or team backups as needed
    e. If it is not clear that the medical supports per plan requirements and job/occupation requirements the appeal is referred for an external medical review – peer review or in some cases an independent medical examination (IME) or functional capacity exam (FCE)
    f. If the medical and vocational reviews support an uphold, the employee must be given the opportunity to review the material to allow for rebuttal or to submit new information, see VI B above

3. Tolling and Extensions on Appeal Review – per Plan provisions:

a. Should additional time be required in which to review the employee's request, the employee will be notified on or before the date the forty-five (45) day period expires
b. The extension notification sent to the employee will indicate:
    i. The special circumstances requiring an extension, and
    ii. The date and time by which the Plan Administrator expects to render a determination on review
c. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received unless specific circumstances warrant a tolling of the time limits and additional time for review and determination

VIII. Employee Not Due Benefits per Plan Provisions – all other denial types – Claim Decision Upheld in Appeal Review

Denial type:

a. Medical records not received
b. Medical records do not support

    i. Medical records are defined as:
        1. All chart notes,
        2. Narrative reports,
        3. Diagnostic testing and

    ii. The disability form.
        1. The disability form states the first date the employee was taken off of work and the estimated return to work date.
        2. It also outlines treatment dates – past and future, diagnosis(es) and diagnosis codes

1. Stop medical reach out process, if previously initiated

2. Draft uphold letter – required contents:

    1. Introduction

2. Claim History
3. Plan Provisions
4. Medical and File Information Reviewed
5. Clinical Judgment or Rationale
6. Conflicting Disability Opinions
7. Social Security Administration Determination
8. Appeal Rights
9. What is Needed to Perfect Your Claim for Benefits
10. Copies of Documents and Disability Claims and Appeals Handling Guidelines
11. Closing Paragraphs – Conclusion

3. Draft plan of action for file documentation for recommendation to uphold the denial on the claim and submit to supervisor with draft denial letter

    a. Plan of action (POA) based on circumstances of the file using the following format:

        i. S.O.A.P. notes
            1. Subjective
            2. Objective
            3. Assessment
            4. Plan – what we are doing and why

4. Supervisor reviews draft letter for:

    a. Agreement with decision to uphold the denial
        ii. Appropriate content
        iii. Required content
            1. Plan language
            2. Steps taken
            3. Medical records reviewed
            4. Required ERISA content*

    * If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request

b. Should the supervisor request clarification of any claim – appeal facts for the letter the appeal specialist to obtain and submit recommendation back to supervisor for final review before the letter can be mailed

5. If supervisor agrees with uphold:

    a. Letter mailed
    b. Employee called to advise of the uphold of the prior denial

IX. Second or Third Level Appeals

- Matrix can support second or third level (voluntary appeals if allowed under the Plan) appeals for any client's STD or LTD self funded plans that call for a second or third level of appeal.
- The process is the same as outlined above.
- Different staff review second level or third level appeals following ERISA and plan guidelines

X. The Final Uphold Letter in Appeal Review

1. The final uphold letter in appeal review will include the following information:
    a. A statement of the right to bring a civil action
    b. Time limits for filing such action as imposed by the Plan
    c. The due date for filing such action as imposed by the Plan

NOTICE OF LANGUAGE ASSISTANCE SERVICES

语言协助服务通知 (Chinese)

SAAD BEE ÁKÁ E'EYEED NIHÁ HÓLǪ́ (Navajo)

AVISO SOBRE LOS SERVICIOS DE ASISTENCIA LINGÜÍSTICA (Spanish)

ABISO SA MGA SERBISYO NG TULONG SA WIKA (Tagalog)

If you need language assistance in translating this letter, language interpretation during phone calls, or language assistance for any other matters relating to your claim, please call.

如果您在翻译本函时需要语言协助，在通话期间需要语言口译，或需要与您理赔有关任何其它事宜的语言协助，请致电。**(Chinese)**

Haada yit'éego díí naaltsoos nich'į' ályaaígíí t'áá shizaad k'ehjí shich'į' yídóoltah nínízingo dóó t'áá shizaad k'ehjí choo'įį dooleeł nínízingo t'áá ha'át'íhí da kwe'é bídéét'i'ígíí biniiye kojį' hodiilnih. **(Navajo)**

Si necesita asistencia lingüística para traducir esta carta, servicios de interpretación durante llamadas telefónicas o asistencia con cualquier otro asunto relacionado con su reclamo, llámenos. **(Spanish)**

Kung kailangan mo ng tulong sa wika sa pagsasalin sa liham na ito, pasalitang pagsasalin sa wika sa panahon ng mga tawag sa telepono, o tulong sa wika sa anumang ibang mga usapin sa iyong paghahabol, pakitawagan ang. **(Tagalog)**