Decoding the Revenue Cycle: Benchmarks That Drive Practice Performance

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2026 Community Oncology Conference

Innovation in Practice

Benchmarking Your Revenue Cycle

COA Annual Meeting

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- April 28, 2026
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Disclaimer and Introductions

- Nothing in this presentation is to promote off-label use of any particular product or service.
- No drug manufacturer sponsored this program or promoted use of products for this webinar. Thus brand names are used where applicable.
- Benchmarks are just suggestive. Your payer mix or patient acuity may significantly impact your numbers and they may differ from what is seen herein.
- This seminar is suggestive and is not consulting or legal advice.
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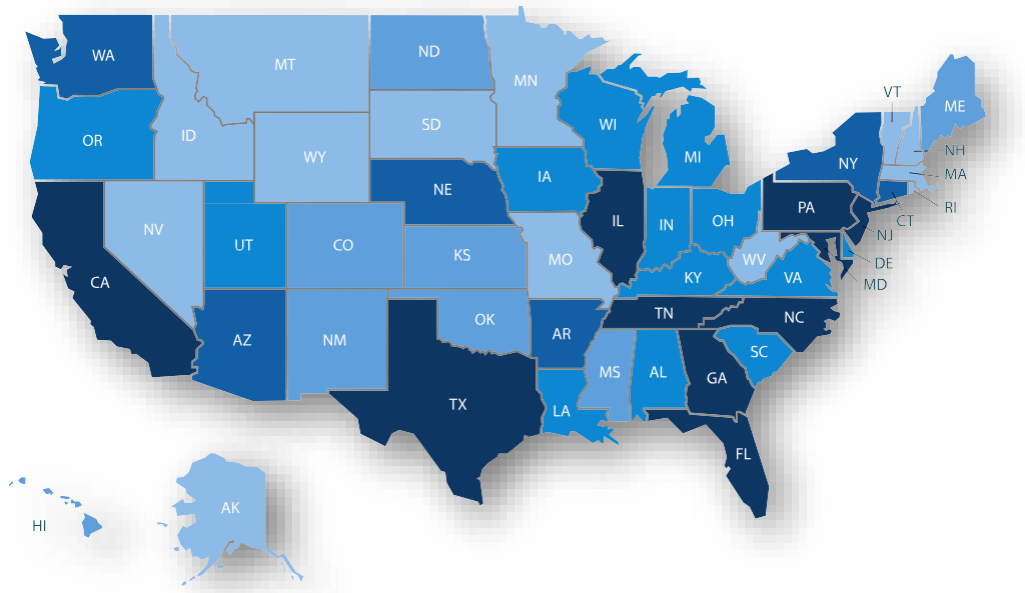
Agenda

- focalPoint Data Set
- Why Do or Don't Benchmarks Matter?
- The Revenue Cycle: Where Are We?
  - Accounts Receivable Aging
  - Days to Pay
  - Days to File
  - Collection Rates/ Contractual Adjustments
  - Profiling
  - Denials
- Utilization
  - Care Management
  - RPM/RTM
- Appendices
  - Hall of Shame
  - Clean Claims
  - State Statistics
  - Denials by Service
  - Appeals: MA and Part D

Learning Objectives

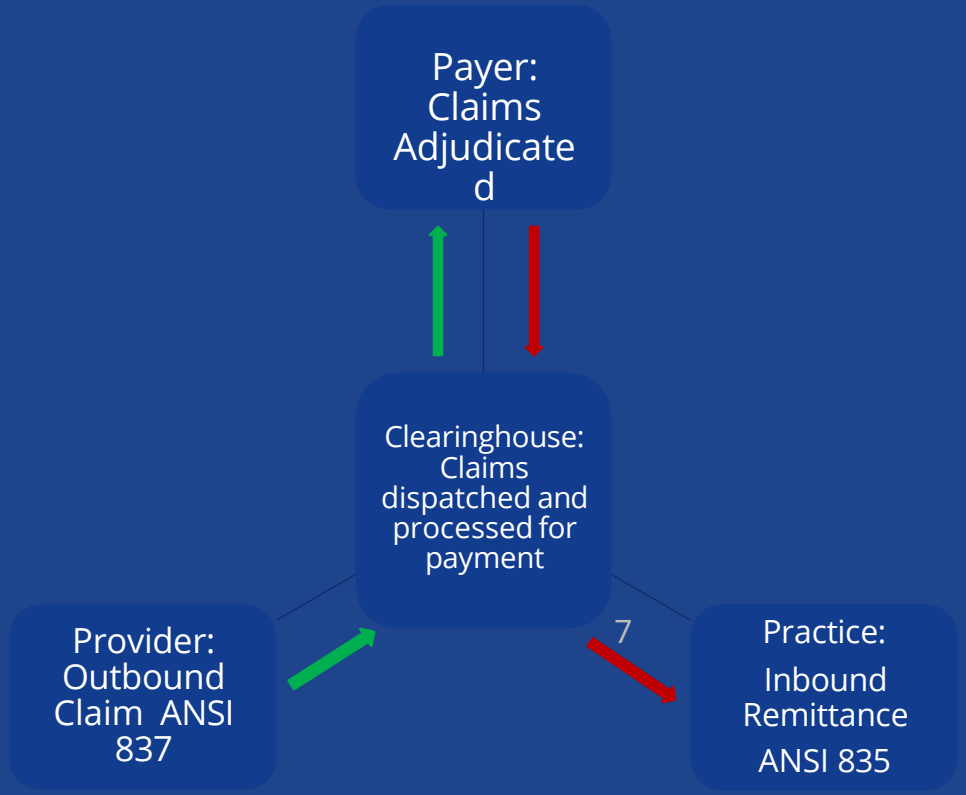
- Explain the steps in the Revenue Cycle and where roadblocks can occur to jeopardize cash flow.
- Discuss Revenue Cycle benchmarks that can be used by Cancer Practices to improve billing processes.
- Provide national- and state-level benchmarks that can help practices gauge the quality of their billing practices.
- Demonstrate participation by practices in Care Management and Remote Management

focalPoint 2025 Data Represents 160+ Cancer Centers, 725 sites of service, 498 payers and 2,200 Hematologists and Oncologists



Metrics for 4/1/2025-3/31/26	Total for Drugs
Payer responses to claims (includes submission and resubmissions)	6,764,012
Distinct patients	534,557
Distinct claims	2,635,985

focalPoint's relationship is with the clearinghouse



focalPoint Data Sets

- National Services Data = Insurance Only Data April 1, 2025 – March 31,2026
- The above are **RESPONSE DATES**
- Collects data on
  - Allowed Amounts
  - Non-Reimbursed Amounts
  - Clean Claims
  - Days To Pay
  - Days to File
  - Claims Adjustment Codes (CARCs) which we will refer to herein as Denial codes
  - Remittance Advice Remark Codes (RARCs) which we will refer to as Reason codes
- Does not collect data on
  - *Statistics for individual practices, UNLESS requested by the practice*
  - *Prescribing behavior of providers*

The Revenue Cycle: Why, How, and Don’t

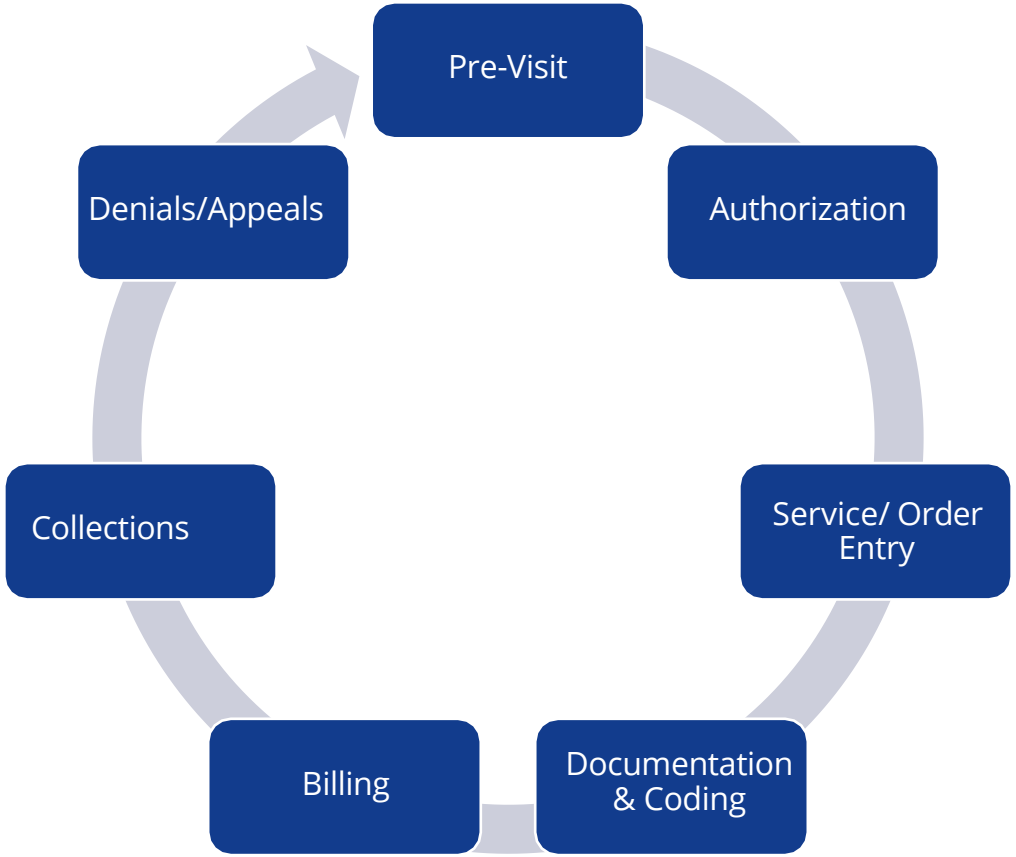
Why Do RCM Benchmarks Matter?

- **Identify Financial Leaks and Inefficiencies**: Benchmarks highlight bottlenecks—such as high denial rates or long A/R days—that cause revenue loss and declines in daily cash.
- **Improves Cash Flow & Reimbursement Speeds**: By tracking metrics against best-practice standards (e.g., A/R days between 30–40), organizations can reduce the time between service delivery and final payment.
- **Proactive vs. Reactive Management**: Instead of discovering financial issues at the end of the year, tracking KPIs like first-pass yield allows for immediate corrective action.
- **Increases Staff Productivity & Accountability**: Benchmarking provides clear targets, helping staff focus on reducing avoidable denials—which now make up 50%+ of all Community Oncology denials—and improving coding accuracy.

When Don't RCM Benchmarks Matter?

- **Cybercrime Attacks—**The first Iranian cyberattack was on a healthcare company. Cyberattacks and ransomware are ubiquitous in our business. This data was subject to one!
- **Type of Facility**—Hospital-owned facilities often have higher A/R due to a disjointed billing process and/or higher dollar claims.
- **Staffing—**Larger practices may have centralized billing which has more people than a 2-3 doctor practice. Staff that is functionally diluted, i.e. wears many hats, is not as efficient.
- **Gene Pool—**Experienced billers and/or coders are not available.

The Billing Cycle: Average Office



Roadblocks Created Pre-Visit and Front Desk

- ✓ Inaccurate or Out of Date Demographics.
- ✓ Patient Registered Under a Different Name than on Insurance Card.
- ✓ Poor insurance verification or lack thereof
- ✓ Relationship of Patient to policyholder error.
- ✓ Failure to ascertain insurance or employment change.
- ✓ Wrong payer order
- ✓ Date of Birth (DOB), Social Security Card, Charge Card, Insurance #s missing or wrong or transposed
- ✓ Payer website not updated.
- ✓ Medicare Secondary Payer Questionnaire.
- ✓ Workers' Comp-related Cancer

Roadblocks When Services are Provided

- ✓ Documentation does not support E/M billed or does not meet -25.
- ✓ Documentation supports only non-specific ICD-10-CM codes.
- ✓ Up/down times not recorded.
- ✓ Medical necessity guidelines/payer pathways for drug or service not followed.
- ✓ Prior auth not obtained or still in peer-to-peer or medical exception..
- ✓ Poor documentation of on-site or remote supervision.
- ✓ Billing system not updated with current CPT/HCPCS/ICD-10 codes
- ✓ New Authorization or referral needed due to # of units/visits already used or Auth/referral expired or new HCPCS
- ✓ Not all charges or drug units captured.

Roadblocks in Claims Processing

- Providers and/or specialty not set up correctly in payer system.
- Incomplete prior authorizations or mismatching claim to PA.
- Wrong information submitted or submitted for the wrong patient.
- Submitting Duplicate Claims rather than working the claim.
- Missing or incomplete patient information requested by payer.
- Claim submitted to wrong payer—primary or secondary
- Transposed NDCs or incorrect UOM (BCBS).
- Drugs billed beyond MUE limit.
- Conflicts with payer's business rules/LCD/NCD.
- Functional dilution—too many hats per person

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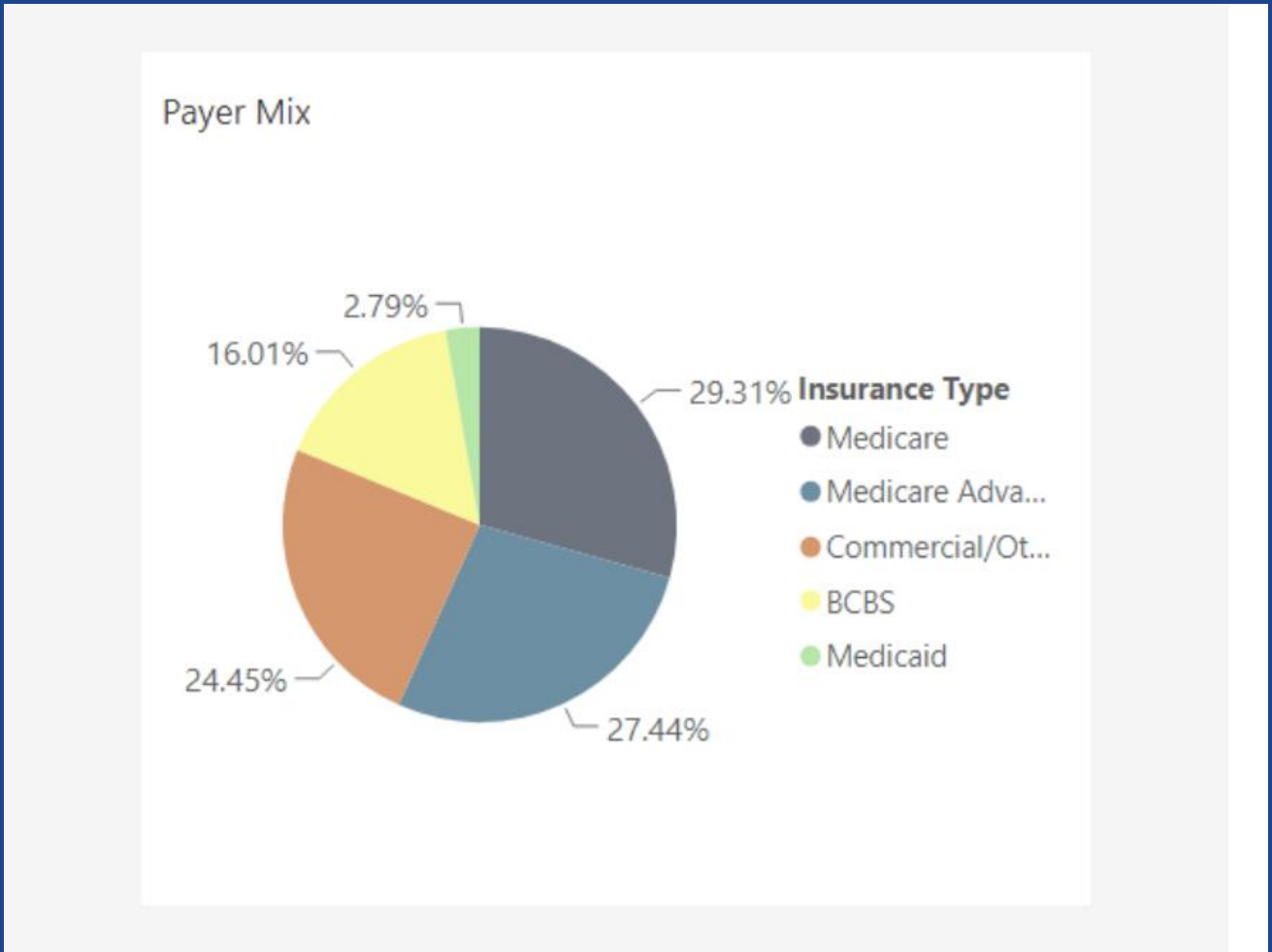
Roadblocks to Collections/Payments

- Errors in posting payments and adjustments.
- Not having a firm Conditions of Admission with patients, incurring bad debt.
- Not collecting co-pays, deductibles and co-insurance amounts at the time of service.
- Not having checks & balances with your billing company.
- Not enforcing or following up with self-pay payment plans or financing.
- Not sending statements in a timely manner. (with a return envelope)
- Not running statement addresses through change of address software
- Not having e-statement options, payment reminder, and additional bill pay options online, including financing
- Not sending patients to collection per practice policy.
- Clinicians not supportive of collections.

Benchmarking for Revenue Cycle Improvement

Payer Mix focalPoint Database of U.S. Office – Administered Drugs Q1



Why Care About Patient Mix?

- Medicare tends to pay faster with less denials. So, if you have more Medicare than average
  - Your A/R should be less than average
  - Your Days to Pay should be shorter
  - But your secondary and patient balances may be slower
- Commercial/MA accounts may have
  - More denials due to prior authorization
  - May have higher Days to File due to Peer-to-Peer/ Medical Exceptions
  - May have higher Days to Pay due to lack of statutory requirement for clean claims (varies by state in terms Prompt Pay Laws)

Revenue Cycle Metrics

A/R Balance and A/R Days

- Measure of overall A/R performance
- Days to Pay for Insurance ONLY (DRUGS)
- A/R for Patient Balances
- Average Daily Cash $

Billing Work in Process

- Measure of accounts that are prevented from being billed the first time by cause
  - Days to Prior auth metric
  - More info: NDC, Diagnosis guidelines, etc.
  - Coding
  - Dictation
  - Audit
- Days to File is a key metric

Follow-up Work in Process

- Measure of accounts that have been filed and not paid
- Measure accounts with "delays" (CARC codes 16, 197, 226, 251, 252, et al)
- Measured at unit and individual employee level

A/R Aging from Date of Service

- Measure of aging of accounts; stratified by dollar amount and age
- Drug claim velocity should be measured from the date that you pay for your drugs (Drug claims > 30 days)
- Analysis of aged accounts by $ can support staff resource allocation
- If you are focused on accounts at 120+ days, it's too late to resolve issues in a timely manner

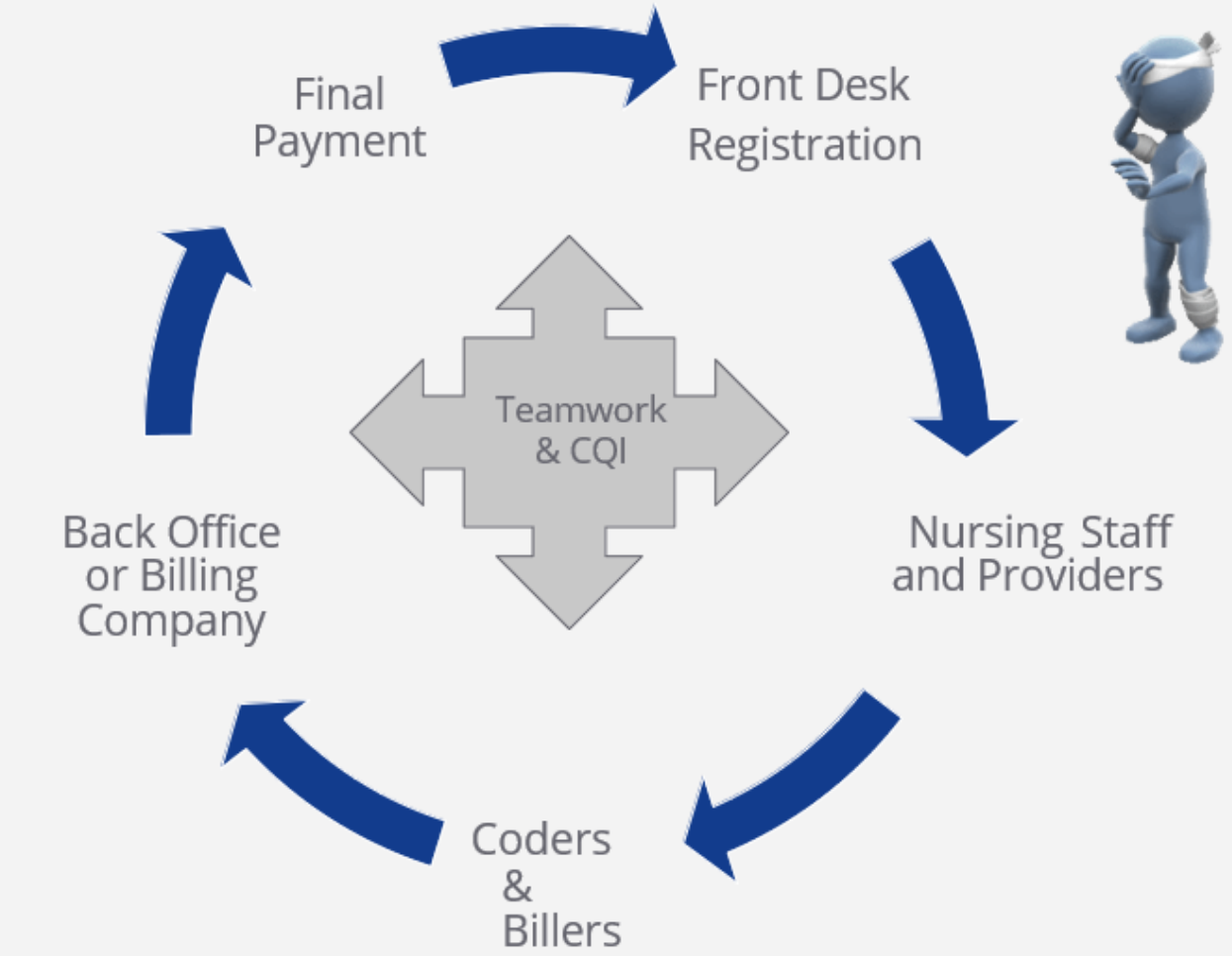
So What You Should You Look At?

- Accounts Receivable from Date of Service
  - A/R for Insurance Only (Primary)
  - A/R for drug claims only
  - A/R Patient Balances
- Average Daily Cash (Total Cash Collected 2026/# of Working Days 2026)
- Days to File (Days from Service to Filing)
- Days to Pay (Days from Service to Insurance Payment)
- Denial Reasons (Claims Reason Adjustment Codes)
- Clean Claims: Claims Paid At First Submission
- Net Collection Percentage (All Collections/ (Charges-Contractual)
- Average Patient Responsibility (Commercial)
- E/M Profiling, once per year, unless there are problems

How Should You Look At Stats?

- Accounts Receivable from Date of Service
  - A/R for Insurance Only (Primary)
  - A/R for Non-Primary
  - A/R Patient Balances
- Average Daily Cash
  - By Payer Class
  - By Personnel Section
- DTF/DTP
  - By Payer Class
  - By Type of Service
  - By Provider
- Clean Claims
  - By Biller
  - By Payer Class

Create A Feedback Loop to Ensure Performance Improvement in your Revenue Cycle



Part B Accounts Receivable: Insurance Across U.S. 4/1/2025-3/31/2026

Caveats

- Patient portions not all captured in terms of collections
- All patient program coverage may not be captured

In terms of line items in A/R

- 0-30 Days = 64.54%
- 31-60 Days = 21.34%
- 61-90 Days = 4.66%
- 91-120 Days = 2.66%
- 120+ Days = 6.80%

In terms of $ in A/R

- 0-30 Days = 71.94%
- 31-60 Days = 20.33%
- 61-90 Days = 3.57%
- 91-120 Days = 1.52%
- 120+ Days = 2.64%

Days to File By Service (Without Outliers) 2025-2026

DTF	Service
10.68	Overall Days to File
11	Rad Onc Days to File
9	Imaging Days to File
10	E/M Days to File
9	Drugs Days to File

U.S. Days To Pay Without Outliers 2025-2026 by Service

Days to Pay	Service
31	Overall Days to Pay
34	Rad Onc Days to Pay
32	Imaging Days to Pay
32	E/M Days to Pay
24.5	Drugs Days to Pay

Denials 2025-2026 Cancer Services

Overall Denial Rates 2025-2026

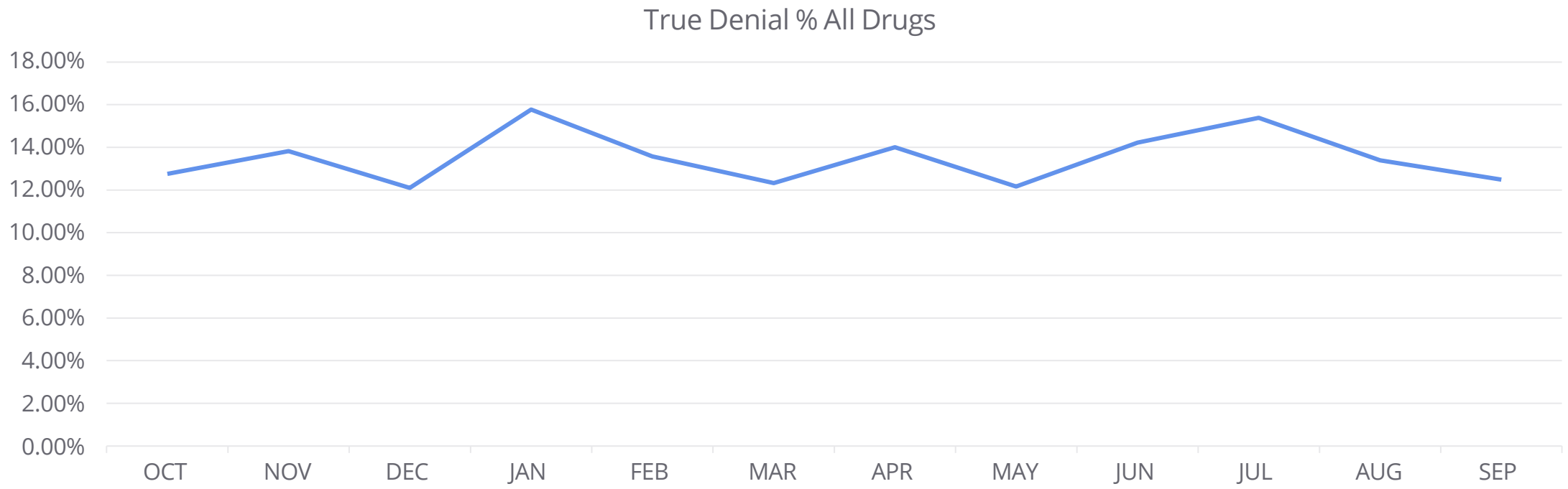
Type	Denial Rate
Imaging	16.55%
E/M	12.88%
Radiation Tx*	14.86%
Drugs	10.18%
Overall	16.59%

*--Mostly old codes

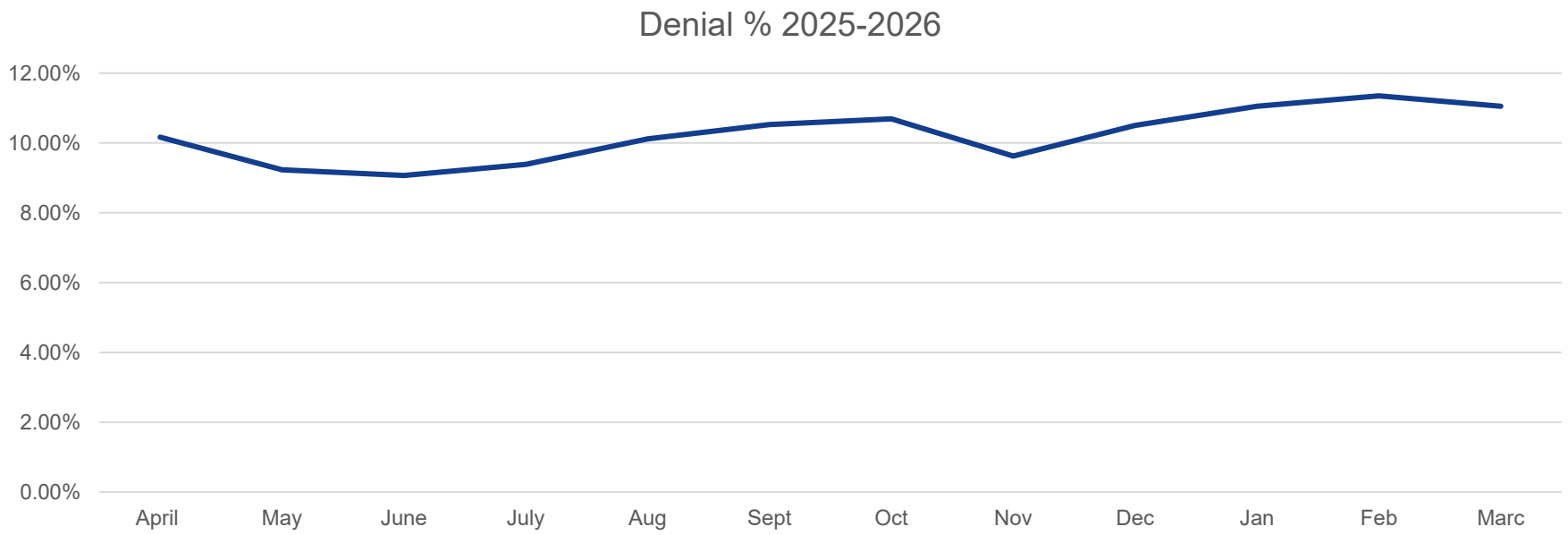
Top 10 2025-2026 Denials for All Services

Code	Definition	lineitems	Category
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	939,315	Overall
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	598,646	Overall
96	Non-covered charge(s).	435,294	Overall
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	298,438	Overall
22	This care may be covered by another payer per coordination of benefits.	257,616	Overall
252	An attachment/other documentation is required to adjudicate this claim/service.	257,018	Overall
197	Precertification/authorization/notification absent.	228,448	Overall
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	219,637	Overall
50	These are non-covered services because this is not deemed a "medical necessity" by the payer..	211,052	Overall
29	The time limit for filing has expired.	206,779	Overall

Drug Denial Trends 2019-2020



Drug Denial Trends 2025-2026



Way to Go, Billing People!!!

Top Ten Drug Denial Codes 2025- 2026

Reason Code	Count Denials	Group-Reason Definition	Percentage of Denials
16	132,878	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	24.89%
197	76,689	Precertification/authorization/notification absent.	14.37%
252	51,232	An attachment/other documentation is required to adjudicate this claim/service.	9.60%
96	34,945	Non-covered charge(s).	6.55%
B11	33,126	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	6.21%
216	33,061	Based on the findings of a review organization	6.19%
29	24,595	The time limit for filing has expired.	4.61%
50	23,634	These are non-covered services because this is not deemed a "medical necessity" by the payer..	4.43%
22	22,329	This care may be covered by another payer per coordination of benefits.	4.18%
109	21,725	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	4.07%

Filing Deadlines for Commercial/MA Payers

Payer	Typical Filing Deadline
Medicare	12 months from the date of service
Medicaid (varies)	90–365 days (state dependent)
UnitedHealthcare	90 days (some allow 180)
Aetna	90–180 days
Cigna	90–180 days
Blue Cross Blue Shield	180–365 days (varies by region)
TRICARE	1 year
Kaiser Permanente	90 days
Workers' Comp	30–90 days (varies by carrier/state)

Check Your Contracts and State Laws!!!

https://cadencecollaborative.com/blog/medical-billing-time-limits-by-state/#:~:text=Typical%20Filing%20Deadline-,Medicare,Proof%20of%20eligibility%20verification

Top (N ≥ 1000 claims) Payers Most Zero (> 180 Days) Paid Claims Over The Last Year

Insurance Name	Patients	Claims	Payer Responses	Denial Percent	Zero Paid Claims	Zero Paid Percent
LOUISIANA HEALTH CONNECTIONS	266	1,705	10,124	15.75%	348	20.41%
United Healthcare PPO One	1,119	3,938	6,437	14.23%	417	10.59%
CALIFORNIA MEDI-CAL	394	1,539	9,852	18.79%	151	9.81%
CAL OPTIMA DIRECT	668	2,893	12,567	25.10%	244	8.43%
ANTHEM BLUE CROSS	1,656	6,810	32,957	33.08%	399	5.86%
ALTAMED	560	1,929	5,218	26.79%	96	4.98%
ALIGNMENT HEALTH CARE	706	2,561	9,896	33.68%	117	4.57%
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	1,264	4,697	14,038	15.61%	211	4.49%
ALLIANCE IPA	526	3,254	9,355	25.93%	137	4.21%
Cal-Optima Direct	487	1,557	5,635	22.93%	64	4.11%
HEATLHCARE LA, IPA	1,460	7,062	17,783	6.65%	268	3.79%
Molina Healthcare California	695	2,737	8,443	23.26%	103	3.76%
ARIZONA COMPLETE HEALTH	582	2,070	8,067	23.78%	76	3.67%
Presbyterian (Medicare Advantage)	410	1,548	3,674	10.04%	48	3.10%
FLORIDA MEDICAID	555	2,068	12,169	27.32%	61	2.95%
Premera BC Washington	488	2,068	6,104	11.70%	61	2.95%
BCBS New Mexico	741	3,192	10,324	13.13%	93	2.91%
NEBRASKA TOTAL CARE	482	2,252	9,377	22.80%	65	2.89%
Molina Healthcare (Medicaid IL MCO)	452	1,691	6,347	11.11%	48	2.84%
INLAND EMPIRE HEALTH PLAN - DOS AFTER 3/31/18	861	3,523	11,198	15.23%	96	2.72%
GEORGIA BCBS	2,201	9,095	24,966	32.21%	240	2.64%
Medicare New Mexico	1,409	6,289	14,802	5.44%	163	2.59%
Medicare Arizona Part B	1,294	4,404	10,742	9.44%	110	2.50%
CALIFORNIA BLUE CROSS	995	4,133	14,662	23.46%	100	2.42%
Anthem BC California	2,880	10,225	27,359	27.06%	245	2.40%
Blue Cross Illinois (Medicare Advantage)	711	2,634	5,583	6.39%	63	2.39%
DEVOTED HEALTH	971	4,533	17,415	20.36%	106	2.34%
HORIZON NJ HEALTH	443	2,141	5,716	18.44%	50	2.34%
TENNESSEE BLUECARE	971	3,311	9,956	18.30%	72	2.17%
Wellmark BCBS Iowa	438	1,917	5,353	22.83%	40	2.09%
Medicaid California (Medi-Cal)	390	1,775	9,018	12.35%	37	2.08%
SANTE COMMUNITY PHYSICIANS MEDICAL GROUP CORP	621	1,688	4,103	40.26%	35	2.07%

Top 10 Drug Denial Reason (RARC)Codes 2025-2026

Remark Code	Count Denials ▼	Remark Code Definition
N816	22,092	Missing/Incomplete/Invalid NDC Unit of Measure
M119	15,932	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
N822	14,710	Missing procedure modifier(s).
M127	11,110	Missing patient medical record for this service.
N381	10,578	Consult our contractual agreement for restrictions/billing/payment information related to these charges.

Unit of Measure for NDC Billing

- Blue Cross/Blue Shield has been editing the NDC Loop Unit of Service (not the J-code units). You can see this under CARC code 16 and RARC code N816
  - Proper Units of Measure include:
    - UN (Unit) – Powder-filled vials for injection (needs to be reconstituted), pellet, kit, patch, tablet,
    - device
    - ML (Milliliter) – Liquid, solution, or suspension
    - GR (Gram) – Ointments, creams, inhalers, or bulk powder in a jar
    - F2 (International Unit) – Products described as IU/vial, or micrograms
  - TEXAS BCBS: ME is also a recognized billing qualifier that may be used to identify milligrams as the NDC unit of measure; however, drug costs are generally created at the UN or ML level. If a drug product is billed using milligrams, it is recommended that the milligrams be billed in an equivalent decimal format of grams (GR). BCBSTX allows up to three decimals in the NDC Units (quantity ornumber of units) field
  - ANTHEM: Allows ME on claims
- **Check your BCBS!**

United's Confusing Waste Policies

- United's policies vary by plan and, for Medicaid, by the State:
  - United Medicare Advantage requires –JW, -JZ
  - United Commercial requires –JW
  - United Community Health Plans require –JW, -JZ EXCEPT

UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
CMS-1500 and UB-04
Policy Number 2026R6004B

State Exceptions	
Colorado	Colorado Medicaid does not recognize modifier JZ on Professional or Facility claims therefore the portions of the policy related to JZ modifier do not apply.
Indiana	Indiana Medicaid does not recognize modifier JZ on Professional or Facility claims therefore the portions of the policy related to JZ modifier do not apply.
Kansas	Kansas Medicaid is exempt from this policy.
Kentucky	Kentucky Medicaid is exempt from this policy.
Maryland	Maryland Medicaid recognizes modifier JZ on professional claims only. JW modifiers are to be allowed on professional, and facility claims.
Michigan	Michigan Medicaid is exempt from this policy.
Missouri	Missouri Medicaid is exempt from this policy.
New Jersey	New Jersey is exempt from this policy.
North Carolina	North Carolina Medicaid is exempt from this policy.
Virginia	Virginia Medicaid does not recognize modifier JZ on Professional or Facility claims therefore the portions of the policy related to JZ modifier do not apply.
Washington	Washington Medicaid is exempt from this policy.
Washington DC	Washington DC is exempt from this policy.
Wisconsin	Wisconsin Medicaid does not recognize modifier JZ on Professional or Facility claims therefore the portions of the policy related to JZ modifier do not apply.

Top ICD-10-CM Denied Codes
OA Drugs CO-50 Q1 2026

ICD Codes

Diagnosis	Distinct Patients	Distinct Claims	Days To File	Days To Pay	Denial Percent	Dx Description
N18.32	659	1,216	54.70		100.00%	Chronic kidney disease, stage 3b
D50.9	597	1,125	40.08	62.80	99.58%	Iron deficiency anemia, unspecified
N18.4	511	917	53.91	22.00	99.92%	Chronic kidney disease, stage 4 (severe)
D46.9	468	904	28.83		100.00%	Myelodysplastic syndrome, unspecified
N18.31	409	670	41.82	42.00	99.88%	Chronic kidney disease, stage 3a
D64.81	337	656	115.49		100.00%	Anemia due to antineoplastic chemotherapy
Z51.11	270	505	44.62	64.00	99.53%	Encounter for antineoplastic chemotherapy
D64.9	302	458	28.32		100.00%	Anemia, unspecified
N18.30	225	406	33.52		100.00%	Chronic kidney disease, stage 3 unspecified
D50.8	184	368	47.07		100.00%	Other iron deficiency anemias
D63.1	202	347	73.35		100.00%	Anemia in chronic kidney disease

SNAPSHOT: Radiation Oncology 2026 (Until 3/31/2026)

Radiation New Codes

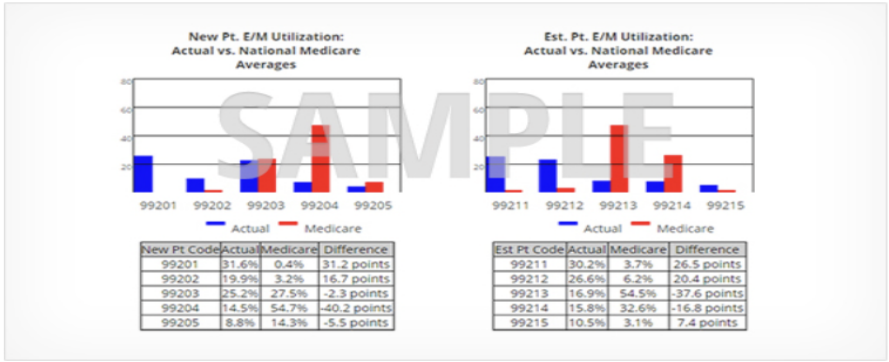
ProcedureCode	DaysToFile	DaysToPay	DenialRate	CleanClaimPercentage
77387	8	24	30.43%	67.27%
77402	6	21	14.27%	81.56%
77407	7	22	19.32%	78.83%
77412	9	22	16.13%	80.86%
77436	11	22	16.94%	34.11%
77437	10	21	5.73%	39.21%

E/M Profiling 2025-2026

E/M Utilization Benchmarking Tool

This tool is provided to compare a physician's, or an entire practice's, evaluation and management (E/M) CPT code utilization to peers in the same specialty. The distribution of utilization by code within each E/M subcategory is benchmarked to the distribution of paid Medicare claims for physicians in the same specialty nationally (based on published 2021 Medicare Part B data).

Remember that the data is useful with some precautions. It is provided by specialty and shows how physicians are using E/M codes. The expected use of any E/M code range is a bell-shaped curve. If the physician(s) in your practice are outside the expected use of E/M codes, there is some risk of audit. If you should find that your data deviates significantly from national and local norms, an appropriate next step may be a focused coding assessment.



New Pt Code	Actual	Medicare	Difference
99201	31.6%	0.4%	31.2 points
99202	19.9%	3.2%	16.7 points
99203	25.2%	27.5%	-2.3 points
99204	14.5%	54.7%	-40.2 points
99205	8.8%	14.3%	-5.5 points

Est Pt Code	Actual	Medicare	Difference
99211	30.2%	3.7%	26.5 points
99212	26.6%	6.2%	20.4 points
99213	16.9%	54.5%	-37.6 points
99214	15.8%	32.6%	-16.8 points
99215	10.5%	3.1%	7.4 points

Enter the CPT units per 12 month period.

Select a specialty: Hematology/Oncology

New Patient Office Visits	Utilization/ Units (12 Month Period)	Office Visits - Established	Utilization/ Units (12 Month Period)
99201 *		99211 *	
99202 *		99212 *	
99203 *		99213 *	
99204 *		99214 *	
99205 *		99215 *	

CALCULATE

Add to your website

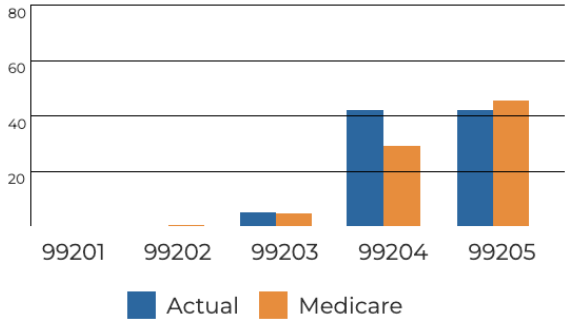
https://www.aapc.com/resources/em_utilization.aspx

E/M Profile for Medicare 4/1/2025-3/31/2026

Hematology/Oncology

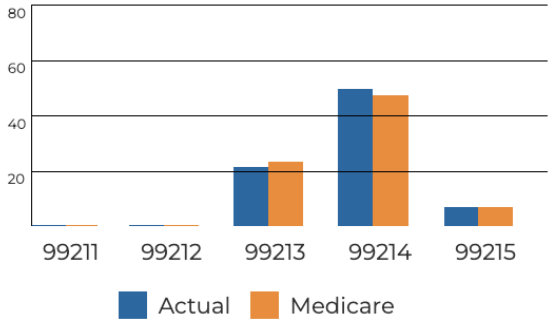
The following analysis shows a distribution of Evaluation and Management (E&M) codes for your practice compared to national Medicare averages f specialty. This can be used as a tool to evaluate your coding practices and identify any potential patterns that may warrant further scrutiny.

New Pt. E/M Utilization: Actual vs. National Medicare Averages



New Pt Code	Actual	Medicare	Difference
99201	0%	0.2%	-0.2 points
99202	0.4%	1%	-0.6 points
99203	10.9%	9.5%	1.4 points
99204	44.3%	38.1%	6.2 points
99205	44.4%	51.2%	-6.8 points

Est. Pt. E/M Utilization: Actual vs. National Medicare Averages



Est Pt Code	Actual	Medicare	Difference
99211	1.2%	1.3%	-0.1 points
99212	1.2%	1.6%	-0.4 points
99213	23.8%	27%	-3.2 points
99214	59.4%	55.4%	4 points
99215	14.4%	14.7%	-0.3 points

Care Management Stats 2025-2026

RPM/RTM 4/1/2025-3/31/2026

Codes Billed	Sum of Distinct Claims
98975	744
98980	1,949
98981	1,262
99445	122
99454	2,342
99457	4,051
99458	2,149
99470	12
Grand Total	12,631

Oncology Volume (from focalPoint®)

E/M Patients 4/1/2025-3/31/2026= 2,619, 231

Code	Brief Descriptor	Patients
99490	Care Management, Staff, monthly	50,079
99495	TCM, Moderate MDM, monthly	6,914 (2894 Discharges)
99497	ACP, First 30 minutes	5,247
99426	PCM, 30 minutes, monthly, staff	16,844
99424	PCM, by physician, monthly	539
G0023	PIN, Monthly	3,754
G2211	E/M add-on O/O	1,043,174

Take-Aways from This Module

- Secure your data—cyberattacks are too common. Change is still impacting practices.
- Benchmarks are useful in terms of measuring yourself against your peers but know where you are different.
- Days to Pay are a more important metric in Hem-Onc practices than other specialties due to the drug payment obligation.
- Most denials in 2026 are clerical and, therefore, they need no appeal and should process quickly.
- Know your claim filing deadlines! Do not sign up for “short windows”.
- Is this the year to start RPM/RTM?

Thank you for Taking Care of Your Patients!!

Appendices—Benchmarks:

By Insurance Company
By State
Denials by Service
Appeals for Parts C&D

Benchmarks By Insurance Company
The Hall of Shame

Worst Days to File (No Outliers) Drugs in 2025-2026 (N ≥ $500,000)

INSURANCE NAME	ACTUAL ALLOWED	PAYMENT AMOUNT	NON-REIMBURSED AMOUNT	DAYS TO FILE
NeueHealth	$565,083	$558,758	$6,326	46.05
IBC Personal Choice Pennsylvania	$998,697	$875,660	$123,037	43.03
CareFirst BlueCross BlueShield Medicare Advantage	$581,914	$570,980	$10,934	37.04
CENTRAL VALLEY MEDICAL PROVIDERS	$1,615,075	$483,834	$1,131,241	36.49
SANTE HEALTH SYSTEM AND AFFILIATES	$1,394,184	$576,141	$818,043	35.59
COMMUNITY HEALTH CHOICE TEXAS I HIM	$654,623	$601,446	$53,177	33.77
Anthem BCBS Maine	$12,095,206	$11,620,261	$474,945	33.19
Medicaid Maine	$1,902,469	$1,750,540	$151,929	32.72
Medicare Maine	$16,423,537	$12,397,578	$4,025,959	31.08
Empire BCBS New York	$712,523	$590,947	$121,576	31.02
Keystone Health Plan East	$873,844	$787,650	$86,194	30.55
AMBETTER FROM SUNSHINE HEALTH	$48,744,901	$52,773,181	($4,028,280)	27.43

Worst Payers: Days To Pay--OA Drugs 2025-2026 (No Outliers; > 2000 claims)

Insurance Name	Days To Pay	Patients	Claims	Responses	Denials	Denial Percent
River City Medical Group	47.33	743	3,113	8,237	1,772	21.51%
Medicare Maine	45.02	730	2,353	5,512	127	2.30%
ALIGNMENT HEALTH CARE	42.81	706	2,561	9,896	3,333	33.68%
CBSA	42.51	1,013	4,191	9,140	864	9.45%
ALLIANCE IPA	39.34	526	3,254	9,355	2,426	25.93%
Meritain Health (Minneapolis, Minnesota)	38.36	762	2,563	5,328	455	8.54%
Health Care LA IPA	36.45	901	2,957	6,452	977	15.14%
FLORIDA MEDICAID	36.30	555	2,068	12,169	3,324	27.32%
Health Net Claims (California, Oregon)	34.80	829	2,869	7,739	727	9.39%
Medicare Maryland Part B	34.16	607	2,704	5,313	297	5.59%
Optimum Healthcare, Inc (Medicare Advantage)	32.57	1,128	4,329	8,934	121	1.35%
HORIZON NJ HEALTH	32.41	443	2,141	5,716	1,054	18.44%
UMR	32.21	3,519	12,987	31,144	4,826	15.50%
Freedom Health Plan	31.77	720	2,777	5,731	84	1.47%
OPTIMUM HEALTHCARE	31.75	1,307	6,736	13,953	150	1.08%
MEDSOLUTIONS, INC.	31.62	658	3,977	8,044	205	2.55%
FREEDOM HEALTH	31.36	986	5,020	9,907	112	1.13%
BCBS North Carolina	30.80	1,398	4,522	10,075	861	8.55%
Simply Healthcare	30.58	656	3,150	10,423	4,798	46.03%
HEATLHCARE LA, IPA	30.56	1,460	7,062	17,783	1,183	6.65%
United Healthcare PPO One	29.94	1,119	3,938	6,437	916	14.23%
COMMUNITY PREFERRED HEALTH PLAN	29.61	3,570	15,937	45,187	8,549	18.92%
INDEPENDENCE BLUE CROSS PERSONAL CHOICE	29.26	967	3,192	8,957	633	7.07%
RETIRED RAILROAD MEDICARE	29.26	899	5,029	11,466	1,001	8.73%
Medicare Alabama	29.23	2,957	11,000	24,446	694	2.84%
Medicare Railroad	29.20	897	3,980	7,888	690	8.75%
Anthem BCBS Georgia	29.13	2,884	10,135	32,854	10,099	30.74%

Worst Insurance Companies with OA Drug Denials 2025-2026 (≥ 1500 claims)

Insurance Name	Patients	Claims	Denials	Denial Percent
Simply Healthcare	656	3,150	4,798	46.03%
SANTE COMMUNITY PHYSICIANS MEDICAL GROUP CORP	621	1,688	1,652	40.26%
MISSOURI BLUE SHIELD - ST LOUIS MO	395	1,641	2,266	34.55%
SIMPLY HEALTHCARE PLANS, INC.	806	3,853	3,247	34.51%
ALIGNMENT HEALTH CARE	706	2,561	3,333	33.68%
ANTHEM BLUE CROSS	1,656	6,810	10,903	33.08%
GEORGIA BCBS	2,201	9,095	8,041	32.21%
SHARP COMMUNITY MEDICAL GROUP	1,440	5,757	4,570	31.99%
Anthem BCBS Georgia	2,884	10,135	10,099	30.74%
Anthem BCBS Connecticut	572	2,717	1,981	28.94%
VIRGINIA BLUE SHIELD	1,926	8,429	7,509	28.47%
INDIANA BLUE SHIELD	1,164	5,605	4,702	28.43%
Anthem BCBS Ohio	1,276	4,013	1,934	27.55%
FLORIDA MEDICAID	555	2,068	3,324	27.32%
Anthem BC California	2,880	10,225	7,404	27.06%
ALTAMED	560	1,929	1,398	26.79%
ALLIANCE IPA	526	3,254	2,426	25.93%
HILL PHYSICIANS MEDICAL GROUP	415	1,781	1,277	25.49%
CAL OPTIMA DIRECT	668	2,893	3,154	25.10%
AMBETTER FROM SUNSHINE HEALTH	3,650	23,307	25,238	24.96%
MAINE BLUE SHIELD	805	3,410	2,812	24.62%
ARIZONA COMPLETE HEALTH	582	2,070	1,918	23.78%
BS California	1,723	6,295	4,209	23.69%
CALIFORNIA BLUE CROSS	995	4,133	3,440	23.46%
Molina Healthcare California	695	2,737	1,964	23.26%
HARMONY HEALTH PLAN OF ILLINOIS, INDIANA, MISSOURI	1,437	5,932	4,916	23.04%
Cal-Optima Direct	487	1,557	1,292	22.93%
SUNSHINE STATE HEALTH PLAN	2,224	9,413	6,351	22.84%
Wellmark BCBS Iowa	438	1,917	1,222	22.83%
NEBRASKA TOTAL CARE	482	2,252	2,138	22.80%
VIRGINIA BLUE CROSS	329	1,718	1,018	22.55%
ARIZONA COMPLETE HEALTH - DOS AFTER 10/1/18	302	1,704	1,396	22.01%

Clean Claims By Payer/Drug

Payers With Most Clean Claims As A % 2025-2026

Insurance Name	Patients	Claims	Clean Claims	Clean Claim Percent
MAINE MEDICARE	821	4,280	4,210	98.36%
MEDSOLUTIONS, INC.	658	3,977	3,902	98.11%
Medicare Mississippi	2,340	12,668	12,412	97.98%
Medicare Nevada Part B	1,224	4,469	4,377	97.94%
Medicare Idaho	477	1,997	1,950	97.65%
Medicare South Carolina	2,317	12,179	11,881	97.55%
MedSolutions, Inc	541	2,253	2,197	97.51%
OPTUM VA CCN	2,661	14,620	14,246	97.44%
Optum - VA (CCN) Region 1,2,3	3,559	16,154	15,737	97.42%
UTAH MEDICARE	724	3,588	3,489	97.24%
Optimum Healthcare, Inc (Medicare Advantage)	1,128	4,329	4,208	97.20%
MISSOURI MEDICARE	838	3,603	3,500	97.14%
DELAWARE MEDICARE	886	4,166	4,045	97.10%
Medicare Oregon Part B	823	3,609	3,501	97.01%
Medicare New Hampshire	556	2,579	2,500	96.94%
OPTIMUM HEALTHCARE	1,307	6,736	6,528	96.91%
CAPITAL HEALTH PLAN	382	2,583	2,501	96.83%
TRIWEST REGION 4 CCN	356	2,206	2,135	96.78%
Medicare Missouri	356	1,759	1,702	96.76%
INDIANA MEDICARE	1,122	6,055	5,856	96.71%
PENNSYLVANIA MEDICARE	3,032	14,541	14,056	96.66%
Medicare Maine	730	2,353	2,272	96.56%
FREEDOM HEALTH	986	5,020	4,844	96.49%
NEBRASKA MEDICARE	1,299	6,646	6,404	96.36%
TriWest Healthcare Alliance - VA (CCN) Region 4,5,6	1,202	5,368	5,171	96.33%
TENNESSEE MEDICARE	8,991	44,223	42,562	96.24%
COMMUNITY HEALTH GROUP	1,051	4,455	4,284	96.16%
VIRGINIA MEDICARE	2,464	12,391	11,912	96.13%
MARTINS POINT HEALTH CARE USFHP/GENERATIONS ADV	510	2,460	2,359	95.89%
NEW YORK EMPIRE MEDICARE	308	1,631	1,564	95.89%

Drugs With > 90% Clean Claims 2025-2026

Drug Name	Patients	Claims	Clean Claims	Clean Claim Percent
Boruzu	289	1,899	1,786	94.05%
Asceniv	46	279	262	93.91%
Leqvio	4,929	6,386	5,992	93.83%
Monoferric	29,889	37,024	34,734	93.81%
Epkinly	136	935	877	93.80%
Decitabine	775	7,627	7,146	93.69%
Azacitidine	3,458	63,184	59,094	93.53%
Pemrydi RTU	798	2,550	2,382	93.41%
Rolvedon	6,303	19,054	17,761	93.21%
Tecvayli	449	4,060	3,782	93.15%
Belrapzo	870	4,712	4,383	93.02%
Evenity	2,371	8,654	8,047	92.99%
Empliciti	324	2,215	2,056	92.82%
Padcev	2,590	18,656	17,296	92.71%
Enjaymo	100	1,056	979	92.71%
Opdualag	991	4,073	3,770	92.56%
Reblozyl	3,653	19,939	18,424	92.40%
Bavencio	283	2,418	2,232	92.31%
Herzuma	334	1,247	1,151	92.30%
Focinvez	12,855	56,901	52,470	92.21%
Faspro	14,119	101,864	93,629	91.92%
PacPro	2,043	9,140	8,399	91.89%
Elrexfio	117	1,067	979	91.75%
Frindovyx	2,708	8,220	7,542	91.75%
Kimmtrak	74	1,124	1,031	91.73%
Vivimusta	480	2,298	2,106	91.64%
Granisetron	15,371	72,726	66,479	91.41%
Libtayo	3,967	20,103	18,366	91.36%
Stoboclo	4,495	4,644	4,240	91.30%
Bivigam	375	2,050	1,870	91.22%
POSFREA	11,538	47,388	43,195	91.15%
Releuko	1,775	9,948	9,053	91.00%

DTF/DTP/Denials by State

Days To File Without Outliers By State OA Drugs 2025-2026 (N ≥ 50 Claims)

Row Labels	Sum of Count of Claims	Average of Avg Days To File
AK	8600	13.70
AL	89663	11.73
AR	104335	8.88
AZ	104351	6.72
CA	173034	12.13
CO	4337	5.39
CT	13253	22.25
DE	8146	5.42
FL	796229	10.34
GA	93986	11.42
HI	589	9.75
IA	9000	10.66
ID	6544	6.09
IL	88272	8.01
IN	30869	8.93
KS	35763	8.44
KY	1367	8.11
LA	24725	9.78
MD	5932	17.20
ME	24498	13.94
MI	7108	20.25
MO	14560	9.94
MS	34001	7.94
NC	50582	9.98
ND	3315	8.98
NE	60445	9.28
NH	9115	11.20
NJ	61473	21.73
NM	19352	8.91
NV	15388	11.82
NY	34529	7.39
OH	20152	5.51
OK	22817	7.54
OR	20426	9.58
PA	65113	14.18
SC	42688	9.54
TN	203368	7.92
TX	113786	8.95
UT	23356	14.53
VA	57994	9.04
VT	451	3.65
WA	2071	16.76
WY	6209	8.83

Days to Pay 2025- 2026: Without Outliers By State for OA Drugs YTD (N≥100 claims)

Row Labels	Sum of Count of Paid Claims	Average of Avg Days To Pay
AK	7514	26.08
AL	79201	26.01
AR	85741	23.76
AZ	94342	23.20
CA	127553	27.94
CO	3484	22.32
CT	11513	37.51
DE	7479	21.13
FL	714437	25.26
GA	78615	26.13
IA	7856	26.36
ID	5953	22.29
IL	80661	22.71
IN	26590	27.83
KS	33005	24.98
KY	1141	22.20
LA	20291	23.03
MD	5061	35.24
ME	21919	41.09
MI	6156	21.86
MO	12482	26.30
MS	30328	23.64
NC	42556	25.54
ND	3021	26.28
NE	55280	24.72
NH	8424	28.07
NJ	52762	36.62
NM	16697	22.82
NV	13650	26.29
NY	31031	24.73
OH	17359	22.24
OK	21103	24.09
OR	19077	27.36
PA	58029	26.43
SC	39521	25.32
TN	183393	23.90
TX	103212	21.92
UT	21131	28.90
VA	52916	23.86
VT	370	25.64
WA	1532	25.92
WY	5679	25.35

Denial Percentage By State 2025 to 2026 (OA Drugs Only)

Row Labels	Sum of Count Responses	Sum of Count Denials	Denial Percentage
AK	28022	4307	15.4%
AL	233996	16023	6.8%
AR	253504	18777	7.4%
AZ	269477	22450	8.3%
CA	554076	110645	20.0%
CO	10633	2004	18.8%
CT	39459	6328	16.0%
DE	23037	1979	8.6%
FL	1961527	180065	9.2%
GA	239141	37066	15.5%
HI	2087	469	22.5%
IA	27015	3112	11.5%
ID	15572	1013	6.5%
IL	248285	16947	6.8%
IN	95916	10932	11.4%
KS	92828	7016	7.6%
KY	3055	485	15.9%
LA	85305	12132	14.2%
MA	110	20	18.2%
MD	13391	1300	9.7%
ME	65955	5905	9.0%
MI	24072	2240	9.3%
MN	102	7	6.9%
MO	46302	6199	13.4%
MS	88597	6466	7.3%
NC	125463	13431	10.7%
ND	9499	873	9.2%
NE	211094	16482	7.8%
NH	26497	2494	9.4%
NJ	145294	17260	11.9%
NM	58139	7049	12.1%
NV	41133	4632	11.3%
NY	86005	7185	8.4%
OH	45316	7724	17.0%
OK	62658	3574	5.7%
OR	53972	3521	6.5%
PA	172778	14753	8.5%
SC	101991	6573	6.4%
TN	536791	48753	9.1%
TX	281519	20137	7.2%
UT	94869	8282	8.7%
VA	144693	17390	12.0%
VT	901	37	4.1%
WA	5069	1056	20.8%
WY	22885	3456	15.1%

DENIAL TYPES BY SERVICE

Denial Types: Radiation 2025-2026 (Most data is old codes)

Code	Definition	lineitems	Category
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	28,327	Radiation
197	Precertification/authorization/notification absent.	24,515	Radiation
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	18,585	Radiation
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	18,374	Radiation
252	An attachment/other documentation is required to adjudicate this claim/service.	13,384	Radiation
96	Non-covered charge(s).	10,724	Radiation
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	8,923	Radiation
22	This care may be covered by another payer per coordination of benefits.	7,139	Radiation
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	6,939	Radiation
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	6,688	Radiation

Denial Types: Imaging 2025-2026

Code	Definition	lineitems	Category
197	Precertification/authorization/notification absent.	18,490	Imaging
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	18,264	Imaging
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	16,933	Imaging
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	15,544	Imaging
252	An attachment/other documentation is required to adjudicate this claim/service.	9,633	Imaging
96	Non-covered charge(s).	8,293	Imaging
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	7,129	Imaging
29	The time limit for filing has expired.	6,252	Imaging
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	5,893	Imaging
22	This care may be covered by another payer per coordination of benefits.	5,870	Imaging

Denial Types: E/M 2025

Code	Definition	lineitems	Category
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	104,774	E/M
22	This care may be covered by another payer per coordination of benefits.	47,437	E/M
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	43,883	E/M
29	The time limit for filing has expired.	39,310	E/M
96	Non-covered charge(s).	39,260	E/M
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	35,508	E/M
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	26,451	E/M
27	Expenses incurred after coverage terminated.	26,250	E/M
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	25,040	E/M
252	An attachment/other documentation is required to adjudicate this claim/service.	24,296	E/M

Appendices—
Appeals Processes

When You Do Not Have to Appeal: Medicare

- What Are Minor Errors or Omissions That Can Be Reopened?
  - Incorrect units of Medically Unlikely Edits (MUE) submitted on a claim
  - Correct units billed within the MUE
  - Reopen a date of service due to receiving two claims for the same service during the same processing period, one claim denied as duplicate and one claim denied for frequency
  - Transposed diagnosis (billed 123 but need to change to 321)
  - Change a diagnosis pointer on a denied procedure
  - Transposed procedure codes (billed CPT® code 92136 but need to change to CPT® code 91362)
  - Change a procedure when it does not change the allowable (e.g., HCPCS code G0008 to G0009)
  - Downcode a procedure (change to a procedure with a lower allowable)
  - Incorrect submitted amount (if it will allow additional payment for the procedure billed)
  - Change date of service (month and day only)
  - Submission of a claim for services that were not rendered
  - Incorrect rendering provider on claim (must verify the PTAN and NPI is associated with the billing group on the claim)

- https://palmettogba.com/jmb/did/ax5prz1510?cat=jmb-appeals

From NGS Medicare

Types of Services That May be Appealed

- Coverage of furnished items and service
- Application of coinsurance provision
- Number of lifetime reserve days used
- Physician certification requirement
- Beginning and ending of a benefit period
- A determination with respect to limitations of liability provision
- CERT denials
- RAC denials
- Amount of deductible
- Number of inpatient hospital days used toward 190-day lifetime limitation of inpatient psychiatric hospital covered days
- Number of SNF days used
- Any issue(s) affecting the amount of benefits payable (including overpayments or underpayments)
- Medical necessity of services
- Benefit integrity support center denials
- Prepay and postpay probes

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National Government Services, Inc.

CALCULATING TIME FRAMES

Time frames are generally calculated from date of receipt of notice

5 days added to notice date

Time frames sometimes extended for good cause, examples include:

- Serious illness
- Death in family
- Records destroyed by fire/flood, etc
- Did not receive notice
- Wrong information from contractor
- Sent request in good faith but it did not arrive

Medicare Appeals – Parts A & B -Standard Appeals

- Appeal deadline – 120 days from date MSN* sent (will be listed on last page of MSN)
- 1st level of appeal – redetermination to Medicare Administrative Contractor (MAC)
- 2nd level – reconsideration to the QIC (deadline 180 days from the decision by the MAC)
- 3rd level – ALJ hearing
  - Use form OMHA-100* to request
  - Standard appeals may take a long time to have an ALJ hearing scheduled
- 4th level - MAC
- 5th level - Federal court
- CMS information on Original Medicare appeals: https://www.cms.gov/index.php/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index

Medicare Appeals – Part C

Medicare Part C – aka Medicare Replacement – Medicare Advantage Plans

Medicare Advantage plans limit services through prior authorization, network restrictions, and other cost containment methods, so the Medicare Advantage plan often denies coverage before patient receives services.

Beneficiary will not receive an MSN

Standard appeals

- Before service
- After service

Expedited appeals

- Before service
- Care is ending

Medicare Appeals – Part C – Standard appeals

- Before a beneficiary can appeal, plan must issue an **organization determination**
- Pre-service determination (like a prior authorization)
- Post-service determination – will receive a denial after receiving the service
  - Notice of Denial of Medical Coverage, EOB, or insert with EOB mailing
- Similar appeals process, just different timelines to get decisions
- CMS information on Medicare Managed Care appeals: https://www.cms.gov/index.php/Medicare/Appeals-and-Grievances/MMCAG/index

Medicare Appeals – Part C – Standard appeals

1st level of appeal – plan reconsideration

Plan reviews appeal and reconsiders whether it will cover the service or item Should issue decision within 30 days (60 for post-service appeals)

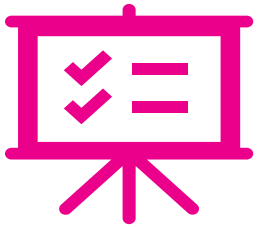
Two outcomes

Favorable decision: Plan should cover service or item

Unfavorable decision: Plan auto-forwards appeal to the second level (IRE)

Medicare Appeals – Part C – Standard appeals

2



2nd level of appeal - Independent Review Entity (IRE)

Reviews plan's decision and reconsiders whether it will cover the service or item

Should issue decision within 30 days (60 days for post-service appeals)

Two outcomes

Favorable decision: Plan should cover service or item

Unfavorable decision: Beneficiary can choose to move to the next level of appeal

Medicare Appeals – Part C – Standard appeals

3rd level of appeal – ALJ Hearing. Steps:

Beneficiary requests Administrative Law Judge (ALJ) hearing within 60 days of receiving the unfavorable reconsideration notice - OMHA-100* form	ALJ receives request and sets time and place for hearing • Beneficiary receives Notice of Hearing 20 days before hearing	ALJ notifies beneficiary of decision by mail • Should issue decision within 90 days of hearing request

4

4th level of appeal – Medicare Appeals Council

- Beneficiary requests MAC Review within 60 days of receiving unfavorable ALJ decision
- MAC reviews ALJ's decision
  - No new hearing. Only reviews evidence from ALJ hearing.
- Can issue favorable, unfavorable, or remand decision

5

5th (final) level of appeal – Federal Court

- No timeline for decision

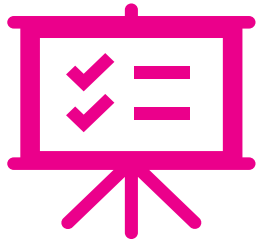
Medicare Appeals – Part C – Standard appeals

Medicare Appeals – Part C – expedited appeals

- **Before service** – beneficiary requests prior approval for a service (similar to standard appeal), but if denied, doctor requests expedited appeal because beneficiary's health would be at risk
- Appeal steps are the same as a standard appeal, just the timeframe is different
- Doctor requests expedited prior approval – plan has **72 hours** to issue organization determination
- If denied, doctor requests expedited appeal – plan has **72 hours** to issue decision (level 1)
- If denied, IRE has **72 hours** to issue decision (level 2)
- Levels 3, 4, & 5 - Same steps (ALJ, MAC, Federal Court) and appeal deadlines as standard appeal

Medicare Appeals – Part C – expedited appeals

Care is ending – hospital, SNF, home health, hospice or other care is ending



<u>Same process as expedited original Medicare appeal</u>

Important Message From Medicare* (hospital) or **Notice of Medicare Non-coverage*** (non-hospital)

- Appeal to BFCC-QIO
- Appeal to (QIC)
- ALJ hearing
- MAC appeal
- Federal Court review

Medicare Appeals – TIPS

Build your case

Look up the coverage criteria

Medicare Appeals – Part D

- Part B and Part D both cover outpatient prescription drugs
- Part B drugs: administered by doctor
- Part D: self-administered
- Part B and Part D drug denials do not use same appeal process
  - Part B drug denials - Appeal using Original Medicare or Medicare Advantage appeal process
  - Part D drug denials - Appeal using Part D appeal process
- Possible coverage problems > Part B drug billed to Part D

Note: LIS/Extra Help and Late Enrollment penalty appeals go through the Social Security Administration (SSA)

Medicare Appeals – Part D

Two situations:

1. Beneficiary goes to pharmacy and learns plan will not cover prescription
   - Possible reasons for non-coverage
     - Refill requested too soon
     - Drug is not on plan's formulary
     - Drug is subject to utilization management tools
       - Prior authorization, step therapy, quantity limits
     - Drug is excluded from coverage for any Part D plan
       - E.g., over-the-counter drugs, medications for weight loss and gain, drugs that treat cold symptoms etc.
2. Beneficiary goes to pharmacy and finds drug is too expensive
   - Higher tier

Medicare Appeals – Part D

Next steps (before filing an appeal)

1. Beneficiary contacts plan to find out reason it will not cover drug
2. Beneficiary files formal coverage request or an exception request to Part D plan:
   - Standard: Should issue decision within 72 hours
   - Expedited: Should issue decision within 24 hours
3. Beneficiary receives coverage determination. If unfavorable decision, beneficiary can begin appeal.

Medicare Appeals – Part D

- CMS information about **exception requests**: https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Exceptions
  - A **tiering exception** - requested to obtain a non-preferred drug at the lower cost-sharing terms of a low tier.
  - A **formulary exception** - requested to obtain a Part D drug that is not included on a plan's formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.
- CMS information about **coverage determinations**: https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminations-

Medicare Appeals – Part D

Next step - beneficiary files an appeal.

Appeal process is similar to other parts of Medicare:

Plan redetermination > IRE reconsideration > ALJ Hearing > MAC appeal > Federal court

01

Each drug plan must have a separate grievance process to address issues that are not appeals

02

May be filed orally /in writing w/i 60 days

03

Plans must resolve grievances

- w/i 30 days generally
- w/i 24 hrs if arise from decision not to expedite coverage determination or redetermination

PART D GRIEVANCE PROCESS