Revenue Cycle State of the State
INDIANA – August 2022

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Summer, 2022
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Disclaimer and Introductions

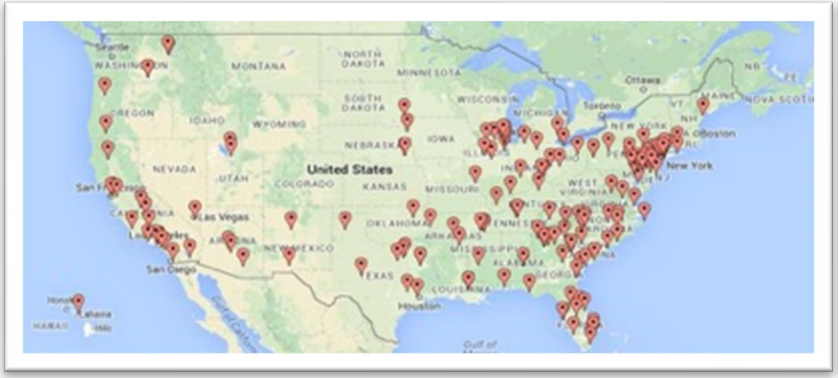
- Nothing in this presentation is to promote off-label use of any particular product or service.
- No drug manufacturer sponsored this program or promoted use of products for this webinar. Thus brand names are used where applicable.
- Benchmarks are just suggestive. Your payer mix or patient acuity may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

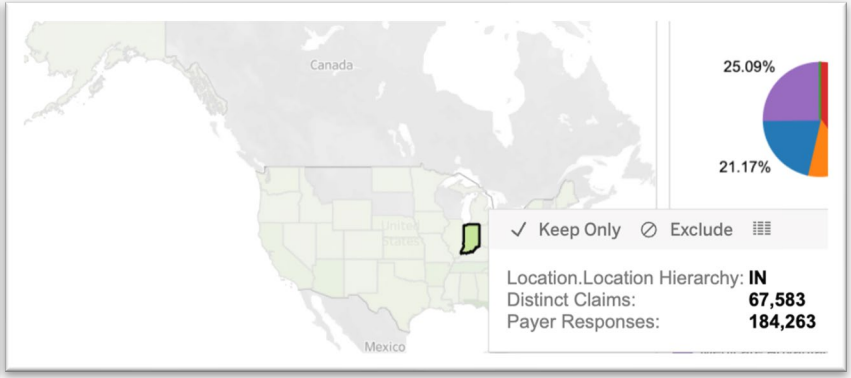
Agenda

- focalPoint Data Set
- Revenue Cycle – Where are we?
  - Accounts Recievable Aging
  - Days to Pay
  - Days to File
  - Resubmission/Clean Claim Rate
  - Top Tens
  - Profiling
  - Resubmission Rate
- Denials
  - Denial Rates
  - Top Denial Codes
  - Next Steps

Our Data Source

focalPoint data represents 170+ Cancer Centers, 725 sites of service, 437 payers, and 2,300 Hematologists and Oncologists



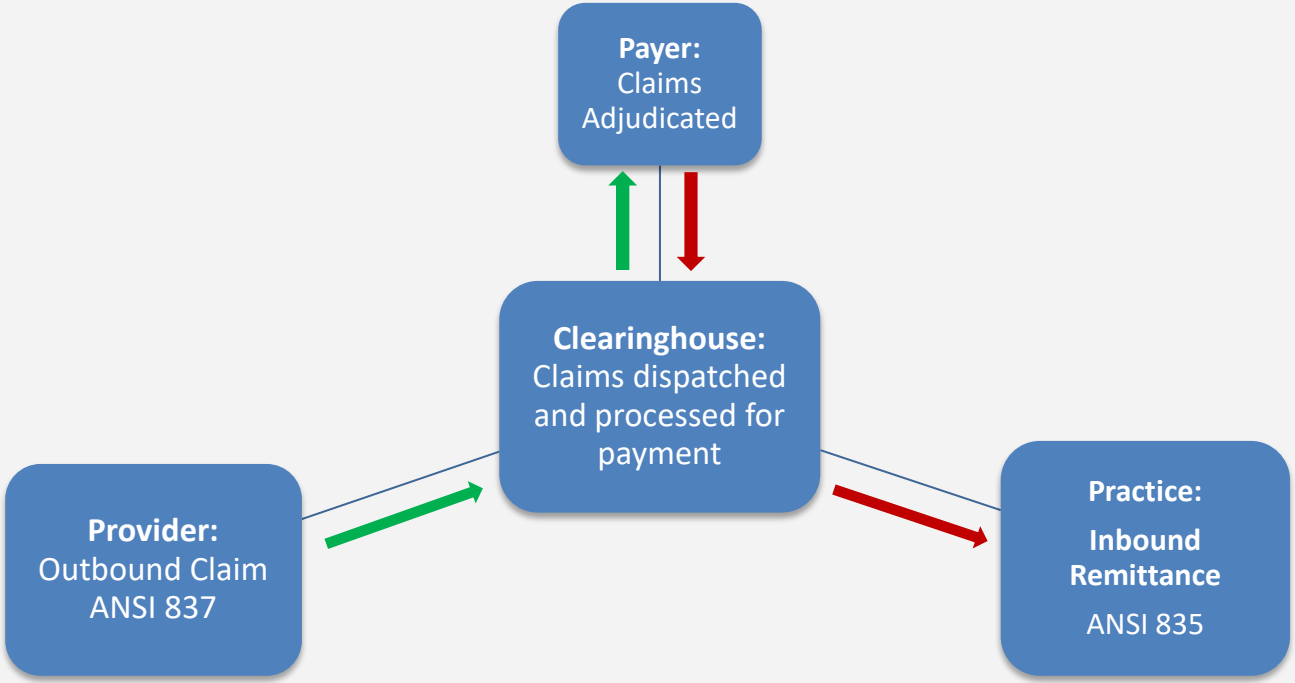


Metrics 2022 YTD		
Measure	**Indiana Total for Drugs**	**U.S. Total for Drugs**
Payer Responses	184,263	6,342,584
Distinct Patients	11,745	443,163
Distinct Claims	67,583	2,234,592

Data Origin

- Clearinghouse:
  - The pathway for claims to be dispatched from providers to the payers and from the payers to the providers seamlessly and electronically
  - The electronic repository for data from outgoing claim and incoming payer adjudication decisions. Data collected at this level includes but is not limited to:
    - Payer adjudication response: denial or payment
    - Allowed and payment amounts
    - Patient portions
    - Diagnosis
    - NDC Number
    - Reason for denial or delay
    - Demographic data
- All community practices, except 6 clinics that are hospital-based but are billing Part B (”Provider-Based”)

focalPoint's relationship is with the clearinghouse



focalPoint Data Sets

- National Service Data: July 1, 2021-June 30, 2022
- IN and U.S. focalPoint Data – 2022 YTD
- Collects data on
  - Allowed Amounts
  - Insurance Payment Amounts
  - Non-Reimbursed Amounts
  - Patient Responsibility
  - Days To Pay and 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
- CPT code Groupings
  - E/M 99201-99499
  - Imaging 70010-77084
  - Radiation Oncology 77261-77615

Revenue Cycle

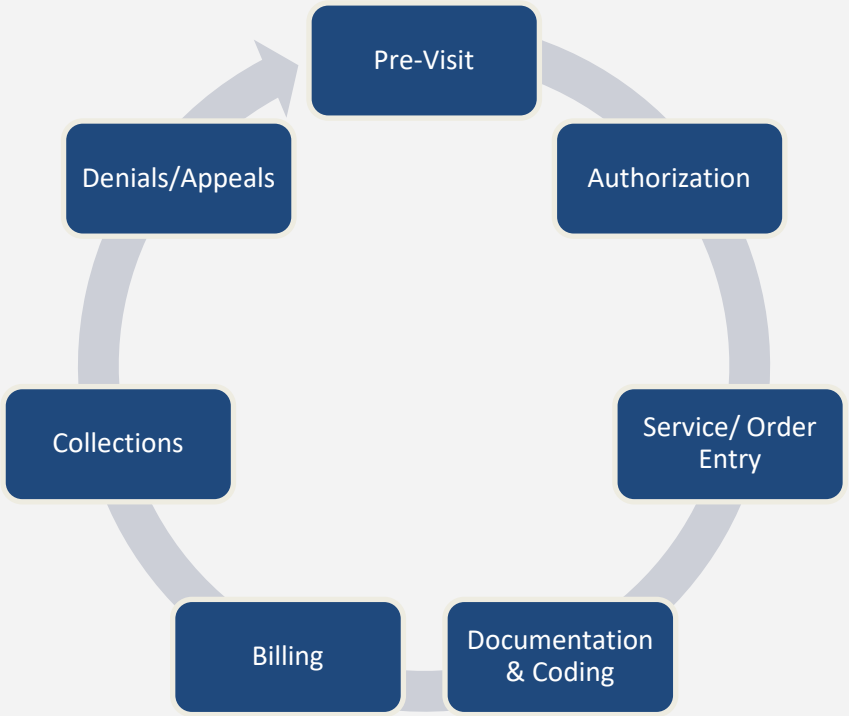
Indiana Executive Summary

- Indiana is performing well in comparison to all geographic areas; they are in the top 50% of states with lowest days to pay, days to file, and denial percentage.
  - State Average True Denial % for 2022 is particularly low at 7.98% (All Indiana Drug Average) vs. 9.02% (All FP Drug Average) with the gap growing in the last quarter of 2022
- Problem Payers are:
  - Ohio Blue Shield: High Days to File / High Days to Pay/ True Denial % is Okay (8%)
  - Homestate Health Plan: High Days to File / High Days to Pay / High True Denial % (41.07%!!!)
  - Managed Health Services Indiana: High Days to File / High Days to Pay / High # True Denials/ True Denial % is OK-ish (10.91%)
  - Ambetter From Managed Health Services (CENTENE) - High # of True Denials/True Denial % (17.04%)

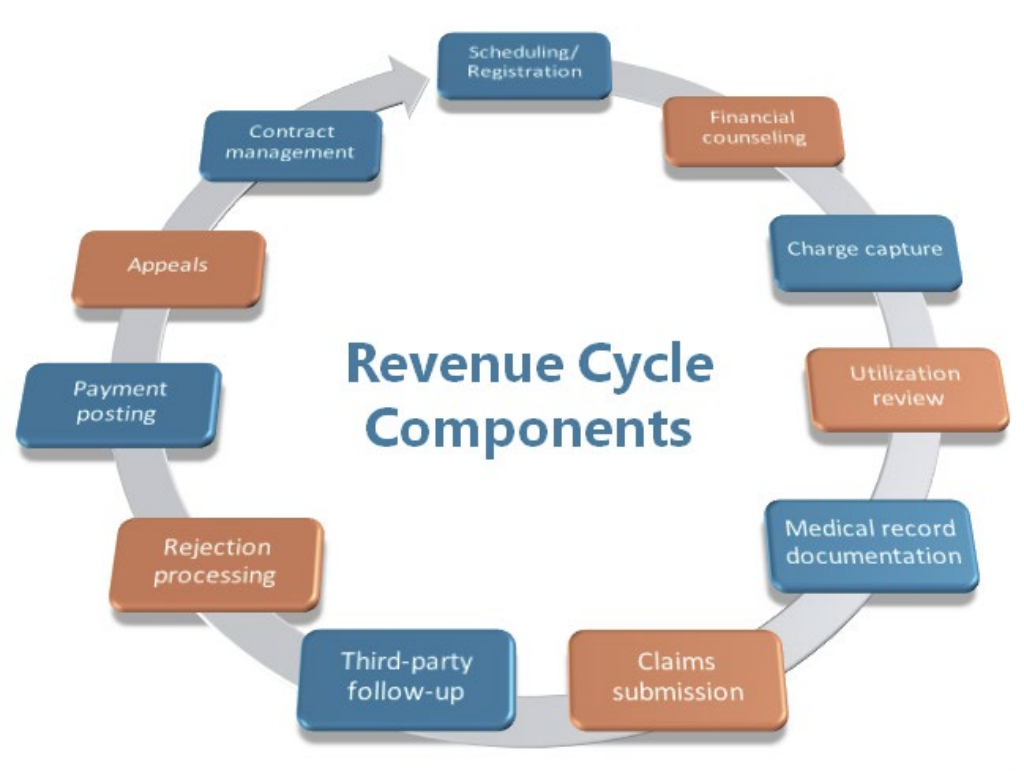
Indiana Executive Summary

- Gold Star Payers
  - Cigna Select: Low Days to File / Low Days to Pay / High # of True Denials but OK Denial %
  - Aetna: Larger Plan with Low Days to File/ Low Days to Pay / High # of Denials but Low True Denial % (4.87%)
  - Humana: Larger Plan with Low Days to File/ Low Days to Pay / High # of True Denials but Low True Denial % (3.94%)

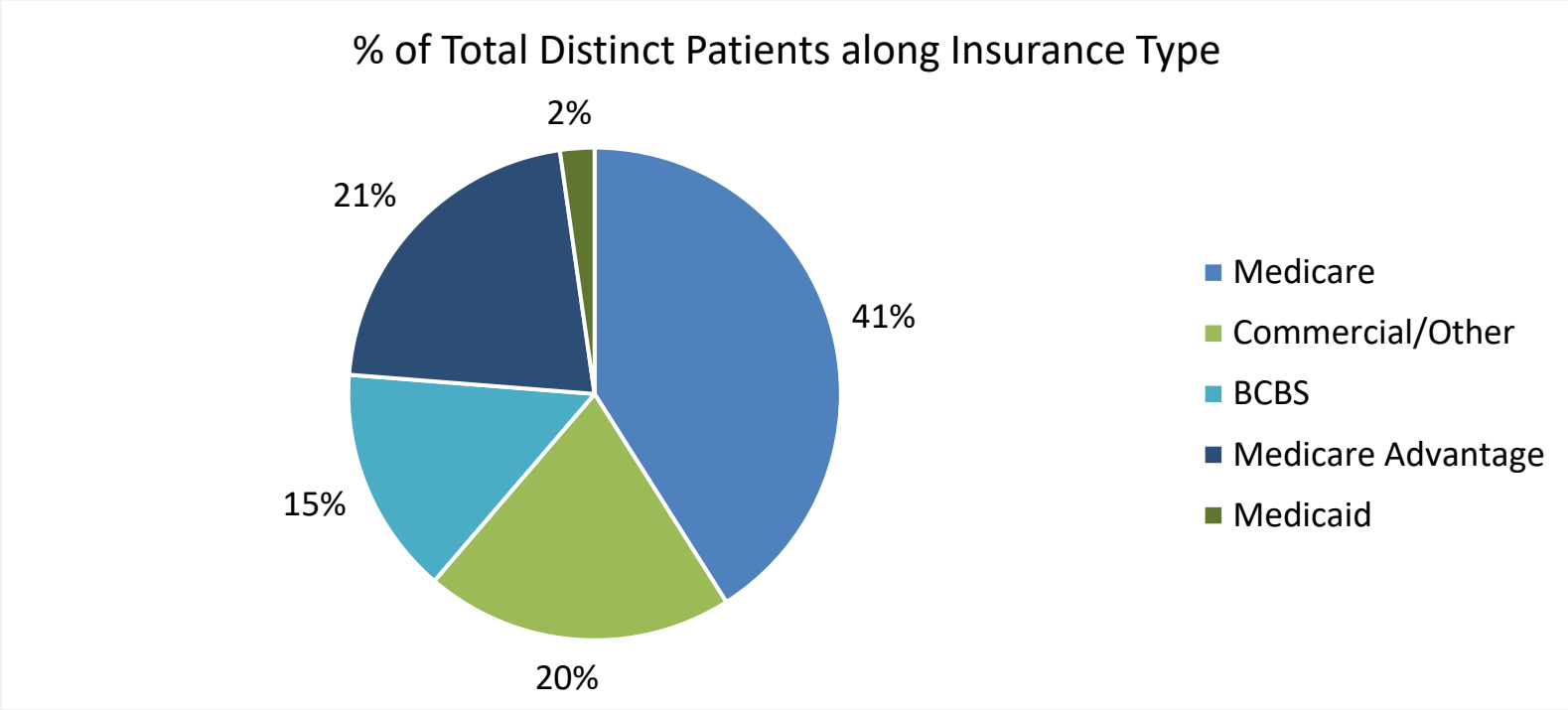
The Billing Cycle: Average Office



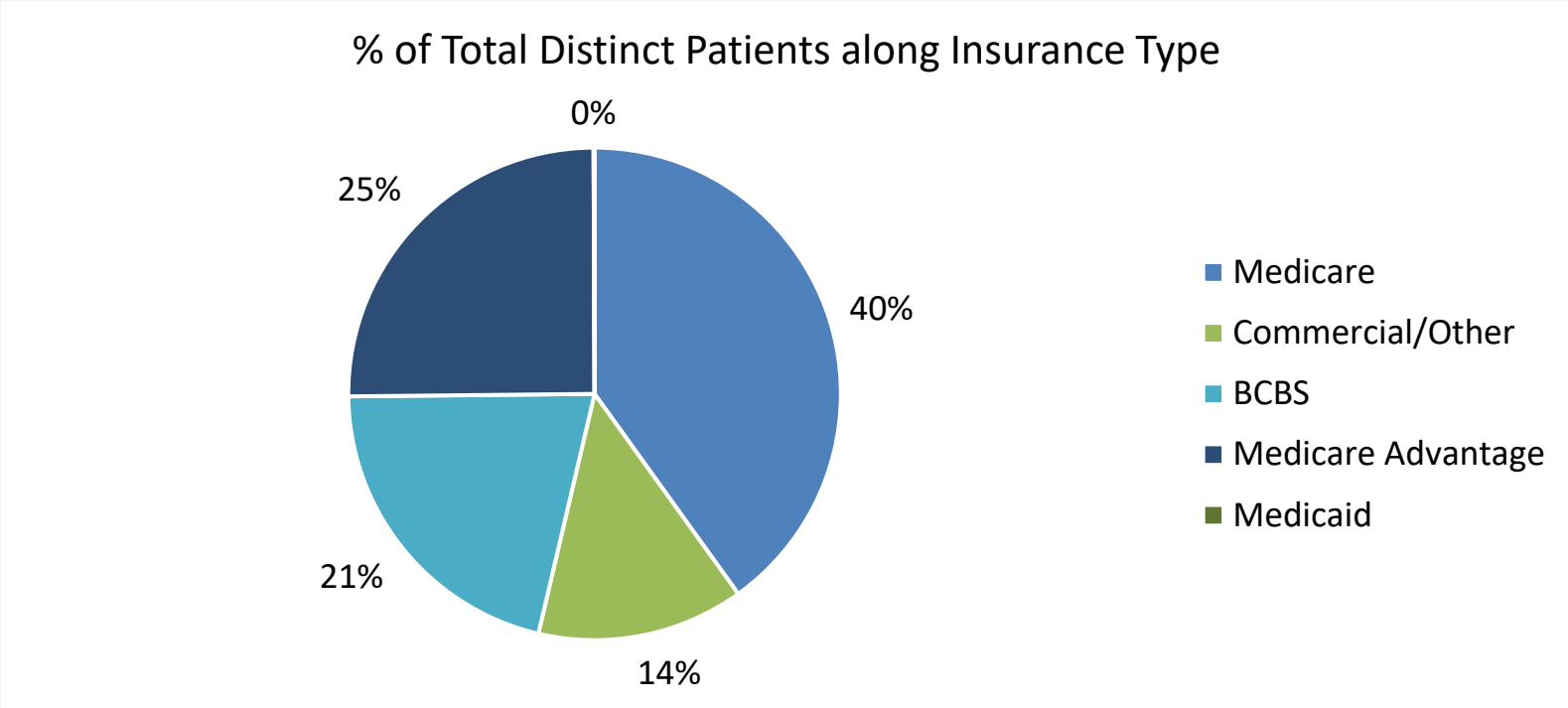
Revenue Cycle: Hospitals



U.S. Payer Mix - focalPoint Database of Office Administered Drugs (2022 YTD)



Indiana - Payer Mix focalPoint Database of Office Administered Drugs (2022 YTD)



U.S. National Service Data Part B Drug Accounts Receivable

July 1, 2021 – June 30, 2022

Caveats

All patient portions not captured in terms of collections

All patient program coverage may not be captured

Name	$ in A/R	Line Items in A/R
0-30 Days	75%	61%
31-60 Days	18%	25%
61-90 Days	3%	5%
91-120 Days	1%	3%
>120 Days	3%	7%

Revenue Cycle Metrics

- Measure of overall A/R performance
- Benchmark for initial payment by insurance = **See Previous Slides**

- Measure of accounts that are prevented from being billed by cause
  - Prior auth
  - More info: NDC, Diagnosis guidelines, etc.
  - Coding
  - Dictation
  - Audit
- DTF is a **key metric**

- Measure of accounts that cannot be billed
- Measure accounts with "delays" (CARC code 15, 16, 251, 252, et al)
- Measured at unit and individual employee level

- Measure of aging of accounts; stratified by dollar amount and age
- Drug claims 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

U.S. National Service Data

Days to File by Service (with Outliers)

July 1, 2021 – June 30, 2022

Days to File	Category
14	Overall Days to File
17	RadOnc Days to File
12	Imaging Days to File
15	E/M Days to File

U.S. Geographic Areas by Lowest Days to File (No Outliers)--DRUGS 2022 YTD

Rank	State	Distinct Claims	Days to File	Rank	State	Distinct Claims	Days to File
1	OR	827	4	23	AZ	114,715	8
2	AK	3,496	4	24	MN	69	8
3	ND	4,616	4	25	GA	63,206	8
4	SC	52,826	4	26	NJ	36,610	8
5	TN	183,252	5	27	OH	30,908	8
6	CT	4,698	5	28	AL	67,153	8
7	DE	6,800	5	29	VA	62,024	8
8	CO	4,948	5	30	MD	18,931	8
9	MS	12,920	5	31	MO	8,494	9
10	ME	18,718	6	32	AR	116,980	9
11	NH	3,091	6	33	ID	1,107	9
12	IL	38,527	6	34	IA	31,080	9
13	KS	44,864	7	35	TX	46,994	9
14	PA	72,115	7	36	CA	76,224	10
15	FL	701,256	7	37	DC	2,003	10
16	OK	29,826	7	38	MI	6,410	10
17	NM	13,647	7	39	NC	53,088	10
18	IN	63,028	7	40	WY	6,327	11
19	WA	29,776	7	41	HI	3,373	12
20	NY	42,887	7	42	NE	31,980	12
21	NV	3,730	8	43	LA	20,440	15
22	UT	27,374	8	44	KY	491	16

U.S Top 20 Plans – Lowest Days to File with No Outliers

2022 YTD (Plans with > 10,000 Claims)--Drugs

Name	Distinct Patients	Distinct Claims	Days to File
SOUTH CAROLINA MEDICARE	4,859	24,557	3
TENNESSEE BLUE SHIELD	9,806	38,750	5
CAROLINA BENEFIT ADMINISTRATORS	2,431	10,812	5
TENNESSEE MEDICARE	15,766	73,472	5
PENNSYLVANIA MEDICARE	5,492	30,769	5
ILLINOIS MEDICARE	3,012	17,317	5
TRICARE - EAST REGION	2,546	10,131	6
NEW JERSEY MEDICARE	3,471	16,346	6
KANSAS MEDICARE	3,880	22,569	6
HEALTHSPRING ILLINOIS	3,046	12,598	6
CIGNA	10,619	46,022	6
WASHINGTON MEDICARE	2,640	13,052	6
FLORIDA MEDICARE	60,510	336,445	7
AETNA	22,714	105,909	7
SUNSHINE STATE HEALTH PLAN	3,001	15,128	7
ARIZONA BLUE SHIELD	2,978	12,255	7
COMMUNITY PREFERRED HEALTH PLAN	3,491	15,356	7
FLORIDA BLUE SHIELD	21,867	102,184	7
INDIANA BLUE SHIELD	3,426	17,755	7
INDIANA MEDICARE	4,620	25,387	7

Indiana Top 20 Plans – Lowest Drug Days to File with No Outliers
2022 YTD (Plans with > 10 Distinct Claims)

Name	Distinct Patients	Distinct Claims	Days to File
CARESOURCE OF GEORGIA	1	12	1
RESERVE NATIONAL INSURANCE	3	36	3
ALLIED BENEFIT SYSTEM, INC.	5	22	4
PRAIRIE STATES ENTERPRISES	42	193	5
AETNA	724	4,252	5
GOLDEN RULE	2	11	5
TRICARE - EAST REGION	18	89	5
INDIAN HEALTH SERVICES	5	23	6
CIGNA SELECT	20	63	6
OPTUM VA CCN	115	595	6
AUTOMATED BENEFIT SERVICES	42	240	6
RETIRED RAILROAD MEDICARE	46	260	6
CIGNA	103	691	7
CBSA	12	65	7
INDIANA BLUE SHIELD	3,202	16,768	7
INDIANA MEDICARE	4,574	25,338	7
COMMUNITY PREFERRED HEALTH PLAN	180	980	7
CARESOURCE HEALTHY INDIANA PLAN (HIP)	24	103	7
HUMANA	551	3,295	7
UNITED HEALTHCARE	1,460	7,584	8

U. S. Plans - Highest Days to File for Drugs with No Outliers

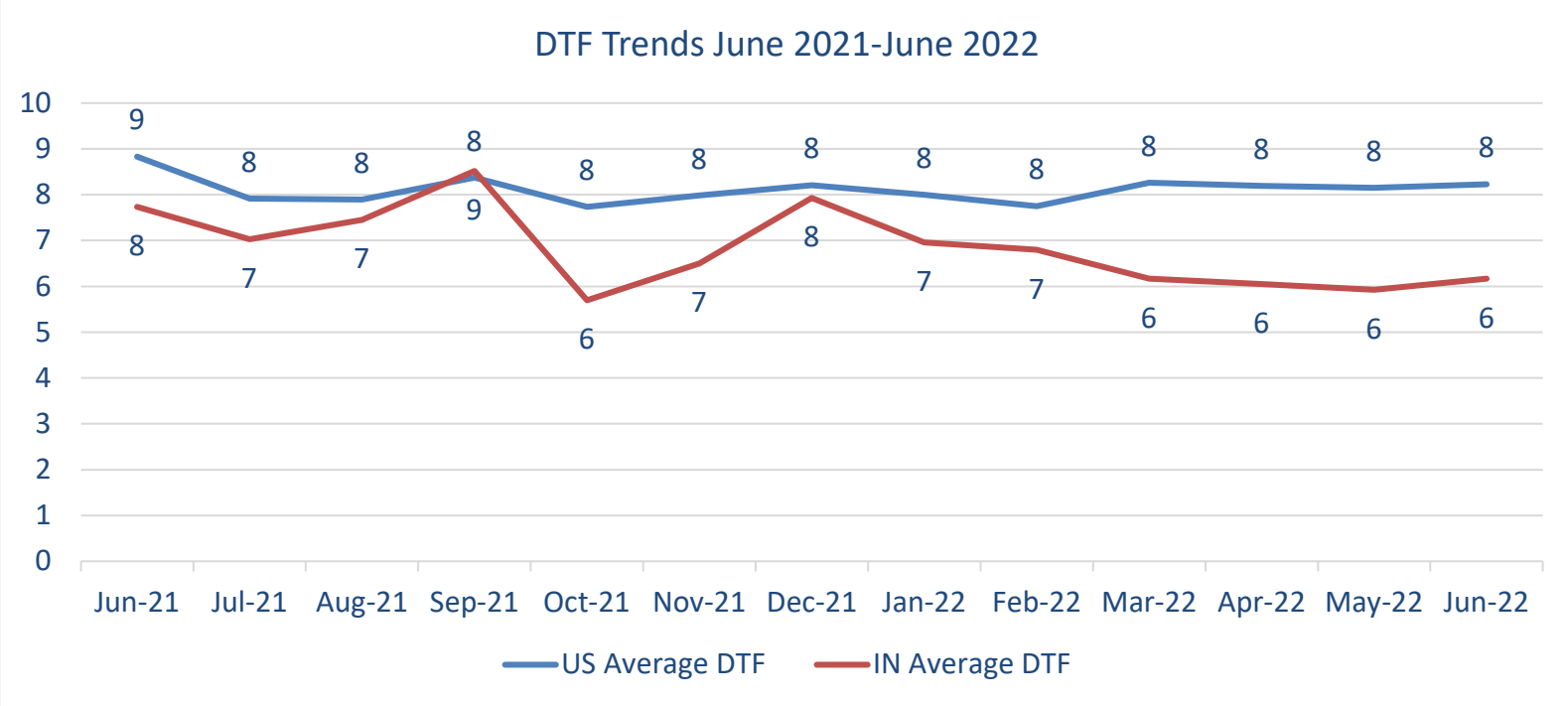
2022 YTD (Plans with > 10,000 Claims)

Name	Payer Responses	Distinct Patients	Distinct Claims	Days to File
NEBRASKA MEDICARE	42,380	2,823	14,507	10
VIRGINIA MEDICARE	70,947	4,742	30,801	10
ARKANSAS BLUE SHIELD	81,639	6,141	24,668	10
NORTH CAROLINA MEDICARE	52,176	4,484	23,210	9
RETIRED RAILROAD MEDICARE	31,223	2,028	11,559	9
ALABAMA MEDICARE	55,819	4,258	21,318	9
UNITED HEALTHCARE	651,517	46,672	218,286	9
OPTUM VA CCN	43,839	3,229	17,706	9
ARKANSAS MEDICARE	131,659	10,261	51,060	8
TEXAS MEDICARE	40,534	3,809	15,996	8
CALIFORNIA MEDICARE	108,171	8,728	41,386	8
IOWA MEDICARE	34,501	2,143	11,486	8
GEORGIA BCBS	38,159	2,670	12,252	8

Indiana Plans - Highest Drug Days to File with No Outlier
2022 YTD (Plans with > 10 Distinct Claims)

Name	Distinct Patients	Distinct Claims	Days to File
ALL SAVERS INSURANCE	4	14	36
OHIO BLUE SHIELD	39	76	25
HOMESTATE HEALTH PLAN	16	71	18
MANAGED HEALTH SERVICES - INDIANA	113	445	18
MDWISE HEALTHY INDIANA PLAN	113	550	14
CARESOURCE OF OHIO	4	17	11
TRICARE FOR LIFE	3	12	11
AMBETTER FROM MANAGED HEALTH SERVICES	113	731	11
ANTHEM BCBS KY	2	11	11
ANTHEM BLUE CROSS	7	39	10

Drug Days to File (No Outliers) U.S. vs. Indiana
June 2021-June 2022



U.S. Days to Pay No Outliers by Service
July 1, 2021-June 30, 2022

Days to Pay	Category
22	OverAll Days to Pay
22	RadOnc Days to Pay
22	Imaging Days to Pay
18	E/M Days to Pay

U.S. Geographic Areas by Lowest Drug Days to Pay (No Outliers) – 2022 YTD

Rank	State	Distinct Claims	Days to Pay	Rank	State	Distinct Claims	Days to File
1	DE	6,676	25	23	NY	42,228	29
2	ME	17,716	25	24	WA	29,604	29
3	SC	48,367	25	25	OK	27,846	29
4	NH	3,002	25	26	MD	18,544	30
5	ND	4,455	26	27	AR	116,719	30
6	CT	4,199	26	28	TX	44,538	30
7	TN	167,417	26	29	AL	66,238	30
8	NV	3,698	26	30	NC	53,199	30
9	KS	42,819	26	31	MI	6,409	30
10	FL	681,497	27	32	NJ	35,672	31
11	MS	12,033	27	33	WY	6,266	31
12	VA	60,275	27	34	UT	26,092	31
13	MO	8,375	27	35	AZ	109,919	31
14	IL	35,304	28	36	NE	31,541	31
15	PA	69,795	28	37	CA	81,695	32
16	MN	68	28	38	KY	688	32
17	GA	61,288	28	39	HI	3,440	34
18	CO	4,639	28	40	NM	12,703	34
19	IA	31,274	29	41	ID	1,200	34
20	OH	30,388	29	42	OR	816	35
21	IN	62,113	29	43	LA	21,740	36
22	AK	3,337	29	44	DC	2,067	37

US Top 20 Plans – Lowest Drug Days to Pay with No Outliers

2022 YTD (Plans with > 10,000 Claims)

Name	Distinct Claims	Days to Pay
SUNSHINE STATE HEALTH PLAN	14,748	18
OPTUM VA CCN	16,228	20
FLORIDA BLUE SHIELD	98,870	22
SOUTH CAROLINA MEDICARE	24,355	24
AETNA	100,740	25
CIGNA	40,664	25
KANSAS MEDICARE	22,655	25
ILLINOIS MEDICARE	17,247	25
TENNESSEE BLUE SHIELD	34,232	26
IOWA MEDICARE	11,528	26
TENNESSEE MEDICARE	72,922	26
INDIANA BLUE SHIELD	16,799	27
PENNSYLVANIA MEDICARE	30,630	27
GEORGIA BCBS	11,570	27
VIRGINIA BLUE SHIELD	14,120	27
HUMANA	102,486	27
VIRGINIA MEDICARE	31,001	27
FLORIDA MEDICARE	326,376	27
GEORGIA MEDICARE	20,892	28
NEBRASKA MEDICARE	14,725	28

Indiana Top 20 Plans – Lowest Drug Days to Pay with No Outliers

2022 YTD (Plans with > 10 Distinct Claims)

Name	Distinct Claims	Days to Pay
TRICARE - EAST REGION	59	14
CIGNA SELECT	65	16
CARESOURCE OF GEORGIA	13	16
ANTHEM BCBS KY	11	17
TRICARE FOR LIFE	11	20
OPTUM VA CCN	488	20
CIGNA	648	22
ALL SAVERS INSURANCE	16	22
RESERVE NATIONAL INSURANCE	35	23
PHYSICIANS HEALTH PLAN OF NORTHERN INDIANA - PHP	287	23
AETNA	3,668	24
INDIANA BLUE SHIELD	15,771	27
INDIAN HEALTH SERVICES	30	27
HUMANA	3,134	27
AMBETTER FROM MANAGED HEALTH SERVICES	621	28
HOMESTATE HEALTH PLAN	117	29
AMERICAN MEDICAL SECURITY (AMS)	197	29
INDIANA MEDICARE	26,419	29
GOLDEN RULE	12	29
AUTOMATED BENEFIT SERVICES	271	30

U.S Plans – Highest Drug Days to Pay with No Outliers

2022 YTD (Plans with > 10,000 Claims)

Name	Distinct Claims	Days to Pay
RETIRED RAILROAD MEDICARE	11,811	36
ARIZONA BLUE SHIELD	10,097	33
COMMUNITY PREFERRED HEALTH PLAN	15,502	32
OKLAHOMA MEDICARE	13,663	32
UNITED HEALTHCARE	220,020	31
WELLMED	16,104	31
ARIZONA MEDICARE	44,077	31
NORTH CAROLINA MEDICARE	23,772	30
TEXAS MEDICARE	16,044	30
ARKANSAS BLUE SHIELD	23,966	30
ALABAMA BLUE SHIELD	21,666	30
ARKANSAS MEDICARE	51,965	30

Indiana Plans - Highest Drug Days to Pay with No Outlier

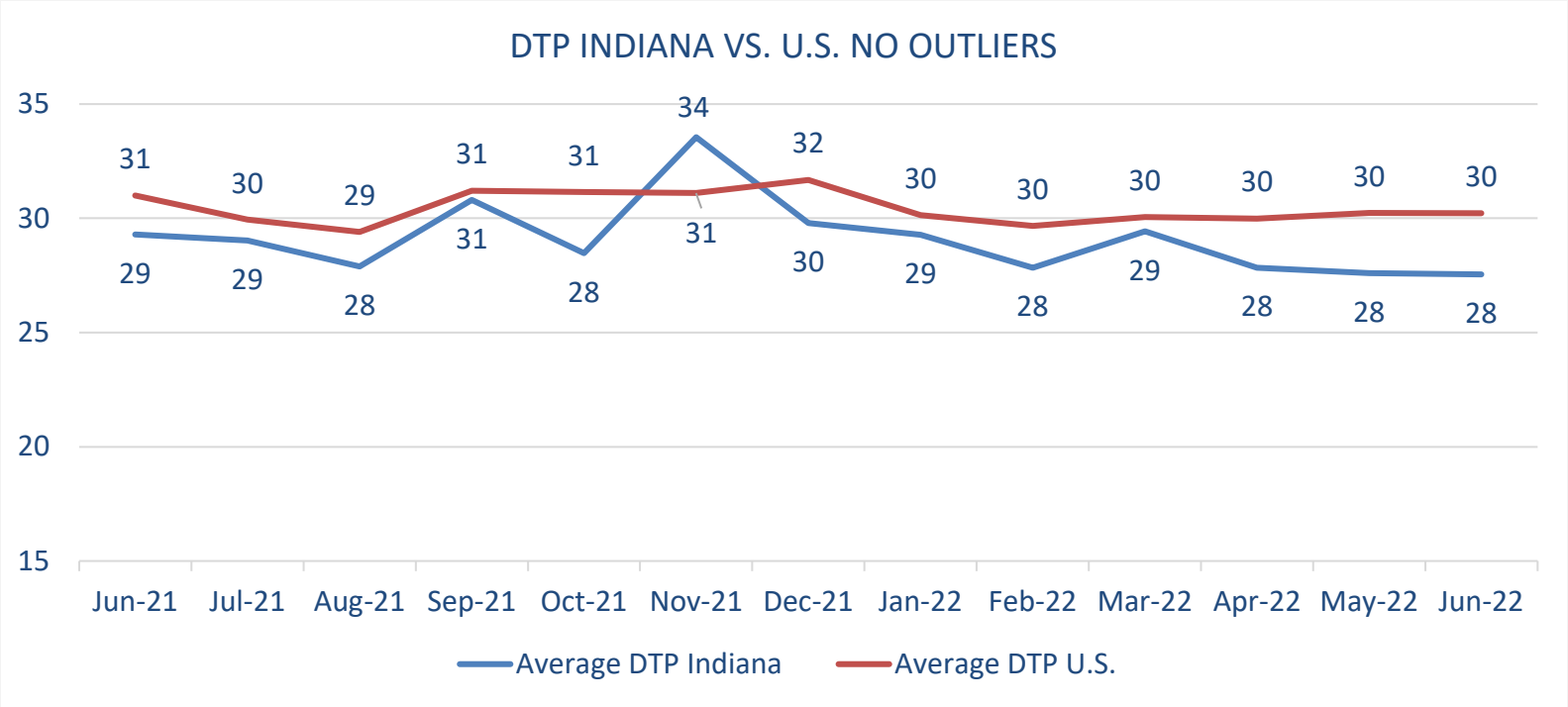
2022 YTD (Plans with > 10 Distinct Claims)

Name	Distinct Claims	Days to Pay
OHIO BLUE SHIELD	36	86
CONSOLIDATED HEALTH PLANS	14	86
PRAIRIE STATES ENTERPRISES	180	49
RETIRED RAILROAD MEDICARE	275	45
CARESOURCE OF OHIO	17	41
ANTHEM BLUE CROSS	33	39
CBSA	65	39
ALLIED BENEFIT SYSTEM, INC.	22	39
MDWISE HEALTHY INDIANA PLAN	558	38
UNITED HEALTHCARE	7,682	33

Indiana - Drugs by Highest Days to Pay No Outliers 2022 YTD (> 50 Claims)

Drug	Distinct Claims	Days to Pay
OCM MEOS Code	4,468	77
Levoleucovorin	309	49
Halaven	64	44
Adcetris	79	40
Avastin	135	40
Neulasta	104	37
Herceptin	115	36
Kyprolis	316	35
Irinotecan	1,038	35
Onpro	1,013	34
Docetaxel	702	34
Cyclophosphamide	691	34
Doxorubicin	592	33
Vincristine	238	33
Yervoy	204	32
Procrit	1,236	32
Fluorouracil	2,600	31
Leucovorin	1,948	31
Cinvanti	681	31
Rituxan	133	31
Oxaliplatin	1,141	30
Fosaprepitant	2,359	30
Cisplatin	558	30
Carboplatin	1,835	30

U.S. vs. Indiana Average Days to Pay No Outliers
June 2021 – June 2022



Drug Denials and Appeals

U.S Geographic Areas by True Denial % (Lowest → Highest) 2022 YTD

All FP Drug True Denial %:

Rank	State	True Denial %	Rank	State	True Denial %
1	NH	4.83%	23	AZ	10.21%
2	ND	5.44%	24	NC	10.78%
3	WY	5.53%	25	MO	10.99%
4	CT	5.86%	26	MN	11.70%
5	KS	5.97%	27	NM	11.70%
6	ME	5.97%	28	AR	11.75%
7	TN	6.01%	29	DC	11.79%
8	MS	6.41%	30	CO	12.15%
9	AL	7.10%	31	NJ	12.34%
10	IL	7.14%	32	WA	12.39%
11	FL	7.21%	33	MD	12.41%
12	UT	7.29%	34	OH	12.74%
13	PA	7.87%	35	NY	13.40%
14	IN	7.98%	36	AK	14.17%
15	VA	8.08%	37	OR	14.21%
16	IA	8.12%	38	HI	14.65%
17	TX	8.19%	39	ID	15.26%
18	SC	8.49%	40	NV	15.76%
19	OK	8.51%	41	CA	15.89%
20	DE	8.77%	42	MI	16.04%
21	NE	10.03%	43	LA	18.33%
22	GA	10.12%	44	KY	29.04%

U.S. National Service Data – E/M Services

Top Denial Codes July 1, 2021 – June 30, 2022

Code	Definition	lineitems	Category
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	70473	E/M
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	41894	E/M
22	This care may be covered by another payer per coordination of benefits.	35460	E/M
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	35362	E/M
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	26860	E/M
27	Expenses incurred after coverage terminated.	21257	E/M
29	The time limit for filing has expired.	20909	E/M
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	20070	E/M
204	This service/equipment/drug is not covered under the patient's current benefit plan	16492	E/M
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	15578	E/M

U.S. National Service Data - Imaging

Top Denial Codes
July 1, 2021 – June 30, 2022

Code	Definition	lineitems	Category
197	Precertification/authorization/notification absent.	17137	Imaging
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11317	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.	11220	Imaging
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	9465	Imaging
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	7056	Imaging
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6154	Imaging
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4519	Imaging
22	This care may be covered by another payer per coordination of benefits.	4247	Imaging
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2809	Imaging
27	Expenses incurred after coverage terminated.	2773	Imaging

U.S. National Service Data - Radiation Oncology

Top Denial Codes
July 1, 2021 – June 30, 2022

Code	Definition	lineitems	Category
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	10817	Radiation
197	Precertification/authorization/notification absent.	10185	Radiation
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	8050	Radiation
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	7820	Radiation
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6275	Radiation
22	This care may be covered by another payer per coordination of benefits.	4177	Radiation
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	3664	Radiation
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	3251	Radiation
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	3161	Radiation
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	2926	Radiation

U.S. National Service Data – Overall Service

Top Denial Codes July 1, 2021 – June 30,2022

Code	Definition	lineitems	Category
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	616679	OverAll
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	537081	OverAll
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	316283	OverAll
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	261209	OverAll
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	258956	OverAll
197	Precertification/authorization/notification absent.	198630	OverAll
22	This care may be covered by another payer per coordination of benefits.	194945	OverAll
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	147765	OverAll
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	142197	OverAll
29	The time limit for filing has expired.	123334	OverAll

Indiana Drugs – All Payers, Top Denial Codes 2022 YTD

Definition	Reason Code	True Denials	% of Total True Denials along Reason Code
Precertification/authorization/notification absent.	197	1,818	12%
Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	16	1,650	11%
An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	252	1,443	10%
The time limit for filing has expired.	29	1,068	7%
Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	226	1,063	7%
These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	50	949	6%
Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	129	603	4%
Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	109	557	4%
This service/equipment/drug is not covered under the patient's current benefit plan	204	540	4%
Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	96	491	3%

Indiana - Payers with Highest # True Denials 2022 YTD

Name	True Denials	True Denial Percent	Distinct Patients	Distinct Claims
INDIANA BLUE SHIELD	6,988	12.08%	3,351	17,446
UNITED HEALTHCARE	2,144	9.74%	1,503	7,774
INDIANA MEDICARE	2,126	3.15%	4,871	29,126
AETNA	541	4.87%	741	4,343
AMBETTER FROM MANAGED HEALTH SERVICES	508	17.04%	117	774
COMMUNITY PREFERRED HEALTH PLAN	381	12.74%	185	997
MDWISE HEALTHY INDIANA PLAN	316	12.86%	116	566
HUMANA	308	3.94%	560	3,403
CARESOURCE HEALTHY INDIANA PLAN (HIP)	236	49.89%	27	128
INDIAN HEALTH SERVICES	232	85.29%	6	30
HOMESTATE HEALTH PLAN	223	41.07%	19	119
CIGNA	157	9.22%	106	713
MANAGED HEALTH SERVICES - INDIANA	148	10.91%	116	454
AUTOMATED BENEFIT SERVICES	61	8.74%	44	273
AMBETTER FROM SUNSHINE HEALTH	38	65.52%	1	5

Indiana – Payers with Highest True Denial % 2022 YTD (Plans with > 10 Claims)

Name	True Denials	True Denial Percent	Distinct Patients	Distinct Claims
INDIAN HEALTH SERVICES	232	85.29%	6	30
ALL SAVERS INSURANCE	37	72.55%	4	16
CONSOLIDATED HEALTH PLANS	21	72.41%	1	14
CARESOURCE OF OHIO	21	67.74%	4	17
CARESOURCE HEALTHY INDIANA PLAN (HIP)	236	49.89%	27	128
HOMESTATE HEALTH PLAN	223	41.07%	19	119
CIGNA SELECT	25	21.55%	21	65
CBSA	34	17.53%	12	66
AMBETTER FROM MANAGED HEALTH SERVICES	523	17.29%	117	775
MDWISE HEALTHY INDIANA PLAN	343	13.38%	119	582
COMMUNITY PREFERRED HEALTH PLAN	384	12.74%	188	1,010
INDIANA BLUE SHIELD	6,988	12.08%	3,351	17,446
MANAGED HEALTH SERVICES - INDIANA	148	10.91%	116	454
CARESOURCE OF GEORGIA	7	10.77%	2	13
UNITED HEALTHCARE	2,155	9.70%	1,509	7,841

Indiana Denials : Payer Spotlight – Indiana Blue Shield 2022 YTD

Definition	Reason Code	True Denials	% of Total True Denials along Reason Code
An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	252	1,147	16%
Precertification/authorization/notification absent.	197	753	11%
Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	226	576	8%
Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	16	569	8%
The time limit for filing has expired.	29	563	8%
Expenses incurred during lapse in coverage	200	370	5%
This service/equipment/drug is not covered under the patient's current benefit plan	204	326	5%
Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	109	294	4%
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	97	289	4%
Precertification/authorization exceeded.	198	194	3%

Indiana Denials: Payer Spotlight – United Healthcare 2022 YTD

Definition	Reason Code	True Denials	% of Total True Denials along Reason Code
Precertification/authorization/notification absent.	197	538	25%
Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	226	406	19%
These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	50	383	18%
Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	16	251	12%
Expenses incurred after coverage terminated.	27	190	9%
Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	96	154	7%
Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	227	35	2%
Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	A1	31	1%
This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	234	20	1%
Expenses incurred during lapse in coverage	200	16	1%

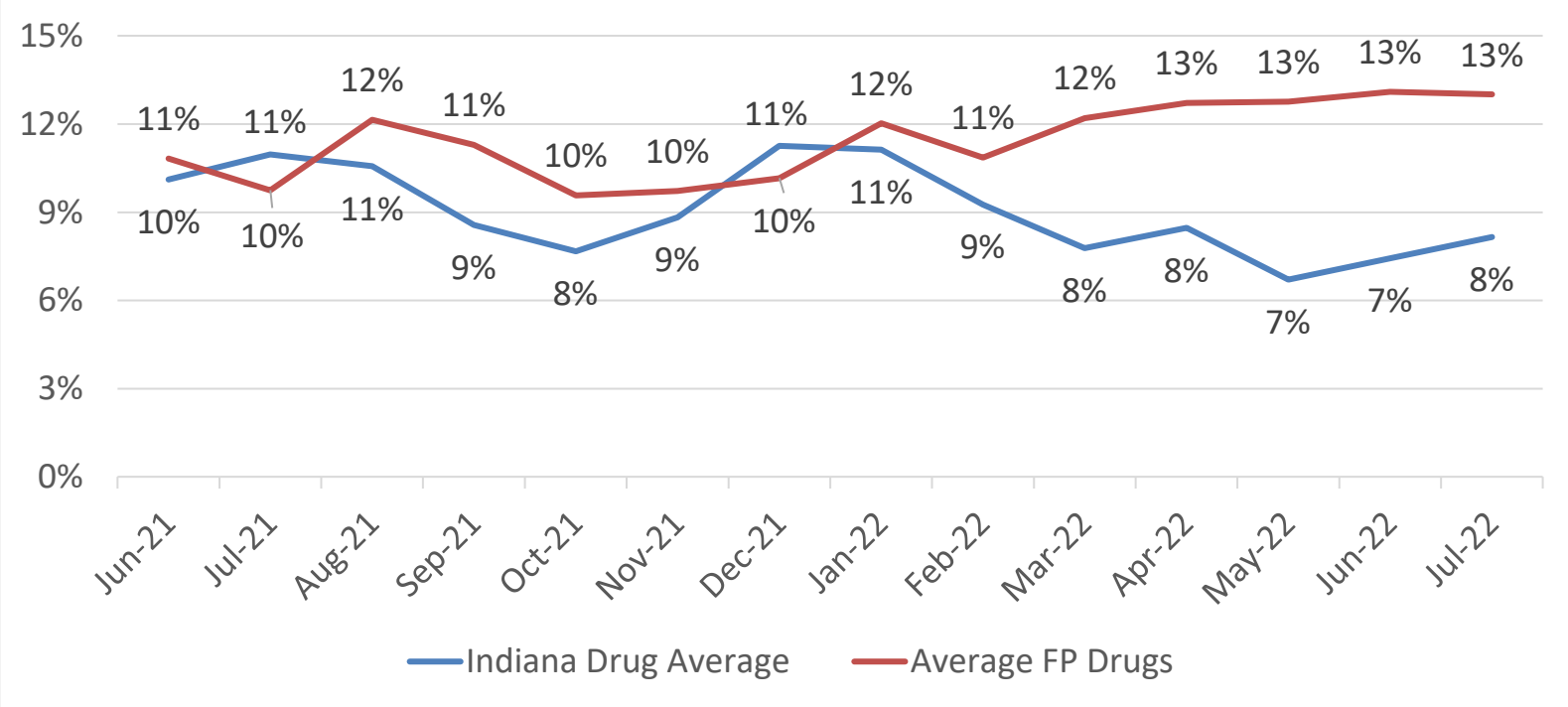
Indiana Denials: Payer Spotlight – Aetna 2022 YTD

Definition	Reason Code	True Denials	% of Total True Denials along Reason Code
Precertification/authorization/notification absent.	197	206	38%
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	97	55	10%
An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	252	53	10%
Payer deems the information submitted does not support this dosage.	153	42	8%
Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	55	42	8%
Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	96	31	6%
Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	227	27	5%
This service/equipment/drug is not covered under the patient's current benefit plan	204	20	4%
Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	226	14	3%
Expenses incurred after coverage terminated.	27	13	2%

Top Denied Drugs in Indiana 2022 YTD

Product	True Denial %	Product	True Denial %
Pemfexy	100.00%	Adakveo	18.52%
Synribo	50.00%	Retacrit (non-dialysis)	18.41%
Soliris	38.81%	Remicade	18.18%
Procrit	33.40%	Aranesp	18.01%
Octreotide	31.65%	Udenyca	17.79%
Bortezomib	31.58%	Avastin	17.09%
Blincyto	29.17%	Rituxan Hycela	16.67%
Neupogen	28.21%	Trazimera	16.29%
S0353	27.69%	Perjeta	15.87%
Aloxi	26.32%	Cinvanti	15.75%
Tivdak	23.81%	Levoleucovorin	15.22%
Enhertu	22.43%	Trodelvy	15.12%
Sandostatin	22.26%	Vincristine	14.58%
Adcetris	21.90%	Zirabev	14.34%
Herceptin	20.22%	Zometa	13.86%
Rituxan	20.21%	Jevtana	13.71%
Neulasta	20.15%	Doxorubicin	13.55%
Renflexis	20.00%	Mvasi	13.53%
Feraheme	19.97%	Abraxane	13.40%
Onpro	18.79%		

Indiana vs. U.S. True Denial %
June 2021 – June 2022



Indiana - Common Denial Codes 2022 YTD

- Denial Code 197 – Precertification/authorization absent
- Denial Code 16 – Claim lacks information for adjudication
- Denial Code 252 – An attachment/other documentation required for adjudication
- Denial Code 29 – Time for filing has expired
- Denial Code 226 – Information requested from billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.

Indiana - RARC Codes for Denial Code 16

Definition	Remark Code	True Denials
Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	M119	359.0
Missing/incomplete/invalid other diagnosis.	M64	180
Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	MA130	153
Missing/incomplete/invalid Hematocrit (HCT) value.	N764	79
Missing/incomplete/invalid HCPCS.	M20	61
Replacement/Void claims cannot be submitted until the original claim has finalized. Please resubmit once payment or denial is received.	N779	57
Missing procedure modifier(s).	N822	46
Missing/incomplete/invalid principal diagnosis.	MA63	43
A lateral diagnosis is required.	N769	25
Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	MA04	25
This should be billed with the appropriate code for these services.	N657	22

Indiana - RARC Codes for Denial Code 252

Definition	Remark Code	True Denials
Missing patient medical record for this service.	M127	438
Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	MA04	235
Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	N479	90
Additional information/explanation will be sent separately.	N202	30
Missing patient medical/dental record for this service.	N729	15
Resubmit a new claim with the requested information.	N517	15
Missing Certificate of Medical Necessity.	M60	10
Missing documentation.	N706	9
Missing/incomplete/invalid plan of treatment.	M135	8

Indiana - RARC Codes for Denial Code 226

Definition	Remark Code	True Denials
Incomplete/invalid patient medical record for this service.	N237	42
Incomplete/invalid progress notes/report.	N394	4
Information provided was illegible.	N205	3
Missing documentation.	N706	339
Missing patient medical record for this service.	M127	230
Resubmit a new claim with the requested information.	N517	22
Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	MA130	7

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 covered hospital days
- Number of SNF days used
- Any issue9s) affecting the amount of benefits payable
- Medical necessity of services
- Benefit integrity support center denials
- Prepay and postpay probes

Medicare Appeals Strategies Overview
$ Cut-offs Vary by Year

Rebuttal and Discussion Period	
Redetermination	Appeal deadline: 120 days (30 days to avoid recoupment)
Reconsideration	Appeal deadline: 180 days (60 days to avoid recoupment)
Administrative Law Judge Hearing	Appeal deadline: 60 days CMS will recoup the alleged overpayment during this and following stages of appeal
Medicare Appeals Council (MAC)	Appeal deadline: 60 days
Federal District Court	Appeal deadline: 60 days

Calculating Time Frames

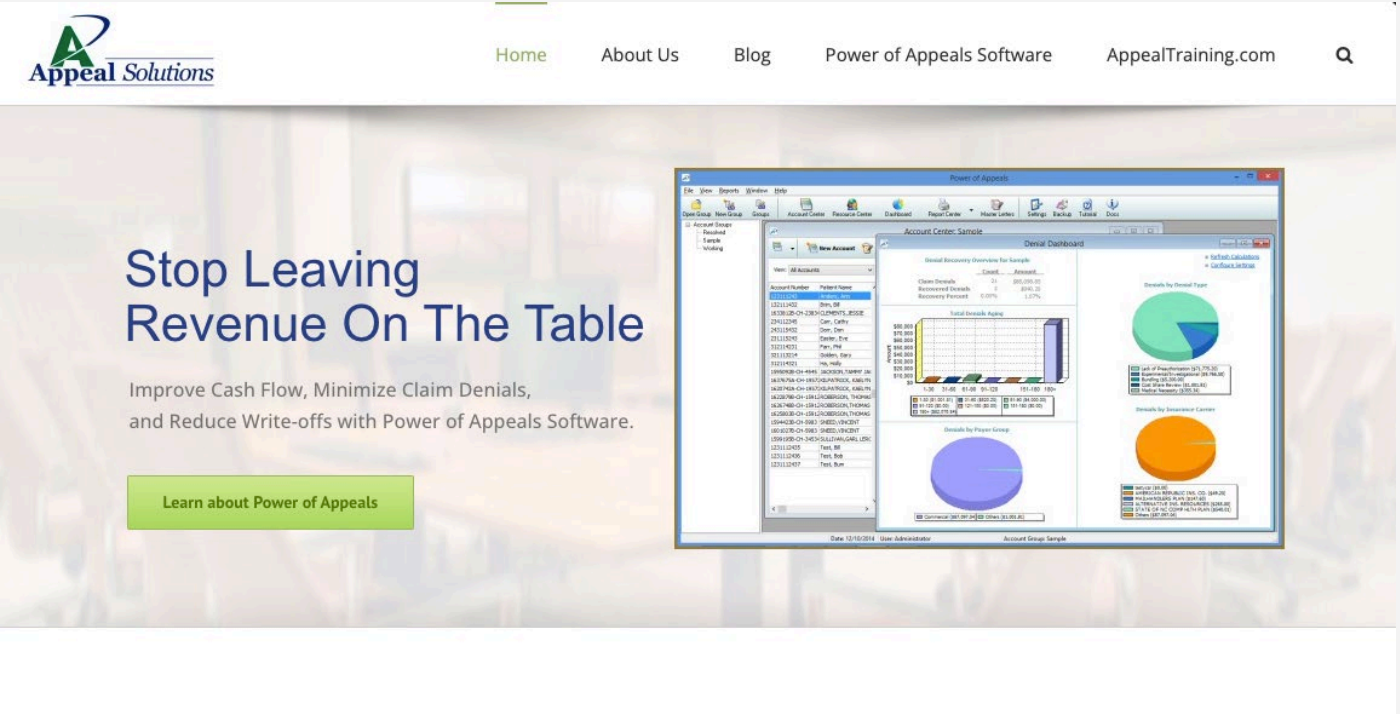
Time frames are generally calculated from date of receipt of notice

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

A Fantastic Resource



U.S. National Service Data

E/M Profiling All Practices by Payer -New Patients

Procedure Code	Payer Type	Distinct Count	Percent
99202	BCBS	828	1%
99203	BCBS	14685	15%
99204	BCBS	48868	48%
99205	BCBS	36509	36%

Procedure Code	Payer Type	Distinct Count	Percent
99202	Medicaid	68	1%
99203	Medicaid	1370	14%
99204	Medicaid	4521	47%
99205	Medicaid	3694	38%

Procedure Code	Payer Type	Distinct Count	Percent
99202	Commercial/Other	1375	1%
99203	Commercial/Other	28362	14%
99204	Commercial/Other	99653	48%
99205	Commercial/Other	78135	38%

Procedure Code	Payer Type	Distinct Count	Percent
99202	Medicare	844	1%
99203	Medicare	16738	11%
99204	Medicare	66530	45%
99205	Medicare	64412	43%

U.S. National Service Data

E/M Profiling All Practices by Payer – Established Patients

Procedure Code	Payer Type	Distinct Count	Percent
99211	BCBS	12174	1%
99212	BCBS	15517	2%
99213	BCBS	271160	32%
99214	BCBS	446887	52%
99215	BCBS	105873	12%

Procedure Code	Payer Type	Distinct Count	Percent
99211	Commercial/Other	24325	1%
99212	Commercial/Other	29701	2%
99213	Commercial/Other	540544	32%
99214	Commercial/Other	897187	53%
99215	Commercial/Other	197525	12%

Procedure Code	Payer Type	Distinct Count	Percent
99211	Medicaid	1253	1%
99212	Medicaid	1061	1%
99213	Medicaid	27715	29%
99214	Medicaid	50854	54%
99215	Medicaid	13100	14%

Procedure Code	Payer Type	Distinct Count	Percent
99211	Medicare	45103	3%
99212	Medicare	26734	1%
99213	Medicare	556096	31%
99214	Medicare	964782	54%
99215	Medicare	206596	11%

AAPC E/M Utilization Benchmarking Tool

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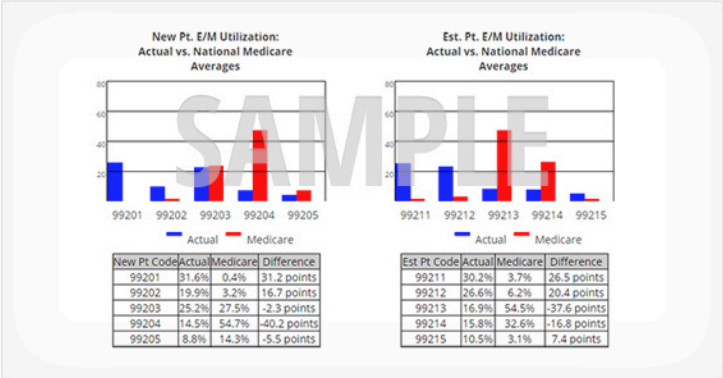
E/M Utilization Benchmarking Tool

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 2018 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

To Do's for Indiana

- Make sure that your claims match your Prior Auths 100%. This means:
  - ICD-10 codes
  - Route of therapy
  - Duration of therapy
  - Number of Cycles
  - Even HCPCS code!
- Make sure your NDCs are 5-4-2
- Aetna has very detailed policies for some cancer drugs. Ensure you know this and get prior auth if you deviate. Otherwise, you will get a "55" denial for drugs.
- Have someone in your practice be the Document Diva
- Keep up the good work!!!

Appendices
Part D and MA Appeals Process

Medicare Advantage Appeals

"Organization determination" is initial determination regarding basic and optional benefits	• Can be provided before or after services received • Issued within 14 days
May request expedited organization determination if delay could jeopardize life/health or ability to regain maximum function.	• Plan must treat as expedited if requested by doctor • Issued within 72 hours

Medicare Advantage (MA)

- Request reconsideration within 60 days of notice of the organization determination.
- Reconsideration decision issued within
  - 30 days for standard reconsideration.
  - 72 hours for expedited reconsideration.
- Unfavorable reconsiderations automatically referred to independent review entity (IRE).
  - Time frame for decision set by contract, not regulation
- Unfavorable IRE decisions may be appealed
  - to ALJ
  - to MAC
  - to Federal Court

Medicare Advantage (MA)

Fast-Track Appeals to Independent Review Entity (IRE) before services end for

- Terminations of home health, SNF, CORF
- Two-day advance notice
- Request review by noon of day after receive notice
- IRE issues decision by noon of day after day it receives appeal request

60 days to request reconsideration by IRE

- 14 days for IRE to act

Part D Appeals Process – Overview

Each drug plan must have an appeals process

- Including process for expedited requests

A coverage determination is first step to get into the appeals process

- Issued by the drug plan
- An "exception" is a type of coverage determination

Next steps include

- Redetermination by the drug plan
- Reconsideration by the independent review entity (IRE)
- Administrative law judge (ALJ) hearing
- Medicare Appeals Council (MAC) review
- Federal court

Part D Appeals Process – Coverage Determination

- A coverage determination may be requested by
  - A beneficiary
  - A beneficiary's appointed representative
  - Prescribing physician
- Drug plan must issue coverage determination as expeditiously as enrollee's health requires, but no later than
  - 72 hours standard request
    - Including when beneficiary already paid for drug
  - 24 hours if expedited- standard time frame jeopardize life/health of beneficiary or ability to regain maximum function.

Exceptions: A subset of coverage determination

- An exception is a type of coverage determination and gets enrollee into the appeals process
- Beneficiaries may request an exception
  - To cover non-formulary drugs
  - To waive utilization management requirements
  - To reduce cost sharing for formulary drug
    - No exception for specialty drugs or to reduce costs to tier for generic drugs
- A doctor must submit a statement in support of the exception

Part D Appeals – Coverage determinations are not automatic

- **A statement by the pharmacy (not by the Plan) that the Plan will not cover a requested drug is not a coverage determination**
  - Enrollee who wants to appeal must contact drug plan to get a coverage determination
  - Drug plan must arrange with network pharmacies
    - To post generic notice telling enrollees to contact plan if they disagree with information provided by pharmacist or
    - To distribute generic notice

Part D Appeals Process – Next Steps

- If a coverage determination is unfavorable:
  - Redetermination by the drug plan.
    - Beneficiary has 60 days to file written request (plan may accept oral requests).
    - Plan must act within 7 days - standard
    - Plan must act within 72 hrs.- expedited
  - Then, Reconsideration by IRE
    - Beneficiary has 60 days to file written request
    - IRE must act w/i 7 days standard, 72 hrs. expedited
  - ALJ hearing
  - MAC review
  - Federal court

Part D Grievance Process