Revenue Cycle State of the State:

Where are we? How can we fight delays and denials?

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

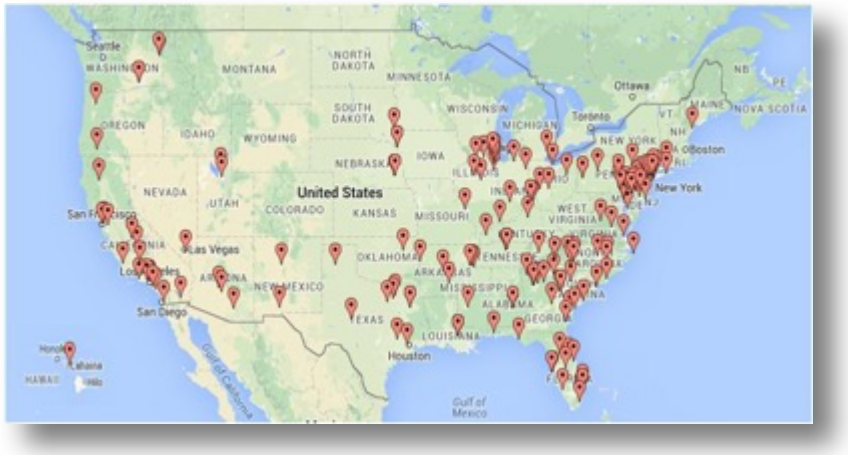
- focalPoint Data Set
- The Revenue Cycle: Where Are We?
  - ❑ Accounts Receivable Aging
  - ❑ Days to Pay
  - ❑ Days to File
  - ❑ Collection Rates/ Contractual Adjustments
  - ❑ Top Tens
  - ❑ Profiling

Denials

- ❑ Denial Rates
- ❑ Top Denial Codes
- ❑ What To Do???

Our Data Source

FocalPoint 2016 Data Represents 165+ Cancer Centers, 725 sites of service,
478 payers and 2,300 Hematologists and Oncologists

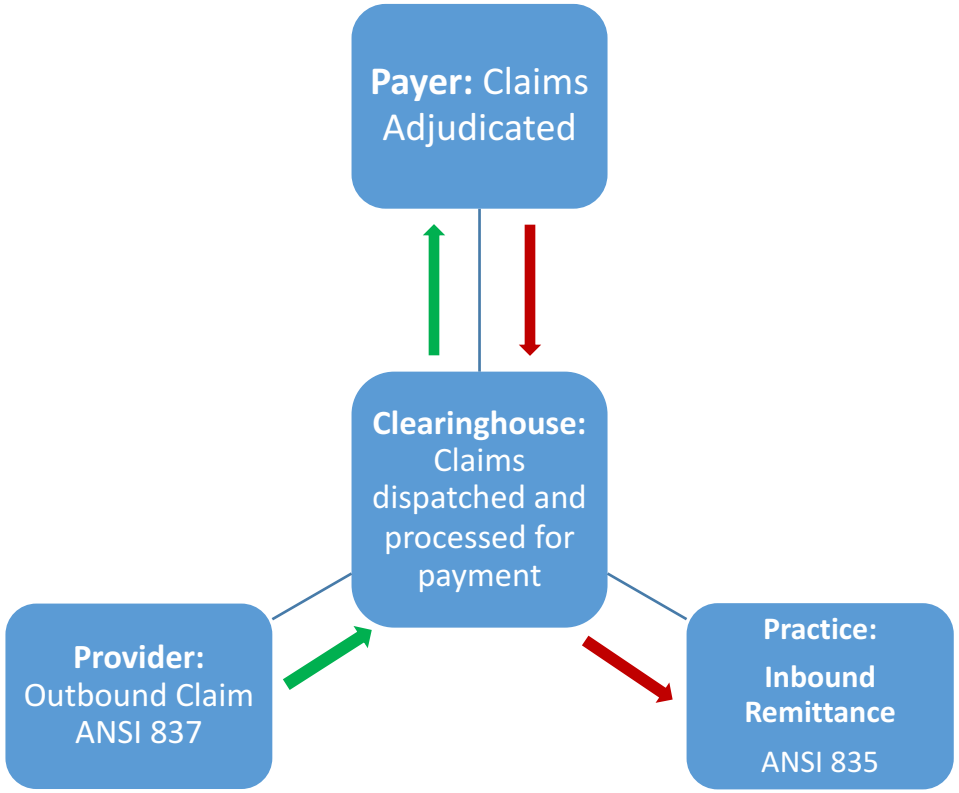


Metrics Through December 20, 2017	Total for Drugs	California for Drugs
Payer responses to claims (includes submission and resubmissions)	7,011,350	335,133
Distinct patients	319,711	17, 481
Distinct claims	2,256, 924	112,198

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

- 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
  - Resubmission Rate = Payer responses divided by number of claims
- 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

The Who, Snafus, and Best Practices

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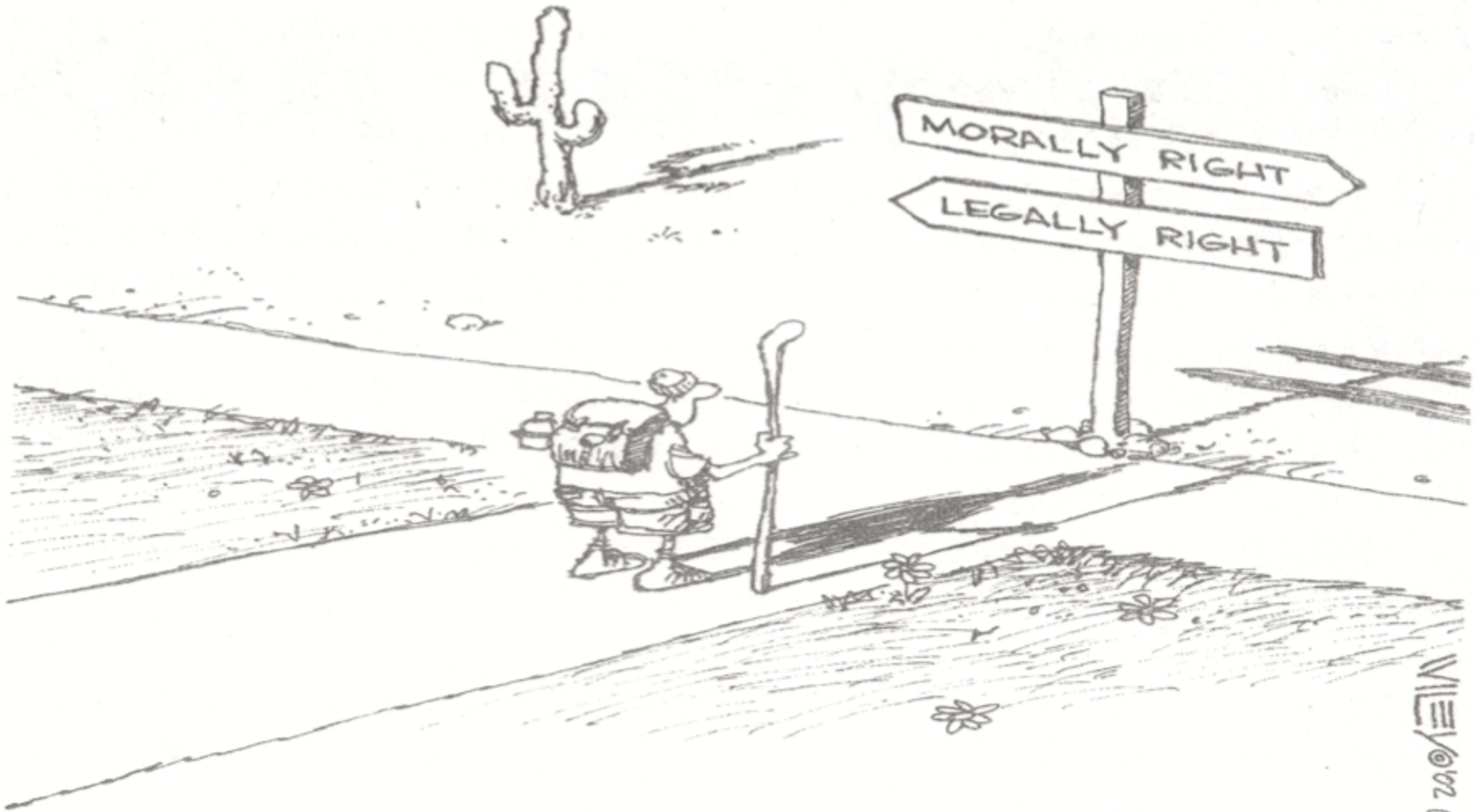
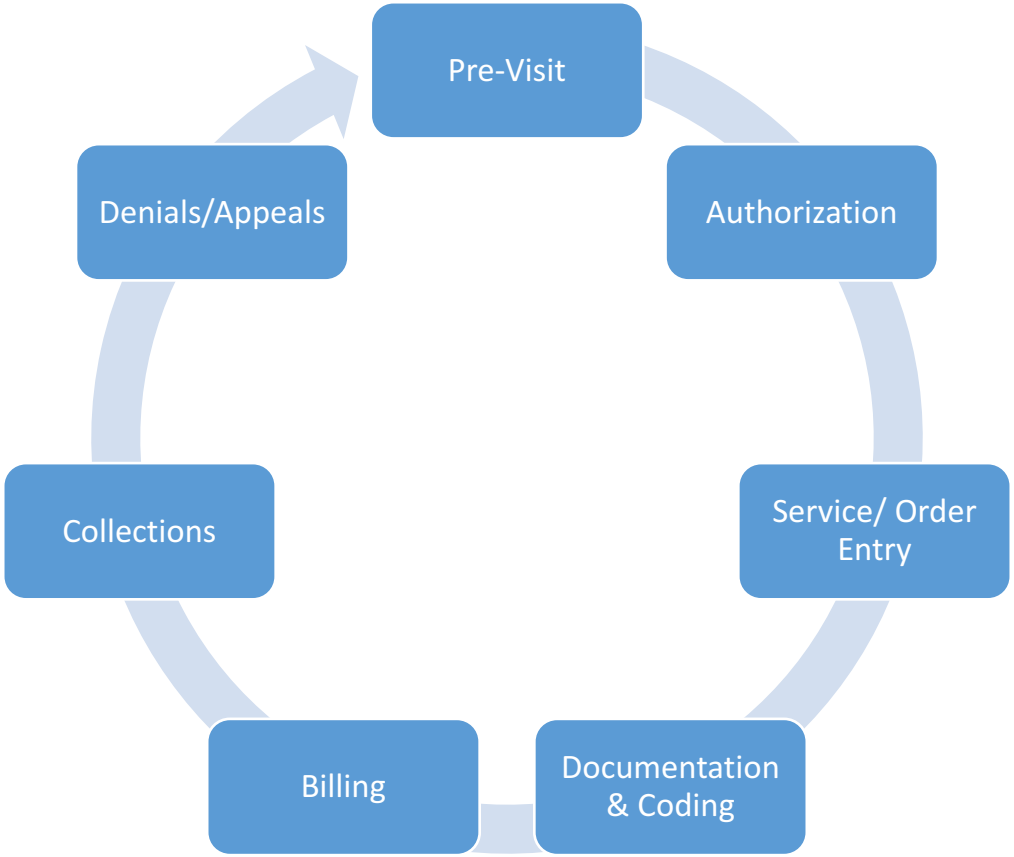
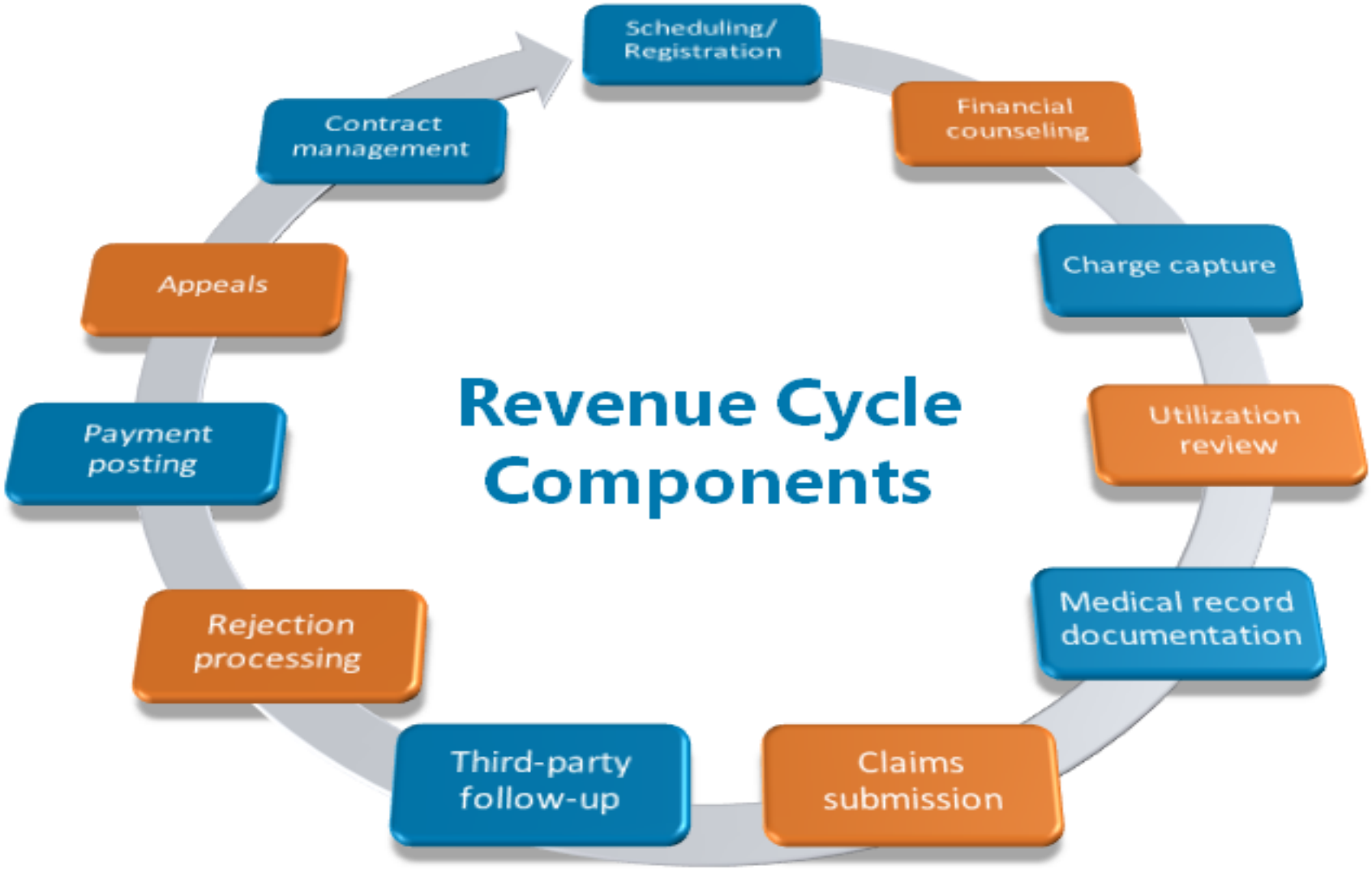


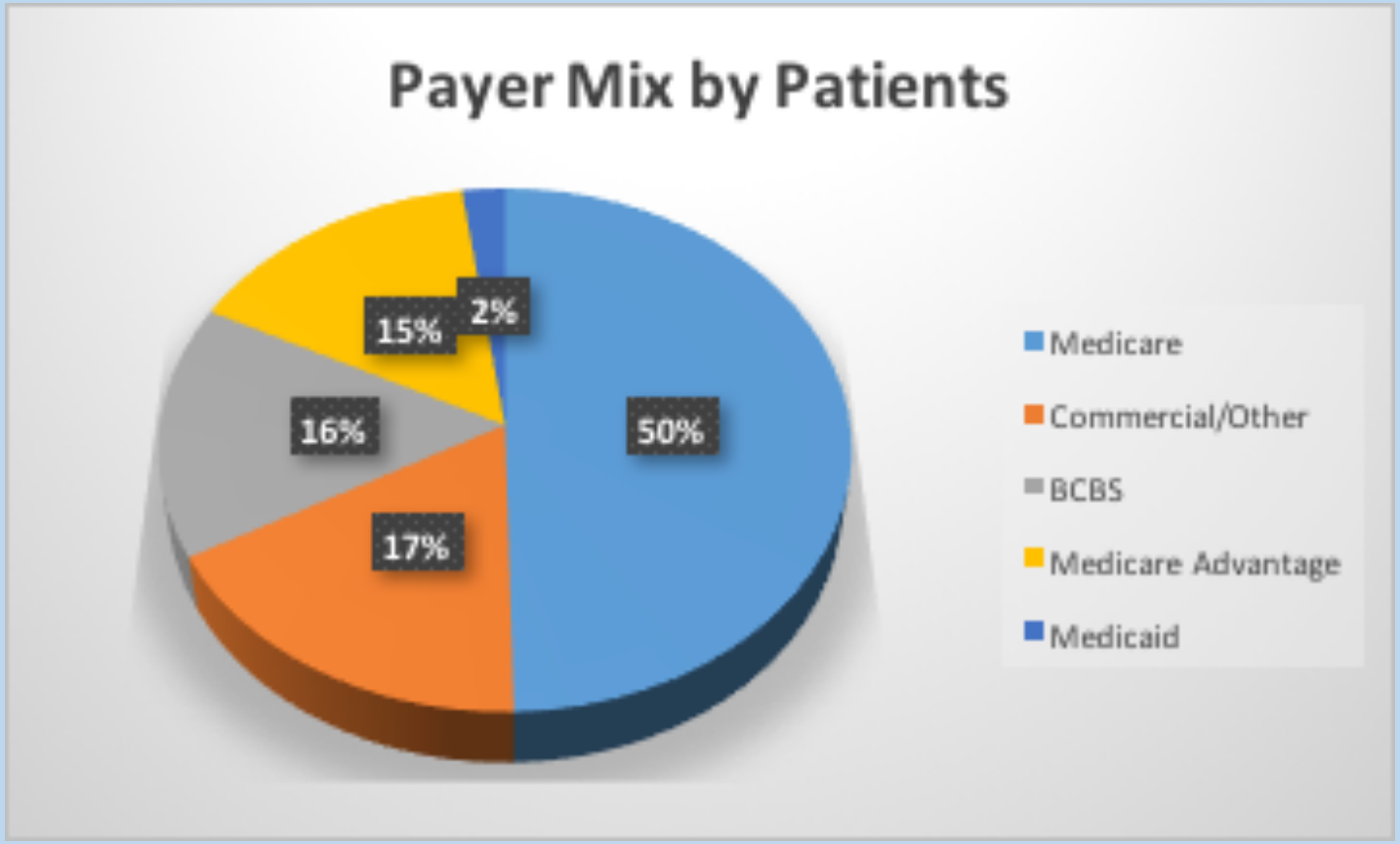
The Billing Cycle: Average Office



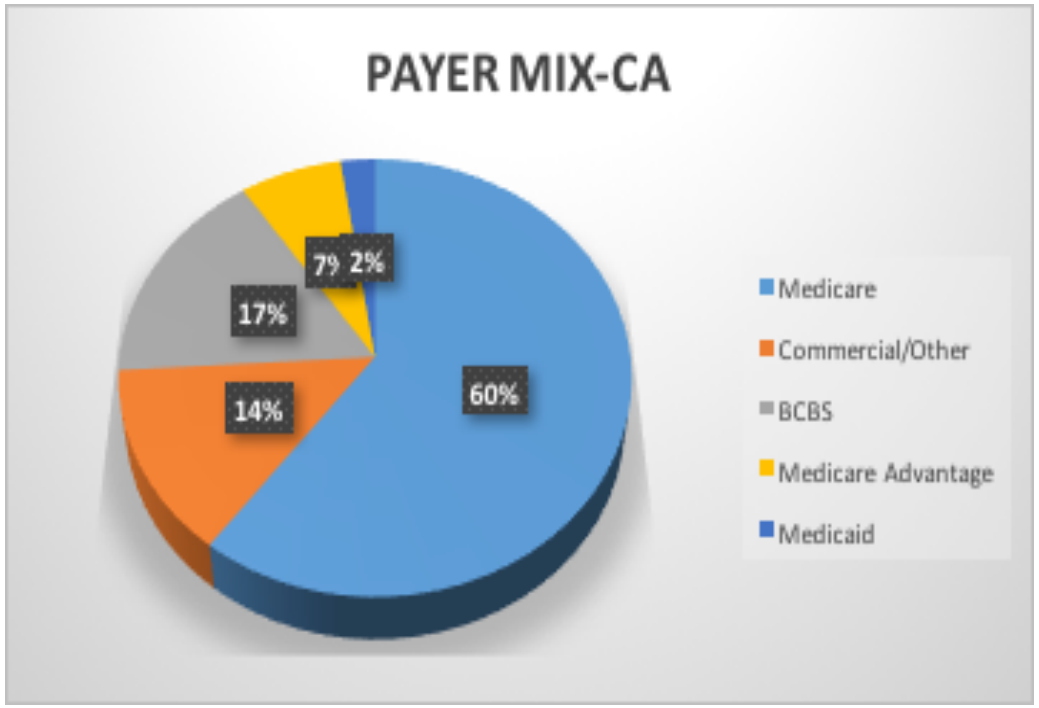
Revenue Cycle: Hospitals



Payer Mix focalPoint Database All of U.S.



Payer Mix by Patients—California



Part B Accounts Receivable: Total Across U.S. (2016)

Caveats

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

In terms of line items in A/R

- 0-30 Days = 68%
- 31-60 Days = 18%
- 61-90 Days = 4%
- 91-120 Days = 2%
- 120+ Days = 8%

In terms of $ in A/R

- 0-30 Days = 73%
- 31-60 Days = 16%
- 61-90 Days = 4%
- 91-120 Days = 2%
- 120+ Days = 5%

Part B: Account Aging for Injectable Drugs California 2017 (Insurance Only-Over $40K Payers)

Name	Actual Allowed	Payment Amount	Non-Reimbursed Amount	Days to File	Days to Pay	Payer Responses	True Denials	True Denial Percent	Distinct Patients	Distinct Claims	% 0 to 30	% 31 to 60	% 61 to 90	% 91 to 120	% Over 120
Grand Total	$250,931,868	$132,135,884	$118,795,984.37	19	44	335,143	30,516	9.11%	17,481	112,198	64%	15%	5%	3%	13%
NORTHERN CALIFORNIA MEDICARE	$101,473,508	$51,707,888	$49,765,620.33	17	35	125,384	7,886	6.29%	6,622	47,847	71%	14%	3%	2%	10%
SOUTHERN CALIFORNIA MEDICARE	$61,910,460	$30,263,719	$31,646,741.35	16	35	82,283	7,631	9.27%	4,307	28,773	71%	15%	4%	2%	7%
ANTHEM BLUE CROSS	$27,283,573	$15,229,607	$12,053,965.65	22	50	32,568	2,172	6.67%	2,232	9,737	54%	14%	8%	6%	18%
CALIFORNIA BLUE CROSS	$15,121,223	$10,281,868	$4,839,354.16	14	48	22,580	1,675	7.42%	1,307	6,142	65%	10%	5%	5%	15%
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	$7,342,162	$4,302,357	$3,039,804.50	35	61	9,366	1,188	12.68%	647	3,105	42%	23%	6%	5%	24%
UNITED HEALTHCARE	$7,165,176	$5,134,799	$2,030,377.02	17	36	10,328	2,311	22.38%	591	2,963	63%	14%	7%	5%	11%
CALIFORNIA MEDI-CAL	$6,862,598	$2,567,683	$4,294,915.29	51	150	13,958	2,136	15.30%	433	3,282	34%	12%	4%	2%	47%
ALLIANCE IPA	$6,218,836	$1,632,312	$4,586,523.54	12	44	9,045	451	4.99%	320	2,906	68%	16%	4%	5%	7%
AETNA	$4,611,901	$1,956,131	$2,655,769.97	19	55	5,518	1,966	35.63%	315	1,287	25%	44%	8%	6%	17%
INLAND EMPIRE HEALTH PLAN	$4,064,366	$3,592,748	$471,618.34	14	24	9,172	256	2.79%	350	2,534	78%	15%	2%	1%	2%
BROWN AND TOLAND MEDICAL GROUP	$2,274,000	$1,558,979	$715,021.27	9	58	3,131	734	23.44%	145	873	20%	47%	17%	7%	9%
GOLD COAST HEALTH PLAN	$1,858,662	$1,230,818	$627,843.47	27	78	3,178	778	24.48%	125	553	13%	28%	19%	7%	32%
CIGNA	$1,832,318	$1,158,955	$673,362.66	16	48	2,165	161	7.44%	138	534	59%	13%	7%	3%	17%
RETIRED RAILROAD MEDICARE	$889,077	$336,594	$552,483.29	30	40	683	144	21.08%	60	307	61%	21%	5%	3%	9%
NOBLE AMA SELECT IPA	$316,797	$209,139	$107,657.78	11	133	408	93	22.79%	26	132	1%	28%	17%	15%	39%
LASALLE MEDICAL ASSOCIATES	$215,922	$130,397	$85,524.36	9	154	270	10	3.70%	16	61	0%	7%	16%	22%	55%
AFFINITY MEDICAL GROUP	$174,878	$102,303	$72,574.82	2	189	386	134	34.72%	21	53	0%	5%	10%	8%	77%
SANTE HEALTH SYSTEM AND AFFILIATES	$162,535	$59,151	$103,383.25	17	79	111	42	37.84%	21	39	39%	8%	3%	14%	36%
MOLINA HEALTHCARE OF CALIFORNIA	$124,198	$105,010	$19,188.04	97	176	204	91	44.61%	17	55	15%	21%	1%	1%	62%
KEY MEDICAL GROUP	$104,453	$38,342	$66,110.85	13	131	243	15	6.17%	13	43	9%	20%	22%	15%	34%
ADVANTEK BENEFIT ADMINISTRATORS	$103,495	$56,131	$47,364.03	18	80	168	9	5.36%	1	18	0%	14%	26%	49%	11%
CALIFORNIA BLUE SHIELD - HMO	$75,354	$35,614	$39,740.33	72	98	98	16	16.33%	10	18	11%	29%	2%	8%	50%
HILL PHYSICIANS MEDICAL GROUP	$60,616	$22,584	$38,031.30	3	194	44	11	25.00%	6	11	0%	2%	7%	2%	89%
COMMUNITY HEALTH CENTER NETWORK	$58,428	$29,029	$29,399.24	3	542	64	2	3.13%	2	7	0%	0%	0%	0%	100%
MOSAIC IPA MEDICAL GROUP	$53,486	$21,766	$31,719.18	20	205	336	137	40.77%	23	68	2%	2%	23%	14%	59%
ST. JOSEPH HERITAGE HEALTHCARE	$52,684	$43,774	$8,909.70	5	36	52	13	25.00%	9	21	46%	25%	0%	0%	29%
HUMANA	$49,539	$38,723	$10,816.12	23	122	203	55	27.09%	18	93	24%	12%	4%	8%	52%
ANGELES IPA	$46,099	$18,899	$27,199.33	26	142	139	36	25.90%	23	62	17%	8%	6%	14%	55%
DELTA HEALTH SYSTEMS	$41,711	$37,399	$4,312.49	12	96	100	2	2.00%	14	41	0%	21%	33%	13%	33%

“Old” Drug Claims (≥ 180 days) in California 2017 YTD

Name	Distinct Patients	Distinct Claims	Payer Responses	True Denial Percent	Zero Paid Claims	Zero Paid Percent
NORTHERN CALIFORNIA MEDICARE	6,292	42,051	111,591	6.43%	213	0.51%
SOUTHERN CALIFORNIA MEDICARE	4,091	25,957	74,525	9.24%	170	0.65%
CALIFORNIA MEDI-CAL	402	2,888	11,937	15.57%	163	5.64%
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	582	2,697	8,258	12.35%	144	5.34%
ANTHEM BLUE CROSS	2,096	8,730	29,008	6.64%	126	1.44%
CALIFORNIA BLUE CROSS	1,194	5,246	19,623	6.97%	60	1.14%
ALLIANCE IPA	296	2,491	7,767	5.14%	49	1.97%
UNITED HEALTHCARE	543	2,525	8,745	20.83%	41	1.62%
GOLD COAST HEALTH PLAN	123	551	3,175	24.44%	34	6.17%
AETNA	296	1,115	4,772	35.54%	33	2.96%
ANGELES IPA	21	55	123	20.33%	12	21.82%
MOSAIC IPA MEDICAL GROUP	19	58	293	34.47%	11	18.97%
NOBLE AMA SELECT IPA	24	103	321	24.92%	11	10.68%
AFFINITY MEDICAL GROUP	21	53	386	34.72%	10	18.87%
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	16	62	232	30.17%	10	16.13%
CIGNA	130	464	1,779	7.14%	9	1.94%
GREATER ORANGE COUNTY MEDICAL GROUP	5	9	28	25.00%	7	77.78%
HEATLHCARE LA, IPA	18	30	93	34.41%	6	20.00%
MOLINA HEALTHCARE OF CALIFORNIA	10	36	74	82.43%	6	16.67%
BROWN AND TOLAND MEDICAL GROUP	136	787	2,867	23.54%	5	0.64%
KERN HEALTH SYSTEMS	279	430	475	2.53%	4	0.93%
LASALLE MEDICAL ASSOCIATES	14	52	225	2.67%	4	7.69%
HUMANA	10	26	103	20.39%	3	11.54%
MEDICARE ADVANTAGE DME (DMENSION)	92	555	1,185	1.18%	3	0.54%
PINNACLE CLAIMS MANAGEMENT, INC.	7	10	12	33.33%	3	30.00%
SANTE HEALTH SYSTEM AND AFFILIATES	20	37	107	36.45%	3	8.11%
HILL PHYSICIANS MEDICAL GROUP	6	11	44	25.00%	2	18.18%
INLAND EMPIRE HEALTH PLAN	310	2,154	7,540	2.03%	2	0.09%
AFFILIATED DOCTORS OF ORANGE COUNTY (ADOC)	2	2	30	96.67%	1	50.00%
CARE 1ST HEALTH PLAN OF CALIFORNIA	3	4	19	31.58%	1	25.00%
DELTA HEALTH SYSTEMS	14	41	100	2.00%	1	2.44%
HEALTH NET OF CALIFORNIA - ENCOUNTERS	1	1	1	100.00%	1	100.00%
KEY MEDICAL GROUP	13	41	194	6.70%	1	2.44%
RETIRED RAILROAD MEDICARE	56	267	583	18.35%	1	0.37%
ST. JOSEPH HERITAGE HEALTHCARE	9	21	43	27.91%	1	4.76%

Revenue Cycle Metrics

A/R Balance and A/R Days

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

Billing Work in Process

- 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**

Follow-up Work in Process

- 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

A/R Aging from Date of Service

- 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

Revenue Cycle Metrics

Cash Factor (Cash/3 month Average Daily Revenue)

- Measures the cash momentum by accounting for shifts in revenue
- Not a good relative measure against other organizations due to contractual differences

Collections

- # of accounts collected per day, week, month by $ size, age, unit, and individual

Write-Off % (ABCs)

- Measure of dollars written off of A/R balance as % of Gross Revenue
- Improvement in Revenue Cycle performance should focus on Non-Routine Administrative and Bad Debt write-offs
- Administrative Write-offs
  - Routine Write-Offs: includes discounts, contractual adjustments
  - Non-Routine Write-Offs: includes write-offs for timely filing, billing, eligibility errors
- Bad Debt Write-Offs
  - Measure of uncollected self pay accounts
  - Typically written off to a collection agency for follow-up
- PAP and Co-pay' Write-Offs'
  - Measure of accounts written off based on program guidelines
  - Track dollar amounts for assistance and no assistance
- Analysis of write-offs in conjunction with A/R performance prevents achieving A/R reduction goals through increased write-offs

Days to File By Service (With Outliers)- 2017

Service Type	Days to File
E/M	16
Imaging	16
Radiation	20
Drugs	18
ALL SERVICES	14

Top Payers DTF Without Outliers for Drugs-California (≥ 5 Claims; ≥ 7 Days) 2017

Name	Payer Responses	Distinct Patients	Distinct Claims	Days to File
MOLINA HEALTHCARE OF CALIFORNIA	58	15	21	23
SCAN HEALTH PLAN	119	2	12	19
ADVANTEK BENEFIT ADMINISTRATORS	167	1	17	18
CARE 1ST HEALTH PLAN OF CALIFORNIA	16	4	7	18
SOUTHERN CAL PHYSICIANS MANAGED CARE	51	3	8	15
KEY MEDICAL GROUP	167	12	37	15
KERN HEALTH SYSTEMS	251	192	238	15
HUMANA	134	16	76	13
MEDICARE DME MAC JURISDICTION D	90	10	36	11
MEDICARE ADVANTAGE DME (DMENSION)	409	54	200	11
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	115	14	36	11
GREATER ORANGE COUNTY MEDICAL GROUP	29	5	11	10
AETNA	4,085	268	1,016	10
DELTA HEALTH SYSTEMS	86	14	36	9
PINNACLE CLAIMS MANAGEMENT, INC.	15	7	9	9
INLAND EMPIRE HEALTH PLAN	6,481	305	1,744	9
CALIFORNIA MEDI-CAL	6,856	328	2,338	9
ABMA (ALTA BATEES MEDICAL ASSOCIATES) MEDICAL CORP	11	4	8	8
ANTHEM BLUE CROSS	21,531	1,922	7,001	8
RETIRED RAILROAD MEDICARE	494	47	209	8
GOLD COAST HEALTH PLAN	2,052	111	459	8
UNITED HEALTHCARE	7,150	493	2,175	8
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	6,108	503	2,166	8
NOBLE AMA SELECT IPA	283	24	97	7
ALLIANCE IPA	5,871	278	2,001	7
CALIFORNIA BLUE CROSS	16,388	1,171	4,759	7
SOUTHERN CALIFORNIA MEDICARE	60,136	3,874	21,047	7
NORTHERN CALIFORNIA MEDICARE	87,319	5,797	33,211	7
CIGNA	1,376	117	373	7
HEATLHCARE LA, IPA	82	16	27	7
SANTE HEALTH SYSTEM AND AFFILIATES	77	13	28	7
CALIFORNIA BLUE SHIELD - HMO	63	9	16	7

Days To File Outliers for Drugs—California
≥ 5 Claims in 2017

Name	Payer Responses	Distinct Patients	Distinct Claims	Days to File
CALIFORNIA MEDI-CAL	3,720	351	1,001	236
HEATLHCARE LA, IPA	25	6	10	224
SANTE HEALTH SYSTEM AND AFFILIATES	52	13	18	219
PINNACLE CLAIMS MANAGEMENT, INC.	20	4	6	183
CALIFORNIA BLUE SHIELD	9	4	5	165
MOLINA HEALTHCARE OF CALIFORNIA	99	4	35	154
CALIFORNIA BLUE CROSS	2,631	303	512	154
UNITED HEALTHCARE	1,739	218	394	153
NORTHERN CALIFORNIA MEDICARE	14,530	2,829	7,251	153
ALLIANCE IPA	747	97	201	149
SOUTHERN CALIFORNIA MEDICARE	9,946	1,493	4,028	146
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	3,629	352	921	144
ANTHEM BLUE CROSS	6,981	627	1,468	133
GOLD COAST HEALTH PLAN	2,245	82	232	130
RETIRED RAILROAD MEDICARE	155	39	83	130
INLAND EMPIRE HEALTH PLAN	460	83	188	126
ANGELES IPA	20	6	8	126
AETNA	866	96	173	124
CIGNA	373	30	86	124
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMP/	63	11	20	119
HUMANA	27	5	8	108
MEDICARE ADVANTAGE DME (DMENSION)	248	34	85	103
NORTH DAKOTA MEDICARE	17	3	6	87
KERN HEALTH SYSTEMS	37	22	23	83
BROWN AND TOLAND MEDICAL GROUP	340	56	78	83
NOBLE AMA SELECT IPA	25	6	6	80
LASALLE MEDICAL ASSOCIATES	60	10	13	77
KEY MEDICAL GROUP	9	4	6	66

Top Drugs in Terms of Days To File--California

	Synribo	Melphalan	Temozolomi	Akynzeo	Portrazza	Zevalin	Yondelis	Xofigo	Levoleucovo	Onivyde	Sylvant	Provenge	Blincyto	Lartruvo	Tecentriq	Bavencio	Empliciti
Distinct Clair	45	8	75	123	728	39	456	1,067	2,830	2,014	161	934	40	867	4,721	81	4,545
Days to File	31	27	22	21	15	14	12	11	11	11	11	11	10	9	9	9	9

Days To Pay With Outliers 2016 by Service

Type of Service	Days To Pay
E/M	18 days
Imaging	46 days
Radiation	28 days
Drugs	41 days
ALL SERVICES	22 days

Top Worst Insurance Companies by Days To Pay-IV Drugs (Without Outliers) California 2017 (≥ 5 Claims)

Name	Billed Units	Distinct Claims	Days to Pay
SCAN HEALTH PLAN	3,547	13	100
ANGELES IPA	3,498	33	99
LASALLE MEDICAL ASSOCIATES	14,739	42	88
DELTA HEALTH SYSTEMS	6,919	32	80
AFFINITY MEDICAL GROUP	11,265	45	78
PINNACLE CLAIMS MANAGEMENT, INC.	677	9	77
MOSAIC IPA MEDICAL GROUP	1,475	54	73
ADVANTEK BENEFIT ADMINISTRATORS	13,652	18	72
COMMUNITY PREFERRED HEALTH PLAN	21	5	67
NOBLE AMA SELECT IPA	18,340	86	66
SANTE HEALTH SYSTEM AND AFFILIATES	2,804	29	63
KEY MEDICAL GROUP	6,208	38	62
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	1,636	35	62
CALIFORNIA BLUE SHIELD	554	5	62
HUMANA	6,239	65	59
HEATLHCARE LA, IPA	5,383	23	51
GOLD COAST HEALTH PLAN	105,517	493	50
BROWN AND TOLAND MEDICAL GROUP	175,350	584	48
CALIFORNIA BLUE SHIELD - HMO	3,001	18	48
MEDICARE DME MAC JURISDICTION D	427	37	46
HILL PHYSICIANS MEDICAL GROUP	1,731	10	40
CHAMPVA - HAC	95	7	39
AETNA	224,762	1,057	37
MEDICARE ADVANTAGE DME (DMENSION)	543	218	35
MOLINA HEALTHCARE OF CALIFORNIA	13,893	42	35
AMVI / PROSPECT HEALTH NETWORK	930	5	34
CALIFORNIA MEDI-CAL	465,691	2,307	33
SOUTHERN CAL PHYSICIANS MANAGED CARE	5,004	8	33
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	445,679	2,379	32
KERN HEALTH SYSTEMS	1,130	240	32

Top 25 Worst Insurance CA Companies by Days To Pay-IV Drugs--Outliers in 2017 (N ≥ 5 claims)

Name	Distinct Claims	Days to Pay
CALIFORNIA MEDI-CAL	810	565
COMMUNITY HEALTH CENTER NETWORK	7	542
MOSAIC IPA MEDICAL GROUP	10	392
KEY MEDICAL GROUP	7	321
HUMANA	28	291
AFFINITY MEDICAL GROUP	25	268
NORTHERN CALIFORNIA MEDICARE	1,554	260
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	354	232
LASALLE MEDICAL ASSOCIATES	22	226
MOLINA HEALTHCARE OF CALIFORNIA	16	224
SANTE HEALTH SYSTEM AND AFFILIATES	6	219
HEATLHCARE LA, IPA	8	219
SOUTHERN CALIFORNIA MEDICARE	1,311	216
AETNA	71	208
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	11	208
BROWN AND TOLAND MEDICAL GROUP	40	197
ALLIANCE IPA	57	197
HILL PHYSICIANS MEDICAL GROUP	7	193
RETIRED RAILROAD MEDICARE	15	184
KERN HEALTH SYSTEMS	8	172
NOBLE AMA SELECT IPA	27	165
GOLD COAST HEALTH PLAN	74	164
DELTA HEALTH SYSTEMS	7	159
ANTHEM BLUE CROSS	1,241	137
CALIFORNIA BLUE CROSS	942	134
UNITED HEALTHCARE	208	130
CIGNA	105	92
INLAND EMPIRE HEALTH PLAN	45	90

Top Ten Injectable Drugs DTP for 2017 In California

	Leukine	Xofigo	Lartruvo	Synribo	Treanda	Provenge	Beleodaq	Blincyto	Tecentriq	Zaltrap	Perjeta	Fusilev	Sustol	Onivyde
Distinct Claims	207	19	21	3	35	9	9	16	80	22	633	928	17	42
Days to Pay	71	67	65	64	55	55	48	45	37	36	32	31	31	30

Re-Submission Rate 2017: U.S. and California

U.S. = 1.62 times

Name	ReSubmission Rate	Days to File	Days to Pay	Payer Responses	True Denials	True Denial Percent	Distinct Patients	Distinct Claims
Grand Total	1.37	19	44	335,143	30,516	9.11%	17,481	112,198
NORTHERN CALIFORNIA MEDICARE	1.35	17	35	125,384	7,886	6.29%	6,622	47,847
SOUTHERN CALIFORNIA MEDICARE	1.34	16	35	82,283	7,631	9.27%	4,307	28,773
ANTHEM BLUE CROSS	1.39	22	50	32,568	2,172	6.67%	2,232	9,737
CALIFORNIA BLUE CROSS	1.39	14	48	22,580	1,675	7.42%	1,307	6,142
CALIFORNIA MEDI-CAL	1.76	51	150	13,958	2,136	15.30%	433	3,282
UNITED HEALTHCARE	1.32	17	36	10,328	2,311	22.38%	591	2,963
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	1.39	35	61	9,366	1,188	12.68%	647	3,105
INLAND EMPIRE HEALTH PLAN	1.1	14	24	9,172	256	2.79%	350	2,534
ALLIANCE IPA	1.19	12	44	9,045	451	4.99%	320	2,906
AETNA	1.29	19	55	5,518	1,966	35.63%	315	1,287
GOLD COAST HEALTH PLAN	1.4	27	78	3,178	778	24.48%	125	553
BROWN AND TOLAND MEDICAL GROUP	1.46	9	58	3,131	734	23.44%	145	873
CIGNA	1.39	16	48	2,165	161	7.44%	138	534
MEDICARE ADVANTAGE DME (DMENSION)	1.06	19	155	1,215	14	1.15%	93	570
RETIRED RAILROAD MEDICARE	1.34	30	40	683	144	21.08%	60	307
KERN HEALTH SYSTEMS	1.08	19	36	578	13	2.25%	328	520
NOBLE AMA SELECT IPA	1.37	11	133	408	93	22.79%	26	132
AFFINITY MEDICAL GROUP	2.04	2	189	386	134	34.72%	21	53
MOSAIC IPA MEDICAL GROUP	1.69	20	205	336	137	40.77%	23	68
LASALLE MEDICAL ASSOCIATES	1.43	9	154	270	10	3.70%	16	61
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	1.03	38	123	243	75	30.86%	17	64
KEY MEDICAL GROUP	1.91	13	131	243	15	6.17%	13	43
MOLINA HEALTHCARE OF CALIFORNIA	1.38	97	176	204	91	44.61%	17	55
HUMANA	1.41	23	122	203	55	27.09%	18	93
ADVANTEK BENEFIT ADMINISTRATORS	1.98	18	80	168	9	5.36%	1	18
MEDICARE DME MAC JURISDICTION D	1.15	15	74	142	17	11.97%	15	61
ANGELES IPA	1.19	26	142	139	36	25.90%	23	62
SCAN HEALTH PLAN	2.27	19	135	125	50	40.00%	3	13
SANTE HEALTH SYSTEM AND AFFILIATES	1.76	17	79	111	42	37.84%	21	39
HEATLHCARE LA, IPA	1.33	12	165	106	34	32.08%	20	35
DELTA HEALTH SYSTEMS	1.18	12	96	100	2	2.00%	14	41
CALIFORNIA BLUE SHIELD - HMO	2.09	72	98	98	16	16.33%	10	18
SOUTHERN CAL PHYSICIANS MANAGED CARE	2.03	18	32	75			4	10

How to PREVENT Denials

Revenue Cycle Step-by-Step

Pre-Visit: Medicare

- Who
  - “Front Desk” or Hospital Admitting Office
  - Financial Counselor /Patient Advocates
  - Drug Programs
- What
  - Verification of benefits (MA versus Medicare)
  - Verification of secondary insurance
  - Provision of an ABN for off-label use, even with compendia
- Best Practices
  - On-line verification of Medicare benefits and plan as necessary

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Situations in which an ABN is Required

- Whether to issue an ABN depends on provider's expectation of Medicare payment or denial
- If provider expects Medicare denial based on any of the following, an ABN should be issued:
  - Medical Necessity
  - Frequency-limited Items and Services
  - Experimental Items and Services

Source: Palmetto GBA MAC 1

Completion of the ABN

- Requirements:
  - Must use approved Form CMS R-131
  - Complete header section with patient name and HICN
  - Identify specific item or service
  - Identify specific reason for expected Medicare denial
  - Estimated cost may be provided
  - Patient must personally select Option 1 or Option 2 or Option 3
  - Beneficiary signature and date

Source: Palmetto GBA MAC 1

Delivery of the ABN

- Must be delivered prior to service rendered
- Copy must be provided to beneficiary
- ABNs should never be delivered to patients in emergency situations.

Source: Palmetto GBA MAC 1

Insurance Verification Check List

- ✓ Patient has the insurance they say they do and it is primary with effective date
- ✓ Insurance address for bill
- ✓ Plan type: HMO/PPO/other
- ✓ Deductibles impacting care delivered in the office, e.g. IV drugs, radiology, labs, chemotherapy administration
- ✓ Episodic patient cost sharing for care delivered in the office, e.g. flat copays for Rx; coinsurance payments, amount
- ✓ Lifetime, annual or episode out of pocket maximum
- ✓ Catastrophic coverage (yes/no)
- ✓ Benefit caps: lifetime or other
- ✓ If possible, patients' current status regarding deductibles and out of pocket maximums; current progress toward caps
- ✓ Insurer requirements: Prior authorization; certification; notification; case management, step therapy
- ✓ Specialty pharmacy preference for patient costs, pharmacy billing.

Authorization: All Requiring Plans

- Who
  - “Front Desk”
  - Financial Counselor /Patient Advocates
  - Nurses
  - Physicians for peer-to-peer
- What
  - Prior authorization
- Best Practices
  - Use correct forms and formats for each payer
  - EMR templates
  - Expedite prior authorization on every drug given in the clinic
  - Don’t take no
  - E-Prior Auth for non-Buy and Bill drugs

Authorization: Private Insurance

- Prior authorization Snafus
  - Insurance companies do not provide correct information as to the need for; the responsible organization; or billing format for the PA
  - Practices do not get PA because plan “has never required it”
  - Practices believe pathways mitigate the need for PA
  - PA is granted and more information is requested delaying the claim
  - PA not renewed on time

Medical Records/ Documentation

Symptoms

- High A/R resulting from inappropriate resources and inaccurate patient care/charge information
- High A/R resulting manual charge entry from outdated coding information
- Loss of revenue from lower level coding due to lack of physician documentation/inappropriate interpretation
- No certified coders in clinics with > 5 providers

Common Underlying Issues

- Physicians do not complete medical records so codes cannot be submitted
- Hospital visits and consults (for private payers) are a mess
- Nurses do not think coding is 'their job'
- Physicians cling to low level codes or bill no visits with chemo because of audit fear

Potential Solutions

- Develop backlog reporting of physicians who have unbilled visit reporting
- Perform account review to determine appropriateness of assigned coding of diagnoses, drug administration, E/M
- Audit every complex chemo regimen bill before it is submitted

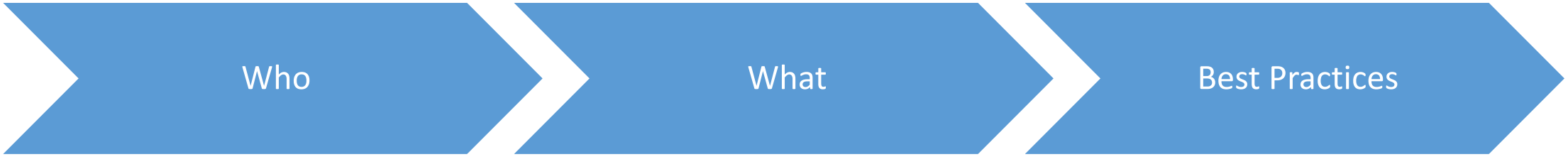
Documentation /Coding: Medicare

- Doc/Coding Snafus
  - ICD-10-CM policies for Medicare not always clear or consistent
  - Physician documentation does not match ICD-10-CM codes particularly in RA, NHL, Leukemia (“in remission”)
  - Coding does not match on-label use when drug is given on-label, e.g. NHL, Laterality
  - Unbundling—billing for fluids, IV start, port access, etc.
  - Billing waste for BENDEKA or other MDVs
  - Correct units for each J-code—worse in hospitals

Signatures: Review Criteria

- Auditors: MACs, CERTs, and RACs, just to name a few. CMS requires that orders for healthcare services and the services that were provided be authenticated by the author using either a handwritten or electronic signature. CMS has made it clear that stamped signatures are not an acceptable form of authentication.
- The previous language in the CMS *Program Integrity Manual* required a “legible identifier”. The 2010 transmittal--- CMS Transmittal 327 has added additional clarification and signature assessment requirements.
- Any auditor can use this rule, unless other laws or regulations supersede this rule.

Billing



- "Back Office"

- Generate the bill
- Trace outstanding A/R
- Perform collections on patient portions
- May process co-pay program payments

- Are familiar to the letter with the billing parameters of the 20% of payers that make up 80% of payments
- Have strong write-off and write down policies
- Average = 30 days for all insurance payments and have no more than 10% of A/R over 90 days

Billing : Private Insurance

- Billing Snafus
  - No guidelines but drug is given and rejected on the back end or in an audit as not being medical necessity. Rejection can include the total drug claim or just the drug or administration. How PA is recorded on the claim is variable
  - Too much information is requested after the treatment is authorized
  - For new drugs, just being informed is a snafu and variation of J9999 requirements
  - No formal appeal or telephonic appeal process outlined anywhere

Collections : All Payers

- Collection Snafus
  - ABN given to patient; no collection because patient did not understand what it meant
  - Patients believe insurance covers everything
  - Medicare Advantage patients have big out-of-pocket and did not this would happen when they signed up
  - Balance between aggressive collections and patient relations. This will gain in importance as patient opinions will really count
  - Cancer patients have collections from many sources and may play on physicians' sympathies

Collection Rates for Common Oncology Services from Allowables

Type of Service	Collection Rate
E/M	81%
Imaging	65%
Radiation	91%
Drugs	59%
ALL SERVICES	87%

Denials & Appeals

Cancer Services 2016

Denial Rates by Service 2017

Type of Service	Denial Rates
E/M	12%
Imaging	18%
Radiation	12%
Drugs	8.1%
ALL SERVICES	17%

Highest Denial Rate for Tracked Drugs In focalPoint (2017)

Drug	Denial Rate
Mylotarg	100.00%
Akynzeo	52.00%
Temozolomide	46.62%
Imfinzi	42.86%
Remicade Biosimilar	28.28%
Bavencio	25.21%
Lartruvo	21.78%
Tecentriq	20.72%
Provenge	19.42%
Sylvant	18.97%
Adcetris	16.80%
Portrazza	15.98%
Onivyde	15.49%
Xofigo	15.37%
Lemtrada	15.36%
Gazyva	14.98%
Yervoy	14.39%
OCM MEOS Code	13.10%
Empliciti	13.05%
Treanda LIQ	12.96%
Arzerra	12.80%
Yondelis	12.76%
Zevalin	12.12%
Rituxan Hycela	11.43%
Darzalex	11.33%
Sustol	10.40%
Entyvio	9.85%
Aranesp	9.79%
Remicade	9.78%
Bendeka	9.71%
Ixempra	9.71%
Zarxio	9.57%
Perjeta	9.28%
Beleodaq	9.12%
Procrit	8.61%
Treanda	8.61%

Geographic Areas With Denials 2017 to Date (Drugs Only)

State	True Denials	True Denial Percent
HI	2,770	19.40%
GA	31,605	14.51%
ND	2,276	14.44%
CO	508	13.71%
AZ	13,087	13.26%
MI	942	12.28%
UN	16	12.12%
MD	10,878	12.01%
SC	16,680	11.71%
TX	17,030	10.00%
OK	11,639	9.74%
KY	2,157	9.70%
CT	6,576	9.47%
NM	4,543	9.42%
AR	13,641	9.34%
CA	26,824	9.03%
FL	152,724	7.98%
IA	2,120	7.95%
ID	11	7.86%
NJ	21,085	7.84%
IN	10,006	7.71%
NY	20,205	7.28%
IL	21,229	7.21%
LA	969	7.12%

Top Denials for 2017—Drugs

Definition	Reason Code	True Denials	% of Total True Denials along Reason Code
The benefit for this service is included in the payment/allowance for	97	68,025	13.51%
Claim/service lacks information or has submission/billing error(s) wh	16	59,286	11.77%
This provider was not certified/eligible to be paid for this procedure/	B7	40,872	8.12%
These are non-covered services because this is not deemed a 'medic	50	38,437	7.63%
Non-covered charge(s). At least one Remark Code must be provided	96	36,620	7.27%
Precertification/authorization/notification absent.	197	25,298	5.02%
This service/equipment/drug is not covered under the patient's curr	204	20,375	4.05%
This care may be covered by another payer per coordination of bene	22	20,034	3.98%
Expenses incurred after coverage terminated.	27	16,352	3.25%
Claim/Service denied. At least one Remark Code must be provided (r	A1	15,440	3.07%
The time limit for filing has expired.	29	13,547	2.69%
Payment adjusted because the payer deems the information submitt	151	12,594	2.50%
Claim/service not covered by this payer/contractor. You must send t	109	11,057	2.20%
Information requested from the Billing/Rendering Provider was not p	226	10,997	2.18%
This service/procedure requires that a qualifying service/procedure b	B15	9,550	1.90%
The authorization number is missing, invalid, or does not apply to the	15	7,857	1.56%
Information requested from the patient/insured/responsible party w	227	7,672	1.52%
This procedure is not paid separately. At least one Remark Code mus	234	6,310	1.25%
The diagnosis is inconsistent with the procedure. Note: Refer to the 8	11	5,857	1.16%
The procedure code is inconsistent with the modifier used or a requi	4	5,213	1.04%
Patient is enrolled in a Hospice.	B9	4,914	0.98%
Patient cannot be identified as our insured.	31	4,089	0.81%
The claim/service has been transferred to the proper payer/processo	B11	4,088	0.81%
Precertification/authorization exceeded.	198	3,863	0.77%
Expenses incurred prior to coverage.	26	3,806	0.76%

Top 2017 Denials for All Services

CARC	Description	Number of Denials
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note	508711
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Re	382123
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attac	346219
22	This care may be covered by another payer per coordination of benefits.	177823
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy	163968
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Rem	127002
27	Expenses incurred after coverage terminated.	113742
204	This service/equipment/drug is not covered under the patient's current benefit plan	111135
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	106194
29	The time limit for filing has expired.	86681

Top Denials for 2017 for CA Drugs

Definition	Reason Code	True Denials	True Denials along Reason Code
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	3,736	13.93%
This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	B15	2,713	10.11%
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	2,499	9.32%
The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	B11	2,383	8.88%
This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	49	1,290	4.81%
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	1,262	4.70%
The time limit for filing has expired.	29	1,247	4.65%
Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	151	1,097	4.09%
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	927	3.46%
The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	898	3.35%
This service/equipment/drug is not covered under the patient's current benefit plan	204	860	3.21%
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	812	3.03%
The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11	711	2.65%
This care may be covered by another payer per coordination of benefits.	22	686	2.56%
Precertification/authorization/notification absent.	197	677	2.52%
Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	109	669	2.49%
Expenses incurred after coverage terminated.	27	621	2.32%
Patient has not met the required eligibility requirements.	177	422	1.57%
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	414	1.54%
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	285	1.06%

All Cali Payers With Denials for 2017 for Drugs (>1%)

Name	Billed Units	True Denials	True Denial Percent
NORTHERN CALIFORNIA MEDICARE	7,705,603	7,175	6.43%
SOUTHERN CALIFORNIA MEDICARE	4,010,687	6,883	9.24%
ANTHEM BLUE CROSS	1,739,974	1,925	6.64%
CALIFORNIA MEDI-CAL	893,957	1,859	15.57%
UNITED HEALTHCARE	504,251	1,822	20.83%
AETNA	257,212	1,696	35.54%
CALIFORNIA BLUE CROSS	1,318,017	1,367	6.97%
HEALTH NET OF CALIFORNIA AND OREGON (CLAIMS)	559,039	1,020	12.35%
GOLD COAST HEALTH PLAN	133,372	776	24.44%
BROWN AND TOLAND MEDICAL GROUP	248,489	675	23.54%
ALLIANCE IPA	371,872	399	5.14%
INLAND EMPIRE HEALTH PLAN	352,744	153	2.03%
AFFINITY MEDICAL GROUP	16,864	134	34.72%
CIGNA	78,257	127	7.14%
RETIRED RAILROAD MEDICARE	34,694	107	18.35%
MOSAIC IPA MEDICAL GROUP	4,227	101	34.47%
NOBLE AMA SELECT IPA	20,721	80	24.92%
GOOD SAMARITAN MEDICAL PRACTICE ASSOC. (GSMPA)	3,741	70	30.17%
MOLINA HEALTHCARE OF CALIFORNIA	11,915	61	82.43%
SANTA CLARA IPA	1,514	58	92.06%
SCAN HEALTH PLAN	4,467	50	40.00%
SANTE HEALTH SYSTEM AND AFFILIATES	2,796	39	36.45%
HEATLHCARE LA, IPA	8,168	32	34.41%
AFFILIATED DOCTORS OF ORANGE COUNTY (ADOC)	654	29	96.67%
ANGELES IPA	9,269	25	20.33%
HUMANA	1,770	21	20.39%
MEDICARE DME MAC JURISDICTION D	477	17	11.97%
MEDICARE ADVANTAGE DME (DMENSION)	1,277	14	1.18%
KEY MEDICAL GROUP	7,835	13	6.70%
KERN HEALTH SYSTEMS	1,793	12	2.53%
ST. JOSEPH HERITAGE HEALTHCARE	679	12	27.91%
HILL PHYSICIANS MEDICAL GROUP	2,824	11	25.00%
ADVANTEK BENEFIT ADMINISTRATORS	15,572	9	5.36%
GREATER ORANGE COUNTY MEDICAL GROUP	3,073	7	25.00%
PACIFICARE CLAIMS (CA, OK, OR, TX, WA)	920	7	36.84%
CARE 1ST HEALTH PLAN OF CALIFORNIA	1,185	6	31.58%
LASALLE MEDICAL ASSOCIATES	13,604	6	2.67%
PINNACLE CLAIMS MANAGEMENT, INC.	126	4	33.33%
ABMA (ALTA BATEES MEDICAL ASSOCIATES) MEDICAL CORP	206	3	37.50%
CALIFORNIA BLUE SHIELD - HMO	2,759	3	4.76%
HEALTHSMART PREFERRED CARE, INC.	914	3	37.50%
REGAL MEDICAL GROUP	217	3	100.00%
COMMUNITY HEALTH CENTER NETWORK	2,026	2	3.13%
DELTA HEALTH SYSTEMS	9,077	2	2.00%
AARP	4	1	50.00%
CALIFORNIA BLUE SHIELD	1,052	1	11.11%
CHAMPVA - HAC	155	1	8.33%
HEALTH NET OF CALIFORNIA - ENCOUNTERS	1	1	100.00%
OXFORD HEALTH PLANS	380	1	33.33%
PARTNERSHIP HEALTH PLAN OF CALIFORNIA	52	1	25.00%

Top Drugs for Denials in 2017 for CA

Drug	Denial Rate
Beleodaq	58.82%
Temozolomide (IV)	50.00%
Tecentriq	27.57%
Provenge	21.43%
Lartruvo	16.67%
Sustol	15.38%
Procrit	12.94%
Feraheme	12.11%
Levoleucovorin S	12.07%
Zarxio	11.76%
Leukine	11.31%
Not Set	11.27%
Doxil	11.04%
Ixempra	10.81%
Levoleucovorin W	10.71%
Aranesp	9.86%
Gazyva	9.80%
OCM MEOS Code	9.74%
Cisplatin	9.42%
Empliciti	9.40%
Treanda	9.23%
Halaven	9.11%
Intron-A	8.97%
Granix	8.89%
Xofigo	8.57%
Darzalex	8.28%
Cyramza	8.01%
Neulasta	7.41%

Classfication	2016-Q1	2016-Q2	2016-Q3	2016-Q4	2017-Q1	2017-Q2	2017-Q3	2017-Q4
Breast Cancer	9.08%	7.34%	10.80%	10.52%	10.71%	13.08%	10.13%	13.58%
Encounter for Infusion	6.11%	2.83%	3.35%	4.74%	6.96%	7.88%	11.24%	11.34%
Lung Cancer	7.69%	6.20%	5.79%	7.78%	10.58%	8.07%	6.15%	7.80%
Malignant Melanoma	8.06%	6.33%	12.33%	7.98%	10.71%	4.84%	7.02%	7.26%

California Denial By Tumor Type Over Time

Denial Code 16—Missing Information

- Most frequent denial code for all items and services outside of Oncology
- Mostly clerical errors in billing
- But, some can be avoided knowing the reasons:
  - Missing or incorrect NDC number (M119)
  - Missing or invalid dose of drug, name of drug
  - Wrong plan information
- Overall, this is a delay tactic, but if a documentation request is made, some MACs will deny the claim permanently if info is not received in 45 days
- Tips
  - NDC must be 5-4-2
  - Check your diagnosis coding
  - Make sure your plan information is right

Denial Code 97—This Benefit Is Included in The Payment for Another Service (California)

Definition	Remark Code	N111	N19	N202	N525	M15
Additional information/explanation will be sent separately.	N202			26		
No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously bi	N111	764				
Procedure code incidental to primary procedure.	N19		95			
Separately billed services/tests have been bundled as they are considered components of the same procedure. Sepa	M15					2
These services are not covered when performed within the global period of another service.	N525				7	

Denial Code 50—Not Medically Necessary

- Most people think this is due to off-label use; but, do not ignore vague coding or incorrect coding, particularly for certain insurance companies
- If it is truly off-label, appeal using
  - Compendia support that meets state requirements
  - Evidence-based guidelines used for the patient
  - All previously failed therapies
  - All therapies ruled out
- Some drug companies can help you with literature

ICD-10-CM Codes Frequently Billed for Drugs 2017

Diagnosis	Description	Distinct Patients	Distinct Claims	Days to File (No Outliers)	Days to Pay (No Outliers)	True Denial Percent
Z51.11	Encounter for antineoplastic chemotherapy	32,167	150,028	8	28	6.11%
C90.00	Multiple myeloma not having achieved remission	7,850	78,005	9	29	7.46%
E86.0	Dehydration	20,909	67,701	7	25	4.30%
D50.9	Iron deficiency anemia, unspecified	26,604	58,608	6	24	6.48%
R11.2	Nausea with vomiting, unspecified	12,198	50,820	8	28	5.28%
C61	Malignant neoplasm of prostate	10,705	50,470	14	33	10.09%
C79.51	Secondary malignant neoplasm of bone	13,592	47,251	7	26	6.15%
D46.9	Myelodysplastic syndrome, unspecified	3,693	40,615	7	26	4.67%
C50.412	Malignant neoplasm of upper-outer quadrant of left fe	6,661	35,116	10	30	9.44%
C50.411	Malignant neoplasm of upper-outer quadrant of right	6,079	29,960	10	29	8.85%
C34.11	Malignant neoplasm of upper lobe, right bronchus or l	4,995	28,054	8	29	6.94%
N18.3	Chronic kidney disease, stage 3 (moderate)	6,752	27,703	7	26	6.77%
C50.919	Malignant neoplasm of unspecified site of unspecified	4,340	25,546	17	35	11.76%
C20	Malignant neoplasm of rectum	3,808	24,219	8	29	8.22%
E53.8	Deficiency of other specified B group vitamins	5,527	21,574	7	25	6.27%
D51.9	Vitamin B12 deficiency anemia, unspecified	5,741	21,510	6	24	5.10%
D70.1	Agranulocytosis secondary to cancer chemotherapy	6,782	21,431	7	25	6.61%
C34.12	Malignant neoplasm of upper lobe, left bronchus or lu	3,806	21,390	9	29	6.25%
C50.912	Malignant neoplasm of unspecified site of left female	3,854	20,834	12	31	8.47%
D63.1	Anemia in chronic kidney disease	5,599	20,437	7	26	10.26%
C50.911	Malignant neoplasm of unspecified site of right female	3,715	20,211	13	32	9.07%
C18.7	Malignant neoplasm of sigmoid colon	2,931	19,830	8	29	8.23%
C91.10	Chronic lymphocytic leukemia of B-cell type not having	3,631	18,156	11	31	7.86%
C34.90	Malignant neoplasm of unspecified part of unspecified	2,782	17,710	10	30	9.41%
162.3	Ca Lung - Upper Lobe	10,136	17,254	10	29	24.69%
D51.8	Other vitamin B12 deficiency anemias	4,292	16,496	6	23	4.03%

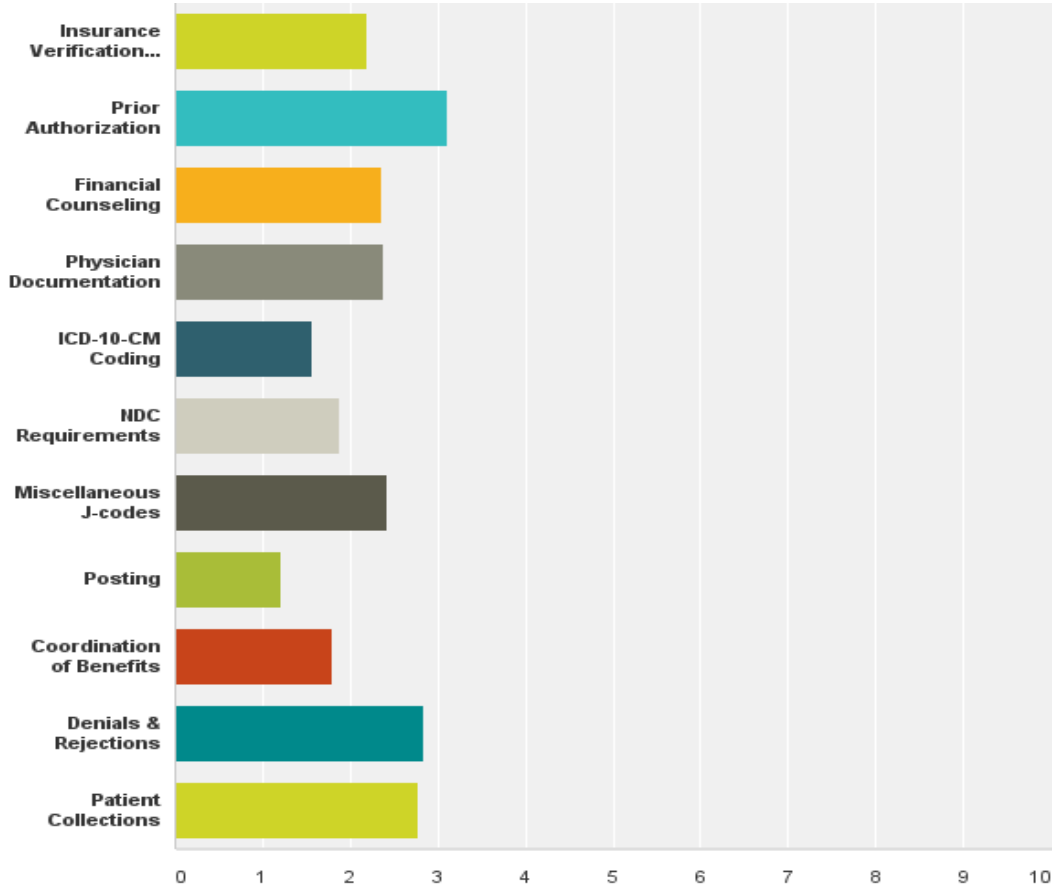
ICD-10 Codes Most Frequently Denied Drugs in 2017 (> 15 claims)

Diagnosis	Description	Distinct Patients	Distinct Claims	Days to File (No Outliers)	Days to Pay (No Outliers)	True Denial Percent
Z45.89	Encounter for adjustment and management of other implanted devices	51	59	7		95.38%
R32	Unspecified urinary incontinence	19	19	11	20	88.89%
Z18.89	Other specified retained foreign body fragments	21	21	24	48	85.19%
R31.21	Asymptomatic hematuria	47	47	14	34	84.00%
N31.9	Neuromuscular dysfunction of bladder, unspecified	19	29	7	22	82.28%
N39.3	Stress incontinence (female) (male)	40	41	16	29	78.72%
R97.21	Rising PSA in prostate cancer	53	55	14	33	78.46%
N20.0	Calculus of kidney	93	99	16	32	76.15%
M94.9	Disorder of cartilage, unspecified	35	39	7	21	69.09%
Z30.2	Encounter for sterilization	25	25	15	44	66.67%
J45.21	Mild intermittent asthma with (acute) exacerbation	6	22	10	31	66.67%
R33.9	Retention of urine, unspecified	52	79	14	35	65.03%
N40.1	Enlarged prostate with lower urinary tract symptoms	150	172	14	35	64.89%
N20.1	Calculus of ureter	77	80	18	42	64.00%
N95.0	Postmenopausal bleeding	22	24	9	19	62.86%
N35.9	Urethral stricture, unspecified	23	25	14	27	60.00%
N40.0	Enlarged prostate without lower urinary tract symptoms	26	27	14	37	58.33%
Z29.9	Encounter for prophylactic measures	23	29	13	21	52.63%
141	CA - tongue; base	9	25	5		52.07%
D61.3	Idiopathic aplastic anemia	13	44	5	37	46.43%
N39.41	Urge incontinence	22	24	15	30	44.44%
R31.29	Other microscopic hematuria	28	28	14	38	43.33%
E11.9	Type 2 diabetes mellitus without complications	40	74	20	40	42.97%
N39.0	Urinary tract infection, site not specified	42	44	14	35	42.37%

ICD-10 Codes Most Frequently Denied for Drugs in California 2017

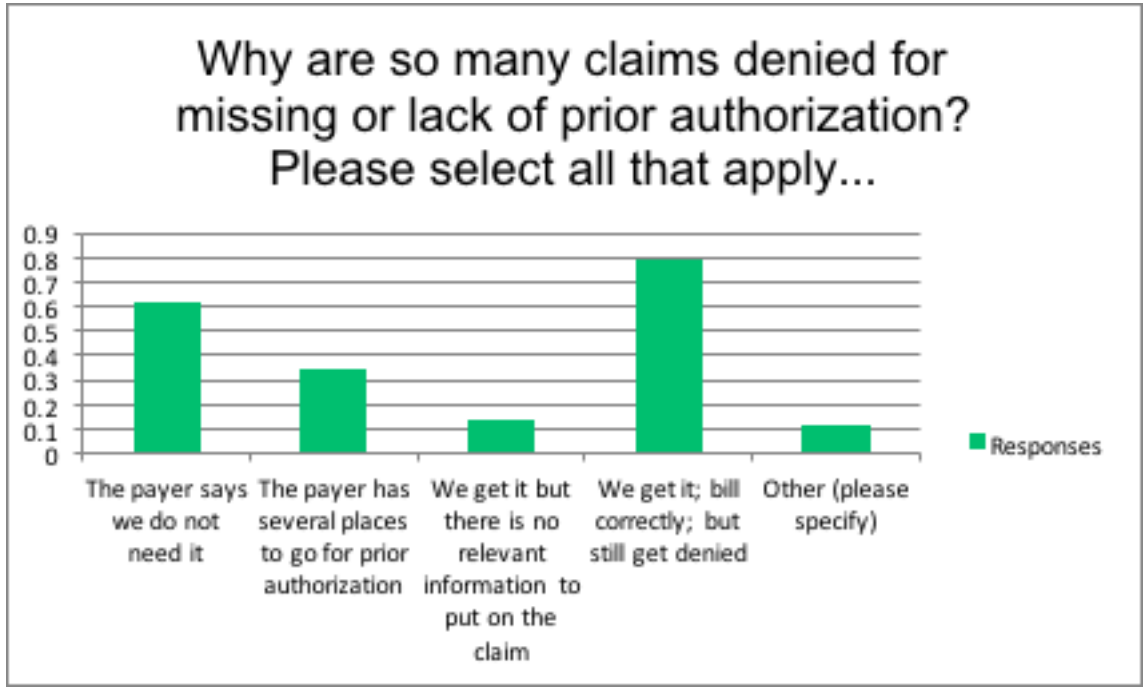
Diagnosis	Description	Payer Responses	Distinct Patients	Distinct Claims	Days to File (No Outliers)	Days to Pay (No Outliers)	True Denial Percent
C62.92	Malignant neoplasm of left testis, unspecified whether descended or undescende	69	9	21	11	33	69.57%
D53.1	Other megaloblastic anemias, not elsewhere classified	52	6	28	7	26	67.31%
E83.118	Other hemochromatosis	60	18	50	6	32	50.00%
Z41.8	Encounter for other procedures for purposes other than remedying health state	2,515	1,000	1,514	13	41	46.44%
E83.110	Hereditary hemochromatosis	44	21	42	9	23	45.45%
D70.9	Neutropenia, unspecified	1,424	167	1,139	6	24	37.85%
C25.8	Malignant neoplasm of overlapping sites of pancreas	143	2	21	5	37	35.66%
Z23	Encounter for immunization	119	72	74	7	48	34.45%
N18.4	Chronic kidney disease, stage 4 (severe)	35	11	20	11	36	34.29%
Z85.46	Personal history of malignant neoplasm of prostate	126	62	77	16	57	30.95%
R60.9	Edema, unspecified	215	27	96	5	25	29.77%
C78.00	Secondary malignant neoplasm of unspecified lung	51	18	31	14	38	29.41%
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites	106	16	47	9	29	28.30%
C16.1	Malignant neoplasm of fundus of stomach	124	3	22	3	21	28.23%
C78.01	Secondary malignant neoplasm of right lung	87	19	40	14	28	26.44%
D75.81	Myelofibrosis	38	5	36	4	18	26.32%
C53.0	Malignant neoplasm of endocervix	710	36	146	8	33	26.20%
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph n	47	11	25	20	32	25.53%
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes	51	14	30	8	22	25.49%
D80.9	Immunodeficiency with predominantly antibody defects, unspecified	60	10	24	7	31	25.00%
D63.8	Anemia in other chronic diseases classified elsewhere	125	16	79	5	24	24.80%
D64.89	Other specified anemias	146	26	96	6	29	23.97%
I26.99	Other pulmonary embolism without acute cor pulmonale	46	20	28	9	38	23.91%
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast	1,070	90	390	11	30	22.90%
C73	Malignant neoplasm of thyroid gland	367	71	169	12	28	22.89%
D69.59	Other secondary thrombocytopenia	44	8	23	5	21	22.73%
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, a	502	36	89	12	31	22.71%
D47.3	Essential (hemorrhagic) thrombocythemia	97	22	58	5	23	22.68%
D47.2	Monoclonal gammopathy	442	67	162	6	27	22.40%
C71.7	Malignant neoplasm of brain stem	192	4	31	11	35	22.40%
D51.1	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with p	81	17	54	11	31	22.22%
C50.612	Malignant neoplasm of axillary tail of left female breast	636	8	172	6	24	22.17%
D75.1	Secondary polycythemia	244	45	109	5	22	22.13%
C53.8	Malignant neoplasm of overlapping sites of cervix uteri	426	17	110	5	22	21.83%
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck	351	6	52	11	24	21.65%
C43.60	Malignant melanoma of unspecified upper limb, including shoulder	48	10	32	12	34	20.83%
E61.1	Iron deficiency	88	21	41	9	28	20.45%

Q7: What part of Revenue Cycle Management for ALL ITEMS and SERVICES do you find most challenging? Use a scale of zero to five with 5 being most challenging and zero being no problem...165 Responses

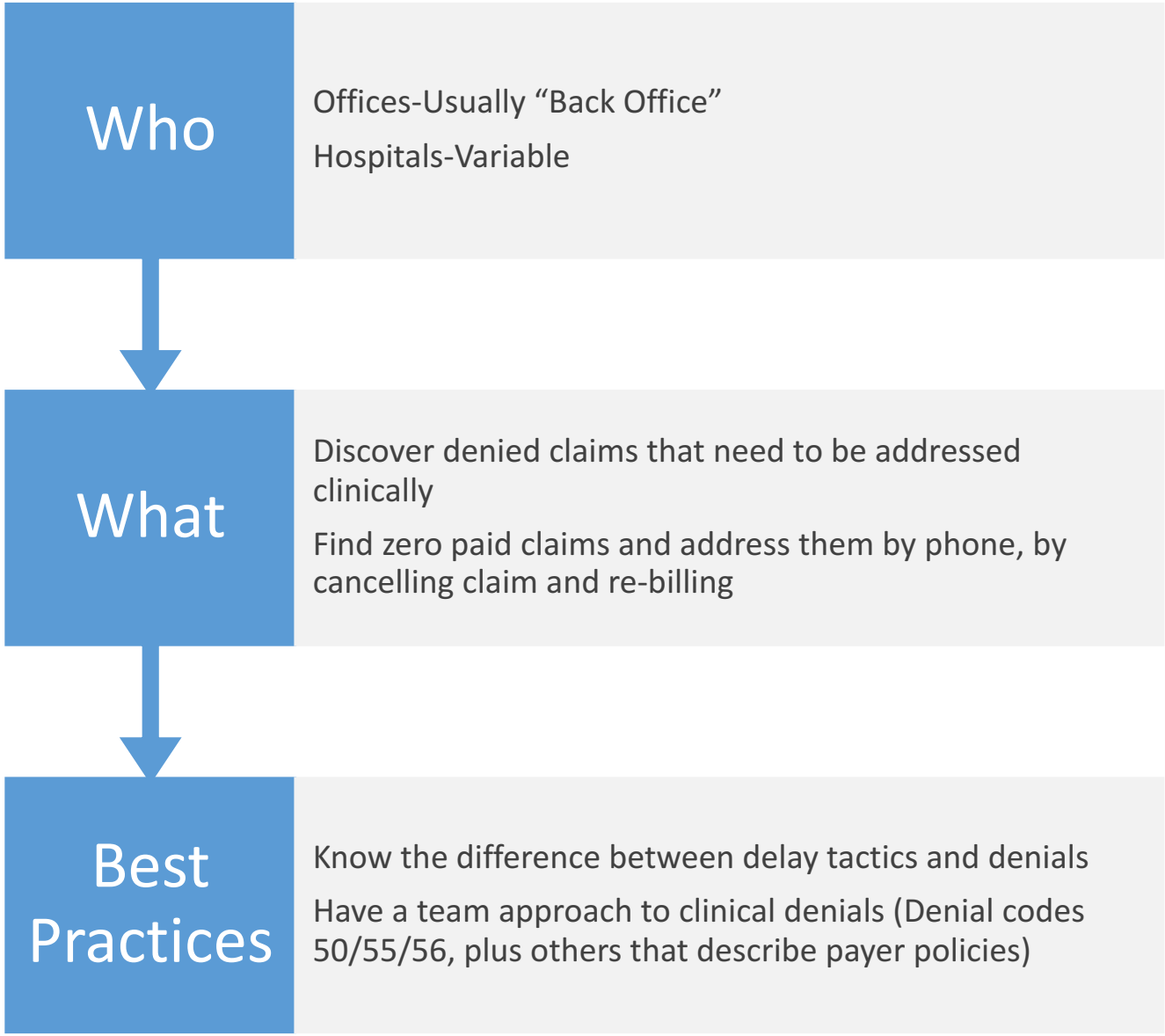


Q10: Why are so many claims denied for missing or lack of prior authorization? Please select all that apply...

- Answered: 160



Denials/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

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

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 w/i 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

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

Writing A Good Appeal

- Pre-Appeal
  - Know your State cancer laws: off-label and clinical trials
  - Know your state insurance laws
    - Prior authorization
    - Appeal rights
    - Medicaid
  - Know your Medicare laws
  - Understand major payer contracts
    - Drug carve outs
    - Appeal deadlines
    - Legal rights
  - Involve the clinician and have them sign the appeal

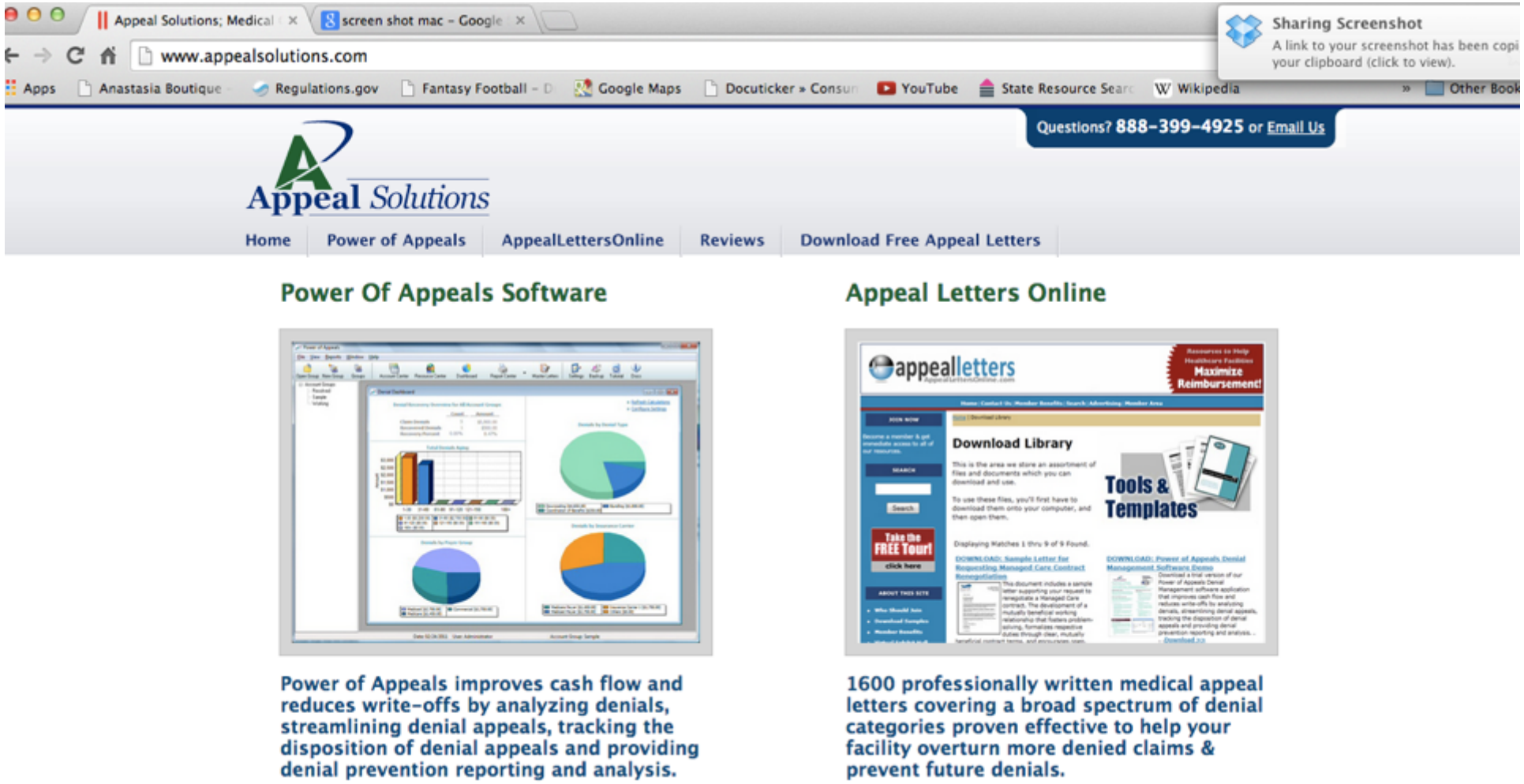
Successful Appeals Strategies: What's Your Argument

- Clinically-based arguments:
  - Medical necessity of the services provided
  - Appropriateness of the treatment based on clinical history or community standard
  - Scientific support for treatment; compendia if possible

- Legally-based arguments:
  - Is the denial legal based on the coverage or contractual parameters surrounding the claim?
  - Summarize submitted medical records and documentation to fit your argument in terms of the parameters chosen or just send proof you complied
  - Have a Medicare or healthcare lawyer review as appropriate

- Use of past Medicare Appeals Council cases
  - http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html
  - http://www.hhs.gov/dab/macdecision/

A Fantastic Resource



Solutions: Front Desk/ Intake

- Front Desk/ Financial Counseling
  - Technology
    - Eligibility/verification products
    - On-line eligibility verification AS LONG AS it's thorough
  - Insurance company websites and links
  - Contract book—describes all plans, prior auth, referral policies, excluded providers
  - Access to denials consistent with poor intake
- Establish standardized registration polices, procedures, processes and performance levels, particularly for registration data quality
- Ensure that registration staff is thoroughly trained
  - Insurance plans and requirements prior to treatment
  - Plan requirements, e.g., referrals, authorizations
  - Importance of correct demographics

Solutions: Billing

- Charge Posting/Billing
  - Have standard billing instructions for every large payer
  - Computerized coding tools, particularly ICD-10-CM
  - Updated charge capture/Superbills
  - Claims editors
  - Claims “scrubbers”
  - Online access to Medicare policies for all providers
  - Online access to policies and procedures for miscellaneous J-codes

Solutions: Prevent Audits

Make	Make sure that you are using evidence-based guidelines for all regimens in the practice
Avoid	Avoid duplicate claims
Stay away	Stay away from “chair visits”
Conform	Conform to profiles for E/M and Radiation
Do not track	Do not track waste for multi-dose vials (“MDVs”), e.g. bendamustine and trastuzumab
Audit	Audit every ’big ticket’ claim (set a benchmark) before transmitting to the payer

Hem-Onc E/M Profiling from AAPC Website (2015)

New Patient Visits	2015 %
99201	0.1%
99202	1.0%
99203	9.1%
99204	36.2%
99205	53.8%

Established Patient Visits	2015 %
99211	2.3%
99212	2.6%
99213	32.0%
99214	51.9%
99215	11.2%

Hem-Onc E/M Profiling for San Francisco (2016)

New Patient Visits	2016 %
99201	0.2%
99202	1.5%
99203	7.1%
99204	22.2%
99205	69.0%

Established Patient Visits	2016 %
99211	3.8%
99212	3.0%
99213	28.4%
99214	54.8%
99215	10.0%

Med Onc E/M Profiling for Sacramento (2016)

New Patient Visits	2016 %
99201	0.2%
99202	0.8%
99203	4.8%
99204	20.3%
99205	**73.9%**

Established Patient Visits	2016 %
99211	0.9%
99212	1.6%
99213	38.2%
99214	54.8%
99215	10.0%

Rad Onc E/M Profiling for San Jose (2016)

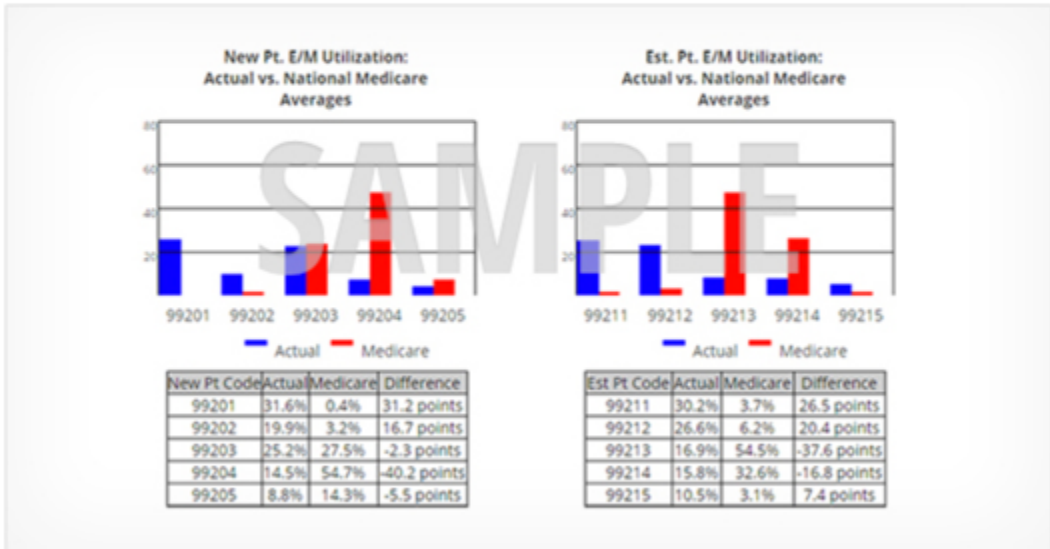
New Patient Visits	2016 %
99201	0.1%
99202	2.8%
99203	13.4%
99204	40.7%
99205	43.0%

Established Patient Visits	2016 %
99211	**2.1%**
99212	14.0%
99213	**50.0%**
99214	26.5%
99215	7.3%

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 2015 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.

What I Tell Practices

- Watch for the next iteration of Trumpcare, if there is one
- Benchmark yourself against local and national statistics
- Remember that the more work done up front, the more will pay off in the long run
- Have someone assigned to DELAYS as well as DENIALS
- Advanced Financial Counseling is a real key to success…
- Co-pay cards and Foundations are key to your solvency—track your revenue
- Every person in the Revenue Cycle should have incentives—pay, PTO, pizza, etc.
- Invest in systems to track, work and report denials, e.g. 835 data and benchmarking
- Assign responsibility for denials and reward people for improvements in denial rates in terms of
  - Correct demographics
  - Correct insurance verification
  - No vague diagnoses
  - Minimal requests for more info
- Measure improvement on an ongoing basis: don’t start and stop!
- Participate in the struggle with ANCO!