

SummaCare



Annual Provider Update

Thank you for joining us today. We will begin shortly!
October 14, 2026



Summary of ICD-10-CM Changes for 2027

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Diagnosis Code Update for 2027

- How many changes are there?
 - Per Society of **Interventional** Radiology and its June 25, 2026, news bulletin, the 2027 ICD-10-CM code set contains 190 new diagnosis codes, 4 revised codes, and 30 code deletions (<https://www.sirweb.org/publications/news/cms-releases-new-icd-10-cm-codes/>);

Diagnosis Code Update for 2027

- How does this compare to prior years?
 - Changes for 2026: 487 new codes, 28 deleted codes, and 38 revised;
 - Changes for 2025: 252 new codes, 36 deleted codes, and 13 revised;
 - Changes for 2024: 395 new codes, 25 deleted codes, and 13 revised;
 - Changes for 2023: 1,176 new codes, 287 deleted codes, and 28 revised;
 - Changes for 2022: 159 new codes, 25 deleted codes, and 27 revised;
 - Changes for 2021: 490 new codes, 58 deleted codes, and 47 revised;
 - Changes for 2020: 273 new codes, 21 deleted codes, 30 revised codes;
 - Changes for 2019: 279 additions, 51 deletions, and 143 revisions;
 - Changes for 2018: 363 additions, 42 deletions, and 250

Diagnosis Code Update for 2027

Be careful with the 190 new codes number:

- 24 new codes are created with anatomic and laterality specificity of osteomyelitis

- 23 new codes are created with anatomic and circumstance specificity of ectopic pregnancies;

- 22 new codes for toxic effects (ex: poisoning) of unusual substances

Two conditions and some odd toxic effects account for about a third of the new codes in 2026.

Diagnosis Code Update for 2027

Download the 2027 Addenda file at:

<https://www.cms.gov/medicare/coding-billing/icd-10-codes>

CDC ICD-10-CM Coordination and Maintenance Committee

<https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html>

Also at the CMS site:

POA exempt codes for 2026

Review *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS Fourth Quarter 2026*, for complete and final details;
Check your EMR/EHR software update.

Diagnosis Code Update for 2027

Chapter 1: Certain Infectious and Parasitic Diseases

The 2027 Addenda file reveals no new codes for 2027.
Some note changes in the chapter.

Diagnosis Code Update for 2027

Chapter 2: Neoplasms

New codes for secondary neoplasms of respiratory and digestive organs:

- Larynx;

- Pharynx;

- Oral Cavity;

Expansion of “other specified sites” coding;

Previously, “only malignant primary ICD-10-CM codes [were] mapped to the Speech Language Pathology (SLP) comorbidity classification related to oral and laryngeal cancers . . . despite their equal or greater clinical need for speech therapy interventions.” (ICD-10-CM Coordination and Maintenance Committee, September 2025)

Diagnosis Code Update for 2027

Chapter 3: Disease of Blood & Blood Forming Organs

New coding for Glanzmann's thrombasthenia (GT);
Expansion of qualitative platelet defects category;
“Diagnosis often requires specialized genetic and platelet function tests, distinguishing GT from other qualitative platelet disorders . . . the National Bleeding Disorders Foundation [requested the new coding] to facilitate accurate data collection, support epidemiological research, and treatment outcomes.”

(ICD-10-CM Coordination and Maintenance Committee, September 2025)

Diagnosis Code Update for 2027

Chapter 04 Endocrine, Nutritional & Metabolic Diseases

- New code for Post Bariatric Hypoglycemia
- Expansion of subcategory “Postprocedural hypoglycemia following a procedure”
- “Post-bariatric hypoglycemia (PBH) is a chronic condition that develops in some individuals who have undergone bariatric surgery. PBH is believed to be caused by changes in hormonal and glycemic patterns, including an excessive insulin and glucagon-like peptide-1 (GLP-1) response, as a result of altered nutrient transit post-surgery . . . [pre-2027] coding options [did] not distinguish PBH from other types of hypoglycemia, resulting in a loss of essential clinical information that could inform and improve patient care in this unique group.”

(ICD-10-CM Coordination and Maintenance Committee, September 2025)

Diagnosis Code Update for 2027

Chapter 5: Mental, Behavioral & Neurodevelopmental D/O

New code for “Gender identity disorder, in remission,” also “Gender dysphoria, in remission (desistance)”

- Desistance refers to a resolution of clinical symptoms associated with a mental health condition;
- “Many of these individuals, who once experienced incongruence between their experienced/expressed gender and natal sex, have come to later accept their biological sex. Whereas they once met the diagnostic criteria for gender dysphoria, they have now entered a period of remission (desistance) from this stated condition. Their cognitive experience of incongruence has remitted whereby experienced/expressed gender and natal sex are now aligned . . . this reality [was] not accounted for in the ICD-10-CM. Similarly, those with a history of detransition or the reversal of gender transition, are not found in the classification system.”

Diagnosis Code Update for 2027

Chapter 6: Diseases of the Nervous System

The 2027 Addenda file reveals no new codes for 2027;
Minor synonym language changes in the chapter.

Diagnosis Code Update for 2027

Chapter 7: Diseases of the Eye and Ocular Adnexa

The 2027 Addenda file reveals no changes for 2027.

Chapter 8: Diseases of the Ear and Mastoid Process

The 2027 Addenda file reveals no changes for 2027.

Diagnosis Code Update for 2027

Chapter 09: Diseases of the Circulatory System

An expansion of coding for dilated cardiomyopathy to specifically identify familial-genetic dilated cardiomyopathy from other and unspecified dilated cardiomyopathy.

Dilated cardiomyopathy (DCM) is the most common form of cardiomyopathy.

Familial-genetic DCM accounts for up to 50% of DCM patients, with up to 40% of familial patients having an identifiable genetic cause.

Affinia Therapeutics requested the code change.

Diagnosis Code Update for 2027

Chapter 10: Diseases of the Respiratory System

- New codes—five new codes—for odontogenic sinusitis (ODS)
- Infectious dental pathology or iatrogenic injury from dental procedures
- “Higher quality evidence has been mounting on ODS in the last 5-10 years, the lack of a unique ICD-10-CM code has hindered both research pursuits and patient care . . . rhinologists, Dr. John Craig and Dr. Alberto M. Saibene [requested] new ICD-10-CM codes for ODS to facilitate both future research and clinical decision-making.” (ICD-10-CM Coordination and Maintenance Committee, September 2024)

Diagnosis Code Update for 2027

Chapter 11: Diseases of the Digestive System

- New code for hypertrophic pyloric stenosis in childhood
- Sequenced following adult hypertrophic pyloric stenosis
- Excludes 1 for congenital pyloric stenosis
- “Pediatric hypertrophic pyloric stenosis is a condition that affects young infants. In infants, hypertrophic pyloric stenosis is the most common cause of gastric outlet obstruction . . . clinically, infants are well at birth. Then, at 3 to 6 weeks of age and up to 6 months of age, they present with ‘projectile’ vomiting, potentially leading to dehydration and weight loss. This condition is rare in children after infancy.” (ICD-10-CM Coordination and Maintenance Committee, September 2025)
- The proposal for the new code was reviewed and supported by the American Academy of Pediatrics.

Diagnosis Code Update for 2027

Chapter 12: Diseases of the Skin

- New code for carbuncle of flank and revision of codes to accommodate flank—clean up of 2026 code changes.

Diagnosis Code Update for 2027

Chapter 13: Diseases of the Musculoskeletal System

Expanded coding for Plantar Fasciitis

- Addition of a unique subcategory code for Plantar Fasciitis with laterality coding
- Clarification of coding for Ledderhose Disease with addition of laterality coding
- “The two [conditions] are very different in presentation, different in treatment and are of different causes. There has been difficulty in tracking Ledderhose Disease with respect to incidence and prevalence due to the lack of a unique diagnosis code.” (ICD-10-CM Coordination and Maintenance Committee, September 2025)
- Podiatrists, Dr. Paul Carroll and Dr. Eddie Davis, requested new ICD-10-CM codes to distinguish between the two conditions and better track these patients.

Diagnosis Code Update for 2027

Chapter 13: Diseases of the Musculoskeletal System

Expanded coding for other osteomyelitis

- Expanded coding creates 24 new codes with anatomic and laterality specificity
- Example: M86.8X11 *Other osteomyelitis, right shoulder*
- Objective was to create a unique code for Pott's Puffy Tumor (PPT), Other osteomyelitis, face and sinuses
- "PPT is characterized by localized swelling of the forehead with edema caused by osteomyelitis of the anterior wall of the frontal sinus and frontal bone subperiosteal abscess. It typically starts from untreated, poorly managed or undiagnosed frontal sinusitis." (ICD-10-CM Coordination and Maintenance Committee, September 2025)
- Children's Hospital Association requested the code.

Diagnosis Code Update for 2027

Chapter 14: Diseases of the Genitourinary System

- New codes for intraoperative and postprocedural nipple ischemia and necrosis;
- “Since the late 1990’s, attention to preserving the nipple areolar complex for optimal cosmetic outcomes has been explored with increasing popularity and is now a routine procedure in many centers . . Nipple ischemia and necrosis rates for nipple sparing mastectomy range from 0-48%.”
 - Wong SM, Chun YS, Sagara Y, Golshan M, Erdmann-Sager J. National Patterns of Breast Reconstruction and Nipple-Sparing Mastectomy for Breast Cancer, 2005-2015. Ann Surg Oncol. 2019 Oct;26(10):3194-3203.
 - S. Ahn SJ, Woo TY, Lee DW, Lew DH, Song SY. Nipple-areolar complex ischemia and necrosis in nipple-sparing mastectomy. Eur J Surg Oncol (2018) 44(8):1170–6.

Diagnosis Code Update for 2027

Chapter 15: Pregnancy, Childbirth, & the Puerperium

Expansion of ectopic pregnancy coding—anatomic site and laterality

- Approximately 2 percent of all reported pregnancies are ectopic
- 90% of ectopic pregnancies occur within the fallopian tube (O00.1), detail for non-fallopian ectopic pregnancies has been limited

New coding to report continuing pregnancy after vanishing twin syndrome

- Vanishing twin syndrome may be more common (7-36%) with in vitro fertilization pregnancies;
- Mercy Health Systems requested the new codes and American College of Obstetricians and Gynecologists (ACOG) reviewed and supported the proposal.

Diagnosis Code Update for 2027

Chapter 16: Certain Conditions in the Perinatal Period

- The 2027 Addenda file reveals no new codes for 2027.

Diagnosis Code Update for 2027

Chapter 17: Congenital & Chromosomal Abnormalities

- Continued expansion of the QA0 Neurodevelopmental disorders related to specific genetic pathogenic variants category created for 2026
- The category was proposed at March 2023 *Coordination and Maintenance Committee Meeting* and followed up at March 2024 and September 2024 meetings
- Expansion is detailed in September 2025 *Coordination and Maintenance Committee Meeting* materials

Diagnosis Code Update for 2027

Chapter 18: Symptoms, Signs, and Abnormal Lab Findings

- Some note changes in the chapter
- New code for abnormal gadolinium levels in blood
 - Follow-up from 2024 update wherein new codes for gadolinium toxicity were added to Table of Drugs and Chemicals;
 - Used in microwave applications, fabrication of computer memory, magnets and data storage discs, *but also as a contrast agent for MRI*;
 - Original reference is the March 2022 *ICD-10-Coordination and Maintenance Committee* material and September 2025 materials.

Diagnosis Code Update for 2027

Chapter 19: Injury, Poisoning, Consequences of External Causes

- As indicated, a number of new codes for toxic effects of certain substances including:
 - Alkenes—a significant component of jet fuel;
 - Cycloparafins—also a significant component of jet fuel;
 - Hexamethylene diisocyanate—a hardening agent in automobile paints, particularly paints used on military vehicles, the codes were DOD, VA, and the Office of Federal Electronic Health Record Modernization (FEHRM);
 - Medetomidine—a veterinary sedative medication that has been detected alongside illicitly manufactured fentanyl.

Diagnosis Code Update for 2027

Chapter 20: External Cause Codes

- The 2027 Addenda file reveals no new codes for 2027.

Diagnosis Code Update for 2027

Chapter 21: Influencing Factors & Contact with Healthcare

- Expansion of Z77 “exposure to” category codes including “exposure to war theater”—see Hexamethylene diisocyanate above for example, also burn pits, Agent Orange, and blast over-pressure codes that were new in 2026;
- Expansion of personal history of sex reassignment subcategory code;
- New subcategory code for personal history of gender detransition;
- Some note changes in the chapter.

Diagnosis Code Update for 2027

Now what?

- Download that addenda file from the hyperlink above
- Review in detail the changes relevant to your practice
- Review *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS Fourth Quarter 2026*, for additional details
- Check references and check with your specialty society
- Be attentive to the note changes.

Questions?

Email:

providerengagement@summacare.com

for CEU certificate



Osteoporosis Management in Women

CPT II for Controlling BP and A1C

Jen Yate, MS
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Wellness

Osteoporosis Management in Women

The US Preventive Task Force recommends DEXA (dual energy x-ray absorptiometry) screening for women 65+ every two years.

HEDIS Measure: Woman 65+ who have fallen and had a fracture need a bone density scan within 6 months of the fracture.

SummaCare offers in-home Bone Mineral Density scans for those in the HEDIS measure with barriers to getting a DEXA. Member's results will be faxed to their PCP.

Referrals can be made by calling
SummaCare's HSM line at **877.888.1164**
or by sending an email to
CaseManagement@summacare.com.



Controlling Blood Pressure & A1C

Please use CPT II codes (in addition to Category I codes) to allow for more accurate risk stratification and enrollment into our programs, as well as reducing requests for medical record review.

CPT Category II for Blood Pressure:

- 3074F - Systolic < 130 mm HG
- 3075F - Systolic 130-139 mm HG
- 3077F – Systolic $\geq$ to 140 mm HG

and

- 3078F - Diastolic < 80 mm HG
- 3079F - Diastolic 80-89 mm HG
- 3080F - Diastolic $\geq$ to 90 mm HG

CPT Category II for A1C:

- 3044F – A1C < 7%
- 3051F – A1C 7% to < 8%
- 3052F – A1C 8% to $\leq$ 9%
- 3046F – A1C > 9%

Care and Condition Management

Programs for members living with chronic conditions, serious illnesses, or high-risk maternity to learn how to better manage their conditions and improve their quality of life.

A registered nurse can provide education on the risks of various conditions, explain medications, teach self-management tools, encourage recommended screenings and coordinate additional services as needed.

Our team also includes a licensed social worker, a registered dietitian, and an exercise specialist, all available to members.

Referrals can be made by calling SummaCare's Health Service Management line at **877.888.1164** or by sending an email to CaseManagement@summacare.com.



2027 SummaCare Medicare Advantage Plans and Reminders

Ana Martinez
Provider Engagement Specialist

Six (6) Medicare Advantage Plan Options in 2027

- **Amber** (MA only with no Part D coverage)
 - **Quartz**
 - **Topaz**
 - **Ruby**
 - **Sapphire**
 - **Emerald**
- All six plan options cover the same medical services that are covered by Original Medicare (Parts A and B).

Discontinued Plan Option in 2027

- SummaCare is discontinuing its **Garnet** plan option in 2027
- Current **Garnet** members will be disenrolled off the **Garnet** plan option effective 01/01/2027
- Current **Garnet** members will have an opportunity to enroll in another SummaCare Medicare Advantage plan option during this year's Annual Enrollment Period (AEP) from October 15 – December 7 for a January 1, 2027, effective date

Plan Type: Amber, Quartz, Topaz, and Ruby

- The Amber, Quartz, Topaz, and Ruby plan options are HMO plans
- These plans offer in-network coverage only

Members must receive care from SummaCare-contracted providers, or from Medicare-participating providers in the plan's visitor/travel benefit area

Exceptions:

Emergency services

Urgently-needed services

Routine Dialysis when outside the plan service area

Plan Type: Sapphire & Emerald

- The **Sapphire** and **Emerald** plans are HMO plans with a Point of Service (POS) option (HMO-POS)
- These plans offer both in-network and out-of-network coverage
- All Part A and Part B services are covered under the POS option

SummaCare Medicare Resources

We are pleased to offer a variety of Medicare materials to support you in assisting patients with their Medicare questions. These resources include:

- Medicare brochures
- Banners
- Window clings

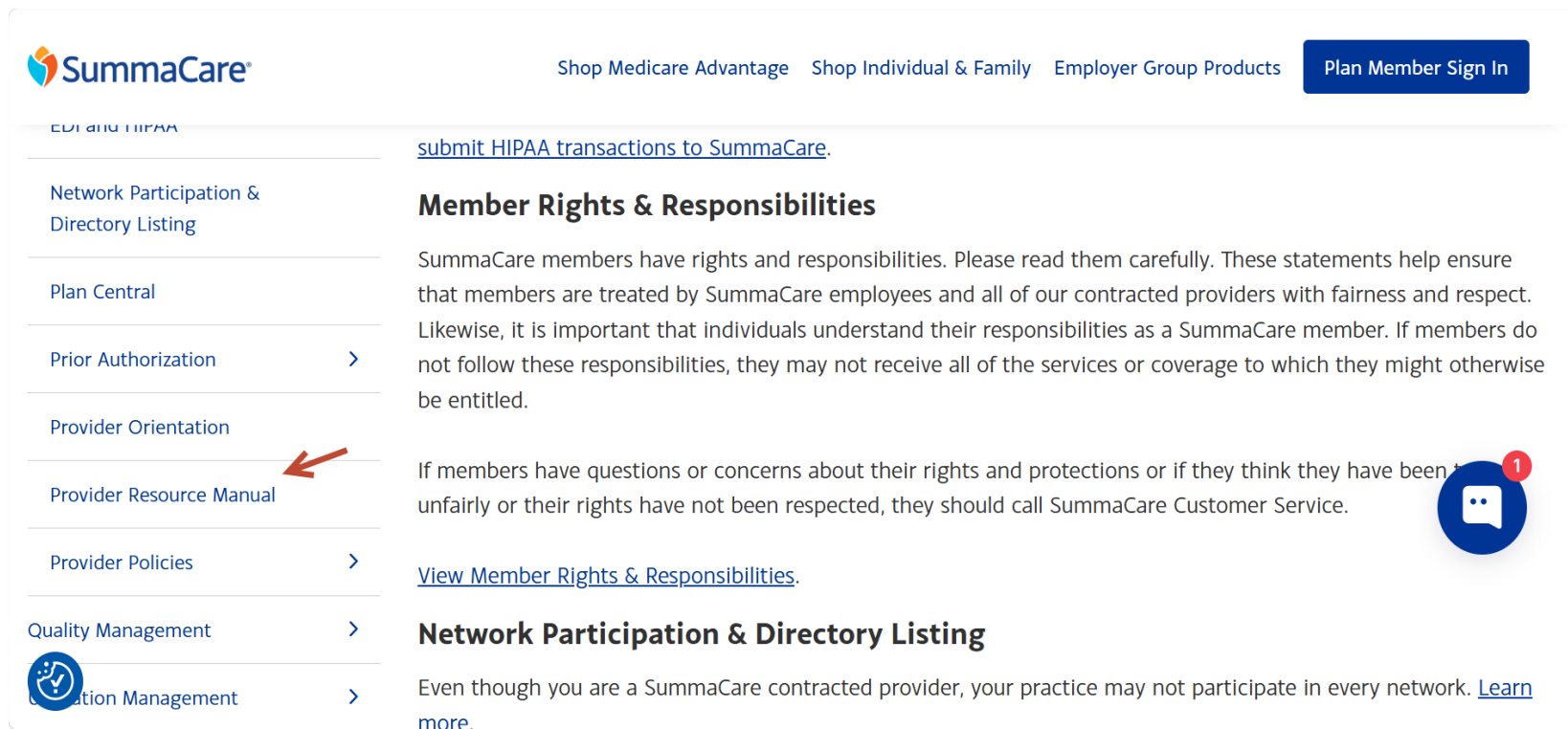
If you would like materials for this Medicare Annual Enrollment Period (10/15-12/7) to assist with patient questions, please contact your Provider Engagement Specialist or email:

PROVIDERENGAGEMENT@SUMMACARE.COM

Provider Resource Manual

The provider menu of the SummaCare website has various sections of information. To make these resources easier to find, a new provider resource manual was created to direct you to the webpages, tools, forms and information your office may use most often.

Visit summacare.com, select providers, provider resources and then provider resource manual.



The screenshot displays the SummaCare website interface. The top navigation bar includes the SummaCare logo, links for "Shop Medicare Advantage", "Shop Individual & Family", "Employer Group Products", and a "Plan Member Sign In" button. The left sidebar contains a list of menu items: "EDI and HIPAA", "Network Participation & Directory Listing", "Plan Central", "Prior Authorization", "Provider Orientation", "Provider Resource Manual" (highlighted with a red arrow), "Provider Policies", "Quality Management", and "Continuation Management". The main content area features a link to "submit HIPAA transactions to SummaCare", a section titled "Member Rights & Responsibilities" with a paragraph of text, a link to "View Member Rights & Responsibilities", and a section titled "Network Participation & Directory Listing" with a paragraph of text. A chat bubble icon with a red notification badge is visible in the bottom right corner of the main content area.

Important Reminders

PROVIDER NEWS

Over the past year, we have sent several communications with changes and updates, please review the Provider News page on the SummaCare website for important updates and changes you may have missed.

A quick review can help your office:

- Confirm that staff are aware of recent requirements
- Identify changes that may affect office workflows

<https://www.summacare.com/providers/provider-news>

Laboratory network requirements

When ordering lab services for SummaCare Medicare Advantage members, please ensure the services are performed by a SummaCare Medicare-contracted lab provider.

This applies whether the member is referred directly to a lab or the specimen is collected in your office and sent to a laboratory for processing. Out-of-network labs should not be used unless prior approval has been obtained.

You can search for participating providers on our website at summacare.com or contact Provider Support Services at 800.996.8401



Questions?



GLP-1 Bridge Program

Tara Hubert PharmD
Clinical Manager Formulary and Pharmacy
Benefit

Jesse Morgan MBA, CPht
Pharmacy Benefits Specialist II

Medicare GLP-1 Bridge Program – Overview

The Centers for Medicare & Medicaid Services (CMS) is expanding access to certain GLP-1 medications for people with Medicare Part D through a short-term demonstration starting July 1, 2026.

Medicare GLP-1 Bridge will operate outside of **Medicare Part D** plan coverage and use a central processor to manage prior authorization, claims processing, and pharmacy payment.



Medicare GLP-1 Bridge is for patients **who have not received a GLP-1 through their Part D plan** and do not have **type 2 diabetes, moderate-to-severe obstructive sleep apnea, or fatty liver disease.**



The patient cost for these drugs under Medicare GLP-1 Bridge is **\$50 per month, regardless of their income level.** This \$50 payment does not count toward the beneficiary's Medicare Part D plan deductible or yearly out-of-pocket limit. These drugs are not eligible for the Medicare Prescription Payment Plan.

Medicare GLP-1 Bridge Program – Criteria for Coverage

Provider attestation: age 18+, lifestyle modification as clinically appropriate, no type 2 diabetes, moderate-to-severe obstructive sleep apnea, MASH or one or more of the following*:

BMI 27+

- Pre-Diabetes
- Previous myocardial infarction
- Previous stroke
- Symptomatic peripheral artery disease

BMI 30+

- Heart failure with preserved ejection fraction
- Uncontrolled hypertension
- Chronic kidney disease stage 3a or above

BMI 35+

- No additional criteria required

Beneficiaries seeking treatment for medically accepted indications (e.g., type 2 diabetes, moderate to severe obstructive sleep apnea, MASH, or risk reduction for major adverse cardiovascular events) should continue to seek coverage as part of their Part D benefit. Eligible beneficiaries for the Medicare GLP-1 Bridge will not include beneficiaries previously or currently taking a GLP-1 in Part D.

*BMI and comorbidities are evaluated at the time the patient initiated GLP-1 therapy

Medicare GLP-1 Bridge Program – Covered Drugs & Plans

Covered Products

- **Foundayo**® Tablet
- **Wegovy**® Oral and Injectable
- **Zepbound**® KwikPen®
- Zepbound® single-dose pens and vials are **NOT** covered.



Eligible Plans

- Most Medicare Part D Patients are enrolled in eligible plans.
- People enrolled in PACE plans, private fee-for-service plans, cost contract plans are **not eligible** to participate unless they're also enrolled in a Prescription Drug Plan (PDP).



Provider Instructions

- Obesity diagnosis code (E66 family) and instruction in notes field: "SEND TO MEDICARE GLP-1 BRIDGE FOR WEIGHT MANAGEMENT"

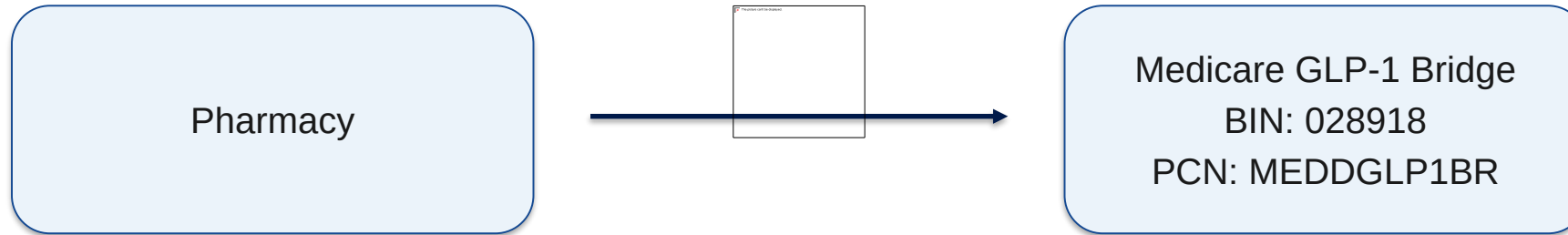


No Existing Part D Fills

- Check your dispensing records to see if you've dispensed a GLP-1 for the patient covered by their Part D Plan.
- If so, the prescription should go to the Part D Plan, not Medicare GLP-1 Bridge.



Medicare GLP-1 Bridge Program – Routing

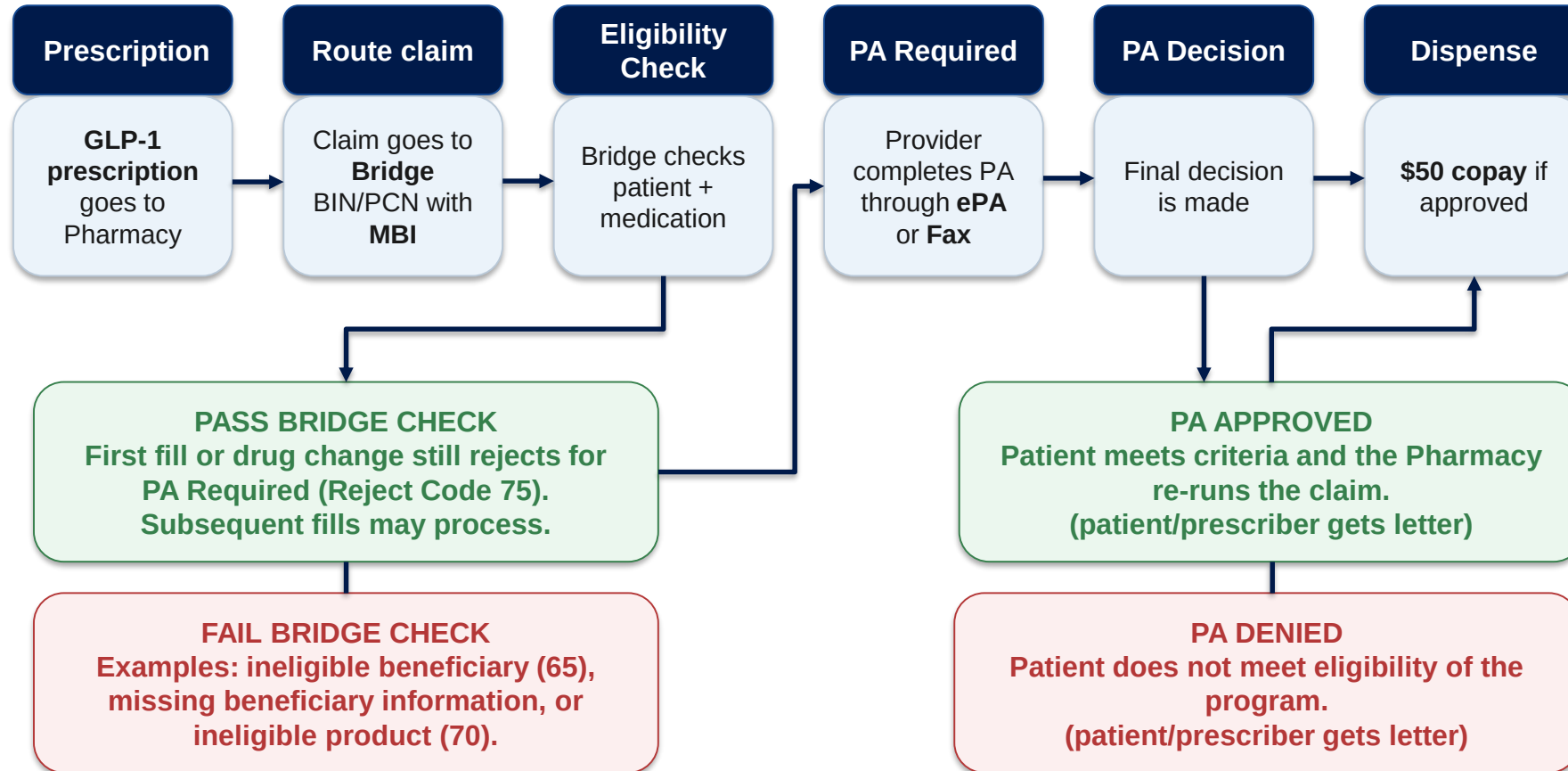


How does the pharmacy route the claim to Medicare GLP-1 Bridge?

- **Medicare Beneficiary ID (MBI) is required** to submit Bridge claims.
- **No Medicare card?** MBI may be retrieved through an **E1 transaction** using the last 4 digits of the patient's SSN.
- Medicare GLP-1 Bridge is the **primary payer**; coordination with other payers is not allowed.
- **Coupons and discount programs cannot be applied.**
- Claims are submitted electronically using the **NCPDP Telecommunication Standard**.

Medicare GLP-1 Bridge Program – Workflow Overview

Medicare Beneficiary ID required to submit the Bridge claim.



Medicare GLP-1 Bridge Program – Pharmacy Pick-Up

Patient Cost & Refills

- Patients will pay a copay of **\$50 per fill**—even for members receiving the Low-Income Subsidy (Extra Help).
- The \$50 ***does not*** count toward the Part D deductible/out-of-pocket maximum and is not eligible for the Medicare Prescription Payment Program.
- A new PA is generally not required for refills unless the patient switches to a different covered GLP-1.
- Only **28- or 30-day** fills are covered under the Medicare GLP-1 Bridge Program.

Pharmacies will be reimbursed at the wholesale acquisition cost of a drug, less the beneficiary copay, plus a dispensing fee of \$3 for each Medicare GLP-1 Bridge claim (\$5 for a beneficiary residing in long-term care) and, as applicable, sales tax.

Medicare GLP-1 Bridge Program – Contact Information

- For more information regarding the Medicare GLP-1 Bridge Program visit:
<https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-pharmacies>
- For technical questions: email CMS at glp1demo@cms.hhs.gov
- Questions for the Summacare Pharmacy team: email us at TM-O-SummaCare-PharmacyDepartment@summahealth.onmicrosoft.com
- If you think you have a member that may benefit or is asking about the program, please refer to the CMS website for additional information.

Questions?



Strategic Clinical Operations & Population Health: Getting It Right the First Time

Beth A. Hall RN CM

Director of Strategic Clinical Ops and Population Health

Connecting
people, data,
and resources
to drive better
outcomes.

Post Acute Team an Expanded Scope of Review

Before

- SNF authorization requests only
- LTAC and Acute Rehab reviews handled elsewhere
- Multiple contacts across the continuum

Now

- SNF, LTAC, and Acute Rehab under one team
- Cross-trained on criteria for all three settings
- Single point of contact for payers and providers

Required Clinical Documentation Required from the Requestor

What to submit with every authorization request

For authorizations to be processed timely, submit all appropriate clinical information that supports the need for the requested service or procedure.

Clinical records

- Physician notes supporting the need for the request
- Consultant notes *
- Vital signs
- Testing results *
- Lab results *

Also include

- Medication list
- Physical therapy / occupational therapy notes *
- Whether the request is inpatient or outpatient
- Reason the member needs an out-of-network provider *
- Direct contact information in case we have questions

* If applicable. Requests received without the supporting clinical information above may be delayed or denied.

Submitting a Complete Request

How to avoid delays and denials

Use the provider portal

Submit through the portal (preferred) or by fax. Review timelines begin only once complete information is received.

Include all clinical documentation

Send the required clinical records with the initial submission rather than in follow-up correspondence.

Complete the full request form

Incomplete forms are the most common cause of avoidable delays and denials.

Add a direct contact number

Give a number our reviewers can reach for any follow-up questions on the request.

Questions?

Provider Support Services, toll-free 800.996.8401 • Provider Engagement, providerengagement@summacare.com

Prior Authorization Turnaround Times (TAT)

Turnaround Times by Line of Business

Plan Type / Line of Business	Standard (Routine) TAT	Expedited (Urgent) TAT	Governing Regulation
Medicare Advantage (MA Part C)	7 calendar days	72 hours	42 CFR 422.568(b)(1)(ii)
Commercial (Employer-Sponsored)	15 calendar days	72 hours	29 CFR §2560.503-1(f)(2)(ii)
ACA Marketplace / Exchange	7 calendar days	72 hours	42 CFR 422.568(b)(1)(ii)

Other Commercial plans are 10 days for standard requests and 48 hours for expedited requests.

Urgent/Expedited definition: A medical care or other service for a condition where application of the timeframe for making routine or non-life-threatening care determinations could seriously jeopardize the life, health or safety of the patient or others due to the patient's psychological state

What Qualifies as an Urgent Request

Criteria for expedited review

The clinical standard

An urgent request involves a condition where waiting for a standard decision could seriously harm the patient's life, health, safety or well-being.

When it does not apply

Requests that do not meet these criteria may be reviewed and processed under the standard timeframe for the plan type.

Label the request — the form drives the timeframe

If “Urgent” is not indicated on the request form, the request will be processed as standard, even when the clinical criteria above are met.

Expedited decisions are issued within 48 or 72 hours depending on plan type — see the review timeline table.

Prior Authorization Turnaround Times (TAT)

Why TAT Matters



Discharge Planning

Delayed decisions push discharge dates back and hold beds.



Patient Flow

Timely submissions protect patient flow and continuity of care.



Complete Documentation

Missing documents are what most often delays a decision.

A decision moves only as fast as the documentation behind it.

Prevent Denials

Top 5 Ways to Prevent Denials

1

**Request the
correct level of
care**

2

**Submit complete,
current clinicals**

3

**Include detailed
therapy
documentation**

4

**Demonstrate
skilled need and
medical necessity**

5

**Send updates and
document
progress**

Denial Prevention Formula

**Medical necessity + skilled need + current clinicals + therapy documentation + timely updates =
higher approval rates**

Clinicals and therapy documentation must be completed within the past 24 to 48 hours.

Why Prevent Denials

What prevention protects



Improves member outcomes



Reduces administrative burden



Supports the appropriate level of care



Enhances provider and member satisfaction



Supports regulatory and accreditation requirements



Reduces costly escalations

Questions?

SummaCare Provider Resources

If you missed any portion of today's webinar, the slide deck will be posted on our website at www.summacare.com, click on the providers tab and then scroll towards the end of the listing to:

Provider Events and Webinars

Questions: providerengagement@summacare.com

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