



Buy-and-Bill Financial Exposure During Renewal Season

Key Takeaways



Buy-and-bill ties up cash before coverage is confirmed. A practice purchases inventory, administers it, then submits a claim and waits on reimbursement — a sequence that only works when coverage is stable.



Renewal season disrupts coverage on three fronts at once. Deductible resets, formulary changes, and expiring prior authorizations can all invalidate a reverification that was accurate weeks earlier.



Reverification volume peaks exactly when coverage data is least reliable. Practices are checking benefits for a larger share of their patient panel during the same window plans are resetting.



A single denial can outweigh weeks of margin. High-cost biologics and infusion therapies carry enough per-claim exposure that one denial offsets a large volume of routine visits.



A successful appeal doesn't undo the cash-flow hit. Even when a denial is later overturned, the practice's money was tied up in purchased inventory for the length of the appeal.



Earlier verification limits exposure. Confirming coverage ahead of the appointment date gives a practice room to catch a coverage or authorization change before it reaches the claim.

Every January, practices brace for the same storm: payer policy updates, plan renewals, and formulary changes all landing at once — what we call “Blizzard Season.” For specialty practices running on a buy-and-bill model — purchasing a drug, administering it, then billing for it after the fact — that storm strikes directly at the assumption the model depends on, that coverage confirmed today still holds by the time a claim is filed. Deductibles return to zero, drugs shift to new coverage tiers, and prior authorizations valid in December expire, all in the same window.

A practice that administers a biologic in the first week of January under last year’s authorization can learn days or weeks later that the drug isn’t covered under the new formulary, or that the patient’s new deductible left a balance no one collected up front.



WHERE THE EXPOSURE COMES FROM

The risk in buy-and-bill rises during the time between administration and confirmation, and renewal season stretches that window from three directions:

1

A reverification completed in December may not reflect January coverage once the benefit year resets.

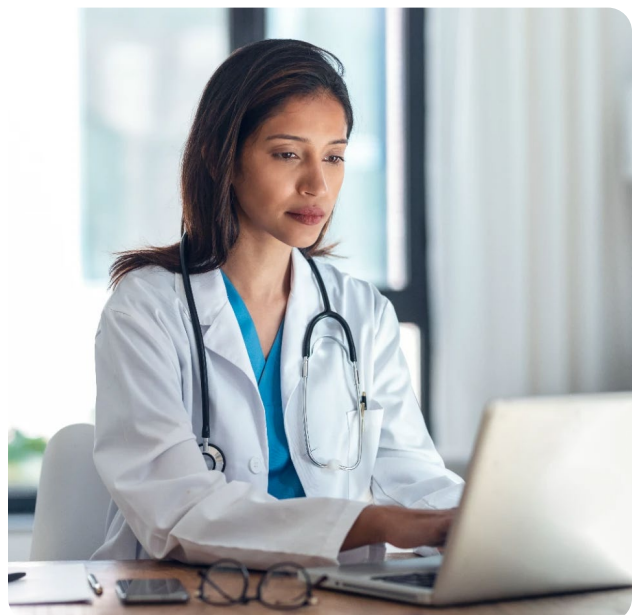
2

A formulary change can move a drug from covered to non-covered or shift it to a tier with higher patient cost-sharing.

3

Prior authorization requirements often change at the same time, so an approval on file from the prior plan year may not carry over.

Getting a complete read on all three at once is harder than it sounds. As our article [“Modernizing Specialty Drug Benefits Verification”](#) lays out, a verification that confirms only active coverage — without checking benefit pathway, formulary tier, and authorization status together — leaves the same three risks unaddressed. A practice working from that kind of partial check, or from a reverification that predates the reset, is administering drugs against last year’s terms rather than this year’s. Each administration made that way adds to what the practice stands to lose once claims start coming back.





WHY THE MATH GETS WORSE IN JANUARY

Reverification volume spikes at the same time coverage is least certain. Practices are checking benefits for a larger share of their patient panel, often for high-cost drugs, and a denial on one of those can wipe out the margin from several routine visits.

Manual reverification wasn't built for this kind of concentrated volume. Phone-based checks and payer portals process one patient at a time, and a month that compresses a year's worth of plan changes creates a backlog regardless of how diligent the staff running it are. That backlog compounds the same administrative strain covered in our post, ["Hidden Costs: How Prior Auth Delays Are Draining Your Practice Revenue,"](#) except that during renewal season, the delay consumes staff time while it's stacking up against a hard deadline of when the next patient is scheduled to receive an expensive drug.



WHEN A CLAIM IS DENIED

A claim denial may be appealed or corrected, but either route can extend the time between administering a drug and receiving payment. By then, the practice had already purchased and administered the therapy. Even if payment is ultimately secured, the practice has carried that cost throughout the resolution process.

Reverification cannot guarantee payment or eliminate every denial. It can, however, give staff an opportunity to identify a coverage change, authorization requirement, or patient cost-sharing issue before administration, when there is still time to address it.



CLOSING THE EXPOSURE WINDOW

[CareTria Provider Connect](#) pre-schedules benefit reverifications ahead of each patient's appointment date, so results are confirmed before the drug goes out. The platform's [real-time benefit investigation](#) returned 99.46% of checks within 24 hours during the 2026 renewal season, with an average turnaround of 1.6 hours. For sponsored products, more than 86% completed in under a minute.

99.46%

OF BIS RETURNED IN

<24 Hours

**Average
Benefit
Verification
Time**



Results in hand days ahead of an appointment give a practice options a same-day check doesn't: time to catch a formulary change, secure a new authorization, or flag a cost-sharing shift for the patient conversation. Download our [renewal-season prep timeline](#) for how to build reverification into the practice's calendar ahead of the reset.

86%

ALL BENEFIT VERIFICATION'S
COMPLETED WITHIN

1 minute



WHAT TO DO BEFORE THE NEXT RESET

Our ["Don't Get Caught in the Blizzard" guide](#) walks through the full renewal-season checklist, including how to time reverifications ahead of the reset. Practices can [sign up for CareTria Provider Connect](#) at no cost, or watch the on-demand [Blizzard Season webinar](#) for a closer look at how pre-scheduled reverification fits a specific caseload. [BlizzardSeason.com](#) has links to these resources and more that can help you ensure a more successful Blizzard Season.





FREQUENTLY ASKED QUESTIONS ABOUT BUY-AND-BILL FINANCIAL EXPOSURE

WHAT DOES “BUY-AND-BILL” MEAN FOR A SPECIALTY PRACTICE?

Buy-and-bill is a reimbursement model where the practice purchases a drug, administers it to the patient, then submits a claim to be reimbursed after the fact. The practice carries the cost of the drug until the claim is paid.

HOW MUCH CAN A SINGLE DENIAL COST A PRACTICE?

It depends on the drug, but high-cost biologics and infusion therapies carry enough per-claim cost that a single denial can offset the margin from many routine visits.

WHY DOES RENEWAL SEASON INCREASE BUY-AND-BILL RISK?

Coverage details accurate in one plan year don't automatically carry into the next. Deductible resets, formulary changes, and expiring prior authorizations can invalidate a reverification done even a few weeks earlier, so drugs administered early in the new plan year carry more risk of denial or reduced reimbursement.

WHY DOES TIMING MATTER IF A DENIAL CAN STILL BE APPEALED OR CORRECTED?

Appealing or correcting a denial can secure payment, but it doesn't undo the cash-flow impact. The practice already purchased and administered the drug, so it carries that cost for as long as resolution takes. Catching a coverage issue before administration avoids that gap entirely, instead of resolving it after the fact.

Keep Calm and Connected

Blizzard Season may always bring new challenges, but you don't have to face them alone. CareTria Provider Connect helps your team stay ahead with automation, reporting, and real human support when you need it most.

READY TO GET THROUGH JANUARY WITHOUT THE SCRAMBLE?

Create your no-cost CareTria Provider Connect account and make the next reverification season the smoothest yet.

Sign Up for CareTria Provider Connect

Learn more at BlizzardSeason.com

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