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Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

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Why OIG Did This Review

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS's annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment. As enrollment in Medicare Advantage continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.

How OIG Did This Review

We selected a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs during June 1–7, 2019. Health care coding experts reviewed case files for all cases, and physician reviewers examined medical records for a subset of cases. From these results, we estimated the rates at which MAOs denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules. We also examined the reasons for these denials and the types of services associated with these denials in our sample.

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Key Takeaway

MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- using MAO clinical criteria that are not contained in Medicare coverage rules;
- requesting unnecessary documentation; and
- making manual review errors and system errors.

What OIG Found

Our case file reviews determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers.

Although some of the denials that we reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and stays in post-acute facilities (e.g., inpatient rehabilitation facilities).

Prior authorization requests. We found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules—in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service). We identified two common causes of these denials. First, MAOs used clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that our physician reviewers determined were medically necessary. Although our review determined that the requests in these cases did meet Medicare coverage rules, CMS guidance is not sufficiently detailed to determine whether MAOs may deny authorization based on internal MAO clinical criteria that go beyond Medicare coverage rules.

Second, MAOs indicated that some prior authorization requests did not have enough documentation to support approval, yet our reviewers found that the beneficiary medical records already in the case file were sufficient to support the medical necessity of the services.

Payment requests. We found that among the payment requests that MAOs denied, 18 percent met Medicare coverage rules and MAO billing rules. Most of these payment denials in our sample were caused by human error during manual claims-processing reviews (e.g., overlooking a document) and system processing errors (e.g., the MAO's system was not programmed or updated correctly).

We also found that MAOs reversed some of the denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules. Often the reversals occurred when a beneficiary or provider appealed or disputed the denial, and in some cases MAOs identified their own errors.

What OIG Recommends

Our findings about the circumstances under which MAOs denied requests that met Medicare coverage rules and MAO billing rules provide an opportunity for improvement to ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately. Therefore, we recommend that CMS:

- (1) issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews;
- (2) update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types; and
- (3) direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

CMS concurred with all three recommendations.

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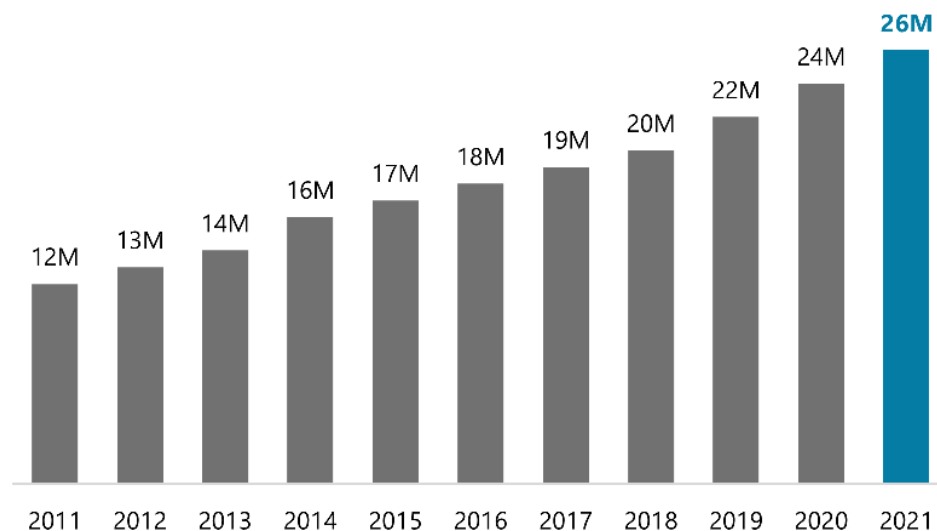
BACKGROUND

Objectives

1. To determine the extent to which selected Medicare Advantage Organizations (MAOs) denied prior authorization requests for services that met Medicare coverage rules, and to examine why these denials occurred.
2. To determine the extent to which the selected MAOs denied payment requests that met Medicare coverage rules and MAO billing rules, and to examine why these denials occurred.
3. To describe the types of health care services involved in denials of services and payments that met Medicare coverage rules and MAO billing rules.

Enrollment in Medicare Advantage (also known as Medicare Part C) has continued to increase over the last decade (see Exhibit 1). Of all Medicare beneficiaries in 2021, 42 percent (26.4 million) were enrolled in a Medicare Advantage plan. The Congressional Budget Office projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to about 51 percent by 2030.¹

Exhibit 1: Total Medicare Advantage enrollment has more than doubled since 2011; Medicare Advantage covered 26.4 million beneficiaries in 2021.



Source: Kaiser Family Foundation, [Medicare Advantage in 2021: Enrollment Update and Key Trends](#), June 2021.

¹ Kaiser Family Foundation, [Medicare Advantage in 2021: Enrollment Update and Key Trends](#), June 2021.

The Medicare program covers a wide range of health care services when they are medically necessary for beneficiaries. Medicare Advantage is designed to cover the same services as original Medicare (also known as fee-for-service Medicare), but in Medicare Advantage, MAOs² are also responsible for the coordination of care for beneficiaries enrolled in their plans.^{3, 4} The goal of coordinated care is to provide efficient, high-quality care that improves patient health outcomes while also managing program costs. To manage care for beneficiaries and to help control costs, MAOs may impose additional requirements, such as requiring that beneficiaries use only in-network providers for certain health care services; requiring prior authorization before certain services can be provided; or requiring referrals for specialty care services.

Although MAOs approve the vast majority of prior authorization requests and provider payment requests, MAOs also deny millions of requests each year. A central concern about capitated payment models—including the model used in Medicare Advantage—is the potential incentive for insurers to deny access to services and payment in an attempt to increase profits.⁵ The Centers for Medicare & Medicaid Services' (CMS's) annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment.⁶ This report focuses on the subset of prior authorization requests and provider payment requests that MAOs denied. We examined these denied requests to assess the extent to which the denied requests met Medicare coverage rules, and thus would likely have been approved in original Medicare.

Medicare Coverage Rules

MAOs must follow Medicare coverage rules, which specify what items and services are covered and under what circumstances. Because MAOs must provide beneficiaries with all basic benefits covered under original Medicare, they may not impose limitations—such as waiting periods or exclusions from coverage due to pre-existing conditions—that are not present in original Medicare.⁷ Medicare coverage rules are outlined in national coverage determinations (NCDs); local coverage determinations (LCDs) in the geographic area in which the MAO operates; the Medicare Benefit Policy Manual; the Medicare Managed Care Manual; legislative changes in benefits applied

² For the purposes of this report, we use "MAO" to mean a parent company that operates one or more Medicare Advantage contracts.

³ At a minimum, MAOs must cover the same services as in original Medicare, although they may also offer supplemental benefits. 42 CFR §§ 422.101(a) and (b); 422.102. MAOs are not responsible for paying hospice care costs for beneficiaries; these costs are paid by original Medicare.

⁴ CMS, [Medicare Managed Care Manual](#), ch. 5, sec. 10.

⁵ In capitated payment models, insurance companies or providers receive a fixed amount of money per patient regardless of the number of services provided to the patient.

⁶ OIG, [Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials](#), September 2018.

⁷ CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 10.2. p. 7.

through notice-and-comment rulemaking, and other coverage guidelines and instructions issued by CMS.⁸ Coverage rules can include administrative requirements (e.g., requiring that a specific form be completed) and clinical requirements (e.g., outlining the types of cancer for which Medicare will cover chemotherapy).⁹

MAO Clinical Criteria and Billing Rules

Although MAOs must follow Medicare coverage rules, they are also permitted to use additional clinical criteria that were not developed by Medicare when they are determining whether to authorize or pay for a service, as long as such criteria are “no more restrictive than original Medicare’s national and local coverage policies.”¹⁰ For example, MAOs may develop and use their own internal clinical criteria or use commercially available clinical guidelines developed by private health care management companies. (This report uses the term “MAO clinical criteria” to refer to any clinical criteria that MAOs adopt.) MAO clinical criteria are typically more detailed than Medicare coverage rules and are intended to assist with clinical decision making. MAOs must provide beneficiaries with an annual Evidence of Coverage document that gives an overview of coverage requirements and beneficiary cost-sharing.¹¹

MAOs may create their own billing and payment procedures as long as all providers are paid accurately, timely, and with an audit trail.¹² Providers must follow MAO billing rules, such as those outlined in provider contracts (e.g., payment requests must be filed within specific timeframes). MAOs may also require that providers adhere to Medicare billing rules, such as the Medicare Claims Processing Manual.

MAO Coverage Determination Process

MAOs must establish procedures for making decisions—also called coverage determinations—about whether to approve or deny requests.¹³ MAOs issue coverage determinations for two types of requests: (1) “prior authorization requests,” which are requests for the MAO to preapprove a service or item before the beneficiary receives

⁸ CMS, [Medicare Managed Care Manual](#), ch. 4, secs. 90.2 and 90.3. National Coverage Determinations are Department of Health and Human Services determinations on whether a particular item or service is covered under Medicare. Local coverage determinations are written coverage decisions of local Medicare Administrative Contractors with jurisdiction for claims in a particular geographic area. MAOs are responsible for monitoring CMS’s national coverage determinations and publications to ensure that they are complying with all Medicare coverage rules.

⁹ If Medicare coverage rules do not exist for a specific service, then MAOs must determine whether the requested service is “reasonable and necessary” for the beneficiary and may use the coverage policies of other MAOs in their service area or other authoritative evidence such as peer-reviewed clinical studies. Social Security Act § 1862(a)(1)(A). CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 90.5.

¹⁰ CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 10.16.

¹¹ 42 CFR § 422.111.

¹² CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 10.2.

¹³ 42 CFR § 422.566; CMS, [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#), sec. 10.4.4.

it; and (2) payment requests from a provider for a service already delivered to the beneficiary. CMS requires that MAOs have a medical director who is responsible for ensuring the clinical accuracy of all coverage determinations involving an assessment of medical necessity.¹⁴

Prior authorization requests. MAOs can require that providers receive authorization for certain services before the MAO will provide coverage and payment.¹⁵ Prior authorization is a utilization management tool that MAOs can use to control costs and ensure the most cost-effective, clinically appropriate treatment is offered to beneficiaries. Prior authorization requests are reviewed by MAO clinical staff to determine whether items and services are medically necessary and reasonable for the beneficiary, and whether they meet Medicare and MAO coverage rules. For context, in 2018, MAOs denied 1.5 million prior authorization requests overall (5 percent of all prior authorization requests) in the Medicare Advantage program.^{16, 17}

Payment requests. Providers who are paid on a fee-for-service basis by the MAO submit payment requests to receive reimbursement for services that the providers have already delivered to beneficiaries. As with the MAO's decision on a prior authorization request, the MAO's decision to approve or deny the payment request must be consistent with applicable rules for Medicare coverage and MAO billing. For context, in 2018, MAOs denied 56.2 million payment requests overall (9.5 percent of all payment requests) in the Medicare Advantage program.¹⁸

Appeals. When an MAO denies a prior authorization request, the beneficiary may elect not to receive the service; the beneficiary may elect to receive the service and pay for it out of pocket; or the beneficiary or the beneficiary's representative can file an appeal of the denial with the MAO.¹⁹ Similarly, when MAOs deny payment requests, providers can dispute or appeal the denial. Providers who enter into a contract with an MAO (i.e., in-network providers) can file a payment dispute, which is processed and resolved according to the provisions in the MAO's provider manual or other document that delineates the MAO-specific dispute process. Providers who do not have a contract with an MAO can file an appeal of the denial.

¹⁴ 42 CFR § 422.562; CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 10.16.

¹⁵ CMS, [Medicare Managed Care Manual](#), Chapter, ch. 4, sec. 110.1.1.

¹⁶ CMS, [2018 Part C Reporting Requirements Data](#), accessed on June 3, 2021. In 2019, CMS changed MAO data reporting requirements to exclude the reporting of payment requests from contracted providers. Because our analysis includes payment requests from contracted providers, we analyzed CMS's data from 2018 to give context on overall MAO denial rates.

¹⁷ In 2018, MAOs overturned 86,193 prior authorization denials following an appeal.

¹⁸ CMS, [2018 Part C Reporting Requirements Data](#), accessed on June 3, 2021. In 2018, MAOs overturned 258,524 payment denials following an appeal.

¹⁹ CMS, [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance \(cms.gov\)](#), p. 15. Individuals who represent beneficiaries may either be appointed or authorized to act on behalf of the beneficiary in dealing with any of the levels of the appeals process.

CMS oversight

CMS uses several tools to oversee the performance of MAOs and ensure that beneficiaries have access to necessary care. CMS assigns an account manager and lead caseworker for each MAO contract. Account managers monitor complaints from beneficiaries and work with MAOs to promote compliance with Medicare program requirements.

Each year, CMS audits a sample of MAOs to measure an MAO's compliance with the terms of its contract with CMS. During the audits, CMS evaluates MAO compliance with requirements associated with beneficiaries' access to covered Medicare services, access to drugs, and other beneficiary protections required by Medicare.²⁰ CMS requires MAOs to implement corrective action plans to address any audit violations and to demonstrate that they have substantially corrected deficiencies before the audit is officially closed. CMS may impose civil money penalties and sanctions for serious violations identified through audits.

Prior OIG work on denials in Medicare Advantage

In a September 2018 report, we found that when beneficiaries and providers appealed denied requests in Medicare Advantage during 2014–2016, MAOs overturned about 75 percent of their own prior authorization denials and payment denials.²¹ We also found that CMS cited more than half of audited MAO contracts in 2015 for inappropriately denying prior authorization and payment requests. We recommended that CMS address persistent problems related to denials identified in its audits. CMS responded that it had increased the penalties for MAO violations that prevent beneficiaries from accessing medically necessary services. We also recommended that CMS enhance its oversight of MAO appeals data and provide beneficiaries with clear, easily accessible information about serious violations by MAOs. As of March 2022, CMS had not yet implemented these recommendations.

Methodology

Scope

Using a random sample of denials from the 1-week period of June 1–7, 2019, this report estimates the rate at which 15 of the largest MAOs denied prior authorization and payment requests that met Medicare coverage rules. It also describes the causes

²⁰ CMS audits MAO compliance in several program areas, including Medicare Advantage (Part C) coverage determinations, appeals, and grievances. CMS's annual audit enforcement reports are available at <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits.html>. During the audits, CMS reviews a sample of MAO denials to determine whether they were appropriate, but CMS does not calculate a rate of inappropriate denials.

²¹ OIG, [*Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*](#), September 2018.

and other issues associated with these denials; prominent service types among these cases; and (when available) MAO-reported actual or estimated costs.

Sample Selection

We selected 15 of the largest MAOs by enrollment as the study population. These MAOs accounted for nearly 80 percent of beneficiaries enrolled in Medicare Advantage as of June 2019, ranging in size from about 165,000 to nearly 6 million beneficiaries.

To compile a sampling frame, we collected a list of all prior authorization denials and payment denials that each selected MAO issued during a 1-week period, June 1–7, 2019. We stratified the sample frame of nearly 283,000 total denials by type of request (prior authorization or payment) and MAO enrollment size. We then selected a stratified random sample of 500 denial cases, consisting of 250 prior authorization denials and 250 payment denials.

During our review, we identified 70 sampled cases that were ineligible for this study (e.g., denials of requests for supplemental benefits that are not covered in original Medicare) and excluded them from our analysis. This resulted in a final sample of 430 cases.

See Detailed Methodology on page 24 for further information.

Case File Collection and Preliminary Screening

To conduct the case file reviews, we contracted with health care coding and billing professionals with expertise in Medicare coverage rules and with physicians. (In this report, we refer to the first group as “health care coding experts.”) Initially, the health care coding experts checked whether a case was eligible for our sample. Then they reviewed the case files of the 430 eligible cases for completeness and made additional requests to the MAOs for missing records or information needed for case file reviews.

Case File Reviews

To design the case file review methodology, we consulted with the following: CMS; the Medicare Advantage Independent Review Entity contractor (which reviews appeals that were upheld by MAOs); physicians; and health care coding experts. We also reviewed CMS policy documents such as the Medicare Managed Care Manual.

The objective of the case file reviews was to determine whether the denied prior authorization and payment requests met relevant Medicare coverage rules and, if applicable, MAO billing rules. For our sample of 430 eligible cases, we conducted reviews for administrative coverage only for 268 cases, and for the remaining 162 cases we conducted reviews for both administrative coverage and medical necessity. Reviewers followed a structured protocol that OIG developed in consultation with health care coding experts and physicians.

Administrative coverage reviews: Our health care coding experts determined whether the prior authorization or payment requests met the Medicare coverage rules and/or MAO billing rules that the MAO cited as support for its denial decision. For example, MAOs often cited NCDs and LCDs; the Medicare Managed Care Manual; the beneficiary's Evidence of Coverage Document; and other MAO billing rules.

Medical necessity reviews: If our health care coding experts assessed that denial cases needed a medical necessity review to determine whether the request met Medicare coverage rules, then the cases received an additional clinical review by a physician. Following a structured OIG protocol, physicians used their clinical judgment to determine whether the denied service was medically necessary for the beneficiary using the medical records and other clinical information available in the case file. For any case for which the physician reviewer determined that the service was medically necessary, or for which the physician reviewer wanted to consult with other physicians, we convened "consensus calls" among a panel of three physicians to discuss the case. The three-physician panel then reached consensus regarding whether a denied service was medically necessary for the beneficiary, based on clinical information in the medical records that the MAO had submitted to OIG. A health care coding expert then reviewed these cases to determine whether the case met administrative rules for Medicare coverage.

Analysis

We analyzed the results of the reviews by health care coding experts and the clinical reviews by physicians, and we generated population estimates of the rates of prior authorization denials and payment denials for requests that met Medicare coverage rules and MAO billing rules. We also generated population estimates for the rates at which prior authorization denials and payment denials were issued for services that met Medicare coverage rules and MAO billing rules, but were then reversed by the MAOs. See Appendix A on page 31 for point estimates, 95-percent confidence intervals, and key statistics.

Limitations

The results of the case reviews were limited to the documentation available in the medical records submitted by the MAOs at the time of our review. Although we followed up with MAOs to help ensure that they submitted all relevant records, we were not able to verify whether additional information might have existed but was not submitted. Further, the case review results were subject to the interpretations and clinical judgments of the health care coding experts and physician reviewers.

Because a significant number of cases in the sample did not have cost data in their records, we were not able to estimate the costs associated with denials, such as added charges to Medicare beneficiaries or unpaid reimbursements to providers. When this information was available, we indicated the cost associated with denials in our sample that we determined met Medicare coverage rules and MAO billing rules.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Thirteen percent of prior authorization denials were for service requests that met Medicare coverage rules, likely preventing or delaying medically necessary care for Medicare Advantage beneficiaries

Of the 12,273 denials of requests for services (prior authorization denials) issued by the 15 selected MAOs during the first week of June 2019, an estimated 13 percent met Medicare coverage rules.²² In other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service). This projects to 1,631 prior authorization denials for requests that met Medicare coverage rules for the selected MAOs during that week. For an annual context, if these MAOs denied the same number of prior authorization requests (1,631) in each of the other 51 weeks of 2019, they would have denied 84,812 beneficiary requests for services that met Medicare coverage rules that year.

MAO denials of prior authorization requests for services that meet Medicare coverage rules can create significant negative effects for Medicare Advantage beneficiaries. These denials can delay or prevent beneficiary access to medically necessary care; lead beneficiaries to pay out of pocket for services that are covered by Medicare; or create an administrative burden for beneficiaries or their providers who choose to appeal the denial. These denials may be particularly harmful for beneficiaries who cannot afford to pay for services directly and for critically ill beneficiaries who may suffer negative health consequences from delayed or denied care.

MAOs denied prior authorization requests for services that were medically necessary by applying MAO clinical criteria that are not contained in Medicare coverage rules

For many of the denials of prior authorization requests in our sample for services that met Medicare coverage rules, MAOs denied the requests by applying MAO clinical criteria that are not required by Medicare. As shown in the examples below, we found that in these cases MAOs used specific, mandatory requirements that resulted in the denial of prior authorization requests for medically necessary services. In contrast, original Medicare does not impose such specific requirements for covering the procedures involved. (For more detailed descriptions of all prior authorization and

²² As stated on page 4 of this report, in 2018, MAOs denied 5 percent of all prior authorization requests in the Medicare Advantage program.

payment cases that met Medicare coverage rules and MAO billing rules, see Appendix B on page 32.)

Case D472: MAO restricted followup MRIs based on the size of the beneficiary’s lesion, a restriction that is not included in Medicare coverage rules.

Eight months after a beneficiary was discovered to have an adrenal lesion of 1.5 cm in size, an MAO denied a request for a followup MRI (estimated cost \$300). The MAO stated that the beneficiary would need to wait at least 1 year for the followup MRI because the size of the lesion (less than 2 cm) was too small to warrant followup before 1 year. However, our health care coding experts determined that the applicable NCD does not restrict the timing of followup MRIs based on the size of lesions. Furthermore, our physician panel stated that the documentation in the original request demonstrated that the MRI was medically necessary to determine whether the lesion seen on an earlier CT scan was malignant. (The MAO reversed its original denial upon appeal. See case D472 in Appendix B for additional details.)

Case D460: MAO applied an ambulatory device limit that is not included in Medicare coverage rules.

An MAO denied a request for a walker (estimated cost \$112) for a 76-year-old beneficiary with post-polio syndrome. The MAO stated that, per its clinical criteria, the beneficiary was not eligible to receive a walker because the beneficiary had already received a cane within the past 5 years. The MAO’s clinical criteria considered these devices to be the “same or similar” and limited beneficiaries to one such device every 5 years. However, our health care coding expert determined that the applicable LCD for walkers does not include a 5-year restriction on more than one ambulatory device. Further, our physician panel determined that the walker was medically necessary given the beneficiary’s history, risk of falling, and physical therapy notes. These factors indicated that the beneficiary could not walk safely with only a cane. (See case D460 in Appendix B for additional details.)

CMS officials reported that MAOs may use internal clinical criteria that do not contradict Medicare coverage rules; however, existing guidance is not sufficiently detailed for OIG to determine whether CMS would consider each of these denials in our sample to be inappropriate

In several cases, we were unable to determine whether the prior authorization denials that met Medicare coverage rules would be considered allowable by CMS because CMS’s guidance regarding MAO use of internal clinical criteria is not sufficiently detailed. The following example helps to illustrate the problem: An MAO denied a prior authorization request for a CT scan (case D479) that our physician reviewers determined was medically necessary. The MAO stated that its clinical criteria required the beneficiary to have an x-ray first to prove that a more advanced imaging procedure (a CT scan) was needed. However, the Medicare NCD for CT scans states:

"[T]here is no general rule that requires other diagnostic tests to be tried before CT scanning is used." This suggests that—all other things being equal—Medicare would have paid for the CT scan for this beneficiary if the beneficiary were enrolled in original Medicare, whereas the service was denied for the beneficiary in Medicare Advantage.

The section of the Medicare Managed Care Manual governing this issue states that MAO internal policies for medical necessity determinations must use "coverage criteria no more restrictive than original Medicare's national and local coverage policies."²³ In the example above, because the Medicare coverage rule does not require a beneficiary to have an x-ray prior to a CT scan, and because the NCD states specifically that there is no such requirement in original Medicare, one could conclude that the MAO used criteria that were "more restrictive" than original Medicare.

CMS officials reported to OIG that MAOs may establish additional clinical criteria for Medicare-covered services, as long as the criteria are evidence-based and do not "contradict" the applicable Medicare coverage rules. Therefore, in the example above, the denial of prior authorization for the CT scan could be considered allowable if CMS judged that the MAO's x-ray requirement was evidence-based and did not contradict the Medicare NCD for CT scans.

Given the current language in the Medicare Managed Care Manual, and because CMS has not issued guidance on what types of clinical criteria would be considered "more restrictive than" or "contradictory to" Medicare coverage rules, OIG was unable to determine whether certain denials of Medicare-covered services would be considered allowable by CMS.

MAOs denied prior authorization requests for medically necessary services when providers did not respond to requests for unnecessary documentation

In some prior authorization cases in our sample that met Medicare coverage rules, MAOs contacted providers to request unnecessary documentation (e.g., additional test results) before making their decision, and then denied the request when providers did not supply the additional documentation. In some of these cases, the MAO reviewer requested additional documents to further support that the requested service was medically necessary; however, our physicians determined that the clinical information in the case file was already sufficient to demonstrate medical necessity. In other cases, the MAO reviewer asked for copies of documentation already contained in the case file.

Case D199: MAO requested documentation that was already on file.

An MAO denied a request for Botox medication for a beneficiary with a diagnosis of urge incontinence (estimated cost \$3,674). The MAO incorrectly stated that there was

²³ CMS, [Medicare Managed Care Manual](#), ch. 4, sec. 10.16.

a lack of clinical information about the beneficiary's previous use of the medication and asked for additional records. However, the MAO had already received records documenting the beneficiary's previous use of Botox as part of the prior authorization request, making the request for the documentation unnecessary. (The MAO noted that it reversed the denial after receiving OIG's data request. See case D199 in Appendix B for additional details.)

Eighteen percent of payment denials were for claims that met Medicare coverage rules and MAO billing rules, which delayed or prevented payments for services that providers had already delivered

Of the 160,378 payment denials issued by the 15 selected MAOs during the first week of June 2019, an estimated 18 percent met Medicare coverage rules and MAO billing rules and should have been approved by the MAOs.²⁴ This projects to 28,949 payment denials that met Medicare coverage rules and MAO billing rules for the selected MAOs during that week. For an annual context, if these MAOs denied the same number of payment requests (28,949) in each of the other 51 weeks of 2019, they would have denied 1.5 million payment requests that met Medicare coverage rules and MAO billing rules that year. Denying payment requests that meet these rules delays or prevents providers from receiving payment for services that they have already delivered to beneficiaries, which can burden providers.

MAOs denied payments to providers because of human error during manual reviews

MAOs rely on their staff to manually review some requests for payments before approving or denying them. However, these manual reviews are susceptible to human error, such as a reviewer's overlooking a document in the case file or inaccurately interpreting CMS or MAO coverage rules. These errors can result in denied payments to providers for services that meet Medicare coverage rules and MAO billing rules.

²⁴ As stated on page 4 of this report, in 2018, MAOs denied 9.5 percent of all payment requests in the Medicare Advantage program.

Case D187: MAO reviewer was unfamiliar with network facility coverage rules.

An MAO reviewer denied a payment request for care at a skilled nursing facility because it was delivered by a provider who was not contracted with the MAO (estimated cost \$50). In most cases, a beneficiary needs prior authorization to receive care from a noncontracted provider. However, the skilled nursing facility was an in-network facility. This qualified the claim as “plan-directed care,” and therefore no prior authorization was required. The MAO attributed the denial to human error. (The MAO noted that it reversed the denial after receiving OIG’s data request. See case D187 in Appendix B for additional details.)

Case D442: MAO reviewer did not account for documentation already on file.

An MAO denied payment for radiation treatment for an elderly cancer patient with a tumor on the pancreas (\$336). The MAO incorrectly claimed that no prior authorization had been submitted for the service. However, the provider subsequently submitted a screenshot demonstrating that the MAO had granted a prior authorization for the billed claim. The MAO attributed this denial to human error and reversed the denial, noting that the MAO’s reviewer did not see the prior authorization in the file. (See case D442 in Appendix B for additional details.)

MAOs denied payment requests because of inaccurate programming of claims processing systems

When MAO systems for claims processing are programmed incorrectly, or are not updated timely, they can result in denials for payments that should be approved. Unlike errors generated on a case-by-case basis during a manual review, system errors can cause greater harm because they automatically generate a potentially larger volume of incorrect denials until the MAO notices the error and fixes it.

Case D444: MAO’s system failed to correctly route claims for manual review.

One MAO’s established procedure was to manually review payment requests from providers with multiple taxpayer identification numbers (TINs) so that the correct TIN could be chosen. However, the system was programmed incorrectly and did not automatically route these cases for manual review. In this case, an in-network provider submitted a claim for physical therapy services, but the MAO’s system chose an incorrect TIN, making the provider appear to be out-of-network. The MAO discovered the error after receiving OIG’s data request and paid the claim (\$108). The MAO reported to OIG that the same error may have affected 163 additional provider payment requests and that it was working to implement an automated process to prevent a recurrence. (See case D444 in Appendix B for additional details.)

Case D441: MAO's system did not recognize the authorized timeframe for a service.

An MAO denied a request for radiation therapy (\$668) for a 74-year-old beneficiary with prostate cancer, incorrectly stating that no prior authorization was on file for the date of service. The provider disputed the denial and submitted a screenshot demonstrating that prior authorization had previously been obtained. The MAO stated that its system had not correctly recognized the timeframe that had been authorized under the approved prior authorization request. The MAO reversed the denial and reported that it updated its system to correct the error. (See case D441 in Appendix B for additional details.)

Imaging services, stays in post-acute facilities, and injections were three prominent service types among the denials that met Medicare coverage rules

Among the denied requests for prior authorizations and payments that met Medicare coverage rules and MAO billing rules that we identified in our sample, there was a wide range of service types. Three of the most prominent service types were advanced imaging services (including MRIs and CT scans); post-acute care in skilled nursing facilities and inpatient rehabilitation facilities (i.e., care after hospital stays); and injections.²⁵ To reduce their costs, MAOs may have an incentive to deny more expensive services, such as inpatient rehabilitation facility stays, and/or require that beneficiaries receive less expensive alternatives. We also observed denials that met Medicare coverage rules and MAO billing rules for items or procedures that may receive extra scrutiny from MAOs because they can be vulnerable to fraud, such as durable medical equipment and injections for pain management.²⁶

MAOs denied requests for advanced diagnostic imaging that met Medicare coverage rules and MAO billing rules, often stating that a more basic imaging service must be performed first

Imaging services were the most common health care service type among the denials that met Medicare coverage rules and MAO billing rules in our sample, and consisted mainly of advanced diagnostic imaging services, such as MRIs and CT scans. Medicare coverage rules state that MRIs and CT scans are covered when medically

²⁵ We also observed denials for physician services, durable medical equipment, surgery, inpatient hospital stays, ambulance transport, lab tests, therapy, radiation treatment, chiropractic services, and other tests. See Appendix B for more detail on the denial cases in our sample that met Medicare coverage rules.

²⁶ Durable medical equipment and injections for pain management have been the subject of many prosecutions for health care fraud. See, for example: Department of Justice, [CEO Sentenced to Prison in \\$150 Million Health Care Fraud, Opioid Distribution, and Money Laundering Scheme](#). Accessed on March 21, 2022.

necessary and appropriate for the beneficiary.²⁷ Medicare does not have a blanket requirement that beneficiaries receive specific tests or treatments prior to receiving an MRI or CT scan.²⁸ However, in several cases MAOs denied requests for advanced diagnostic imaging that our physician panel determined were medically necessary, and that health care coding experts determined met Medicare coverage rules, because the beneficiary had not first received a more basic imaging service or more conservative treatment. As discussed earlier in this report, MAOs often cited MAO clinical criteria not contained in Medicare coverage rules to justify these denials of imaging services.

Case D221: MAO required an x-ray before it would approve an MRI.

An MAO denied a request for an MRI (estimated cost \$365) of the hand for a Medicare beneficiary who continued to have pain and weakness in the hand 5 months after a fall. The MAO cited its clinical criteria that required, among other things, that the beneficiary undergo an x-ray that then failed to provide a diagnosis before the MAO would authorize an MRI. However, our reviewers determined that the MRI was medically necessary and reasonable for the beneficiary and the applicable Medicare NCD does not have a requirement that a beneficiary receive an x-ray prior to an MRI. Further, our physician panel explained that an x-ray would not be sufficient for this patient because some hand injuries—such as those involving small bones, muscles, and ligaments in the hand—may not be visible with an x-ray. The physician panel also noted that delayed treatment could cause further harm for this beneficiary because the muscles and ligaments might retract. The MAO reversed the prior authorization denial upon appeal. (See case D221 in Appendix B for additional details.)

Case D406: MAO required provider-directed treatment before it would approve an MRI.

An MAO denied a request for an MRI (estimated cost \$297) for a 91-year-old beneficiary with worsening chronic low back pain with sciatica (pain that radiates from the lower back through the hips and down the leg). The MAO's medical director denied the request because the beneficiary had not completed 6 weeks of provider-directed treatment within the preceding 3 months. However, our physician panel determined that the beneficiary needed the MRI because of the beneficiary's age, the diagnosis, and the results of a previous back x-ray. Further, the NCD for MRIs does not require that beneficiaries complete 6 weeks of provider-directed treatment before receiving an MRI. (See case D406 in Appendix B for additional details.)

²⁷ CMS, [National Coverage Determination \(NCD\) for Computed Tomography \(220.1\)](#), March 12, 2008. CMS, [National Coverage Determination \(NCD\) for Magnetic Resonance Imaging \(220.2\)](#), April 10, 2018.

²⁸ In individual cases, the use of an MRI or CT scan as the initial diagnostic test may not be reasonable and necessary because it is not supported by the beneficiary's symptoms (and it would then be appropriate to deny the request for the advanced imaging and suggest more conservative treatment first).

MAOs denied requests for transfers to post-acute care facilities that met Medicare coverage rules, claiming that beneficiaries' needs could be met at a lower, less costly level of care

Among the denial cases that met Medicare coverage rules in our sample, several were prior authorization requests to discharge patients from the hospital to inpatient rehabilitation facilities or to skilled nursing facilities. In their justifications for these denials, MAOs often claimed that the patients did not need intensive therapy or skilled care, and that their needs could be met at a lower level of care, such as home health services at the patient's residence. However, our physician panel determined in these cases that the patients met the clinical criteria for admission to the relevant facilities, that they would have benefited from the higher level of care ordered by the requesting physician, and that the alternatives offered by the MAOs were not clinically sufficient to meet the patients' needs.

Post-acute services provided in facilities for rehabilitation and skilled nursing care are significantly more expensive than home health services, which may lead to increased scrutiny from MAOs for these types of requests. (See Exhibit 2.)

Exhibit 2: Costs for post-acute care can vary widely across different settings

Inpatient rehabilitation facilities provide intensive therapy and medical services in a hospital environment to patients with complex nursing, medical management, and rehabilitative needs.

Average payment per stay in 2018 under original Medicare: **\$20,124**.

Skilled nursing facilities provide skilled nursing or therapy services to patients for rehabilitation following inpatient hospital stays.

Average payment per stay in 2018 under original Medicare: **\$11,592**.

Home health services include intermittent skilled nursing care, physical therapy, or speech-language pathology, and continuing occupational therapy services for patients who are unable to leave home or can leave home only with considerable effort.

Average payment per stay in 2018 under original Medicare: **\$3,089**.

Sources: CMS, [Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements, Medicare Coverage of Skilled Nursing Facility care, and Medicare Home Health Benefit Booklet](#). Information on costs from: [Medicare Payment Advisory Commission, A Data Book: Health Care Spending and the Medicare Program, July 2020](#). Skilled nursing facility costs calculated using the number of Medicare skilled nursing facility stays and total Medicare skilled nursing facility payments.

Case D260: MAO offered an insufficient alternative level of care.

An MAO denied a request to transfer a beneficiary from the hospital to a skilled nursing facility, stating that a lower level of care (home health services) could meet

the beneficiary's medical needs. The beneficiary had pain and swelling from cellulitis (a bacterial skin infection) and bedsores. The patient was unable to carry out activities of daily living, could stand for only a few minutes at a time, and was no longer able to walk with the help of a rolling walker. Our physician panel determined that, considering the beneficiary's deteriorating functional status, comorbidities, and need for daily skilled care, the patient met Medicare coverage requirements for skilled nursing facility care outlined in the Medicare Benefit Policy Manual and would benefit from occupational and physical therapy. The MAO reversed this denial upon appeal. (See case D260 in Appendix B for additional details.)

Case D278: MAO denied care that met patient's needs.

An MAO denied a request for a referral to an inpatient rehabilitation facility for a beneficiary with a fractured femur who was recovering from screw placement surgery. The MAO stated that the beneficiary did not meet all medical necessity criteria for admission to an inpatient rehabilitation facility, and that the beneficiary's needs could be met in other, lower-level-of-care settings, such as a skilled nursing facility, home with home health services, or home with outpatient therapy. However, our physician panel determined that the beneficiary met the medical necessity criteria for an inpatient rehabilitation facility stay as outlined in the Medicare Benefit Policy Manual, including the need to be examined by a rehabilitation physician at least 3 days per week. The physician reviewer added that a lower level of care was not a clinically sufficient alternative because the beneficiary would not have access to physician supervision to facilitate recovery from pneumonia and other post-operative risks. (See case D278 in Appendix B for additional details.)

MAOs denied requests for injections, in some cases by misapplying Medicare coverage rules

A third prominent service type among the denials that met Medicare coverage rules in our sample was injections. Some of these injections were for pain management, which have been subject to improper billing and fraud in Medicare, and so may receive extra scrutiny from MAOs. However, in two of the pain-management injection cases in our sample, case reviews determined that MAO reviewers misapplied Medicare coverage rules (see examples below).

Case D401: MAO misapplied Medicare coverage rules.

An MAO denied a request for an injection to alleviate severe and worsening neck pain for a 72-year-old beneficiary. The request was for an injection in the cervical 1-2 joint between the first and second vertebrae at the top of the spine (estimated cost \$238). The MAO stated that the LCD allowed for that type of injection only for lower areas of the spine. However, our physician panel determined that the injections were medically necessary given the beneficiary's chronic, continuous pain, and our health care coding expert determined that the LCD referenced by the MAO did not preclude

the use of injections in the cervical 1-2 joint. (See case D401 in Appendix B for additional details.)

Case D475: MAO misstated Medicare coverage utilization limits.

An MAO denied a request for facet joint injections in three sections of the spine (estimated cost \$95), incorrectly stating that the number of injections requested exceeded the Medicare coverage limit of: (1) one to two injections per section of the spine per session, or (2) up to five injection sessions in a 12-month period. Our physician panel determined that the injections were medically necessary and reasonable because the beneficiary, who had degenerative osteoarthritis of the spine and a history of neck, low back, and hip pain, had reported significant relief from two prior injection sessions. Further, our health care coding expert determined that the LCD that the MAO cited does not include a limit on the number of injections per section of the spine per session, and that the requested session would not cause the beneficiary to exceed five sessions in a 12-month period. (See case D475 in Appendix B for additional details.)

MAOs reversed some initial prior authorization denials and payment denials for requests that met Medicare coverage rules and MAO billing rules

For 3 percent of prior authorization denial cases, and 6 percent of payment denial cases, MAOs initially denied requests that met Medicare coverage rules, and then reversed their decisions before our data request (within 3 months of the original denial).²⁹ Although reversed denials for prior authorization requests mean that beneficiaries ultimately were offered coverage for needed care, the process also can create a burden for beneficiaries who need to navigate the appeals process. Similarly, reversed denials for payment requests mean that providers were ultimately paid for the services that they delivered. However, each denial for a payment request that met Medicare coverage rules and MAO billing rules represents a case in which providers were delayed payment and/or had to dispute a denial that ideally would have been approved upon the first request. These avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.

²⁹ We requested case file documentation in September 2019, 3 months after MAOs issued the initial denials. In a small number of cases, MAOs discovered errors while preparing cases files for our data request and notified OIG that they reversed the denials. Because we do not know if these reversals would have occurred in the absence of our data request, we did not include them in our estimates.

MAOs reversed some denials for prior authorization requests following beneficiary appeals

For 3 percent of prior authorization denials, MAOs initially denied requests that met Medicare coverage rules, and later reversed these denials within 3 months and approved the requests. Most of these reversals occurred because beneficiaries or their providers filed appeals. Among the denials for prior authorization requests in our sample that met Medicare coverage rules and that were appealed, MAOs reversed all of the denials and authorized all of the requested services.

Case D421: MAO delayed a CT scan by 5 weeks for a beneficiary with cancer.

An MAO denied a request for a CT scan of the chest and pelvis for a beneficiary with endometrial cancer. The provider was able to get the denial reversed 5 weeks after the initial request by submitting additional information and filing an appeal. However, our physician panel determined that the original request had sufficient documentation to demonstrate that the CT was needed to assess the stage of the cancer and to determine the appropriate course of treatment. Delayed care can negatively affect beneficiary health, particularly for urgent conditions. Our physician reviewer noted the importance of timely monitoring the growth and extent of cancer to assess severity of the disease and determine the course of treatment. (See case D421 in Appendix B for additional details.)

MAOs reversed some payment denials following provider disputes

For 6 percent of payment denials, MAOs initially denied payment requests that met Medicare coverage rules and MAO billing rules, and later reversed these denials within 3 months and paid the claims. In some cases, providers presented evidence in their dispute that the MAO should have approved payment, such as screenshots that the MAO had previously approved a prior authorization for the service that had been provided. (See cases D073, D119, and D441 in Appendix B.) In other cases, the provider's dispute prompted the MAO to acknowledge system or manual errors that resulted in payment denials, such as incorrect configuration of provider coverage details. (See case D116 in Appendix B.)

Case D489: MAO acknowledged that prior authorization was not required after the provider disputed the denial.

An MAO denied payment for x-ray services for a patient with osteoarthritis, incorrectly stating that prior authorization was required for the x-rays. The provider disputed the denial and included screenshots of an email exchange with a plan representative who confirmed that prior authorization was not needed. On reviewing the dispute, the MAO acknowledged its error and reversed the denial, and then paid the claim (\$102). (See case D489 in Appendix B for additional details.)

CONCLUSION AND RECOMMENDATIONS

As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately. MAOs are expected both to ensure access to high-quality care and to implement critical program controls in order to avoid unnecessary costs and ensure program integrity. However, capitated payment models, such as Medicare Advantage, can create an incentive for MAOs to deny the prior authorization of services for beneficiaries, and payments to providers, including some services and payment that would not have been denied in original Medicare. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Further, beneficiaries enrolled in Medicare Advantage may not be aware that there may be greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.

Our findings about the circumstances under which MAOs denied requests that met Medicare coverage rules and MAO billing rules provide an opportunity for improvement to ensure that beneficiaries enrolled in Medicare Advantage have timely access to all necessary health care services, and that providers are paid appropriately. In some cases, the MAOs identified their own errors and reversed the denials, in others, MAOs reversed denials following appeals. This suggests that improvement efforts by MAOs could reduce the number of similar errors in the future. The causes of other cases of denied prior authorization and payments for services that met Medicare coverage rules and MAO billing rules warrant further action by CMS, including guidance to MAOs and CMS's oversight audits.

Therefore, we recommend that CMS:

Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews

To help ensure that Medicare Advantage enrollees receive all medically necessary and covered services, to help promote MAO compliance with Medicare coverage rules, and to help improve program transparency, CMS should issue new guidance on both the appropriate use and the inappropriate use of MAO clinical criteria that are not contained in Medicare coverage rules. The guidance should clarify what the Medicare Managed Care Manual means when it says that MAO clinical criteria must not be "more restrictive" than Medicare coverage rules, and it should include specific examples of criteria that would be considered allowable and unallowable. CMS

should also instruct MAOs to examine and revise their procedures for making coverage determinations, as needed, considering CMS's new guidance.

Update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria, and/or examine particular service types

CMS should update its audit protocols to look for issues identified in this report. Although CMS's audit protocols already direct auditors to review a sample of denial cases to determine whether the denials were issued appropriately, CMS should add additional prompts for auditors. For example, following the publication of the new guidance relating to the use of clinical criteria in medical necessity reviews, CMS could add questions for auditors in section 3.2 of its audit protocol (Clinical Appropriateness of Denials) to determine whether MAOs are following the new guidance. Similarly, CMS could add a question for auditors examining whether MAOs requested unnecessary documentation.

If MAOs are found to be noncompliant because they are using more restrictive clinical criteria or requesting unnecessary documentation, CMS should follow its normal enforcement action process, including adding aggravating factors in civil money penalty calculations if MAO denials resulted in beneficiaries' not being able to access needed services. Further, CMS should consider additional enforcement actions for MAOs that demonstrate a pattern of inappropriate payment denials.

CMS also should consider targeting in its audits specific service types that have a history of inappropriate denials, which could include the service types identified in this report. CMS could choose to focus on service types for which inappropriate denials may have a significant impact on beneficiary health and well-being, such as stays in post-acute facilities. Selecting a targeted sample may increase the likelihood of finding inappropriate denials.

Direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors

Although some of the denials discussed in this report were attributable to one-off human errors, others seemed preventable through process or system changes by MAOs. CMS should direct MAOs to examine their processes for manual review and system programming and remediate vulnerabilities that may result in inappropriate denials. For example, CMS could point to this report, including the detailed explanations of the errors in Appendix B, to help MAOs identify the types of errors that they should be looking for. To help avoid system errors, CMS could direct MAOs to take additional steps to ensure that any changes affecting coverage or payment (especially those on an established schedule, such as renewal of a provider's contract

with the MAO), are properly coded in their systems. CMS could also direct MAOs to consider additional staff training on documentation that should be verified before issuing a denial, and the level of documentation required.

AGENCY COMMENTS AND OIG RESPONSE

In response to the draft report, CMS stated that it is committed to oversight and enforcement of the requirements of the Medicare Advantage program and concurred with all three recommendations. CMS reiterated that MAOs must follow Medicare coverage rules. CMS further stated that MAOs may implement additional coverage requirements to better define the need for a service as long as the additional requirements do not violate the requirements in the relevant NCD or LCD. However, as we note in our report, this statement is not clearly outlined in existing guidelines.

CMS concurred with the first recommendation to issue new guidance on the appropriate use of MAO clinical criteria for medical necessity reviews, stating that it plans to issue such guidance.

CMS concurred with the second recommendation to update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types. CMS stated that it will update its audit protocol and auditor training materials, as needed, to align with the guidance that it plans to issue under the first recommendation. CMS did not indicate whether it would consider targeting in its audits specific service types that have a history of inappropriate denials.

CMS concurred with the third recommendation to direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors. CMS stated that it would direct MAOs to examine their manual review and system programming processes and to address vulnerabilities that may result in inappropriate denials. Although CMS stated that these efforts would be “in keeping with” the guidance that it plans to issue in response to the first recommendation, OIG notes that the manual review errors and system processing errors identified in this report were unrelated to reviews for medical necessity.

For the full text of CMS’s comments, see Appendix D.

DETAILED METHODOLOGY

Sample selection

MAO selection. To select the MAOs for this review, we used CMS Part C enrollment data to identify the number of beneficiaries in health maintenance organization (HMO) plans and preferred provider organization (PPO) plans administered by each MAO in June 2019. We selected 15 of the largest MAOs by enrollment. The 15 selected MAOs accounted for nearly 80 percent of beneficiaries enrolled in Medicare Advantage in June 2019, ranging in size from about 165,000 to nearly 6 million beneficiaries.

Case selection. We collected a list of all prior authorization denials and payment denials that each selected MAO issued during a 1-week period, June 1–7, 2019 (282,830 total denials). We created a sampling frame from this list by grouping denials into 7 strata based on denial type (prior authorization or payment) and the number of denials issued by the MAO during that week. From this sampling frame, we selected a stratified random sample of 500 cases (250 prior authorization denials and 250 payment denials).

We stratified by denial type in order to make projections of the rates of prior authorization denials and payment denials that were issued for requests that met Medicare coverage rules and MAO billing rules. We also stratified by MAO size. We under-sampled MAOs with larger numbers of denials to avoid over-burdening them with a high number of requests for case file documentation. See Exhibit 3 on page 26 for a description of each stratum, sample size, and population of denial cases.

Excluding ineligible cases. We instructed MAOs to exclude certain denials, such as those for supplemental services and claims with third-party liability, from the lists of prior authorization denials and payment denials that they submitted. During the course of our review, we identified and excluded additional types of ineligible cases from our analysis.

We identified 70 ineligible cases in our original sample of 500 cases, making our final sample 430 cases (183 payment and 247 prior authorization cases). Types of denials that were ineligible for this review included:

- Services already paid for under another payment arrangement: In some cases, MAOs pay providers under a capitated arrangement. Providers may “bill” the MAO to document a service/encounter with the beneficiary, and these “bills” can create the appearance of a denial, but providers do not expect reimbursement for the specific services in addition to the capitated payment that they are already receiving. These cases were ineligible for this study

because the MAO did not make a coverage decision based on the merits of the case, and there was no expectation of payment to the provider.

- Cases denied because of a GY modifier: In some cases, providers may bill for a service that they know will not be covered (for example, to get a record of a Medicare denial before billing secondary insurance). They may attach a GY modifier to the HCPCS (Healthcare Common Procedure Coding System) code on the claim, which signals that the claim should not be paid. These cases were ineligible for this study because providers were not requesting payment.
- Exact duplicates: In some cases, system or human errors may cause the same claim to be submitted from a provider to the MAO more than once. Cases that were denied as exact duplicates were ineligible for this study because they were not denials based on the merits of the case.
- Services paid by Medicaid for beneficiaries dually eligible for Medicare and Medicaid: Some beneficiaries who are dually eligible for both Medicare and Medicaid are enrolled in special plans through which a single MAO administers both their Medicare and Medicaid benefits. Some of these MAO systems are set up to process requests for certain services as Medicare “denials” before they will approve and pay for them under the beneficiary’s Medicaid benefit. These cases were ineligible for this study because they were not true denials based on the merits of the case, but rather a system processing step.
- Supplemental services: MAOs are allowed to cover extra health and wellness services that are not normally covered under Medicare, such as gym memberships. These “supplemental” services are not covered by all MAOs. These cases were ineligible for this study because the services would not be covered by original Medicare, and the cases would have had different coverage rules depending on the MAO.

Exhibit 3: Total and Eligible Denial Sample Sizes and Populations, by Stratum

Stratum	Case type	MAOs	Total sample size	Population of denials	Eligible sample size	Estimate of population of eligible denials
1	Prior authorization	Two largest MAOs by volume of denials for prior authorization	50	5,177	50	5,177
2	Prior authorization	Four medium-sized MAOs by volume of denials for prior authorization	80	4,761	77	4,582
3	Prior authorization	Nine smallest MAOs by volume of denials for prior authorization	120	2,514	120	2,514
Total prior authorization cases			250	12,452	247	12,273
4	Payment	Largest MAO by volume for payment denials	70	150,405	31	66,608
5	Payment	Six medium-sized MAOs by volume for payment denials	85	100,402	64	75,597
6	Payment	Three small MAOs by volume for payment denials	45	12,570	42	11,732
7	Payment	Remaining five MAOs with the smallest volume for payment denials	50	7,001	46	6,441
Total payment cases			250	270,378	183	160,378
Total cases			500	282,830	430	172,651

Case File Collection and Preliminary Screening

For the original 500 sampled cases, we collected case file documentation in September 2019 (3 months after the denials were originally issued). We requested complete administrative and medical records from the MAOs. Among other information, we requested that the MAOs provide a summary of the basic facts of the case, an explanation of their reason for denying the request, any coverage rules that MAOs cited to deny the request, records of the MAO decision-making process, copies of notices sent to the beneficiary and/or provider, any medical records on file, and whether the denial had been appealed.

To conduct the case file reviews, we contracted with health care coding and billing professionals with expertise in Medicare coverage rules (“health care coding experts”)

and with physicians. Health care coding experts used an OIG-developed protocol to complete a preliminary screening for all 500 cases in our sample. The first step of the preliminary screening process was to determine whether the denial case was eligible for our sample (as described above). The health care coding experts then reviewed the case files of the 430 eligible cases for completeness and made additional requests to the MAOs for missing records or information needed for case file reviews.

Case File Reviews

To design the case file review methodology, we consulted with the following: CMS; the Medicare Advantage Independent Review Entity contractor (which reviews denial appeals that are upheld by MAOs); physicians; and health care coding experts. We also reviewed CMS policy documents such as the Medicare Managed Care Manual.

The objective of the case file reviews was to determine whether the denied prior authorization and payment requests met relevant Medicare coverage rules and, if applicable, MAO billing rules. For our sample of 430 eligible cases, we conducted reviews for administrative coverage only for 268 cases, and for the remaining 162 cases we conducted reviews for both administrative coverage and medical necessity. Reviewers followed a structured protocol that OIG developed in consultation with health care coding experts and physicians.

Administrative coverage reviews. For denial cases that did not need a clinical review to determine medical necessity, a health care coding expert followed a structured OIG protocol to determine whether the denial met the Medicare coverage rules and/or MAO billing rules that the MAO cited as support for its denial decision. Examples of cases that did not need a medical necessity determination included denials that were issued because the beneficiary was no longer enrolled with the MAO; claims that were filed past required deadlines; claims for services that require prior authorization but for which the MAO did not have an authorization on file; and other administrative or billing inaccuracies. Health care coding experts reviewed the MAO's justification for issuing the denial and determined whether the request met applicable Medicare coverage rules and MAO billing rules, such as NCDs and LCDs; the Medicare Managed Care Manual; and the provider's contract. They also examined MAO coverage documents (i.e., the Evidence of Coverage document for the beneficiary's plan), and any other documentation in the case file that supported or disputed whether the request met Medicare coverage rules and MAO billing rules.

Medical necessity reviews. If the health care coding experts assessed that denial cases needed a medical necessity review to determine whether the request met Medicare coverage rules, then the cases received an additional clinical review by a physician. We assigned a physician reviewer to each of these cases on the basis of the service type and the physician's specialty. Following a structured OIG protocol, physicians used their clinical judgment to determine whether the denied service was medically necessary for the beneficiary using the medical records and other clinical information available in the case file. Physicians considered factors such as a

beneficiary's symptoms, diagnosis, and medical history to determine medical necessity and explain how they arrived at their decision. Physicians also determined whether the MAO offered an alternate service to the beneficiary and if so, whether the alternate service was clinically sufficient to meet the beneficiary's needs.

For cases in which the physician reviewer indicated that the service was not medically necessary for the beneficiary, OIG determined the denial to be appropriate because Medicare does not pay for services that are not medically necessary. For any case for which the physician reviewer determined the service was medically necessary, or for which the physician reviewer wanted to consult with other physicians, we convened a panel of three physicians to discuss the case (see more on physician conference calls, below). Services were determined to be medically necessary if the three-physician panel reached consensus that the requested service was medically necessary for the beneficiary.

For denied requests that the physician panel determined were medically necessary, a health care coding expert reviewed the case to determine whether the request met Medicare coverage rules. To do this, the health care coding expert reviewed the circumstances of the case, including the specific justification(s) that the MAO cited to deny the service and the panel's explanation for why the service was medically necessary. The health care coding expert then assessed—conferring with the physician reviewer as needed—whether the request met applicable Medicare coverage rules and/or criteria from the MAO Evidence of Coverage document.

Quality Assurance

To promote consistency and accuracy across reviews, we issued a study-specific guidance document for improved decision-making, provided training to all physicians and health care coding experts, facilitated conference calls with the panel of physician reviewers, and conducted quality assurance reviews.

Guidance Document. We worked with the health care coding experts and physician reviewers to develop a structured protocol to ensure thorough and consistent case reviews. We provided reviewers with a guidance document that included detailed instructions for each question in the health care coding and physician protocols, definitions for key terms, and a list of frequently asked questions. The guidance included detailed instructions for determining whether a case was eligible for the study, which types of cases should be referred for physician review, and how to determine whether a denial met Medicare coverage and/or MAO billing rules.

Training. We provided two trainings for each reviewer type (i.e., health care coding experts and physicians) regarding the OIG protocol for reviewing the denial cases. The trainings included a review of the guidance document and an explanation of the protocol questions. We also conducted pre-test reviews with some reviewers to pilot the protocols and give feedback to reviewers.

Physician Consensus Calls. We facilitated regular conference calls for physician reviewers to examine the medical necessity of individual cases and to promote consistency across reviews. During these calls, physician reviewers discussed cases that a physician reviewer assessed to be medically necessary or wanted to discuss with the rest of the physician panel. Denial cases were determined to be medically necessary if the physician reviewer and the physician panel reached consensus that the case was medically necessary.

Quality Assurance Reviews. We reviewed health care coding expert and physician protocol responses to ensure that they were following the standardized review protocols when assessing cases. We worked with the medical review contractor to identify and address any inconsistencies across health care coding and physician clinical reviews. Separately, we worked with health care coding experts and physicians to clarify or discuss any questions we had about their protocol responses. We also had a health care coding expert conduct independent second reviews for a portion of denial cases. Finally, we reviewed each case using the original case file and additional information we collected from MAOs to ensure: (1) that it was eligible to be included in our sample and (2) that protocol responses accurately reflected the circumstances of the case.

Analysis

We analyzed the results of the reviews by health care coding experts and the clinical reviews by physicians, and we generated population estimates of the prior authorization denials and payment denials that met Medicare coverage rules and MAO billing rules. We also generated population estimates for the rates at which MAOs initially denied prior authorization denials and payment denials in our sample that met Medicare coverage rules and MAO billing rules, but then reversed their decision before our data request (within 3 months). See Appendix A on page 31 for point estimates, 95-percent confidence intervals, and key statistics.

To examine the reasons that denials occurred for requests that met Medicare coverage rules and MAO billing rules, and the service types associated with those cases in our sample, we conducted qualitative analysis of the case files and case review results. We coded each denial that met Medicare coverage rules as resulting from one or more of six causes that surfaced from the reviewed cases. To determine the cause of denials for requests that met Medicare coverage rules, we examined the MAO's justification for the denial, the results of the health care coding expert reviews and/or physician clinical reviews, and relevant documentation in the case files. In some cases, we determined that the denials resulted from more than one cause, for example, when an MAO applied MAO clinical criteria not in Medicare coverage rules *and* required unnecessary documentation. To describe service types, we categorized items or services using information from the case files. Because of the small number of denials within each stratum that met Medicare coverage rules, it was not possible to project the results of the denial causes and service type categories.

To provide cost information for the denials in our sample that met Medicare coverage rules, we reviewed case files to determine if cost information was available. If available, we included this information in Appendix B and in some of the case examples presented in the report. For cases where the MAO reversed the denial and documented paying for the service, we used the actual amount paid to the provider. For all other cases, we used the actual or estimated cost of the denied service as reported by the MAO. Because a significant number of cases in the sample did not have cost data in their records, we were not able to estimate the overall costs associated with denials that met Medicare coverage rules.

APPENDIX A

Point Estimates and Confidence Intervals for Denials of Prior Authorization and Payment Requests That Met Medicare Coverage Rules, Issued by 15 Selected MAOs During June 1–7, 2019

Description	Weighted Frequency	Percentage	95-Percent Confidence Interval	
			Lower Bound	Upper Bound
Denials of prior authorization requests that met Medicare coverage rules	1,631	13.3%	8.9%	19.3%
Denials of prior authorization requests that met Medicare coverage rules and were reversed within 3 months	343	2.8%	1.4%	5.7%
Denials of payment requests that met Medicare coverage rules	28,949	18.1%	11.7%	26.8%
Denials of payment requests that met Medicare coverage rules and were reversed within 3 months	10,140	6.3%	3.0%	12.9%

APPENDIX B

Detailed Descriptions of Denials for Requests That Met Medicare Coverage Rules

Prior Authorization Denials of Requests That Met Medicare Coverage Rules

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D221	Imaging: MRI of right hand without contrast	A 69-year-old continued to have pain and weakness in a hand 5 months after a fall.	Applied MAO clinical criteria not in Medicare coverage rules Required unnecessary documentation	The MAO denied the request and cited internal clinical criteria requiring an inconclusive x-ray and documentation that the patient had not improved with more conservative treatment. However, our reviewers determined that an MRI was necessary for this patient and the NCD for MRIs does not require that a beneficiary receive an x-ray prior to receiving an MRI. Our physician panel explained that an x-ray would not be sufficient for this patient because some hand injuries, such as those involving small bones, muscles, and ligaments in the hand, may not be immediately visible with an x-ray. The panel noted that delayed treatment could cause further harm for this patient because the muscles and ligaments might retract.	Denial reversed upon appeal	\$365

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D249	Imaging: Chest CT	A 68-year-old who was a smoker had a history of lung nodules.	Required unnecessary documentation Applied MAO clinical criteria not in Medicare coverage rules	The MAO requested unnecessary additional medical records to support the scan, asking for the results of the previous chest x-ray and CT scan. When the provider did not submit those results within 1 week, the MAO denied the request. The MAO also cited internal clinical criteria that limited CT scans based on the size of nodules and the receipt of chest x-rays. However, our physician panel determined that given the patient's history as a smoker, and the presence of a lung nodule, the case file contained sufficient clinical evidence to determine that the requested scan was medically necessary. A health care coding expert then determined that the request met all other applicable Medicare requirements, including that the NCD for CT scans does not require prior x-rays or that the nodules be a specific size.	Not reversed	\$154
D406	Imaging: MRI of the lumbar spine without contrast	A 91-year-old had lower extremity pain that radiated into the upper leg, hip, and lower back (sciatica). Back x-rays showed scoliosis and joint disease.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the service and cited internal clinical criteria stating that the patient had not completed 6 weeks of provider-directed treatment in the last 3 months. However, our physician panel determined the MRI was medically necessary to plan treatment options due to the patient's age, symptoms, and results of a previous back x-ray. Further, the NCD for MRIs does not state that completion of prior conservative therapy is needed before receiving an MRI.	Not reversed	\$297
D397	Imaging: Shoulder CT scan for preoperative evaluation	A 77-year-old had a history of left shoulder pain that had progressed for the last 3 years. The patient had received therapy and injections, but the patient's condition had not improved.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request, stating that conducting a CT in this context was investigational and, therefore, not covered by Medicare. However, our physician panel determined that a CT scan was warranted and within expected standards of care because it could more accurately assess the condition of the shoulder and determine type of surgery needed. Further, the applicable NCD did not indicate that the use of a CT scan in this context was considered investigational.	Not reversed	\$1,400

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D421	Imaging: CT of chest, abdomen, and pelvis	An 81-year-old had adenocarcinoma of the endometrium, a cancer of the lining of the uterus.	Applied MAO clinical criteria not in Medicare coverage rules Required unnecessary documentation	The MAO denied the request and cited internal clinical criteria which required information to support that the disease had spread to the cervix or that the tumor was advanced. However, our physician panel determined that the request was consistent with the applicable NCD and had sufficient documentation to show that the CT scan was needed to determine the stage of the cancer, whether it had spread, and to determine the appropriate course of treatment for the beneficiary.	Denial reversed upon appeal	No cost available
D479	Imaging: Chest CT	A 64-year-old with a pacemaker, diabetes, hypertension, and heart valve disease was seen for chest pain and shortness of breath.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the CT scan and cited internal clinical criteria that require prior x-ray imaging results to prove medical necessity. Our physician panel determined the CT scan was needed to exclude a life-threatening diagnosis (aneurysm) considering the beneficiary's symptoms and comorbidities. Further, the applicable NCD does not require that a patient receive an x-ray prior to receiving a CT scan.	Not reversed	\$150
D427	Imaging: MRI of lower extremity joint without contrast	A 75-year-old had left hip pain and an x-ray showing mild degenerative changes. An exam revealed a limp caused by the pain. The beneficiary had tried nonsteroidal anti-inflammatory drugs, oral steroids, and immobilization with a brace.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the MRI request and cited internal clinical criteria requiring that the beneficiary receive conservative treatments for 6 weeks. However, our physician panel determined an MRI was medically necessary due to the beneficiary's signs and symptoms of hip changes and altered gait. Further, NCD guidelines do not require conservative treatment prior to an MRI.	Not reversed	\$275

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D472	Imaging: MRI of abdomen	A 65-year-old had a history of chest pain that radiated to the shoulder and left jaw. The beneficiary had a previous MRI showing two adrenal lesions of indeterminate origin, the largest of which was 1.5 cm.	Applied MAO clinical criteria not in Medicare coverage rules Required unnecessary documentation	The MAO denied the request (after requesting and not receiving additional records) stating that the beneficiary would need to wait at least 1 year for another MRI given the size of the largest lesion. The MAO cited internal clinical criteria that allowed follow-up MRIs only at 12 months for a lesion of 1-2 cm in size or at 6-12 months for lesions greater than 2-4 cm in size. A health care coding expert determined that the applicable NCD does not restrict the timing of MRIs based on the size of the lesion. Furthermore, using clinical information already in the case file, the physician panel stated the MRI was medically necessary to determine whether the lesions seen on the CT scan were malignant.	Denial reversed upon appeal	\$300
D236	Post-acute care: Discharge to a skilled nursing facility (SNF)	An 81-year-old had a history of dementia, hypertension and was legally blind due to glaucoma. The patient was admitted to the hospital for worsening dementia and acute agitation.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request stating that the beneficiary did not have a need for skilled care in accordance with internal clinical criteria. However, our physician panel determined that the admission to a SNF was medically necessary and consistent with the Medicare Benefit Policy Manual because the beneficiary required physician supervision and should have access to physical and occupational therapy.	Denial reversed upon appeal	\$425 per day

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D260	Post-acute care: Discharge to a SNF	A 64-year-old had a diagnosis of cellulitis (a bacterial skin infection) on leg and bedsores with complaints of worsening swelling, redness, and pain in lower right leg.	Required unnecessary documentation	The MAO denied the request stating that it needed to review the beneficiary's most recent therapy records and suggested that the beneficiary's needs could be met either in the current hospital setting or at a lower level of care (home health services). Our physician panel determined that the medical records available to the MAO were sufficient to demonstrate that given the beneficiary's deteriorating functional status and morbidities, the beneficiary should have been discharged to a SNF with access to physical and occupational therapy. Further, a health care coding expert determined that the request for a SNF admission was consistent with the Medicare Benefit Policy Manual.	Denial reversed upon appeal	No cost available
D426	Post-acute care: Discharge to a SNF	A 63-year-old had a complex medical history including multiple chemotherapy regimens, cognitive impairment, and prior stroke was treated in the hospital for cough, fatigue, and shortness of breath.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request, stating that the beneficiary did not meet coverage criteria for admission to a SNF because the beneficiary may not be able to do 1 to 2 hours of therapy per day. Our reviewers determined that SNF was medically necessary for this beneficiary and in line with the Medicare Benefit Policy Manual. The beneficiary had multiple ongoing medical conditions which need daily skilled nursing care. Further, the beneficiary could have benefited from and tolerated occupational or physical therapy.	Not reversed	No cost available
D270	Post-acute care: Discharge to an inpatient rehabilitation facility (IRF)	A 67-year-old was diagnosed with acute right-sided ischemic stroke and seen at the emergency department with new onset slurred speech.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request stating that the beneficiary's condition did not meet Medicare coverage rules for admission to an IRF. However, our physician panel determined that admission to an IRF was medically necessary and in line with the Medicare Benefit Policy Manual. The beneficiary had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore, should have been under the frequent supervision of a rehabilitation physician.	Not reversed	No cost available

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D278	Post-acute care: Discharge to an IRF	A 68-year-old had chronic obstructive pulmonary disease, congestive heart failure, and peripheral vascular disease. The beneficiary was admitted to the hospital with a femur fracture and underwent a screw placement surgery. After the surgery, the beneficiary developed anemia and pneumonia.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request stating that the beneficiary's condition did not meet all medical necessity criteria for admission to an IRF under Medicare guidelines. The MAO recommended instead that the beneficiary could be discharged to a SNF, home health, or home with outpatient therapy. Our physician panel determined that the recommendations for outpatient therapy were not sufficient and that admission to an IRF was necessary and consistent with the Medicare Benefit Policy Manual. The beneficiary had ongoing medical conditions that could generate more medical complications if not closely assessed by a physician daily. The beneficiary also had the ability and need to participate in physical therapy and occupational therapy for 3 hours at least 5 days per week, needed help with walking, and at least two people to help with balance and recovery from the screw placement in the beneficiary's hip.	Not reversed	No cost available
D343	Post-acute care: Discharge to an IRF	An 89-year-old had a history of Parkinson's disease, dementia, and prostate cancer who had been treated in the emergency department.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request stating that the beneficiary did not have a medical problem that required care in an IRF. However, our reviewers determined that the requested inpatient rehabilitation stay met requirements in the Medicare Benefit Policy Manual and was medically necessary because it would allow the beneficiary to regain the ability to perform the activities of daily living that the beneficiary was able to do prior to the hospital admission.	Denial reversed upon appeal	\$3,039

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D393	Post-acute care: Discharge to an IRF	A 75-year-old was hospitalized after a motorcycle accident with rib fractures, a collapsed lung, and an acute kidney injury. The beneficiary had a history of heart attacks, irregular heart rate, diabetes, and chronic obstructive pulmonary disease.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request stating that the beneficiary did not need daily care from a physician, as required by the Medicare Benefit Policy Manual. However, our physician panel determined that the beneficiary did require this level of care from a physician due to the beneficiary's complex health needs and medical history and felt that the beneficiary could tolerate the level of therapy in the inpatient rehabilitation facility. The MAO's medical director offered 5 days of skilled nursing care, but our physician reviewer judged that this alternative care would be insufficient for this patient.	Not reversed	\$750 per day
D224	Injection: Steroid injection in the cervical spine	A 66-year-old suffered neck pain from degenerative disc disease that had not improved from conservative therapy.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request stating that the beneficiary was not currently enrolled in or planning to complete formal therapy or a home exercise program, a requirement from internal clinical criteria. However, our reviewers determined that the injection was medically necessary given the beneficiary's diagnostic test results and history of completing conservative therapy without relief. Further, a health care coding expert determined that there was no NCD or LCD relevant to this service, and thus there is no Medicare requirement that beneficiaries enroll in a therapy or exercise program before receiving treatment.	Denial reversed upon appeal	\$261

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D199	Injection: Botox injection for urge incontinence	An 82-year-old was diagnosed with urge incontinence. Beneficiary had been receiving Botox injections, but the effectiveness was perceived to be wearing off, so requested a stronger dose.	Required unnecessary documentation	The MAO denied the request and cited a lack of clinical information about the beneficiary's previous medication use and asked for additional records. However, the MAO had already received records documenting this information as part of the prior authorization request, making the request for additional documentation unnecessary.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$3,674
D416	Injection: Sacroiliac joint injection for pain management	A 66-year-old had lower back pain that radiated into the legs. Patient had both knees replaced and used a shoe lift to treat a leg length discrepancy. Patient experienced significant pain when standing or walking with no improvement from previous conservative treatments.	Required unnecessary documentation	The MAO denied the injection request after asking for more documentation. The MAO stated that the available doctor's notes did not support medical necessity. Our physician panel determined that, based on the information available in the case file, the injection was medically necessary as opioids and anti-inflammatory medications were not reasonable alternatives to manage the patient's pain. Further, our health care coding expert determined that the request met requirements in the applicable LCD.	Not reversed	No cost available

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D339	Injection: Injection to treat anemia	A 75-year-old had low blood iron level caused by abnormal kidney function.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request stating that the beneficiary's blood counts were not low enough to meet requirements established in internal clinical criteria. Our reviewers determined that the requested item was necessary and reasonable given the downward trend in the beneficiary's hemoglobin count, and that the beneficiary met the requirements in the applicable NCD.	Not reversed	\$754
D401	Injection: Upper cervical spine (C1-2) joint injection	A 72-year-old had severe, worsening neck pain, and scans showed deterioration and changes in spine. Beneficiary had tried other conservative treatments with limited improvement.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the service stating that per Medicare coverage rules, the requested injections were covered only for the lower areas of the spine, and not at the C1-2 joint. However, our health care coding expert determined that the LCD referenced by the MAO does not preclude the use of injections in the C1-2 joint. Further, our physician panel determined that an injection at this level is a reasonable diagnostic and therapeutic option and that the service was medically necessary given the beneficiary's chronic, continuous pain.	Not reversed	\$238
D475	Injection: Cervical/ thoracic facet injection	A 59-year-old had a diagnosis of spondylosis (degenerative osteoarthritis of the spine) and a history of neck pain, low back pain, and pain in both hips.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request stating that the number of injections requested exceeded the Medicare coverage limit of (1) one to two injections per section of the spine per session, or (2) up to five injection sessions in a 12-month period. However, our health care coding expert determined that the LCD the MAO cited does not include a limit on the number of injections per section of the spine per session, and that the requested session would not cause the beneficiary to exceed five sessions in a 12-month period. Further, our physician panel determined that the injection was medically necessary and noted that the beneficiary experienced significant relief from two previous injection sessions.	Not reversed	\$95

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D232	Durable medical equipment: Hospital bed with rails	A 93-year-old had a history of epilepsy, early onset Alzheimer's, rheumatoid arthritis, chronic back pain, knee and joint stiffness, and limited range of motion.	Manual review error Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request, incorrectly stating that the only diagnosis listed in the beneficiary's medical records was hypertension. This finding led it to determine that the beneficiary did not meet internal clinical criteria for a hospital bed because there was no indication of a condition requiring positioning that could not be accommodated by a standard bed. However, our reviewers determined the request was medically necessary and in accordance with the NCD for hospital beds due to the beneficiary's chronic conditions and movement limitations.	Not reversed	\$150/month
D294	Durable medical equipment: Hydraulic lift	An 83-year-old had progressive cognitive impairment, progressive decline in walking, cervical spine stenosis, and worsening urinary incontinence.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request based on internal guidelines stating that the lift would not improve the beneficiary's balance or ambulation and that it is only for beneficiaries who require complete assistance with sit-to-stand transfers. However, our physician panel determined that this item was medically necessary given the patient's mobility needs and progressive weakness and to decrease the risk of falls during transfers to and from bed. Further, our reviewers determined that the proposed use was consistent with the applicable LCD.	Not reversed	\$1,476
D419	Durable medical equipment: Manual wheelchair	A 57-year-old had multiple sclerosis, hypertension, bladder dysfunction, tibia fracture, and mobility issues related to activities of daily living.	Required unnecessary documentation	MAO denied the request after requesting more documentation from the beneficiary's doctor. The MAO stated that the patient did not meet wheelchair criteria from Medicare coverage rules, such as documentation of whether the beneficiary could propel the wheelchair and whether it could be used in the beneficiary's home. However, our reviewers found that there was already documentation in the beneficiary's file that demonstrated the beneficiary met established criteria in the applicable LCD. Further, our physician panel determined a wheelchair was medically necessary because of the beneficiary's fractured tibia.	Not reversed	No cost available

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D460	Durable medical equipment: Walker	A 76-year-old had a history of joint pain, post-polio syndrome, ankle and foot surgery, and was at-risk for falls.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request and cited internal clinical criteria, stating that the beneficiary was not eligible to receive a walker because the beneficiary had already received a cane within the past 5 years. The internal clinical criteria considered a cane and walker to be "same or similar" devices and limited beneficiaries to one such device every 5 years. However, according to our physician panel, a cane was not stable enough given the beneficiary's history of polio and arthritis, fall risk, and physical therapy notes that the right knee buckled and the right shoulder was in pain. Further, our health care coding expert determined that the LCD for walkers did not include a 5-year restriction on more than one ambulatory device.	Not reversed	\$112
D320	Physician services: Interventional radiology consult and follow-up for peripheral arterial disease	An 85-year-old had type 2 diabetes with polyneuropathy (dysfunction in the nerves) and venous insufficiency (restricted blood flow from the limbs to the heart).	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the consultation stating that there was no evidence that the beneficiary experienced restricted blood flow or a blockage of the arteries, as required by internal clinical criteria. However, the applicable NCD includes no such requirement and our physician panel determined this service was medically necessary given the beneficiary's unstable condition and lack of sensation below the hips.	Not reversed	\$286
D300	Physician services: Referral for a follow-up office visit after an emergency department visit.	An 80-year-old received treatment in the emergency department for a fractured humerus.	Determined that the request did not meet Medicare coverage criteria	The MAO denied the request for a follow-up visit to the physician who treated the beneficiary in the emergency department citing Medicare's prohibition against self-referral by physicians. However, the MAO determined that the original denial was inappropriate because Medicare self-referral rules make an exception for emergency department follow-up care.	Denial reversed after provider inquiry	\$1,641

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D463	Physician services: Breast cancer follow-up visit with a radiation oncologist	A 72-year-old had a history of breast cancer surgery and partial mastectomy.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the followup visit citing internal clinical criteria, but it did not indicate the specific criteria that were not met. However, Medicare does not have a policy that explicitly addresses followup visits after cancer treatment. Further, our physician panel determined that the visit with the radiation oncologist was medically necessary and reasonable, as there may be potential cardiac, pulmonary and other complications from breast radiation and the most appropriate physician to evaluate these would be the radiation oncologist, who would then be able to make appropriate treatment and referral decisions on the patient's behalf.	Not reversed	\$140
D193	Surgery: Implantation of a neurostimulator device that can treat bowel incontinence	A 74-year-old was diagnosed with full incontinence of feces. The beneficiary had involuntary stool and gas leakage that had not improved with other conservative treatments.	Applied MAO clinical criteria not in Medicare coverage rules Required unnecessary documentation	The MAO denied the request stating that the beneficiary's medical records lacked evidence that the beneficiary experienced incontinence episodes for at least 2 weeks over a 6-month period, criteria established in internal MAO review guidelines. Our reviewers determined that the service was necessary and consistent with the applicable NCD based on documentation showing that the beneficiary had, for years, tried more conservative treatments with no improvement.	Denial reversed after peer to peer was conducted by Medical Director with additional information	\$1,096

Case ID	Service requested	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost (actual or estimated)
D207	Surgery: Reverse total arthroplasty - a surgical procedure that repairs and provides a prosthetic replacement for the shoulder joint (including the rotator cuff tear and biceps tendon)	A 72-year-old experienced pain in the right shoulder for years. An x-ray demonstrated osteoarthritis and a physical exam indicated a Popeye deformity (reflecting an abnormal shortening or displacement of the bicep muscle). The patient had completed 6-weeks of physical therapy.	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the request stating that the beneficiary did not meet requirements from internal clinical criteria, such as providing the results from an exam that uses physical manipulation of the joint to test for pain and confirmation from an MRI that the tendon structures needed repair. However, our physician panel determined that there was already sufficient clinical information in the beneficiary's medical records to justify the joint replacement with the tendon structure repair based on the beneficiary's history, physical exam, and x-ray. Further, Medicare does not have an NCD or LCD specific to reverse shoulder arthroplasty and so does not require the results of these tests for approval.	Not reversed	No cost available

Payment Denials That Met Medicare coverage rules and MAO billing rules

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D489	Imaging: x-rays of shoulders and knees	A 67-year-old had lupus and osteoarthritis.	Manual review error Misapplied MAO rule	The MAO denied payment stating that there was no prior authorization on file. The provider disputed the denial, stating that no prior authorization was required for that service and the MAO agreed.	Denial reversed after provider dispute	\$102
D178	Imaging: MRI of the lower spine	A 20-year-old was diagnosed with lumbar spondylosis (degeneration in the bones of the spine).	Manual review error	The MAO denied payment for the service, stating that it needed documentation from the beneficiary's primary insurance carrier. After OIG's data request, the MAO acknowledged that the requested documentation was already included in the original claim.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$73
D383	Imaging: Echocardiogram, a type of imaging test of the heart	A 48-year-old was diagnosed with heart disease received an echocardiogram during an inpatient psychiatric admission.	System processing error	The MAO denied the payment, stating that services received during an inpatient stay required prior authorization. After OIG's data request, the MAO acknowledged that it had a prior authorization on file already, but had not identified it because non-behavioral services (e.g., the echocardiogram) were billed to a separate entity from behavioral services (e.g., the patient's inpatient psychiatric admission).	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$73

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D019	Durable medical equipment: Home nebulizer rental (nebulizers change medication from liquid to mist)	A 65-year-old had chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).	System processing error Misapplied MAO rule	MAO denied payment stating that the nebulizer was being rented from an out of network provider. However, because a participating provider had issued a referral for this service, the MAO's requirements for plan directed care had been met.	Denial reversed after provider dispute	\$5
D024	Durable medical equipment: Wheelchair rental	A 68-year-old uses a wheelchair.	System processing error	MAO denied payment stating that the service had not been authorized. Upon review, the MAO found that an authorization had been approved but that the MAO had failed to link the authorization number to the payment request.	Denial reversed after provider dispute	\$22
D073	Physician services: Radiation treatment consultation	A 58-year-old had skin cancer of the nose.	System processing error	The MAO denied payment stating that the required prior authorization was not on file. However, the provider submitted a copy of an authorization letter from the MAO that included the service and date of service.	Denial reversed after provider dispute	\$82
D096	Physician services: Hospital visit for respiratory failure	A 73-year-old received critical care services from a physician.	System processing error	The MAO denied payment stating that payment for the services should be bundled. However, after the provider disputed the claim, the MAO later determined these services had in fact been billed correctly.	Denial reversed after provider dispute	\$230

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D119	Physician services: Eye exam and treatment	A 73-year-old with glaucoma received an ophthalmological exam.	System processing error	The MAO denied payment for the visit, stating that no prior authorization was in place for the out-of-network provider. A prior authorization had been approved for the procedure but listed a different, though related, procedure code than the one included on the claim. The provider resubmitted the claim showing the existing prior authorization. The MAO acknowledged that either procedure code could have been used to pay the claim and that the original claim was denied in error.	Denial reversed after provider dispute	\$114
D177	Physician services: Office visit	A 57-year-old visited the doctor for a sinus infection.	Manual review error	The MAO denied the payment stating that there was no prior authorization on file. After OIG's data request, the MAO acknowledged that a prior authorization was not needed because the provider was in-network and had been marked out of network due to a manual error. The MAO reversed the denial and paid the provider.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$81
D187	Physician services: Treatment of chronic ulcer on the foot	An 85-year-old was being treated in a skilled nursing facility.	Manual review error Misapplied MAO rule	The MAO denied the payment for lack of prior authorization. Typically, the MAO required a beneficiary to receive a prior authorization to use a non-contracted provider. However, because the beneficiary was in an in-network skilled nursing facility, the claim met the MAO and CMS requirement for "plan directed care" and, therefore, no prior authorization was required.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$50
D385	Surgery: Breast reconstruction surgery	A 72-year-old had a cancerous breast tumor.	Manual review error	The MAO denied payment for the procedure stating that the service was not covered. However, the MAO's claims analyst incorrectly denied the entire claim, rather than denying several line items that were noncovered services. The MAO paid the claim after it discovered the error.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$4,043

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D090	Surgery: Intestinal obstruction	A 67-year-old had laparoscopic surgery to remove an obstruction in stomach.	System processing error	The MAO denied payment for the procedure stating that the claim was submitted too late. However, the provider submitted evidence that the invoice had been previously submitted to the MAO.	Denial reversed after provider dispute	\$1,985
D128	Surgery: Cardiac surgical procedure	An 80-year-old underwent surgery for the removal and replacement of a defibrillator, an implanted device to help control pacing of the heart.	System processing error	The MAO denied payment for the service, incorrectly stating that there was no prior authorization on file. Although the beneficiary had received prior authorization for the surgery, the MAO denied the provider's payment request six times.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$401
D454	Inpatient hospital: Inpatient admission and advanced care planning	A 93-year-old was diagnosed with congestive heart failure, anemia, coronary artery disease and myelodysplastic syndrome (a disorder of the production of blood cells).	System processing error	The MAO denied payment for two service codes, stating that the diagnosis codes were listed incorrectly on the claim. However, our reviewers found that of the two services on the claim, one was correctly coded and should not have been denied.	Not reversed	\$502

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D183	Inpatient hospital: Hospitalization after emergency room visit	A 72-year-old went to the emergency room and was diagnosed with a pulmonary embolism, a blockage in the arteries in the lungs.	Manual review error	The MAO denied the payment because the request did not have required information, such as discharge summary and physician's notes and orders. After OIG's data request, the MAO acknowledged that the information had already been received and ultimately reversed the denial.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$6,218
D440	Inpatient hospital: Inpatient admission	An 80-year-old went to the emergency room; the patient had fallen 24 hours before and was unable to get up. Beneficiary was diagnosed with a fracture in the thigh bone (femur).	Applied MAO clinical criteria not in Medicare coverage rules	The MAO denied the provider's request for inpatient admission based on internal clinical criteria and stated that the patient did not need an inpatient level of care. The MAO offered a lower level of care: observation. However, our physician panel determined that the patient's age and health concerns, such as a fall at home and hip fracture, required a higher level of care than an observation stay would have provided.	Not reversed	\$9,516
D116	Ambulance: Ambulance ride to a health care facility	A 61-year-old with sepsis was transported by ambulance to the hospital.	System processing error	The MAO denied payment for an ambulance trip because it had exceeded coverage limits on costs. When the provider filed a dispute, the MAO acknowledged that the contract had been updated and the ambulance ride should have been covered.	Denial reversed after provider dispute	\$274
D375	Ambulance: Ambulance transport to hospital	An 80-year-old fell at home and was transported by ambulance to the hospital.	System processing error	The MAO denied payment for the ambulance transport for being out of area. The provider resubmitted the claim six times. After OIG's data request, the MAO determined that the calculation of "out of area" was completed using ground mileage rather than air mileage and, therefore, was incorrect.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$2,627

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D060	Lab tests: Collection of blood sample (blood draw)	A 53-year-old was diagnosed with multiple myeloma, a type of cancer.	System processing error	The MAO denied payment stating that the approved prior authorization only covered chemotherapy and medications related to cancer treatment and not the lab work. However, after reviewing the case file, our health care coding expert found that a valid prior authorization, which covered lab work, was in effect on the date of service.	Not reversed	\$30
D135	Lab tests: Lab work using a blood sample	A 70-year-old with lymphedema received laboratory work on a blood sample.	System processing error	The MAO denied payment, stating that it had a capitated contractual agreement for the provider to cover lab work, meaning the MAO did not need to pay the hospital separately for lab services. After the MAO received OIG's data request, it discovered that the capitated contractual agreement had ended prior to the denial and thus the denial was inappropriate.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$54
D444	Therapy: Physical therapy	An 83-year-old had issues with gait and mobility following a stroke.	System processing error	MAO denied payment, incorrectly stating that the provider was out-of-network. The MAO's established procedure was to manually review payment requests for providers with multiple taxpayer identification numbers, which did not happen for this payment request. The MAO investigated this case after receiving OIG's data request and determined, using the correct taxpayer identification number, that the provider was in-network.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$108
D103	Therapy: Home skilled nursing visit and physical therapy evaluation	A 91-year-old received a home skilled nursing visit and physical therapy evaluation.	System processing error	The MAO denied payment stating that it was filed too late after the date of service. The provider submitted evidence showing the claim had been filed within the required timeframe.	Denial reversed after provider dispute	\$275

Case ID	Service received	Beneficiary profile	Denial cause	Denial summary	Resolution at time of OIG data request	Cost: actual or estimated
D441	Radiation treatment: Intensity Modulated Radiation Treatment Delivery (a type of radiation therapy to treat cancer)	A 74-year-old was diagnosed with prostate cancer.	System processing error	The MAO denied payment stating that no prior authorization was on file. The provider disputed the denial and submitted a screenshot demonstrating that prior authorization had previously been obtained for the date of service. The MAO acknowledged an error in which the number of authorized days was not being recognized in its system.	Denial reversed after provider dispute	\$668
D442	Radiation treatment: Delivery of Radiation treatment	A 78-year-old was diagnosed with pancreatic cancer.	Manual review error	MAO denied payment stating there was no prior authorization on file. The provider disputed the denial and included a screenshot demonstrating that the MAO had granted a prior authorization for the billed claim. The MAO indicated that the denial resulted from human error—the claim processor did not recognize that there was an authorization on file.	Denial reversed after provider dispute	\$336
D433	Chiropractic: Chiropractic manipulative treatment	A 70-year-old was diagnosed with radiculopathy, a pinched nerve along the spine.	Manual review error	MAO denied payment stating there was no prior authorization on file. However, after OIG's data request, the MAO found that a prior authorization had previously been extended to cover the date of service, so the claim should have been approved.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$25
D435	Other test: Electrocardio-gram, a procedure that records electrical signals from the heart	An 85-year-old was diagnosed with tachycardia, rapid heartbeat, and previously had abnormal electrocardiogram results.	Incorrectly determined that the request did not meet Medicare coverage criteria	MAO denied part of the claim as a duplicate service, citing edits from the National Correct Coding Initiative. After OIG's data request, the MAO indicated that the edit had been incorrectly applied because the services were rendered by physicians with different subspecialties.	Not reversed <i>(MAO noted that it reversed the denial after receiving OIG's data request)</i>	\$66

APPENDIX C

Characteristics of Sampled MAOs

The 15 MAOs included in this review varied in size, enrolling between 165,000 and 5.9 million Medicare beneficiaries in 2019. Service areas for these MAOs covered all 50 States, the District of Columbia, and five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.)

MAO	Number of enrolled beneficiaries in 2019	Number of States or territories in service area
UnitedHealth Group, Inc.	5,857,700	56
Humana Inc.	3,922,929	52
CVS Health Corporation	2,249,248	54
Kaiser Foundation Health Plan, Inc.	1,617,713	8
Anthem Inc.	1,135,946	56
WellCare Health Plans, Inc.	532,053	54
Blue Cross Blue Shield of Michigan	520,485	54
Centene Corporation	259,356	48
InnovaCare Inc.	249,523	15
Highmark Health	227,298	54
SCAN Health Plan	203,766	1
UPMC Health System	191,460	54
Medical Card System, Inc.	174,157	1
Healthfirst, Inc.	165,266	51
EmblemHealth, Inc.	165,238	54



APPENDIX D - AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: March 24, 2022

TO: Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections

FROM: Chiquita Brooks-LaSure *Chiq B LaS*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OEI-09-18-00260

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to its oversight and enforcement of the requirements of the Medicare Advantage program.

Medicare Advantage plans are Medicare-approved managed care plans offered by Medicare Advantage Organizations (MAOs), which are private companies, as an alternative to original Medicare. MAOs must generally cover the same benefits as original Medicare. However, as part of the managed care structure, MAOs may apply internal coverage policies that are no more restrictive than original Medicare's national and local coverage policies to ensure that plan-covered items and services are medically necessary and appropriately targeted to the beneficiary's condition and diagnostic needs. MAOs are required to establish and maintain written standards, such as coverage rules, practice guidelines, payment policies, and utilization management policies, that allow for individual medical necessity determinations.

MAOs must follow national and local Medicare coverage determinations (NCDs and LCDs) and coverage guidance specified in original Medicare manuals, if specific guidelines exist for a given service. However, in many cases, NCD or LCD requirements are broad enough that an MAO may implement additional coverage requirements to better define the need for the service, as long as these additional requirements do not violate the requirements of the applicable NCD or LCD. Where there are no applicable NCDs or LCDs, MAOs may establish coverage guidelines, as long as the MAOs' guidelines are supported by medical evidence. Additionally, for services that are not subject to existing LCD and NCD requirements, MAOs may apply third-party guidelines, such as guidelines used by contractors engaged by the MAO to make coverage determinations.

CMS uses several tools to oversee the Medicare Advantage program and help ensure enrollees have adequate access to health care services. For example, CMS conducts annual audits of a sample of MAOs to evaluate compliance with the terms of the MAOs' contracts with CMS; in particular, the requirements associated with access to medical services, drugs, and other enrollee protections required by Medicare. CMS also targets audits to areas of concern, such as service types with a high rate of denial. CMS notifies plans of noncompliance, such as when it believes a plan's coverage is more restrictive than under original Medicare and represents a possible barrier to accessing care. MAOs are required to submit corrective action plans to address cited

deficiencies. Plans that are found to have repeated violations are subject to increasing penalties, including Civil Monetary Penalties, intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and even contract terminations.

In recent years, CMS has increased the transparency of audit findings by publishing them on the Medicare.gov website and developing a publicly available audit annual report with best practices MAOs can adopt to continue improving performance. Our oversight efforts are yielding positive results, with the average number of issues cited per audit declining approximately 70 percent from 2012 to 2019. In addition, CMS has populated information on the Medicare Plan Finder website to provide beneficiaries with information on MAO performance. In addition to the Star Ratings mentioned in this report, CMS has utilized the enrollment function in Medicare Plan Finder to cease enrollment in MAOs that fail to meet certain requirements. In addition, CMS continues to examine ways in which we can use technology tools to streamline processes like prior authorization to make them less burdensome on patients and providers.

While the Medicare Advantage payment denial rate is an important area to continue to monitor closely, CMS notes that the overall Medicare Advantage payment request denial rate cited by OIG for 2018 (9.5 percent) is comparable to the original Medicare denial rate during the same time period.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews.

CMS Response

CMS concurs with this recommendation. CMS plans to issue clarifying guidance regarding appropriate use of clinical criteria in medical necessity reviews.

OIG Recommendation

CMS should update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types.

CMS Response

CMS concurs with this recommendation. CMS will update its audit protocol if changes are necessary to align its audit processes with the guidance CMS plans to issue under Recommendation 1. Similarly, CMS will update its auditor training materials if changes are necessary as a result of the guidance CMS plans to issue under Recommendation 1.

OIG Recommendation

CMS should direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review and system errors.

CMS Response

CMS concurs with this recommendation. CMS will direct MAOs to examine their manual review and system programming processes and address vulnerabilities that may result in inappropriate denials in keeping with clarifying guidance that CMS plans to issue under Recommendation 1.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Rosemary Rawlins Bartholomew and Linda Min served as the team leaders for this study. Others in the Office of Evaluation and Inspections who conducted the study include Camille Harper, Eunji Kim, and Ivy Ngo. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli, Kevin Farber, Robert Gibbons, and Christine Moritz.

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office and Abby Amoroso, Deputy Regional Inspector General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
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