CMS CITES MEDICARE ADVANTAGE ORGANIZATIONS FOR “INAPPROPRIATE” DENIALS; OIG FINDS EXTREMELY LOW APPEAL UTILIZATION RATES

THERAPY ACCESS SOLUTIONS CAN HELP PROVIDERS CHALLENGE ERRONEOUS DENIALS

A recent investigation by the U.S. Office of Inspector General (OIG) found that, when beneficiaries and providers appealed preauthorization and payment denials, there were higher than expected overturn rates. They note, “CMS audit findings about inappropriate denials raise concerns that some beneficiaries and providers may not be getting services and payment that Medicare Advantage Organizations (MAOs) are required to provide.”

The OIG studied CMS audit data from 2014—2016 and concluded, “beneficiaries and providers rarely use[d] the appeals process designed to ensure access to care and payment.” They also found that the Centers for Medicare and Medicaid Services (CMS) has repeatedly cited MAOs for “issuing incorrect or incomplete denials letters,” which can disrupt and delay – if not completely halt – the proper appeals process.

CMS agreed with the OIG’s recommendations, stating that they are “strongly committed to oversight and enforcement of the Medicare Advantage Program and appreciates OIG’s recognition of CMS’ efforts to address Medicare Advantage performance when necessary.”

At a weighted average of 59% overturned upon appeal from 2014–2016, a potential 58.6 MILLION APPROVALS were lost.

OIG & CMS data showed:

- **75%** OF DENIALS WERE OVERTURNED UPON APPEAL
- **56%** OF AUDITED MAOs CITED FOR “INAPPROPRIATE” DENIALS IN 2015
- **45%** OF AUDITED MAOs WERE CITED FOR “INCORRECT OR INCOMPLETE” INFO IN DENIAL LETTERS IN 2015
- **>99%** MILLION DENIALS WENT UNCONTTESTED

**DID YOU KNOW THAT MAOs ARE SUPPOSED TO AUTOMATICALLY FORWARD ANY DENIALS THEY UPHOLD TO AN INDEPENDENT REVIEW ENTITY (IRE) FOR SECOND-LEVEL APPEAL REVIEW?**

Medtronic’s **Therapy Access Solutions (TAS)** does.

And they can help you, your staff, and your patients navigate the Medicare Appeals process – and commercial payor appeals processes – to ensure that inaccurate denials are disputed and barriers to medically-necessary care are confronted. TAS can work difficult appeals on your behalf throughout the four-level Medicare Appeals process.* Call them today at 866.446.3873 to be connected with the expert TAS analyst for your area, or email them.

Insurance providers denied treatment coverage to one-in-four (24%) patients with a chronic or persistent illness or condition; 41% of the patients denied coverage were denied once, while 59% were denied multiple times.

55% of those denied treatment said they were denied a prescription medication; 41% of those denied treatment said they were denied a diagnostic or screening test; 24% of those denied treatment said they were denied a medical procedure.

More than one-third (34%) of patients whose insurance provider denied treatment for a chronic or persistent illness had to put off or forego the treatment.

70% of the treatments for a chronic or persistent illness denied coverage by insurers were treatments for conditions described as “serious.”

Nearly a third (29%) of patients whose insurance providers denied treatment for a chronic or persistent illness reported that their condition worsened.

Of those patients whose insurance provider denied coverage for a screening or diagnostic test, or for a medical procedure to address a chronic or persistent illness, patients reported most often that the justification for the denial was, “lack of medical necessity.”

Of the patients whose insurance provider denied coverage of a treatment for a chronic or persistent illness, more than one-third (34%) said they did not undergo the recommended treatment because their insurer would not cover the cost.


* The goal of the TAS team is to enable and enhance patient access to needed care and therapies by helping effectively navigate the prior authorization and appeal processes. TAS may provide assistance for products and procedures with significant and/or unique coverage issues. In the event an office/hospital submits a case that does not require the expertise and effort of our TAS team, TAS will notify the office/hospital that they are unable to work the case. TAS will in no way replace the office/hospital staff in working prior authorizations/appeals.