Federal Investigators Find Medicare Advantage Plans Too Often Deny, Delay Needed Care

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Medicare Advantage plans that provide health insurance coverage to millions of US seniors deny some medically necessary care that should be covered, possibly unfairly rejecting tens of thousands of such requests annually, says a new report from the Department of Health and Human Services Office of Inspector General (OIG).

The report also found that Medicare Advantage plans often deny payments to physicians for services that met Medicare coverage rules.

“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,” the report notes. “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.”

About 26.4 million (42%) of all Medicare beneficiaries in 2021 were enrolled in a Medicare Advantage plan, according to the report. A March 2022 report from the Medicare Payment Advisory Commission said that if enrollment trends of the past decade continue, a majority of eligible Medicare beneficiaries will be enrolled in Medicare Advantage by 2023.

The OIG said it undertook the report because of concerns that under Medicare Advantage’s payment model, which pays private insurers a fixed amount per patient, insurers might be motivated to limit access to care to reduce costs and increase company profits.

Although these Medicare Advantage organizations (MAOs) approve the vast majority of requests for services and payment, they issue millions of denials each year, the report said, noting that audits by the Centers for Medicare & Medicaid have found widespread and persistent problems with respect to inappropriate denials of services and payment.

The OIG investigators reviewed case files and medical records of a random sample of cases involving denials of prior authorization requests by MAOs for medical care during 1 week in 2019, finding that 13% of such denied requests actually met Medicare's coverage rules. Assuming this rate applies to all requests from these MAOs during the year, “they would have denied 84,812 beneficiary requests for services that met Medicare coverage rules that year,” the report said.

To conduct the study, the OIG investigators focused on 15 of the largest MAOs, which encompassed nearly 80% of beneficiaries enrolled in Medicare Advantage as of June 2019. They included a random sample of 430 denials from the first week of June in 2019 to estimate the rate at which the organizations rejected prior authorization requests and payment requests that met Medicare coverage rules and the organizations’ billing rules.

Two of the most common types of denied services were advanced imaging—including magnetic resonance imaging (MRI) and computed tomography (CT) scans—and care in skilled nursing facilities or inpatient rehabilitation facilities following hospitalizations.

“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,” the report notes.

In many cases, the MAOs denied requests for services that met Medicare coverage rules, instead applying clinical criteria developed by the MAO that are not required by Medicare.
For example, in one case, an MAO turned down a request for a follow-up MRI of an adrenal gland lesion observed on an earlier CT scan (a decision that was reversed on appeal), saying the patient would need to wait at least 1 year because of the lesion’s small size. This restriction is not included in Medicare coverage rules, and a physician panel reviewing cases for the OIG’s study also said that the documentation in the original MRI request demonstrated that the scan was medically necessary to determine whether the lesion was malignant.

Some MAOs denied requests for transfers to postacute care facilities that met Medicare coverage rules, claiming that beneficiaries’ needs could be met at a lower and less costly level of care. “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,” the report said.

The investigators noted that other denials that met Medicare coverage rules were for items or procedures that MAOs may subject to extra scrutiny because of vulnerability to fraud, including durable medical equipment (such as hospital beds with rails and manual wheelchairs and walkers) and injections for pain management.

Some denied requests for medically necessary services occurred when clinicians did not respond to a demand from the MAO for unnecessary documentation, the OIG said. In some of these cases, the OIG’s physician reviewers found that the information in the case file was already sufficient to demonstrate medical necessity, and in others, documentation requested by the MAO was already in the case file.

The report also found that the 15 selected MAOs denied 160,378 payments to clinicians during the first week of June 2019, and that 18% of these denials were for claims that met Medicare coverage rules and should have been approved. “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,” the report notes.

Most of the payment denials were the result of human error during manual reviews, the OIG investigators found.

The MAOs reversed 3% of the improper denials of care and 6% of improperly denied payment requests, often when a patient or clinician appealed or disputed the denial, and in some cases after identifying their own mistakes.

The report recommended that the Centers for Medicare & Medicaid Services issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews and update its audit protocols to address the problems the OIG investigators identified. It also advised the agency to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.