MEDICARE ADVANTAGE CONSULTANTS LLC

Your Partner in Financial Health

TOP

15 MEDICARE ADVANTAGE HMO DENIALS & HOW TO FIX THEM

SECRETS

YOU NEED TO KNOW

BY FALICIA PONDER

Top 15 Medicare Advantage HMO Denials & How to Fix Them

A Practical Guide for Agencies, Providers & Community Partners

By Felicia Ponder
Advantage Consultants, LLC (MAC)

Closing Care Gaps. Ensuring Payment. Advocating for Seniors.

About This Guide

This guide highlights the fifteen most common Medicare Advantage HMO denials and provides actionable strategies to overturn them. MAC equips agencies and providers with proven solutions to secure payment, reduce administrative burden, and ensure seniors receive the care they deserve.

1. Authorization Not Obtained

Why it Happens: Service performed without prior authorization.

How to Fix It: • Always pre-check plan-specific PA grids. • Use MAC's e-PA workflow tool with 72h/7d tracking. • Build payer 'fast-lane' templates for recurring service lines.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

2. Service Not Medically Necessary

Why it Happens: Plan applies stricter-than-Medicare criteria.

How to Fix It:

- Submit robust medical necessity packets (SOAP notes, MEAT documentation).
- Attach published guidelines & CMS equivalency language.
- Appeal with CMS National Coverage Determinations (NCDs).

MAC Pro Tip: Document every step and keep evidence ready for appeals.

3. Incorrect Coding / Missing Modifiers

Why it Happens: Claim rejected due to coding errors.

How to Fix It:

- Conduct pre-submission audits.
- Use certified coding software (Axxess, Kinnser, DSL).
- Run quarterly 'denial heatmap' audits.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

4. Late NOA (Notice of Admission) Submission

Why it Happens: NOA not submitted within required timeline.

How to Fix It:

- Automate NOA submission with PM system alerts.
- Always submit NOA to MA plans (best practice).
- Maintain a 'NOA Watchlist' in MAC Tracker.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

5. Provider Out-of-Network

Why it Happens: Provider not contracted with the MA plan.
How to Fix It:
• Use single-case agreements & continuity-of-care protections.
• Negotiate letters of agreement with MAC support.
• Document patient harm risk if denied.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

6. Duplicate Claim

Why it Happens: Claim refiled without corrections flagged as duplicate.
How to Fix It:
• Use corrected claim process instead of resubmission.
• Maintain denial tracking logs (MAC templates).
• Confirm payer claim number references.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

7. Timely Filing Denials

Why it Happens: Claims submitted outside filing window.
How to Fix It:
• Establish internal 30-day submission rule.
• Appeal with evidence of system delays.
• Request exceptions using CMS timeliness standards.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

8. Level of Care Not Covered

Why it Happens: Plan disputes setting (SNF vs custodial care).
How to Fix It:
• Provide physician notes justifying acuity.
• Appeal with STAR measure risk (readmission prevention).
• Use MAC's 'clinical risk memo' template.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

9. Coordination of Benefits (COB) Errors

Why it Happens: Plan flagged other coverage as primary.
How to Fix It: • Submit proof of insurance primacy. • Appeal with updated EOB from secondary insurer. • Train staff on COB workflows with MAC Academy.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

10. Experimental / Investigational Service

Why it Happens: Service denied under policy exclusions.
How to Fix It:
• Submit peer-reviewed evidence and FDA approvals.
• File for exception when clinical efficacy supported.
• Partner with physician champions for appeals.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

11. W-9 Form Missing / Invalid

Why it Happens: Plan denies because W-9 missing/expired/mismatched.
How to Fix It:
• Keep updated W-9s on file with every MA plan.
• Ensure legal name, TIN, and NPI match PECOS/IRS records.
• Resubmit W-9 with corrected claim.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

12. B11 – Other Payor Responsibility

Why it Happens: Plan claims another insurer is primary.
How to Fix It:
• Submit updated insurance info or proof of MA plan primacy.
• Attach Medicare EOB showing plan responsibility.
• Train front-office staff to verify COB at intake.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

13. Bundling / Non-Covered Services

Why it Happens: Service denied as bundled under another code.
How to Fix It:
• Review payer-specific bundling rules.
• Use modifier -59 or XE/XS/XU/XR appropriately.
• Submit corrected claims clarifying service separation.
MAC Pro Tip: Document every step and keep evidence ready for appeals.

14. Patient Ineligible / Not Enrolled

Why it Happens: Patient not active in MA plan on date of service.
How to Fix It:
• Verify eligibility before service via real-time portals.
• Document retroactive enrollment corrections.
• Resubmit claim after active coverage confirmed.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

15. Medical Records Not Submitted

Why it Happens: Claim denied after ADR request not fulfilled.

How to Fix It:

- Track ADR deadlines with alerts (10–30 days).
- Submit complete records including orders/notes/signatures.
- Keep 'rapid response packet' templates ready.

MAC Pro Tip: Document every step and keep evidence ready for appeals.

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Bonus: Fill-in-the-Blank Appeal Template – Out-of-Network Denial

This is a simple template you can copy, paste, and complete to appeal an out-of-network denial. It's a preview of the full Appeals Toolkit available through MAC Academy.

[Provider Letterhead / MAC Logo]

Date: ____/____/_____
To: [Insurance Plan Name] – Attn: Appeals Department
Fax/Address: _____

Re: Appeal of Out-of-Network Denial
Patient Name: _____
DOB: ____/____/_____
Member ID: _____
Claim # / Reference #: _____

Dear Appeals Department,

I am writing to formally appeal the denial of medically necessary services for the above-named patient. The denial was based on the provider being **out-of-network**.

1. **Medical Necessity:** The patient required _____ (service type). Services were urgent/essential to avoid risk of harm or hospitalization.

2. **Continuity of Care:** This patient has an existing care relationship with _____ (provider/facility name). Denying coverage interrupts care and creates avoidable risk.

3. **CMS / Regulatory Basis:** CMS requires Medicare Advantage plans to provide access to medically necessary care and continuity of care when in-network options are not reasonably available.

Requested Action: We request that this denial be overturned and the claim paid in full based on medical necessity, continuity of care, and patient protections.

Supporting Documents Attached:
- ☐ Physician notes / orders
- ☐ Clinical risk memo
- ☐ Patient medical history / prior services
- ☐ Copy of denial letter

Thank you for your prompt reconsideration.

Sincerely,

_____
[Provider/Agency Name]
[Contact Name / Title]
[Phone / Fax / Email]