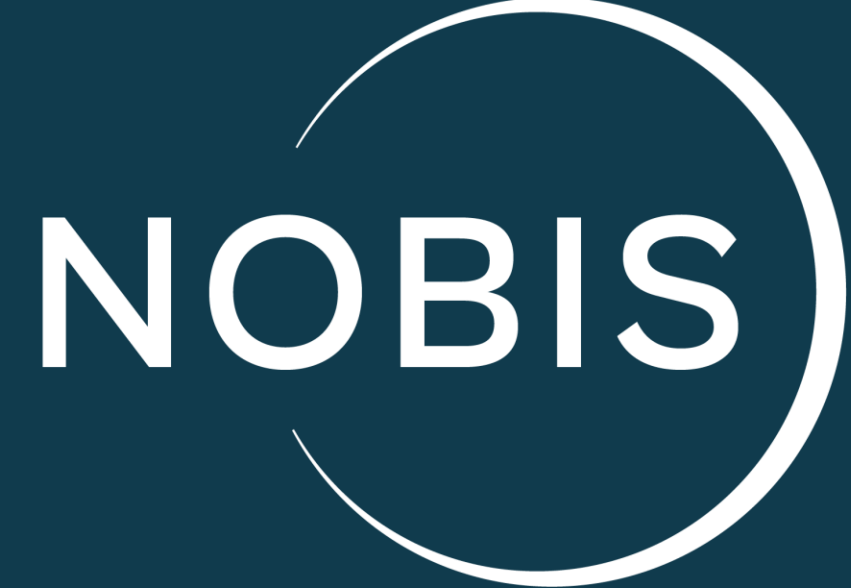




OVERTURNING MEDICARE ADVANTAGE POST-DISCHARGE DENIALS

An organized, interdisciplinary approach to recognition, appeal, tracking, and persistence

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Nobis Rehabilitation Partners

AMRPA Fall Conference, September 2026

WHY THIS MATTERS

Medicare Advantage plans, MAPs, may seek full or partial reimbursement after discharge.

This is commonly done through Post Payment Accuracy Audits.

No limits on Payment Accuracy Audits, unlike Medicare Fee for Service audits.

Common denial focus areas:

- GG or H coding
- IPOC documentation
- Team Conference documentation
- PAS documentation
- IGC selection

TECHNICAL DENIALS

Missing required documentation

The most common documentation vulnerabilities identified were:

- 1 Timely PAS signatures
- 2 IPOC documentation
- 3 Team Conference documentation

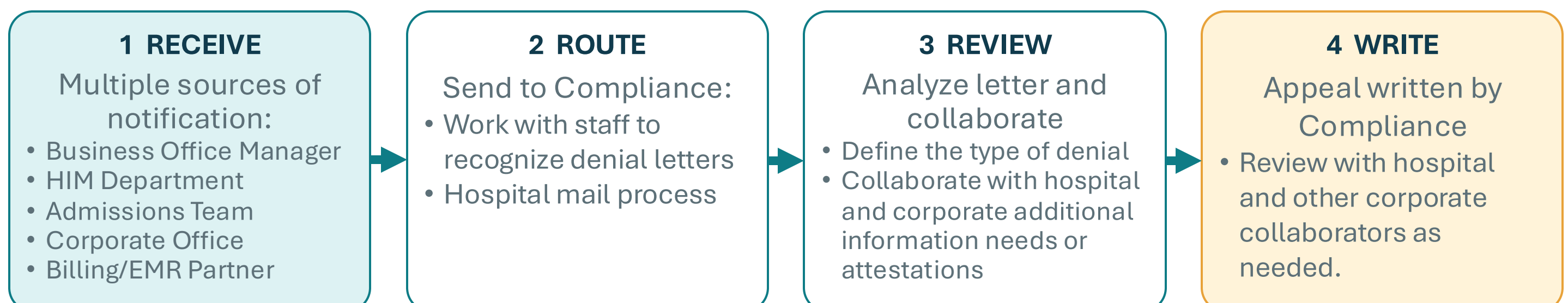
Provide timely feedback to the hospital and Corporate support with technical denials. If needed, audit current compliance.

LESSONS LEARNED

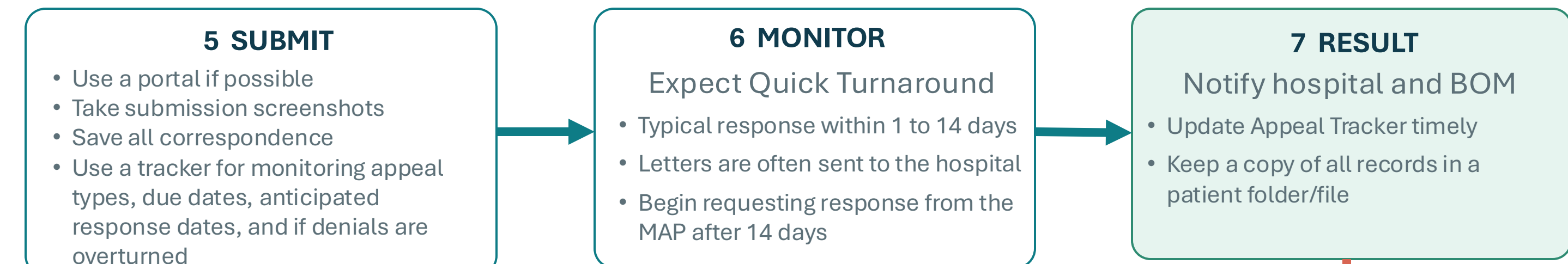
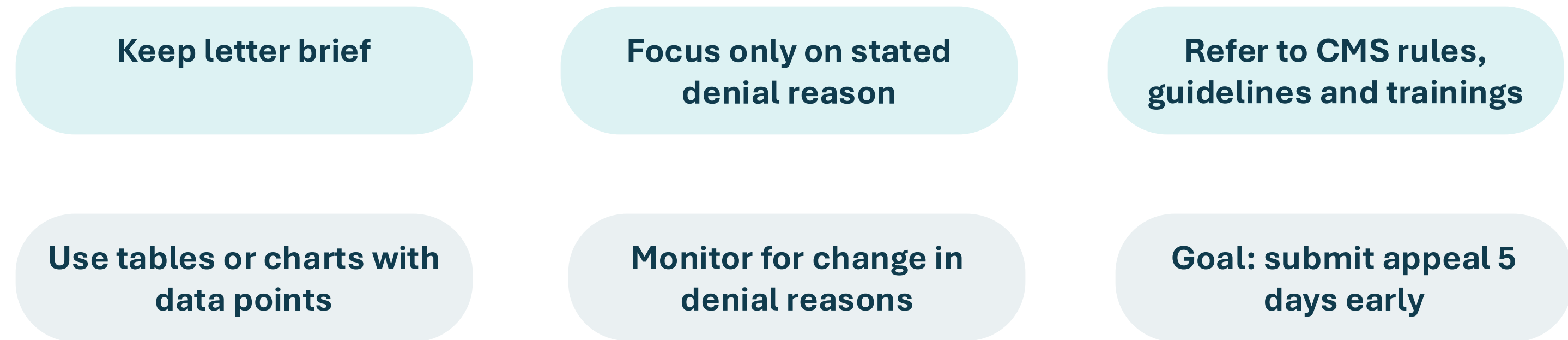
- 01 Recognize post-discharge denial letters quickly.
- 02 Denials can be delayed due to lost or misrouted correspondence.
- 03 Understand the specific denial reason before developing the appeal strategy.
- 04 Persistence matters. Continue through available appeal levels.

POST-DISCHARGE APPEAL PROCESS

The process connects hospital operations, corporate review, clinical expertise, submission tracking, and repeated appeals when necessary.



Appeal Letter Recommendations



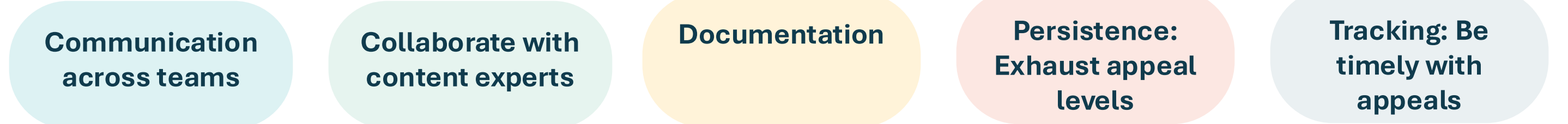
IF DENIED:

Return to Review & Collaboration. Continue until the appeal process is exhausted. MAPs will typically participate in 5 rounds of appeals, then move to a peer-to-peer discussion with the Medical Director.

Review denial reason closely between appeal levels.

- MAPs are not permitted to change the denial reason, but will attempt it by selecting other GG items to contest, or change their recommended GG score of an item.
- Refer to MLN Matters article number: SE1521 Revised

WHAT SUPPORTS SUCCESS



Appeal requirements and timelines should be verified against the applicable plan correspondence.

KEY RESOURCES

Medicare Benefit Policy Manual

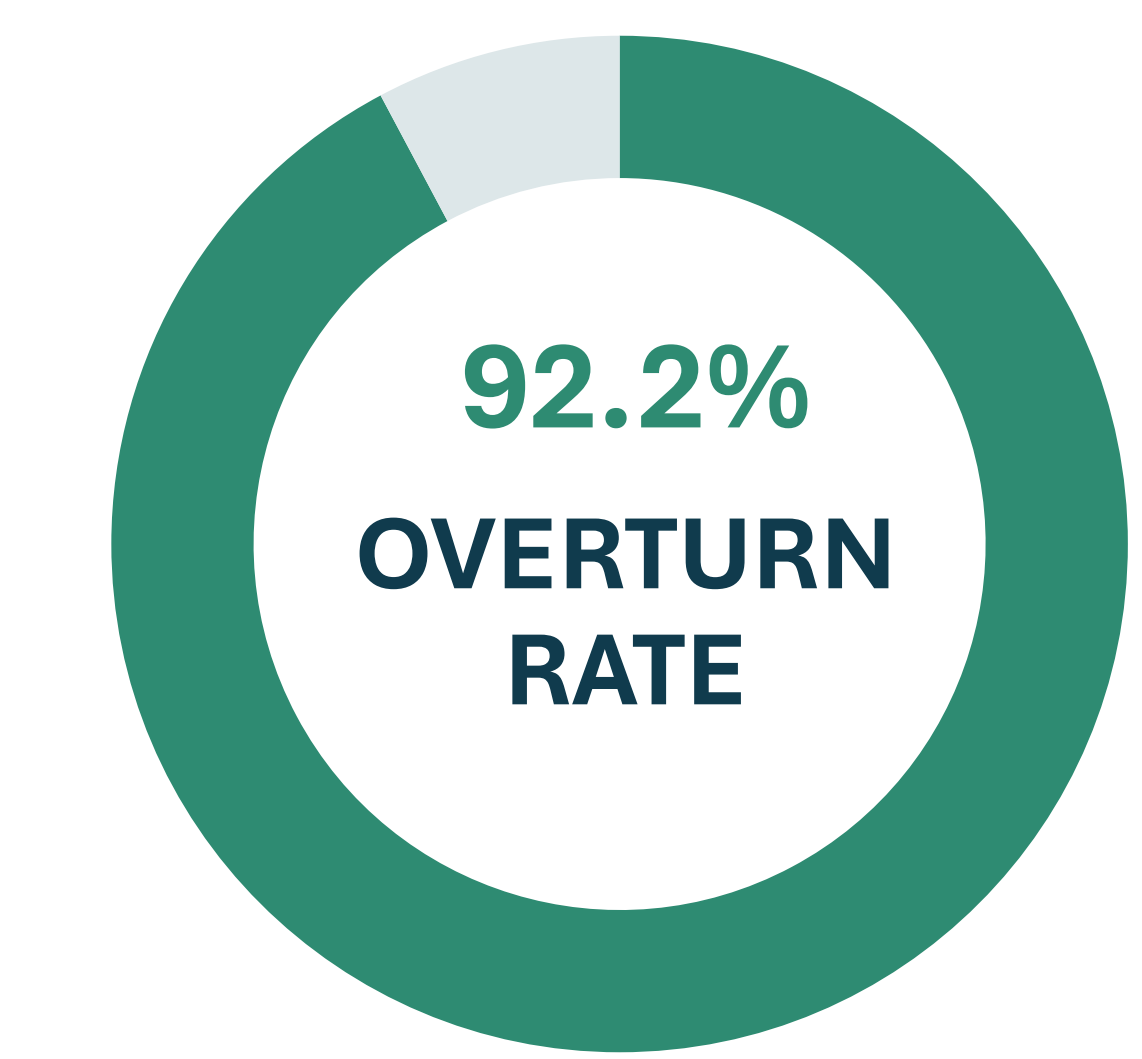
IRF QRP FAQs: The latest with CMS IRF guidance, especially helpful with GG and H scenarios;
<https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-faqs>

<https://www.cms.gov/medicare/appeals-grievances/managed-care>

CMS Provider Complaint Form: <https://www.cms.gov/medicare/health-drug-plans/provider-complaints-form>

Medicare Web Based Learning for Part C Determinations, Appeals & Grievances:
<https://www.cms.gov/Outreach-and-Education/MLN/WBT/PartCOrganizationDetermination/story.html>

OUTCOME METRICS TIMEFRAME: January 2024 – July 2026



\$1.8M

APPROXIMATE RECOUPMENT AVOIDED

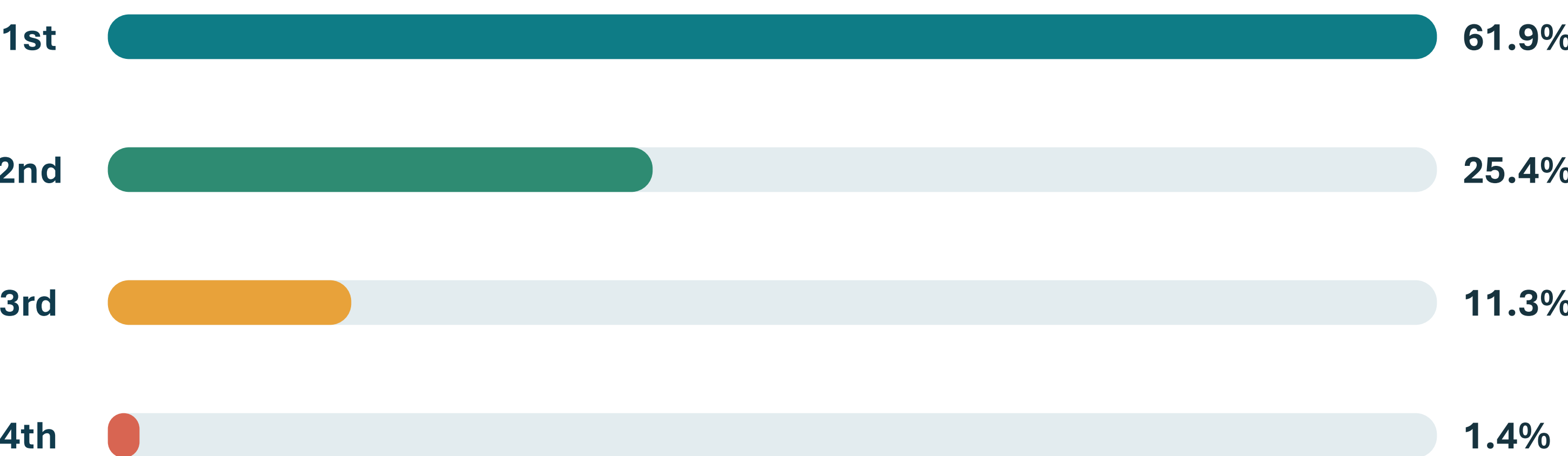
\$0.5M

APPROXIMATE RECOUPMENT

10 Technical Denials, 77 appeals: 71 overturned, 6 lost

APPEAL LEVELS and OVERTURN RATE

Distribution across the 71 successful appeals



One fifth-level appeal was recorded in the worksheet.

KEY TAKEAWAY

Many Medicare Advantage post-discharge clawbacks can be successfully overturned with an organized approach.

Recognize • Route • Research • Appeal • Track • Persist

92.2% overturn rate in this project