The Dispatch

A monthly briefing on denial patterns, appeal strategy, and payer policy. The fix, not the fear.

ISSUE 01 AUGUST 4, 2026 MONTHLY · FIRST TUESDAY

THE LEAD · OIG ON MEDICARE ADVANTAGE POST-ACUTE CARE DENIALS

95 percent of appealed skilled nursing denials were overturned. *Only 18 percent were ever appealed.*

In June, the HHS Office of Inspector General published two reports that quietly reset the conversation on Medicare Advantage. The three largest MA plans denied long-term acute care admissions at rates between 71 and 80 percent. When providers actually appealed, 36 to 95 percent of those denials were overturned. That is not a claims problem. That is a strategy problem, and it is worth real money on your bottom line. And here is the part the headline hides: skilled nursing was the setting these plans denied the least. The full picture below is worse.

Welcome to Issue 01. Every month: one denial pattern, one EDI Lab walkthrough, one appeal anatomy, one policy watch. No filler. Here is how to work this one before Labor Day.

Mindy Corbett
Founder, Revenue Optimization & Intelligence · Source. HHS OIG, June 11, 2026.

65%
LTCH DENIAL RATE ACROSS THE 19 MAOS REVIEWED

80%
CVS/AETNA LTCH DENIAL RATE, THE HIGHEST OF ANY PLAN

95%
SNF DENIALS OVERTURNED WHEN ACTUALLY APPEALED

18%
SNF DENIALS THAT WERE APPEALED AT ALL

01 · THE REPORT

What the OIG actually found, *and why the numbers are cleaner than they look.*

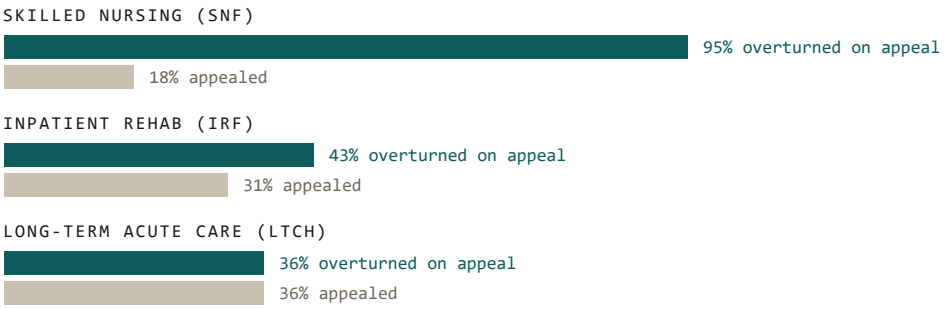
Two reports, released June 11, 2026. OEI-09-24-00330 covered long-term acute care (LTCH) and inpatient rehab (IRF) admissions. OEI-09-24-00331 covered skilled nursing (SNF). Nineteen Medicare Advantage organizations were reviewed, covering 86 percent of MA enrollment. Across the two reports, roughly 132,000 post-acute prior authorization requests were examined. About 26,000 were denied.

POST-ACUTE ADMISSIONS ACROSS THE 19 MAOS REVIEWED

SETTING	DENIAL RATE	HIGHEST PLAN	OVERTURNED	APPEALED
Long-term acute care	65%	CVS/Aetna, 80%	36%	**36%**
Inpatient rehab	54%	Range 4 to 66%	43%	**31%**
Skilled nursing	12%	UHC, 99.7% overturn	**95%**	**18%**

SOURCE. HHS OIG OEI-09-24-00330 & OEI-09-24-00331, JUNE 11, 2026.

FIGURE 01 · THE APPEALS GAP



OVERTURN RATES DWARF APPEAL RATES IN EVERY POST-ACUTE SETTING. SNF IS THE WIDEST GAP IN THE DATA.

That is money that walked out the door on procedure alone. The 18 percent appeal rate is not accidental.

There is a teachable point in this, but it is not what you think. It is not "send more appeals." It is learning to determine which denials are procedural, which are policy, and which are just wrong, then categorizing and prioritizing them so you are filing the **right** appeals. Then it is automated workflows that sort denials into those categories so nothing falls through the cracks. If you are sorting by the adjustment code alone, without an actionable process behind it, you **will** have leaks.

> *"Ninety-five percent of appealed SNF denials were overturned. Ninety-nine point seven percent of UHC SNF denials. And more than 80 percent of the denials in the OIG sample were never appealed."*

02 · THE PLAY

Medical necessity denials. *Appeal tips and prevention strategies.*

Most of the time, the adjustment code on a medical necessity denial is going to be Claim Adjustment Reason Code (CARC) 50. Typically, it will come with group code "CO" so it will appear as "CO-50" on your remit. The CARC alone is only half of the story. The full story relies on the RARC (Remittance Advice Remark Code) that follows it. If you are approaching medical necessity denials by working the CARC code alone, then you are missing half of the information you need to appeal it effectively.

TO COMPLETE THE STORY AND HAVE ALL OF THE INFORMATION YOU NEED TO WORK THE DENIAL

i. **Start with the RARC, not the CARC.** N115 is an LCD-based decision, N386 is NCD-based, and N130 points to the payer plan policy. Your documentation and appeal needs to support the named policy. If it does not, you will not win the appeal.

ii. **If the RARC names a specific policy, pull and read that policy.** LCDs and NCDs are on the CMS Medicare Coverage Database. MA and commercial policies are on the payer portal. Print it. Highlight every "must," "shall," and "will." **SAVE IT.** You will need it again.

iii. **Structure the appeal to the policy, not to your narrative.** Five criteria in the policy means five sections in your letter, each quoting the chart line that proves the criterion is met.

iv. **For Medicare Advantage claims, name the regulation.** If the plan applied criteria more restrictive than Traditional Medicare, cite 42 CFR 422.101(b). That is a regulatory violation, not a coverage disagreement.

DO THIS BEFORE FRIDAY — 30 MINUTES, NO NEW TOOLS REQUIRED

i. Pull your ten oldest post-acute MA denials and sort them into three piles: true denial, information request, billing error. Only pile one gets an appeal.

ii. For every medical necessity denial, write down the RARC beside it and the document or policy it references (e.g., LCD, NCD, or payer policy). Save those documents, and make them available to your team.

iii. Divide appeals filed by denials received for the last quarter. If your rate is anywhere near the OIG's 18 percent, you most likely have recoverable revenue. Go after it.

Are you stuck on any denials? Send me an email with the codes you need help with, and I will point you to the resolution path. hello@roithatworks.com

03 · THE WALKTHROUGH

The same denial. *Decoded.*

The same denial, in ROI's EDI Intelligence Lab. Completely decoded with action plans, appeal tips, and prevention strategies. Enter your adjustment code, complete the story by entering your remark code, and get everything you need to understand how to appeal the denial now and prevent it in the future. Explore the full decode at roithatworks.com.

FIGURE 02 · THE CARC 50 + N115 PAIRING VIEW. THE LAB NAMES THE POLICY DOCUMENT, THEN WALKS THE APPEAL TO ITS EXACT CRITERIA.

04 · THE ANATOMY

What a first-level appeal looks like *when it actually overturns these denials.*

A merit-based first-level appeal is a specific document. The sections have to be there for the reviewer to engage with them.

HEADER BLOCK	Patient identifiers, claim number, denial date, and the exact CARC and RARC quoted verbatim.
STATEMENT OF APPEAL	One sentence naming the specific policy identifier being appealed against.
POLICY-MAPPED ARGUMENT	The payer's policy has five criteria, so your letter has five sections. Each one quotes the chart.
REGULATORY CITATIONS	For MA post-acute, 42 CFR 422.101(b). Cite the OIG report numbers where relevant.
ATTACHMENTS LISTED	In the order the reviewer will use them. Charts, orders, notes, prior auths.
SIGNATURE BLOCK	By someone who knows the chart. Not the coder. Not the billing manager alone.

This letter is not a re-litigation of the clinical decision. It defends the documentation of the decision against the specific criteria the plan cited. Stay in that lane and your overturn rate will move.

The full anatomy, with worked examples for medical necessity, prior authorization, timely filing, and the bundling and modifier family, is in the appeal-letter hub at roithatworks.com.

EFFECTIVE JUL 01 2026

CARC/RARC code set update

CMS Change Request 14410, implementation July 6. If you have not refreshed your denials data set, do it now. The American Medical Billing Association provides free Excel downloads of both the CARC and RARC code sets at americanmedicalbillingassociation.com.

LIVE JAN 01 2026

WISeR AI prior authorization

The CMS WISeR Model is using AI and machine learning to do the first review for prior auths on select Traditional Medicare services in New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington. If you do not have a prior auth workflow, now is the time to implement one.

ACTIVE 2026

State prior authorization reform

Five states have implemented prior authorization reform, including Washington and Alaska. Alaska set 72-hour standard decision deadlines for routine cases, and Washington passed a law banning AI-only PA denials without review by a licensed health professional. A dozen other states are advancing similar bills. If you do not have an appeals workflow to manage these, build one today. These are enforceable, but only if you are tracking them.

EFFECTIVE JAN 01 2026

Aetna level of severity, MA inpatient

A Level of Severity review on stays of 1 to 4 midnights produces underpayments for Aetna Medicare Advantage claims. Watch for admissions paying less than expected. Variance work, not appeal work. Look for RARC N610 and "Alert: Payment based on an appropriate level of care" on your ERAs. You have 14 calendar days from the decision notification, and it must be before the claim is submitted, to request a "Severity Discussion" if you disagree with Aetna's decision.

THE ASK

If you see one of these patterns on your remits, *start with the assessment.*

Seven questions, two minutes, no PHI. It surfaces the specific denial families you are losing money to. Score your practice free at roithatworks.com.

Thanks, Mindy

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SOURCES · ISSUE 01

HHS OIG, OEI-09-24-00330 (LTCH and IRF), June 11, 2026 · HHS OIG, OEI-09-24-00331 (SNF), June 11, 2026 · CMS Change Request 14410 / Transmittal R13666CP, CARC/RARC update, effective July 1, 2026 · 42 CFR 422.101(b), MA coverage criteria no more restrictive than Traditional Medicare · ASC X12, official CARC and RARC lists, x12.org · American Medical Billing Association, CARC and RARC code set downloads · CMS Innovation Center, WISeR Model, live January 1, 2026 · Washington SB 5395, signed March 23, 2026 · Alaska prior authorization decision deadlines, effective 2026 · Aetna, Level of Severity Inpatient Payment Policy, effective January 1, 2026

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