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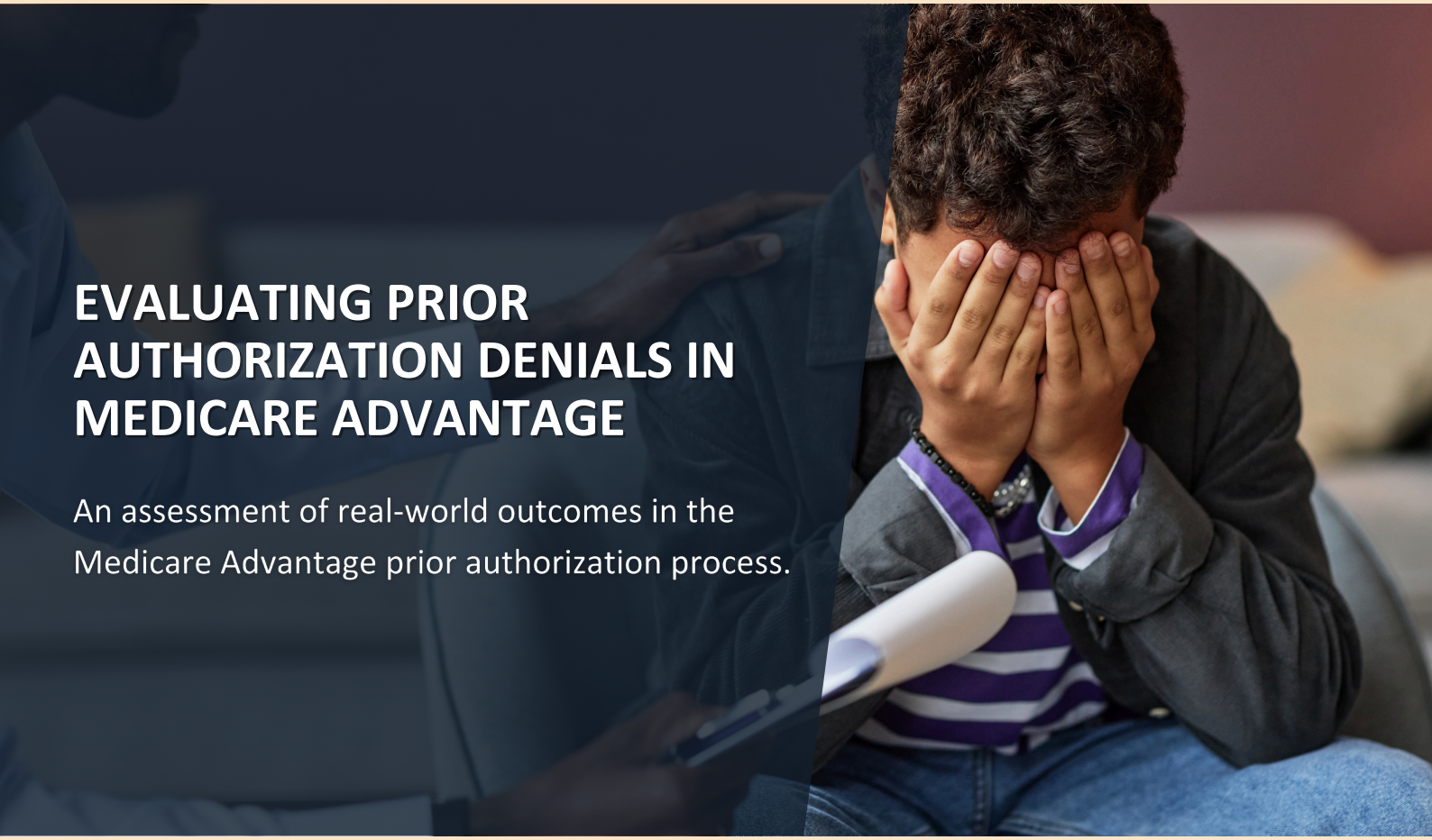


EVALUATING PRIOR AUTHORIZATION DENIALS IN MEDICARE ADVANTAGE

An assessment of real-world outcomes in the Medicare Advantage prior authorization process.

In April 2022, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) released a report highlighting widespread, systemic failures in Medicare Advantage prior authorization (PA) practices.

To validate these findings, Walnut Hill Medical launched **the MAD Study** with an independent team to conduct an independent review of its internal prior authorization database. The study analyzed records from 1,210 Medicare Advantage patients who sought prior authorization for Peripheral Nerve Stimulation (PNS)—a non-opioid, non-steroidal therapy for chronic pain.

The findings point to a **structurally flawed system that routinely delays or denies medically appropriate care**—not due to clinical concerns, but because of the high burden placed on patients and physicians in challenging prior authorization denials.

INTRODUCTION

The MAD Study evaluates the human and structural impact of Medicare Advantage prior authorization (PA) processes. Drawing on a dataset of 1,210 patient-level records from 2024 Peripheral Nerve Stimulation (PNS) prior authorization patients, the study examines how administrative barriers—not clinical judgment—often determine whether and when patients receive care.

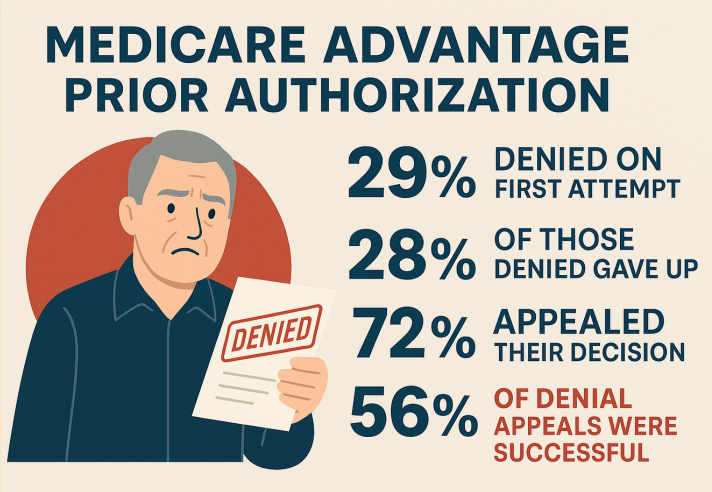
Our analysis identifies national trends and pinpoints key pressure points where the PA system breaks down. The findings are designed to inform Congress, CMS, and healthcare stakeholders working toward equitable, transparent, and timely access to medically necessary therapies.

DATASET OVERVIEW

- **Population:** 1,210 Medicare Advantage patients seeking authorization for Peripheral Nerve Stimulation (PNS) in 2024
- Inclusion criteria: Patients whose PA cases were opened after Jan 1, 2024 and had a final determination
- Key data tracked: Approval or denial outcome, number of prior authorization attempts, patient dropout or abandonment of care, appeal activity and outcomes, time to initial and final determination

KEY FINDINGS

- 29% of Medicare Advantage patients were denied care on their first attempt.
- 28% of those denied gave up after the first denial due to administrative attrition.



- 72% of denied patients fought back — and 56% of them were eventually approved.
- Only 1.3% of patients appealed their PA denial to an Administrative Law Judge.
- 69% of patients who appealed to an Administrative Law Judge won their appeals and had their PA denials overturned.

While 71% of Medicare Advantage patients in this study were approved on their first attempt, 29% were denied, meaning more than a quarter of patients immediately encountered barriers to care.

Among patients who were initially denied but pursued further review—through appeal or resubmission—an estimated 56% were ultimately approved.

While this excludes the 28% of patients who dropped out after an initial denial and never re-engaged the process, it offers a clearer picture of the cost of persistence within the system. It demonstrates that while the majority of patients who appealed or resubmitted were eventually approved, that approval came only after additional administrative burden and delay.

As such, the 56% rate should not be read as evidence of fairness or efficiency, but rather as a signal that initial denials often delay—rather than deny—access. It underscores the need to examine not just whether patients are eventually approved, but how many are discouraged, delayed, or denied in the process of trying.

Persistence should not be the price of access. Initial denials often delay—not deny—care. And for many patients, that delay becomes denial.

While most approvals occurred on the first attempt, later rounds saw sharp drop-offs in volume and few successful outcomes.

The timeline to final determination reveals sharp disparities in how long Medicare Advantage patients must wait for care. While the median case was resolved within 8 days, others extended beyond 100—and in some cases, up to 290 days—highlighting significant delays for a subset of patients. This disparity raises serious concerns about prolonged waiting periods, despite CMS guidelines intended to ensure timely access to medically necessary treatment.

BROAD FINDINGS: MEDICARE ADVANTAGE PRIOR AUTHORIZATION OUTCOMES

HIGH DENIAL RATES PERSIST

Of the 1,210 MA patients examined, 29% were denied at the first attempt.

This confirms that **MA beneficiaries are disproportionately subjected to initial barriers to access**, even when pursuing clinically accepted treatments like PNS trials.

APPROVAL IS COMMON—BUT DELAYED AND UNEVEN

While over 70% of patients were approved, the process required multiple attempts for many. **Approvals were not front-loaded; instead, they followed extended review cycles, with decisions often occurring only after one or more denials.** This elongation of the pathway imposes unnecessary strain on both patients and providers.

DROPOUT BEFORE RELIEF IS ALARMINGLY HIGH

28% of patients dropped out of the PA process after an initial denial, never reapplying or appealing through formal channels. These patients did not progress toward a determination by an independent reviewer, such as an ALJ.

ALJ REVIEW OFFERS RELIEF—BUT TOO FEW REACH IT

Only 1.3% of patients reached an Administrative Law Judge (ALJ) hearing. Among those, 69% received favorable decisions. This outcome suggests that systemic barriers—not merit—prevent most patients from obtaining the care they deserve.

Given the number of denials and dropouts, these figures imply that **hundreds of patients may have been wrongfully denied care simply because they never escalated.**

TIME DELAYS COMPOUND ACCESS ISSUES

The average time to final determination was 15.4 days, with a median of 8 days—but outlier patients took nearly 300 days to resolve**. These extreme delays were not isolated incidents; they represent a structural vulnerability where MA patients can languish for months without care.**

Importantly, time was a key predictor of both abandonment and outcome: each additional day in the process increased the likelihood of patient dropout by 1.88%, while the probability of eventual approval actually decreased by 1.32%.

This pattern reflects not a system of delayed course correction, but rather one in which administrative delays actively suppress care access.

SUMMARY AND IMPLICATIONS OF THE MAD (MEDICARE ADVANTAGE DENIAL) STUDY

While the overall approval rate might appear reassuring, the underlying system imposes disproportionate burdens on MA beneficiaries. Frequent denials, minimal relief through appeal, and long delays in decision-making combine to create a structurally inequitable experience.

Of the 1,210 Medicare Advantage patients analyzed, 210 were denied care or ultimately never received therapy. Based on 2024 reimbursement base rates for Peripheral Nerve Stimulation (including evaluation and permanent implant procedures), the average cost for PNS therapy per patient is $29,432.

This group represents approximately $6.2 million in avoided costs to Medicare Advantage plans. **These patients would have received care under Traditional Medicare.**

This raises critical questions about how Medicare Advantage plans contain costs by delaying or denying access, rather than through clinical appropriateness or efficiency. The financial “savings” come not from better outcomes, but from obstructed access.

These findings underscore **the need for systemic reform**—not just to improve initial accuracy but to ensure equitable navigation and access throughout the prior authorization process.

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