# Medicare Advantage Denial Toolkit

For practice managers and billers who want to stop writing off Medicare Advantage denials they could win. Three tools, each one page.

**Page 2**
### Denial checklist
Sort a denial, fix what's fixable, and build an appeal packet.

**Page 3**
### Deadline cheat sheet
Filing windows and decision times, each with its CMS source.

**Page 4**
### Appeal letter template
A one-page reconsideration request you fill in.

## Start here: are you contracted with this plan?

Your appeal path depends on it. Check before you do anything else.

**IN NETWORK (CONTRACTED)**

- Your contract and the plan's provider manual set the dispute steps and deadlines. Pull both first.
- For a service not yet given, the treating physician can request reconsideration for the patient.
- Paid less than agreed? Compare the payment to your contract fee schedule and dispute through the plan.

**OUT OF NETWORK (NON-CONTRACTED)**

- You can request reconsideration of a payment denial yourself, with a signed Waiver of Liability.
- If the plan upholds the denial, it goes to CMS's Independent Review Entity automatically.
- Underpaid (wrong rate, transposed code, fee schedule misapplied)? Ask the plan to reopen the claim. A reopening is not an appeal.

**Before you use this**

This is general information, not legal advice. CMS rules change every year and each plan adds its own steps, so check the plan's provider manual and the sources on page 3 before you file. Rules were checked against CMS sources on October 1, 2026. Never email patient information to anyone without a Business Associate Agreement in place.

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15+ years on the health plan side of Medicare Advantage claims. If a denial doesn't fit this toolkit, I'm glad to talk it through, without patient details.

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# Before you write off an MA denial

Work top to bottom. Most denials are settled in A and B, before you ever write an appeal.

## A Sort it (5 minutes)

- [ ] Plan and product confirmed (HMO, PPO, D-SNP) from the member ID card or eligibility check.
- [ ] Contracted or not? (See page 1.) This sets your appeal path.
- [ ] Denial type: prior auth (before service), during a stay or course of treatment, $0 payment denial, or underpayment.
- [ ] Date on the denial notice or remittance written down, and your filing deadline on the calendar (page 3).
- [ ] Plan's stated reason and the remittance codes (CARC and RARC) copied exactly.

## B Fix it first if you can

- [ ] Member eligible on the date of service, with the right plan on file.
- [ ] Auth number on the claim matches the approval: codes, units, dates and rendering provider.
- [ ] Coding and modifier edits checked. A corrected claim is often faster than an appeal.
- [ ] Timely filing denial? Your clearinghouse acceptance reports (999 and 277CA) are your proof.
- [ ] Duplicate or other-insurance (COB) denial? Confirm the facts before appealing.
- [ ] Underpaid or a clerical error? Request a reopening, not an appeal (page 3). Note the call reference number.

## C Build the packet

- [ ] Denial notice or remittance, and a copy of the claim.
- [ ] Prior auth approval letter, if there was one.
- [ ] Medical records that answer the plan's stated reason, not the whole chart.
- [ ] The coverage rule you rely on: the NCD or LCD, or your contract section and fee schedule.
- [ ] Non-contracted: signed Waiver of Liability (use the plan's form if it has one).
- [ ] Cover letter (template on page 4): one claim per letter, under two pages.

## D Send and track

- [ ] Sent the way the plan's manual says (portal, fax or mail), with proof of delivery saved.
- [ ] Date sent and the plan's decision deadline logged in your denial tracker.
- [ ] Follow up if the deadline passes with no answer. Note who you spoke with.
- [ ] Plan upheld it? Non-contracted cases go to the IRE automatically. Watch for that letter.
- [ ] Write down why it was denied and what fixed it. Repeat denials point to a front-end fix.

# Deadline cheat sheet

Medicare Advantage time limits under current CMS rules. Plans add their own steps, so check the plan's provider manual too.

| SITUATION | DEADLINE OR TIME LIMIT | SOURCE |
|---|---|---|
| **Prior authorization, standard** | Plan must decide within 7 calendar days (since Jan 1, 2026) | 1 |
| **Prior authorization, expedited** | Plan must decide within 72 hours | 1 |
| **Request reconsideration (appeal) of a denial** | File within 65 calendar days of the date on the denial notice* | 2 |
| **Plan decision: standard, before service** | 30 calendar days | 2 |
| **Plan decision: payment, after service** | 60 calendar days | 2 |
| **Plan decision: expedited / Part B drug** | 72 hours / 7 calendar days | 2 |
| **Plan upholds the denial** | Sent automatically to the Independent Review Entity, C2C Innovative Solutions since May 1, 2026. You don't file. | 2, 3 |
| **Hearing with a judge (ALJ), after the IRE** | Request within 60 days of receiving the IRE decision. At least $200 in dispute (2026). | 4 |
| **Underpayment or clerical error, non-contracted** | Request a reopening within 1 year of the payment decision (4 years with good cause). Not an appeal: a refusal to reopen can't be appealed. | 7 |
| **Denial or underpayment, contracted** | Plan's provider dispute process, per your contract and the provider manual. | Contract |

*CMS raised this limit to 65 days. Some plan manuals still say 60; the CMS rule applies. Late? Ask for a good-cause extension in writing and explain why.

## Rules worth quoting in an appeal

MA plans must follow Traditional Medicare coverage rules, including NCDs and LCDs. [5]

A new enrollee mid-treatment gets a 90-day transition with no new prior auth. [5]

An approved inpatient admission can be reopened only for obvious error or fraud (2026). [6]

A prior auth approved for a course of treatment stays valid as long as medically necessary. [5]

A denied prior auth must give a specific reason (2026). [1]

Decisions made during a stay or course of treatment are appealable determinations (2026). [6]

**Sources (checked October 1, 2026)**
[1] CMS fact sheet: Interoperability and Prior Authorization Final Rule (CMS-0057-F)
[2] CMS: Reconsideration by the Medicare Advantage (Part C) Health Plan
[3] AHA News, Apr 1, 2026: CMS awards new contract for MA independent reviews
[4] CMS: Hearing by an Administrative Law Judge (Part C)
[5] CMS fact sheet: 2024 MA and Part D Final Rule (CMS-4201-F)

# Appeal letter template

Copy this onto your letterhead and replace everything in [brackets]. Keep it to one claim and under two pages.

[Practice name, address, phone, NPI and Tax ID]
[Date]

[Plan name]
Attn: Provider Appeals / Reconsiderations
[Appeals address or fax from the denial notice or provider manual]

**Re: Request for reconsideration of claim denial**

Member name: [name]
Member ID: [ID]
Claim number: [number]
Date(s) of service: [dates]
Service and codes: [CPT/HCPCS]
Amount billed: [$]
Denial date: [date on notice]
Denial reason/codes: [CARC/RARC]

We request reconsideration of the denial of the claim above. [Practice name] is a [contracted / non-contracted] provider with [Plan name].

The plan denied this claim because "[quote the plan's stated reason exactly]." The denial should be reversed for these reasons:

1. [The fact that answers the reason. Example: Prior authorization #____ was approved on ____ for these codes and dates. Copy enclosed.]
2. [The coverage rule. Example: The service meets the criteria in LCD/NCD ____ (title), which Medicare Advantage plans must follow.]
3. [The documentation. Example: The visit note dated ____ shows ____, which meets criterion ____.]

Please reverse the denial and pay the claim[, in the amount of $____ under our contract / at the Original Medicare rate]. Enclosed: [list each document].

**Non-contracted providers only.** Waiver of Liability: [Practice name] waives any right to collect payment from the enrollee for this service, regardless of the outcome of this appeal. [Use the plan's Waiver of Liability form instead if it has one.]

Please contact [name] at [phone and email] with any questions.

Sincerely,
[Signature]
[Name and title]

**Answer their reason.** Quote the plan's stated reason and rebut that, point by point.

**Send only what matters.** Records that prove the point beat a full chart.

**Keep proof.** Save the fax confirmation or portal receipt, and log the decision deadline.