UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients

By Bob Herman and Casey Ross STAT News December 28, 2023

Health insurance giant UnitedHealth Group used secret rules to restrict access to rehabilitation care requested by specific groups of seriously ill patients, including those who lived in nursing homes or suffered from cognitive impairment, according to internal documents obtained by STAT.

The documents, which outline parameters for the clinicians who initially review referrals for rehab care, reveal that many patients enrolled in Medicare Advantage plans were routed for a quick denial based on criteria neither they, nor their doctors, were aware of.

UnitedHealth kept the restrictions in place until early November, when managers abruptly told frontline clinical reviewers to stop following them and apply more of their own discretion, according to a current employee and internal documents. The directive to toss out the rules coincided with increased scrutiny of Medicare Advantage insurers from federal lawmakers and the Centers for Medicare and Medicaid Services, which will begin auditing their denials of medical services early next year. That scrutiny came after a series of STAT stories exposed UnitedHealth's practices of pressuring employees to follow an algorithm to cut off care for sick and elderly people already in rehab.

The company's reversal also marked a sudden — and sweeping — change for clinicians who had become accustomed to enforcing rigid restrictions on patients who requested skilled nursing care following hospitalizations for serious illnesses and injuries. The restrictions were applied by clinicians working for a UnitedHealth subsidiary called NaviHealth, which not only manages rehab care within UnitedHealth's Medicare Advantage plans, but also within Medicare Advantage plans run by Humana and many regional insurers, encompassing more than 15 million patients.

"All of us were like, 'What's happening?'" the current NaviHealth employee said of the decision to lift the restrictions. "You tied our hands so tight, and then all of sudden, you're just giving us freedom to approve stuff?"

Some of the restrictions appear to have had little or no basis in clinical evidence. As a result, the process of applying their own standards and denying care could run afoul of longstanding federal rules that require Medicare Advantage plans to cover the same services as traditional Medicare, lawyers said.

The documents show, for example, that frontline clinician reviewers were blocked from approving rehab care for most patients who lived permanently in nursing homes. Unlike other patients, their requests had to be sent straight to NaviHealth's physician medical reviewers, who almost always denied them, according to experiences described by a current employee and a former NaviHealth staffer familiar with the physician review process.

"We all had a big issue with that because … just because you live in a nursing home doesn't mean you should be denied skilled care," said the current NaviHealth employee, who asked not to be named because of concerns about professional and legal consequences of speaking publicly about confidential matters. "That happened all the time. That's just wrong."

In response to questions from STAT, a NaviHealth spokesperson rejected the employee's characterization that the cases referred to the company's medical reviewers were almost always denied. The company said the cases outlined in the documents obtained by STAT were referred to the physician medical reviewers because they were deemed to involve a greater degree of complexity, such that a physician's expertise was required to make coverage decisions. However, NaviHealth said it does not know the rates of its denials.

NaviHealth confirmed that it pulled back the restrictions. The company said the decision was not related to greater federal scrutiny of denials, but was driven by an internal review that found more of the cases could be handled by the frontline clinical reviewers, who are mostly nurses and therapists.

"Following a standard review of protocols, we identified an opportunity to simplify care approvals in certain clinically complex conditions that do not require escalated review by a physician medical director for approval," the company said in a statement. "Any adverse coverage decision is made by physician medical directors based on Medicare coverage criteria and supporting clinical records."

STAT previously reported that NaviHealth has used a computer algorithm and its own internal coverage rules to limit how long patients recovering from strokes, cancer, and serious injuries can stay in rehab facilities. The prior stories focused on decisions to cut off payment for care based on algorithmic predictions about how long patients were expected to stay in facilities, after they were already there. Soon after they were published, Medicare beneficiaries filed class action lawsuits alleging UnitedHealth, NaviHealth and Humana illegally denied their care.

The newly obtained documents expose a more direct and deliberate strategy to restrict access to rehab care even before patients began receiving it. Inside NaviHealth, patients who fell into certain categories were singled out for more scrutiny, even though in the eyes of their own doctors they were not clinically different from so many other patients with lingering infections, open wounds, and broken bones.

The documents outline rules for frontline NaviHealth clinicians who run a process known as "prior authorization," which is when doctors request advance approval for coverage of medical services. By first restricting access to rehab care and then limiting how much care patients ultimately receive, the company has increased profits by hundreds of millions of dollars a year in Medicare Advantage, one of its most lucrative lines of business.

One current and one former NaviHealth employee told STAT the algorithm used to predict the length of their stays was also used to screen their prior authorization requests for skilled nursing care. That practice was halted in the summer, the current clinical employee said. Around that same time, a U.S. Senate subcommittee began investigating care denials by Medicare Advantage insurers, with a particular focus on prior authorization denials, following an initial report by STAT.

NaviHealth demurred when asked about the use of the algorithm in prior authorization, saying only that it does not use the tool to make coverage decisions.

But the broader restrictions — those focused on patients who lived in nursing homes or had cognitive impairment — remained in place for several more months, the internal documents reveal. One document shows that it was not until Nov. 8 that clinical employees who review prior authorization requests were told they no longer had to

operate within "very strict parameters," and now had more discretion to determine how to handle requests for care.

Denials of rehab services often upend the lives of extremely sick patients who are forced to either forgo treatment or pay thousands of dollars out-of-pocket to continue their recoveries. If they disagree with an insurer's denial, they can file an appeal, but that process often takes many months to play out and is used by only a fraction of patients denied care, according to federal records.

In many cases, insurers cite vague reasons for the denials, asserting simply that patients do not meet Medicare's criteria to stay in certain facilities or could be treated at a "lower level of care." The patients are not told exactly why they do not meet the criteria, nor are they aware that insurers are applying their own standards behind the scenes of their care.

This was the system that confronted the family of Susan Hagood in late 2022. The 80-year-old Hagood was hospitalized in North Carolina with a long list of medical problems, including acute kidney failure, kidney stones, a urinary tract infection, and inflammation that resulted in painful swelling against her spine. At the end of her hospital stay, doctors recommended that Hagood, then 80, be transferred to a long-term acute care hospital to continue her recovery.

But her Humana Medicare Advantage plan denied the request, agreeing to pay for cheaper care in a nursing home. "She should have been in the [long-term care hospital] — and her doctors said that from the get-go," Susan Hagood's son, Chris, told STAT. It is unclear whether restrictions applied by NaviHealth's frontline reviewers affected that decision. But after his mother arrived at the nursing facility, her condition deteriorated swiftly, resulting in sepsis, a life-threatening complication of infection, and other problems.

Chris Hagood said Humana denied payment for her continued care in the skilled nursing facility after two weeks, forcing her family to pay out-of-pocket because she was still incapacitated. The family appealed that decision, but was denied by an administrative law judge. Susan Hagood remains in a nursing home and is still struggling to recover — and her family is now pursuing its claims through the class action suit filed against Humana.

In response to that lawsuit, Humana issued a statement saying the company uses "various tools, including augmented intelligence, to expedite and approve utilization management requests and ensure that patients receive high-quality, safe and efficient care." The statement added that Humana's denials "are only made by physician medical directors," and "coverage decisions are made based on the health care needs of patients, medical

judgment from doctors and clinicians, and guidelines put in place by CMS." Humana declined to comment for this story.

But the restrictions given to clinical case managers at NaviHealth create distinctions between patients and clinical situations not found in Medicare's coverage regulations, lawyers said.

The rules, spelled out in internal NaviHealth documents, list what types of prior authorization requests the company's clinical workers were required to route straight to physicians for extra review — the final step before any denial, under Medicare law. For example, requests for people who had dementia or other cognitive impairments that affected "participation or benefit from daily skilled therapy" were automatically sent to physician review. If someone requested a transfer from a long-term care hospital to a skilled nursing facility, that case had to go straight to a physician to make the final call. People who had wounds and asked for skilled nursing care likewise were routed directly to NaviHealth's physicians for medical review. Even in cases where patients had wounds that exposed their bone, the clinical workers had to send those cases to the physicians, where they were frequently denied, the current NaviHealth employee said.

"Our doctor is going to argue that you were managing this before, and you can still manage it, and it doesn't take a nurse to do it," the employee said. "You've got these big, gruesome wounds, and they're not going to [approve] it."

The restrictions against approving skilled rehab care for nursing home residents seemed especially unfair, the current and former NaviHealth employees said. If someone who lived permanently in a nursing home broke her hip, went to the hospital, and then requested daily physical and occupational therapy to rehab, that case had to be directed to a physician reviewer, and, in their cases, usually were denied, they said. If that person had lived in an apartment or house, they likely would have received care, at least until the company's algorithm told them their time was up.

NaviHealth eventually added some exceptions for long-term care patients — for example, if the patients had a new feeding tube, a new breathing tube, or were on IV antibiotics — but those were only a small minority of cases, the NaviHealth sources said.

A lawyer who frequently contests care denials on behalf of providers and patients of inpatient rehabilitation hospital care said the restrictions and internal criteria described in the documents obtained by STAT appear to conflict with Medicare rules that bar insurers from using their own rules to make coverage decisions.

"They're completely inconsistent with the coverage policies that Medicare has established under the fee-for-service program, which require individual determinations of medical necessity and no use of 'rules of thumb,'" said Peter W. Thomas, managing partner of Powers Pyles Sutter and Verville, a law firm based in Washington D.C. "The [Medicare Advantage] plans are supposed to use the same criteria. That's really pretty egregious."

The NaviHealth spokesperson who responded to STAT's questions denied that the restrictions focused on long-term care residents were designed to systematically block their access to rehab care. The spokesperson said those cases were sent to the company's physician reviewers because they often present complicated medical issues, and deciding whether those patients meet Medicare criteria for skilled nursing care is best left up to a physician.

But NaviHealth's spokesperson added that, under the recent changes, frontline reviewers are now allowed to approve those residents if they meet Medicare criteria as determined by an algorithmic tool known as Interqual, which was developed by Change Healthcare, a company acquired by UnitedHealth in 2022.

The current and former employees also did not know the specific denial rates of the cases they were required to send to physician medical reviewers. But they said a denial was by far the most common result in their experience.

The current employee said these types of cases would get denied "all the time," a characterization that was corroborated by a former NaviHealth employee who was directly involved in the review process. The current employee was then responsible for calling the denials into rehab facilities, triggering an often contentious conversation that resulted in angry complaints about NaviHealth and UnitedHealth. "It's what they're making us do," the employee recalled telling the rehab facilities.

In some instances, the patients hit with the denials would return home, only to end up injuring themselves and coming back to the hospital. "We knew they weren't safe to go back home, and they'd fall again and break something," the current employee said. "They were back in the ER in less than a week."

A rehabilitative care doctor in California said his interactions with NaviHealth's physician reviewers over prior authorization requests followed a particular pattern. "Their

physicians don't typically have much information in front of them," said the rehab doctor, Karl Sandin. "There's substantial evidence in my experience that they've never really heard much about [the] patient."

Nevertheless, Sandin said, NaviHealth physicians often take an adversarial approach to their conversations. "They are just a way to put the 'no' stamp on the [patients]," he said, adding that the company is the most difficult of the managed care entities he deals with in California. "Their only button is adversarial."

Sandin said, however, that he often persuaded NaviHealth's physicians to approve requests for inpatient rehabilitation care for his patients, an outcome he attributes to being a small practitioner who has been fighting prior authorization denials for many years.

NaviHealth said the company's physicians review the merits of each individual case and make decisions based on Medicare's criteria.

NaviHealth lifted its prior authorization restrictions in November, right before federal auditors were gearing up to crack down on insurers' use of their own coverage rules and proprietary algorithms in coverage decisions. New regulations that will go into effect in January explicitly require Medicare Advantage insurers to "ensure that they are making medical necessity determinations based on the circumstances of the specific individual … as opposed to using an algorithm or software that doesn't account for an individual's circumstances." Insurers also cannot deny care based on their own criteria, unless Medicare coverage rules are not "fully established" and the insurer's criteria are rooted in medical evidence.

STAT previously reported that the Centers for Medicare and Medicaid Services, which oversees Medicare Advantage plans, would start holding "strategic conversations" with insurers in November to explain how they can comply with Medicare's coverage requirements — including the use of prior authorization and denials. The agency also told STAT it was specifically looking into the practices used by UnitedHealth and NaviHealth and "may take necessary enforcement or compliance actions."

Formal audits that look at these types of medical review and denial practices — called "utilization management" audits — will begin in January. A new memo from CMS, sent on Dec. 19, details that the audits will be far-reaching. The agency expects to audit the coverage practices of companies that cover 88% of Medicare Advantage enrollment.

"This expansion of our audit activity will help make sure that MA beneficiaries get the care they need without excessive burden or delays and have access to the benefits and services to which they are entitled," John Scott, the head of Medicare's auditing and oversight division, wrote in the memo to insurers.

It's still unclear what the penalties could be for Medicare Advantage plans that fail their audits.

Meanwhile, the current NaviHealth employee said the company is still keeping a close watch on how they are handling prior authorization requests, especially for residents of long-term care. The employee said managers asked frontline clinical reviewers to log approvals of care for such patients in an Excel spreadsheet.

"I'm not doing it," the employee said. "You can't give me the open door, and turn around and want to watch everything. I mean, that's ridiculous. We should be following the same guidelines as CMS sets no matter where this person lives."

The NaviHealth spokesperson said she was unaware of a directive to log the approvals in Excel.

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