DOJ Investigates Medicare Billing Practices at UnitedHealth

Civil probe of diagnoses that triggered extra payments to the company's Medicare Advantage plans adds to scrutiny of the healthcare giant

The Justice Department's look into UnitedHealth's billing practices is separate from a longer-running antitrust probe. PHOTO: MAANSI SRIVASTAVA FOR WSJ

By Christopher Weaver and Anna Wilde Mathews

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The Justice Department has launched an investigation into UnitedHealth Group'sMedicare billing practices in recent months, people familiar with the matter say.

The new civil fraud investigation is examining the company's practices for recording diagnoses that trigger extra payments to its Medicare Advantage plans, including at physician groups the insurance giant owns.

A series of articles in The Wall Street Journal last year showed that Medicare paid UnitedHealth billions of dollars for questionable diagnoses. Attorneys with the Justice Department as recently as Jan. 31 interviewed medical providers named in the articles.

In the Medicare Advantage system, insurers get lump-sum payments from the federal government to oversee enrollees' Medicare benefits. When patients have certain diagnoses, the payments go up, creating an incentive to diagnose more diseases.

The Medicare billing investigation adds to the scrutiny on UnitedHealth, the $400 billion company that owns the largest U.S. health insurer and a sprawling network of other health-industry assets including its doctor practices, a large pharmacy-benefit manager and data and technology operations.

The civil investigation, some of the people said, is separate from a longer-running Justice Department antitrust probe that the Journal reported last February. The DOJ also has sued to block UnitedHealth's $3.3 billion planned acquisition of home-health company Amedisys on antitrust grounds.

The probe of UnitedHealth's Medicare billing comes on top of a DOJ effort to block its planned $3.3 billion acquisition of a home-health company. PHOTO: PATRICK SISON/ASSOCIATED PRESS

A spokesman for the Justice Department declined to comment. A spokeswoman for the Department of Health and Human Services' Office of Inspector General, which is also involved in the civil fraud probe, declined to comment.

UnitedHealth declined to comment. UnitedHealth previously has said its practices lead to more accurate diagnoses, that it performs well in Medicare audits and that its approach benefits patients.

In December, the Journal reported that its analysis of billions of Medicare records showed that patients examined by UnitedHealth-employed doctors had huge increases in lucrative diagnoses after joining the company's Medicare Advantage plans.

Doctors said UnitedHealth, based in the Minneapolis area, trained them to document revenue-generating diagnoses, including some they felt were obscure or irrelevant. The company also used software to suggest conditions and paid bonuses for considering the suggestions, among other tactics, according to the doctors.

Last summer, the Journal also reported that UnitedHealth added diagnoses to patients' records for conditions that no doctor treated, which triggered an extra $8.7 billion in federal payments in 2021. The untreated diagnoses stemmed from sources including in-home visits by nurses working for the company's HouseCalls unit. Each visit by the UnitedHealth-employed nurses was worth an average of $2,735 in additional federal payments, a Journal analysis of Medicare data spanning 2019 to 2021 found.

Last month, Justice Department lawyers from the offices of the U.S. Attorney for Minnesota and the Washington, D.C.-based Civil Division contacted at least three doctors and a nurse practitioner who were named in the Journal's story on UnitedHealth-owned clinics. One of the people was told the health department's Office of Inspector General was involved as well.

Three said they were questioned about specific diagnoses UnitedHealth promoted for employees to use with patients, incentive arrangements and pressure to add the diagnoses. At least two provided documents, including a contract with a UnitedHealth unit, to the Justice Department.

Valerie O'Meara, a nurse practitioner who worked for UnitedHealth in Washington state, said she was interviewed on Jan. 31 by Justice Department attorneys who were interested in the company software that suggested diagnoses and the role of a UnitedHealth manager who she said urged her to make new diagnoses beyond what doctors had treated.

The attorneys zeroed in on certain diagnoses the company often suggested, such as an obscure hormonal condition called secondary hyperaldosteronism, she said. The Journal's analysis found the condition was rarely diagnosed by Medicare doctors not working for UnitedHealth.

O'Meara said the attorneys focused on her account of how she was told she could add the hyperaldosteronism diagnosis to patients' records without a lab test.

More broadly, she said, "they were looking at, 'Is this abuse?' "

UnitedHealth has said its practices help detect diseases earlier, saving money for the health system. The company says Medicare Advantage plans generate better health outcomes and reduce costs.

In a press release published on its website on Dec. 30, UnitedHealth said the Journal's articles "rely on often incomplete and inaccurate data to conduct flawed studies through a murky government 'agreement'."

The Journal's analyses used data UnitedHealth and other Medicare Advantage insurers themselves submitted to the federal government for payment purposes. Reporters accessed the data under a standard research agreement with the agency overseeing Medicare.

UnitedHealth has faced investigations of its diagnosis-documenting practices before, and its Medicare payments have been examined in health department inspector general reports. The Justice Department took over an earlier lawsuit by a former UnitedHealth employee alleging the company failed to retract inaccurate diagnoses added to patients' records.

UnitedHealth has disputed the allegations against it in that continuing case