
— COVERAGE AND MANAGED CARE LITIGATION

When an Algorithm Says No

Coverage Denials and the Patient the Prediction Missed

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

Most of what we write about is care that was given and fell short. Coverage cases are about care that was asked for and refused, or that stopped before the patient was ready. The harm is just as real. A woman goes home from rehab before she can walk safely. A procedure waits weeks while an appeal crawls along. A stay ends on a date a computer picked.

That last one is now the subject of serious litigation. In *Estate of Lokken v. UnitedHealth Group*, filed in federal court in Minnesota in November 2023, the plaintiffs allege that a predictive tool estimated how long Medicare Advantage members would need post-acute care and that coverage was cut off to match the estimate rather than the patient. On February 13, 2025, the court threw out several claims but let the breach of contract and breach of the implied covenant of good faith claims go forward. It's in discovery now, with plaintiffs' expert disclosures due in October 2026. Similar suits have been brought against Humana and, over an automated claims review process, against Cigna. The insurers deny the allegations, and none have been proven.

Government reviewers have raised related concerns. In 2022, the HHS Office of Inspector General found that 13 percent of the Medicare Advantage prior authorization denials it sampled met Medicare's coverage rules and would probably have been approved under traditional Medicare. In October 2024, a Senate investigations subcommittee reported steep increases in post-acute prior authorization denials at several of the largest MA insurers.

The legal side of these cases is complicated, with preemption, exhaustion of appeals, and in commercial plans ERISA, and that's for counsel. The clinical side comes down to one question: did the decision fit the person it was about?

THE RULES THAT APPLY

Medicare Advantage has to follow Medicare's coverage rules. CMS's 2023 rule (CMS-4201-F), in force since 2024, requires MA plans to use traditional Medicare's coverage criteria, including national and local coverage determinations, and to decide medical necessity based on the individual patient (42 C.F.R. § 422.101(b)(6)). A medical necessity denial has to be reviewed by a physician or other professional with the right expertise (42 C.F.R. § 422.566(d)).

Algorithms can assist but can't decide. In a February 2024 FAQ, CMS said plans may use algorithms and software to help with coverage decisions, but the decision has to rest on the individual's circumstances, meaning history, physician recommendations, and clinical notes, and not just a prediction drawn from a big data set. CMS spoke directly to post-acute care: a length-of-stay prediction on its own isn't a basis for ending services.

Faster answers, with reasons. Starting January 1, 2026, under CMS's interoperability and prior authorization rule (CMS-0057-F), MA plans and certain other payers have to decide prior authorization requests within 72 hours for expedited requests and 7 calendar days for standard ones, and give a specific reason for any denial.

Traditional Medicare now has prior authorization too, in six states. CMS's WISeR model started January 1, 2026, in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington. It adds prior authorization for 17 services CMS considers prone to overuse, including certain spine procedures, nerve stimulators, epidural steroid injections, knee arthroscopy for osteoarthritis, and skin substitutes. Technology vendors help with review, and CMS says licensed clinicians make the final denials. It runs through 2031.

Some states have gone further. California's SB 1120 (2024), for example, requires that medical necessity decisions in utilization review be made by a licensed physician or qualified health professional, not an algorithm alone.

Improvement isn't the test. Since the 2013 *Jimmo v. Sebelius* settlement, CMS has acknowledged that skilled nursing and therapy coverage doesn't depend on whether the patient is improving. It depends on whether skilled care is needed, and that includes skilled care to maintain function or slow decline. If a denial says "plateaued" or "no further progress," look hard at it.

A FICTIONAL CASE

She's 81. She breaks her hip, has surgery, and goes to a skilled nursing facility for rehab. She also has heart failure and some memory problems. On day 14, her MA plan sends notice that coverage ends in two days. Her therapists write that she's improving but still needs a lot of help to walk and can't manage stairs. Her family appeals. The appeal isn't decided in time. She goes home, falls within a week, and comes back with a head injury.

DID HER CHART SUPPORT MORE SKILLED CARE?

That's the whole case, clinically. Read the SNF record with that question in mind. What were her therapy goals, and how far off was she? What did PT and OT measure: how far she could walk, how much help she needed to stand, whether she could do stairs? What were the nurses seeing with her heart failure, her weights, her swelling, her breathing, her medications, her thinking? Did any clinician write that she was ready to go home? Or did every note say she wasn't?

PUT THE PREDICTION NEXT TO THE PATIENT

If a tool projected a 14-day stay for patients with her diagnosis, the real question is what made her different. Heart failure, memory problems, a house with a flight of stairs, a slower-than-average recovery: any of those could explain why she didn't fit the average. Then ask whether anyone at the plan actually looked at her as an individual, and whether the reviewer had and used her records.

The documents that matter: the denial notice and its stated reason, the plan's internal review notes, who the reviewer was and what their specialty is, the records the facility sent, and, if the court allows it in discovery, what the tool produced and how the plan used it.

REBUILD THE APPEAL

For SNF, home health, and outpatient rehab, MA members generally get a Notice of Medicare Non-Coverage at least two days before services end, and they can ask an independent Quality Improvement Organization for a fast appeal. Lay it out day by day: when the plan decided and what it knew at that moment, when and how the notice was delivered, when the family appealed and what they sent, and when and how the appeal was decided.

If she eventually won on appeal, that's meaningful evidence the first decision didn't match her condition. And a denial that was reasonable on what the plan knew but turned out to be too early is a different finding from one that was never supported. Keep those apart.

DID THE DENIAL CAUSE THE HARM?

Same discipline as any case. What was her condition the day she left? What was the discharge plan? Who was home to help? How exactly did she fall: was she using her walker, was anyone there, had a new medication been started, was she getting sick?

And remember the facility has its own obligations. A SNF has to discharge safely no matter who's paying, with proper notice and a real plan. The facility's assessments and discharge planning are part of the record, and sometimes part of the claim.

BEYOND MEDICARE ADVANTAGE

Commercial prior authorization for surgery, imaging, specialty drugs, and behavioral health raises the same clinical question. The legal remedies differ, sharply so in ERISA plans.

FOR PROVIDERS

Documentation drives coverage. “Patient progressing well” is true and useless. Compare it to this: “Needs moderate assist of one for sit-to-stand. Walks 40 feet with rolling walker and contact guard. Unable to do stairs; home has 12 entry steps.” That tells the plan, and anyone reviewing the file later, exactly why she still needs skilled care.

RECORDS WORTH REQUESTING

- The full SNF record: MDS assessments, therapy evaluations and daily notes, nursing notes
- The hospital discharge summary and therapy recommendations
- Coverage notices, the NOMNC, and the plan’s detailed explanation of non-coverage
- The plan’s internal review notes, the reviewer’s credentials, and the criteria used
- Appeal requests, what was submitted, and every appeal decision
- Home health, ER, and hospital records after discharge
- If the court allows it: predictive tool outputs and the policies governing their use

SOURCES

- *Estate of Lokken v. UnitedHealth Group, Inc.*, No. 0:23-cv-03514 (D. Minn.), Memorandum Opinion and Order (Feb. 13, 2025); Georgetown Health Care Litigation Tracker
- CMS-4201-F, 88 Fed. Reg. 22120 (Apr. 12, 2023); 42 C.F.R. §§ 422.101(b)(6), 422.566(d); CMS FAQs on CMS-4201-F coverage criteria and utilization management (Feb. 6, 2024)
- CMS-0057-F, Interoperability and Prior Authorization Final Rule (Jan. 2024)
- CMS Innovation Center, WISeR Model
- HHS-OIG, OEI-09-18-00260 (Apr. 2022)
- U.S. Senate Permanent Subcommittee on Investigations, *Refusal of Recovery* (Oct. 2024)
- *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt.) (settlement approved 2013)
- Cal. SB 1120 (2024)

This newsletter is for education only and isn’t medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a coverage denial case and want the patient's documented needs compared, line by line, with the reason she was given and the Medicare criteria that apply, we'd welcome the conversation.

Michelle Carroll

FOUNDER & CEO, LEXCURA SUMMIT

