MINORITY STAFF BRIEFING

Senate Permanent Subcommittee on Investigations

RE: Medicare Advantage Fraud Evidence — Prior Knowledge Omission Mechanism — S.3829 Supporting Documentation

Submitted by: Michael Joseph Kissling, Medicare Advantage Beneficiary & Healthcare Advocate | March 2026

UHC PRIOR AUTH OVERTURN RATE (KFF 2023) **85.2%**	**INDUSTRY AVERAGE OVERTURN RATE** **81.7%**
TRADITIONAL MEDICARE OVERTURN RATE **~29%**	**TAXPAYER COST — THIS CASE ALONE** **$1.1M+**

> ***This is not a dispute over medical judgment. It is a documented mechanism of deceptive business practice — executed with paper trail proof of intent.***

I. EXECUTIVE SUMMARY

This briefing presents documented evidence of a systematic, nationwide fraud scheme executed by UnitedHealthcare (UHC) against Medicare Advantage beneficiaries. The mechanism — termed Prior Knowledge Omission — operates through the willful suppression of established medical facts to execute wrongful denials.

The evidence in this submission is not circumstantial. It is a timestamped, physician-corroborated, IRE-validated paper trail demonstrating that UHC:

- Officially acknowledged a beneficiary's K3 functional mobility status in March 2023
- Denied a permanent prosthetic six months later — while possessing that same prior knowledge
- Was immediately overturned by the Independent Review Entity (Maximus Federal Services)
- Had no medical or regulatory basis for the denial — only financial motivation

The human cost of this single case: preventable falls, loss of the capacity to protect an autistic daughter, and an emergency amputation generating over $1.1 million in taxpayer-funded medical costs that began with a denied $55,000 preventative surgery.

The legislative remedy — the Clinical Integrity & Patient Safety Amendment to S.3829 — is enclosed and ready for staff review.

II. THE FRAUD MECHANISM: PRIOR KNOWLEDGE OMISSION

UHC medical directors deny legitimate, life-saving claims by deliberately ignoring qualifying medical information already in their possession. This is not administrative error. It is documented, repeatable policy.

How It Works

- The insurer acknowledges a patient's qualifying status through an approval decision
- The insurer then denies a directly related claim while possessing that prior knowledge
- The reviewing physician excludes objective clinical data on procedural pretexts
- The patient is forced through an appeals process that functions as a delay weapon
- The insurer offloads the financial cost of the resulting harm onto taxpayers

The Wrongful Denial Echo Chamber

The fraud is enforced through what this submission terms the Wrongful Denial Echo Chamber: a system in which corporate reviewers manufacture administrative pretexts to exclude objective clinical evidence, stripping physicians of the ability to make medical decisions. The chamber operates because:

- Reviewing physicians face no personal accountability for wrongful denials
- The appeals process requires patients to survive the delay while their condition deteriorates
- IRE overturn rates above 80% are treated as normal claims administration rather than prosecutable fraud

III. THE DOCUMENTED CASE: KISSLING v. UNITEDHEALTHCARE

The Paper Trail

Mar 16, 2023	UHC approves learner prosthetic — officially acknowledging K3 functional mobility status (AMPnoPRO score: 35). This classification is MANDATORY KNOWLEDGE in UHC's possession.
Mar 22, 2023	Six days after K3 establishment: UHC changes beneficiary's plan, making all existing physicians and physical therapists out-of-network. Care continuity disrupted.
Sep 13, 2023	UHC denies transition to permanent tertiary prosthetic — claiming beneficiary does not demonstrate sufficient functional ability. Denial issued while UHC possesses K3 approval AND updated K4 PT evaluation (AMPnoPRO: 44/47).
Sep 19, 2023	Updated PT evaluation confirms advancement to K4 status (AMPnoPRO: 44/47). UHC reviewer explicitly refuses to acknowledge this data because it was not written in his specific office note.
Sep 27, 2023	UHC denial letter states: "Medicare Guidance says that the requested computerized knee advanced feet exceed your needs" — a statement made with documented prior knowledge that patient was K3-K4.
Oct 2, 2023	Maximus Federal Services (IRE) immediately overturns UHC denial. Finding: medically necessary. This overturn is equivalent to summary judgment — UHC's position was indefensible.
2024	Medicare lowers microprocessor knee standard from K3 to K2 — meaning patient would have qualified under even the future relaxed standard. UHC's denial had no medical or regulatory basis at any point in time.

The Smoking Gun: Dr. Stockhausen's Documentation

The attending physician, Dr. Sean T. Stockhausen, documented in writing that the UHC peer-to-peer reviewer:

- Confirmed he remembered arguing that the patient was K4
- Stated the reviewer's counterpoints included: (1) mention of a wheelchair in his note, and (2) that he could not use objective PT data — including walking speed and AMPPRO score — unless it was written directly in his office note
- Subsequently amended his office note specifically to include the AMPPRO score

> *This is the echo chamber mechanism documented by the treating physician himself: objective clinical data — standardized, Medicare-approved assessment scores — excluded on a procedural pretext manufactured by the corporate reviewer.*

Regulatory Violations

Medicare LCD L33787 and Policy Article A52496 establish that only ONE of three qualifying conditions is required for prosthetic replacement. This patient met ALL THREE:

- Change in physiological condition: weight loss from 265 lbs to 210 lbs; residual limb circumference decreased from 72cm to 55-60cm
- Irreparable wear: knee mechanism began unlocking randomly, causing documented falls (7/19/2023); had already been warranty-replaced once because patient's capabilities exceeded the device's mechanical limits
- Medical necessity: the transition from learner to tertiary prosthetic is the standard, prescribed progression path

Furthermore, Medicare Policy Article A52496 (page 6) explicitly states: once initial medical need is established, ongoing need for a lower limb prosthesis is assumed to be met. UHC denied this claim in direct violation of the policy under which it operates.

The Cascading Taxpayer Cost

The Wrongful Denial Echo Chamber does not save money. It shifts costs from the insurer onto the public:

- A denied $55,000 iliac vein stenting surgery (85-90% five-year patency rate) triggered cascading wound care failures
- 17-month delay in FDA-standard Apligraf wound treatment (PMA P950032S016, established 2000) allowed infection to progress until bone pathology showed demineralization described as "cuttable with a scalpel"
- When Apligraf was finally approved, it closed the wounds in two weeks — vindicating the standard UHC suppressed for 17 months
- The denied permanent prosthetic resulted in statistically preventable falls and the loss of physical capacity to protect an autistic child from danger
- Total taxpayer-funded cost: $1.1 million and climbing — on a case that began with a $55,000 denial

IV. THE SYSTEMIC PATTERN — THIS CASE IS NOT AN ANOMALY

The KFF 2023 analysis of Medicare Advantage prior authorization data confirms this mechanism is not an isolated error. It is industry practice:

CURRENT SYSTEM	DENIAL ON TRIAL MODEL
Patient bears full burden of proving need	Insurer must prove denial is justified
Reviewer may exclude data outside their note	All submitted clinical data reviewed under penalty of perjury
IRE acts as judge and patient advocate simultaneously	Administrative Law Judge rules independently
No consequence for wrongful denial	Mandatory State Medical Board referral on IRE overturn
Prior Knowledge Omission goes unpunished	Suppression of known qualifying evidence = malpractice trigger

The statistical fingerprint of fraud: UHC overturns 85.2% of appealed prior authorization denials at independent review. The traditional Medicare overturn rate is approximately 29%. The gap between these numbers is not a medical disagreement rate. It is a fraud rate.

Five companies produce the gross disparity. The pattern is not random. It is structural.

V. THE LEGISLATIVE REMEDY: CLINICAL INTEGRITY & PATIENT SAFETY AMENDMENT

S.3829 (Corporate Crimes Against Healthcare Act) targets executives. The Clinical Integrity & Patient Safety Amendment targets the mechanism. Together, they close the Wrongful Denial Echo Chamber.

What the Amendment Provides

- §1 — Prohibition on Prior Knowledge Omission: Establishes K-level and functional classifications as Established Medical Facts for 12 months. Denials issued against an Established Medical Fact without new regression evidence are void ab initio.
- §2 — The Clinical Integrity Rule: Requires specialty-matching for all adverse benefit determinations. Like PA Act 146 that is also being ignored in denials. Reviewers must certify under penalty of perjury that they have reviewed all submitted clinical data.
- §3 — The Patient Safety Buffer Fund: Provisional coverage upon treating physician override. Capitalized by S.3829's clawback penalties — the insurer funds the safety net their denials require.
- §4 — Administrative Cure Mandate: 48-hour cure period before any administrative denial is finalized. Closes the paperwork-pretext loophole.
- §5 — Physician Accountability / Malpractice Trigger: IRE overturn based on Prior Knowledge Omission triggers mandatory State Medical Board referral. Reviewing physicians may not shield behind corporate employment. As their professional medical opinion is given automatic higher credit than anything the treating physician can do. While the patient suffers and waits or dies.

How This Completes S.3829

- S.3829 punishes the corporation. The Amendment strips the license from the physician who pulled the trigger.
- S.3829 generates penalty revenue. The Buffer Fund deploys it to protect the next patient in line.
- S.3829 calls for investigation. The mandatory board reporting pipeline makes every IRE overturn a self-executing referral.

> ***S.3829 is the sword. The Clinical Integrity Amendment is the shield. The Buffer Fund is the refuge. The Department of Recovery is the courthouse.***

VI. REQUEST FOR STAFF BRIEFING

This submission respectfully requests a staff briefing to present the complete evidence file, including:

- Timestamped UHC approval letter establishing prior knowledge (March 2023)
- UHC denial letter containing demonstrably false statements (September 2023)
- Dr. Stockhausen's written documentation of the peer-to-peer reviewer's explicit refusal to consider objective PT data
- Maximus Federal Services IRE overturn decision (October 2023)
- Medicare LCD L33787, Policy Article A52496, and the 2024 standard reduction from K3 to K2
- FDA PMA P950032S016 establishing Apligraf standard-of-care timeline
- Full medical record documenting cascading harm and taxpayer cost

This is not a constituent grievance. This is a documented fraud mechanism with a prosecutable paper trail and a ready legislative remedy. The evidence supports: investigation of UHC's systematic use of Prior Knowledge Omission across its Medicare Advantage population; enforcement action for violation of Medicare adverse action requirements; and the inclusion of the Clinical Integrity & Patient Safety Amendment in S.3829.

I am prepared to provide testimony, documentation, and expert medical opinion to support investigation and enforcement action.

Respectfully submitted,

Michael Joseph Kissling
Medicare Advantage Beneficiary & Healthcare Advocate
AbilityForge.net | 2855 E. Texas Blvd, Allentown, PA 18103
(610) 551-2460 | mkissling@abilityforge.net | mkissling65@gmail.com

ATTACHMENTS:

1. Clinical Integrity & Patient Safety Amendment (full text)
2. Denial on Trial: A Framework for Medical Due Process Reform
3. Michael Kissling v. UnitedHealthcare — Executive Summary (8.19.2025)
4. Wall Street Journal coverage & Status Coup interview (links on file)