

# CIGNA

## Member Appeals Policy and Processing Overview

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August 2011

### Introduction

CIGNA's goal with regard to appeals processing is to ensure consistent delivery of quality service and compliance with state and federal regulation, internal policy and accreditation standards for appeals through creation of a national appeals delivery infrastructure. This infrastructure supports CIGNA's overall strategy for standardization and quality service by driving:

- Process consistency across products
- Operational efficiency
- Single source/reliable reporting
- Results accountability
- Ongoing assessment of medical review
- Requirements and product offerings

### Call Member Services First

Customers are encouraged to contact Customer Service to resolve complaints about a previous adverse decision made by CIGNA. Most of the time, contact with Customer Service resolves the customer's issue. However, if the customer is not satisfied with the response or decision, the customers or their authorized representative (e.g., their treating provider) can begin the appeals process.

### Appeal Types

There are two types of appeals:

#### **Administrative Appeals**

An administrative appeal is a request to change a benefit denial where the initial decision was based on benefit exclusions or requirements of the customers benefit plan. Administrative appeals include, but are not limited to, benefit plan coverage interpretations, contract terms, limitations or exclusions, eligibility, and claim administrative policies.

#### **Medical Necessity Appeals**

A Medical Necessity appeal is a request to change a denial of a covered medical or dental benefit under the customer's benefit plan on the basis that the treatment or service is medically necessary. Or, that the service could be considered a covered benefit depending on the circumstances of the customer's medical condition (e.g., customer's benefit plan does not cover cosmetic procedures but based on the participant's medical condition, the appeal is requesting coverage of the procedure for medical necessity reasons). Medical necessity appeals include prior authorization/precertification denials, concurrent review for continuing inpatient or outpatient services, retrospective review for medical necessity, many formulary related denials, experimental & investigational treatments and cosmetic procedures.

#### **Expedited Medical Necessity Appeals**

If the appeal involves a denial of coverage for ongoing treatment previously approved, the customer is entitled to a simultaneous external review in advance of the reduction or termination in coverage.

### How to Appeal

Requests for appeals may be made verbally or in writing. If the customer requests an appeal after contacting Customer Service, the customer will be advised that they may submit the appeal on an Appeal

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Submission Form. The form will be requested and mailed to the customer. The customer or their authorized representative is instructed to complete the form and submit it to the address noted on the form. The customer is not required to complete the form, however. If the customer requests an appeal and does not choose to use the appeal form, their written appeal request should be sent to the address on the appeal submission form or in the SPD, the address shown on the EOB or the address included in the denial correspondence. The appeal form may be found on [www.CIGNA.com](http://www.CIGNA.com).

### Timely Filing of Appeals

Our standard National Appeal Policy for customers establishes a 365 day timely filing limit for Level 1 and Level 2 appeals. Clients may allow less than the 365 days, but no less than 180 days -- the ERISA minimum requirement for Level 1 appeals. Clients may allow more than our standard 365 days for filing appeals. Timely filing limits for other appeal levels can vary with ASO clients. ERISA does not mandate a minimum timely filing limit for other levels of appeal.

### Where to Send Appeals

Appeals should be sent to our National Appeals Organization (NAO). The appropriate address should be included in the SPD and is included on the Appeal Submission Form, and any denial correspondence. The address for our National Appeals Unit is shown below.

CIGNA National Appeals Organization P. O. Box 188011 Chattanooga, TN 37422
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### Appeals Policy

Our National Appeals Policy consists of a two-level internal appeals process for all adverse benefit determinations including pre/post-service medical necessity denials of covered benefits as well as post-service benefit coverage denials.

If an issue cannot be quickly resolved, the formal internal appeals process can be initiated via telephone or in writing up to one year from the date of last determination, or a shorter time period if specified by the plan.

Pre-service medical appeal reviews are conducted within 15 calendar days following receipt of the claim. Post-service administrative and medical appeal reviews are conducted within 30 calendar days following receipt of the claim. In each case, a customer may request or agree to a one-time extension of not more than 15 days. Expedited appeals are conducted within 72 hours of receipt of the appeal request.

Reviewers making appeal determinations are selected to assure that neither they themselves, nor their managers were directly involved in the original decision.

#### Level One Appeals

- Approval decisions on medical necessity appeals may be made by a non-physician health care professional, including a pharmacist or nurse.
- Only physicians can make denial decisions for medical appeals.
- Administrative appeals are resolved by non-clinical staff.

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- Decisions for expedited appeals are communicated verbally and followed up in writing. All other appeal denial decisions are communicated in writing.

### Level Two Appeals

- Administrative appeals are resolved by non-clinical staff.
- Issues of medical necessity or potential experimental treatments are reviewed by a committee of usually at least three reviewers, including a physician, a nurse, and a non-clinician.
- Decisions for expedited level two appeals are initially communicated verbally. All other appeal decisions are communicated in writing.

### Additional Information

- In the event there is any new or additional evidence considered, relied upon, or generated by CIGNA in connection with the appeal, we will provide a copy free of charge to the customer and give them reasonable time to review **prior to making the appeal decision**. The customer may request a stay of the appeal to allow time to consider the new evidence and respond to it.

### Other Appeal Options

For appeals involving medical judgment, an external review by an Independent Review Organization (IRO) is available. An external review by an IRO is available for administrative decisions if the external review is initiated before September 20, 2011. CIGNA has contracted with three IRO's (IMEDECS, MCMC, and MES Group) and will randomly choose one of the IRO's to review the external appeal.

Self-funded plans may offer their own external appeal options through their own contracts with IRO vendors. If the client chooses to "opt out" of the External program, they will take responsibility for ensuring their employees are offered an external review process that meets minimum Health Care Reform standards.

If plan is governed by ERISA, customer also has the right to bring a legal action under Section 502 (a) of ERISA.

The appeal form may be found on [www.CIGNA.com](http://www.CIGNA.com)

## Appeals Processing

- The CIGNA HealthCare Appeal Policy is compliant with state, federal, and accreditation organization requirements.
- Customers have access to internal and external appeal processes following initial determination decision.

There is a single level appeal process for expedited appeals (a second level internal appeal is optional) and two levels for pre- and post-service appeals.

- Decisions are based on benefit plan and relevant clinical criteria.

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- All appeals are processed through a sophisticated Appeals Processing System.

Appeals are loaded, processed and stored online, allowing:

- Improved communication between all internal partners
- Access to centrally located customer information
- Access to state-specific rules
- Correspondence generation
- Appeal records to be stored electronically
- Data integrity for accurate analysis of appeal activity, service improvements, reporting and volume reduction opportunities

CIGNA accesses all internal and external resources and documentation necessary to ensure that a full and fair review occurs and the customer is afforded the maximum benefit allowed under the benefit plan. Should the initial denial be upheld, the customer is notified of the rationale behind the decision and any subsequent appeal rights.

### Appeals Decisions

To maintain objectivity and ensure the appropriate expertise for appeals reviews, specific criteria are utilized by the appeals decision-makers. Decisions are made as indicated below using the following documents and tools, as indicated below:

#### Administrative

- Non-clinical appeals processors.
- Client's SPD or GSA/Certificate is source document for decisions.
- CIGNA administrative guidelines and tools.

#### Medical Necessity

- Nurse Reviewers render approval decisions if additional information satisfies medical necessity criterion.
- Physicians render denial decisions.
- Client's SPD or GSA/Certificate is source document for decisions.
- CIGNA's clinical resource tools including vendor guidelines (if applicable) are used to help determine whether clinical criteria are met.

Decision-makers are not involved in previous discussions nor are they subordinate to previous decision-makers. CIGNA will ensure that all appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision.

#### Decision Letters

- Adverse determination notices will include information sufficient to identify the claim involved.
- Notices will include information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- Adverse determination letters include all other elements required under state and federal law.

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### *Inquiries About Appeals*

If customers have questions about a previously submitted appeal, they should contact Customer Service at 1-800-Cigna-24, the number shown on their ID card.

### *Summary*

To summarize the appeals policy and processes at CIGNA:

- The CIGNA Appeal Policy is compliant with state, federal and accreditation (NCQA and URAC) requirements.
- Customers have access to internal and external (for appeals involving medical judgment only) appeal processes following initial determination decisions.
- There is a single level mandatory appeal process for expedited appeals and two levels for pre- and post-service appeals. A voluntary level-two expedited appeal process is also offered to the customer.
- Decisions are based on benefit plan and appropriate clinical criteria.
- All appeals are processed using a sophisticated appeal processing system.
- As identified throughout the document, CIGNA is compliant with federal Health Care Reform laws.