Health Care

How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them

by Patrick Rucker, Maya Miller and David ArmstrongMarch 25, 5 a.m. EDT

Internal documents and former company executives reveal how Cigna doctors reject patients' claims without opening their files. "We literally click and submit," one former company doctor said.

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How the Insurance Industry Denies Coverage to Patients

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Join the reporters Tuesday, March 28, for a virtual discussion with a former Cigna executive and other experts about America's broken health insurance system.

When a stubborn pain in Nick van Terheyden's bones would not subside, his doctor had a hunch what was wrong.

Without enough vitamin D in the blood, the body will pull that vital nutrient from the bones. Left untreated, a vitamin D deficiency can lead to osteoporosis.

A blood test in the fall of 2021 confirmed the doctor's diagnosis, and van Terheyden expected his company's insurance plan, managed by Cigna, to cover the cost of the bloodwork. Instead, Cigna sent van Terheyden a letter explaining that it would not pay for the $350 test because it was not "medically necessary."

The letter was signed by one of Cigna's medical directors, a doctor employed by the company to review insurance claims.

Something about the denial letter did not sit well with van Terheyden, a 58-year-old Maryland resident. "This was a clinical decision being second-guessed by someone with no knowledge of me," said van Terheyden, a physician himself and a specialist who had worked in emergency care in the United Kingdom.

The vague wording made van Terheyden suspect that Dr. Cheryl Dopke, the medical director who signed it, had not taken much care with his case.

Van Terheyden was right to be suspicious. His claim was just one of roughly 60,000 that Dopke denied in a single month last year, according to internal Cigna records reviewed by ProPublica and The Capitol Forum.

The rejection of van Terheyden's claim was typical for Cigna, one of the country's largest insurers. The company has built a system that allows its doctors to instantly reject a claim on medical grounds without opening the patient file, leaving people with unexpected bills, according to corporate documents and interviews with former Cigna officials. Over a period of two months last year, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of 1.2 seconds on each case, the documents show. The company has reported it covers or administers health care plans for 18 million people.

In the one hour and 31 minutes and 55 seconds you've been on this page, Cigna's doctors could have denied 6618 claims, according to company documents.

Before health insurers reject claims for medical reasons, company doctors must review them, according to insurance laws and regulations in many states. Medical directors are expected to examine patient records, review coverage policies and use their expertise to decide whether to approve or deny claims, regulators said. This process helps avoid unfair denials.

But the Cigna review system that blocked van Terheyden's claim bypasses those steps. Medical directors do not see any patient records or put their medical judgment to use, said former company employees familiar with the system. Instead, a computer does the work. A

Cigna algorithm flags mismatches between diagnoses and what the company considers acceptable tests and procedures for those ailments. Company doctors then sign off on the denials in batches, according to interviews with former employees who spoke on condition of anonymity.

“We literally click and submit,” one former Cigna doctor said. “It takes all of 10 seconds to do 50 at a time.”

Not all claims are processed through this review system. For those that are, it is unclear how many are approved and how many are funneled to doctors for automatic denial.

Insurance experts questioned Cigna’s review system.

Patients expect insurers to treat them fairly and meaningfully review each claim, said Dave Jones, California’s former insurance commissioner. Under California regulations, insurers must consider patient claims using a “thorough, fair and objective investigation.”

“It’s hard to imagine that spending only seconds to review medical records complies with the California law,” said Jones. “At a minimum, I believe it warrants an investigation.”

Do You Have Insights Into Health Insurance Denials? Help Us Report on the System.
Insurers deny tens of millions of claims every year. ProPublica is investigating why claims are denied, what the consequences are for patients and how the appeal process really works.

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Which of the following applies to you? (Select all that apply)Which of the following applies to you? (Select all that apply)

I am a patient or family member of a patient. My insurer denied my claim or the claim of someone I know. I work for a health insurance plan and am familiar with the claims process. I work for an independent medical review company. I am a health care provider, doctor or clinician. I work for a public or regulatory agency that oversees health insurance.

Is there anything else you think we should know?

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Within Cigna, some executives questioned whether rendering such speedy denials satisfied the law, according to one former executive who spoke on condition of anonymity because he still works with insurers.

“We thought it might fall into a legal gray zone,” said the former Cigna official, who helped conceive the program. “We sent the idea to legal, and they sent it back saying it was OK.”

Cigna adopted its review system more than a decade ago, but insurance executives say similar systems have existed in various forms throughout the industry.

In a written response, Cigna said the reporting by ProPublica and The Capitol Forum was “biased and incomplete.”

Cigna said its review system was created to “accelerate payment of claims for certain routine screenings,” Cigna wrote. “This allows us to automatically approve claims when they are submitted with correct diagnosis codes.”

When asked if its review process, known as PXDX, lets Cigna doctors reject claims without examining them, the company said that description was “incorrect.” It repeatedly declined to answer further questions or provide additional details. (ProPublica employees’ health insurance is provided by Cigna.)

Former Cigna doctors confirmed that the review system was used to quickly reject claims. An internal corporate spreadsheet, viewed by the news organizations, lists names of Cigna’s medical directors and the number of cases each handled in a column headlined “PxDx.” The former doctors said the figures represent total denials. Cigna did not respond to detailed questions about the numbers.

Cigna's explanation that its review system was designed to approve claims didn’t make sense to one former company executive. “They were paying all these claims before. Then they weren’t,” said Ron Howrigon, who now runs a company that helps private doctors in disputes with insurance companies. “You’re talking about a system built to deny claims.”

Cigna emphasized that its system does not prevent a patient from receiving care — it only decides when the insurer won’t pay. “Reviews occur after the service has been provided to the patient and does not result in any denials of care,” the statement said.

"Our company is committed to improving health outcomes, driving value for our clients and customers, and supporting our team of highly-skilled Medical Directors,” the company said.

PXDX

Cigna’s review system was developed more than a decade ago by a former pediatrician.

After leaving his practice, Dr. Alan Muney spent the next several decades advising insurers and private equity firms on how to wring savings out of health plans.

In 2010, Muney was managing health insurance for companies owned by Blackstone, the private equity firm, when Cigna tapped him to help spot savings in its operation, he said.

Insurers have wide authority to reject claims for care, but processing those denials can cost a few hundred dollars each, former executives said. Typically, claims are entered into the insurance system, screened by a nurse and reviewed by a medical director.

For lower-dollar claims, it was cheaper for Cigna to simply pay the bill, Muney said.

“They don’t want to spend money to review a whole bunch of stuff that costs more to review than it does to just pay for it,” Muney said.

Muney and his team had solved the problem once before. At UnitedHealthcare, where Muney was an executive, he said his group built a similar system to let its doctors quickly deny claims in bulk.

In response to questions, UnitedHealthcare said it uses technology that allows it to make “fast, efficient and streamlined coverage decisions based on members benefit plans and clinical criteria in compliance with state and federal laws.” The company did not directly address whether it uses a system similar to Cigna.

At Cigna, Muney and his team created a list of tests and procedures approved for use with certain illnesses. The system would automatically turn down payment for a treatment that didn’t match one of the conditions on the list. Denials were then sent to medical directors, who would reject these claims with no review of the patient file.

Cigna eventually designated the list “PXDX” — corporate shorthand for procedure-to-diagnosis. The list saved money in two ways. It allowed Cigna to begin turning down claims that it had once paid. And it made it cheaper to turn down claims, because the company’s doctors never had to open a file or conduct any in-depth review. They simply denied the claims in bulk with an electronic signature.

“The PXDX stuff is not reviewed by a doc or nurse or anything like that,” Muney said.

The review system was designed to prevent claims for care that Cigna considered unneeded or even harmful to the patient, Muney said. The policy simply allowed Cigna to cheaply identify claims that it had a right to deny.

Muney said that it would be an “administrative hassle” to require company doctors to manually review each claim rejection. And it would mean hiring many more medical directors.

“That adds administrative expense to medicine,” he said. “It’s not efficient.”

But two former Cigna doctors, who did not want to be identified by name for fear of breaking confidentiality agreements with Cigna, said the system was unfair to patients. They said the claims automatically routed for denial lacked such basic information as race and gender.

“It was very frustrating,” one doctor said.

Some state regulators questioned Cigna’s PXDX system.

In Maryland, where van Terheyden lives, state insurance officials said the PXDX system as described by a reporter raises “some red flags.”

The state's law regulating group health plans purchased by employers requires that insurance company doctors be objective and flexible when they sit down to evaluate each case.

If Cigna medical directors are "truly rubber-stamping the output of the matching software without any additional review, it would be difficult for the medical director to comply with these requirements," the Maryland Insurance Administration wrote in response to questions.

Medicare and Medicaid have a system that automatically prevents improper payment of claims that are wrongly coded. It does not reject payment on medical grounds.

Within the world of private insurance, Muney is certain that the PXDX formula has boosted the corporate bottom line. "It has undoubtedly saved billions of dollars," he said.

Insurers benefit from the savings, but everyone stands to gain when health care costs are lowered and unneeded care is denied, he said.

Speedy Reviews

Cigna carefully tracks how many patient claims its medical directors handle each month. Twelve times a year, medical directors receive a scorecard in the form of a spreadsheet that shows just how fast they have cleared PXDX cases.

Dopke, the doctor who turned down van Terheyden, rejected 121,000 claims in the first two months of 2022, according to the scorecard.

Category of Treatment: Outpatient

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
[redacted]	11/03/2021 – 11/03/2021	$1,126.00	$358.00

Cigna Health Management, Inc., on behalf of [redacted]

Dear Nicolas J Van Terheyden,

We received claim [redacted] for services received between 11/03/2021 – 11/03/2021 from Labcorp Holdings. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because the treatment is not medically necessary. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

Note: We sent this letter to meet federal and state requirements.

Van Terheyden's denial letter from Cigna Credit:highlights and redactions added by ProPublica

Dr. Richard Capek, another Cigna medical director, handled more than 80,000 instant denials in the same time span, the spreadsheet showed.

Dr. Paul Rossi has been a medical director at Cigna for over 30 years. Early last year, the physician denied more than 63,000 PXDX claims in two months.

Rossi, Dopke and Capek did not respond to attempts to contact them.

Howrigon, the former Cigna executive, said that although he was not involved in developing PXDX, he can understand the economics behind it.

"Put yourself in the shoes of the insurer," Howrigon said. "Why not just deny them all and see which ones come back on appeal? From a cost perspective, it makes sense."

Cigna knows that many patients will pay such bills rather than deal with the hassle of appealing a rejection, according to Howrigon and other former employees of the company. The PXDX list is focused on tests and treatments that typically cost a few hundred dollars each, said former Cigna employees.

"Insurers are very good at knowing when they can deny a claim and patients will grumble but still write a check," Howrigon said.

Muney and other former Cigna executives emphasized that the PXDX system does leave room for the patient and their doctor to appeal a medical director's decision to deny a claim.

But Cigna does not expect many appeals. In one corporate document, Cigna estimated that only 5% of people would appeal a denial resulting from a PXDX review.

"A Negative Customer Experience"

In 2014, Cigna considered adding a new procedure to the PXDX list to be flagged for automatic denials.

Autonomic nervous system testing can help tell if an ailing patient is suffering from nerve damage caused by diabetes or a variety of autoimmune diseases. It's not a very involved procedure — taking about an hour — and it costs a few hundred dollars per test.

The test is versatile and noninvasive, requiring no needles. The patient goes through a handful of checks of heart rate, sweat response, equilibrium and other basic body functions.

At the time, Cigna was paying for every claim for the nerve test without bothering to look at the patient file, according to a corporate presentation. Cigna officials were weighing the

cost and benefits of adding the procedure to the list. “What is happening now?” the presentation asked. “Pay for all conditions without review.”

By adding the nerve test to the PXDX list, Cigna officials estimated, the insurer would turn down more than 17,800 claims a year that it had once covered. It would pay for the test for certain conditions, but deny payment for others.

These denials would “create a negative customer experience” and a “potential for increased out of pocket costs," the company presentation acknowledged.

But they would save roughly $2.4 million a year in medical costs, the presentation said.

Cigna added the test to the list.

“It’s Not Good Medicine”

By the time van Terheyden received his first denial notice from Cigna early last year, he had some answers about his diagnosis. The blood test that Cigna had deemed “not medically necessary” had confirmed a vitamin D deficiency. His doctor had been right, and recommended supplements to boost van Terheyden’s vitamin level.

Van Terheyden Credit:Jared Soares for ProPublica

Still, van Terheyden kept pushing his appeal with Cigna in a process that grew more baffling. First, a different Cigna doctor reviewed the case and stood by the original denial. The blood test was unnecessary, Cigna insisted, because van Terheyden had never before been found to lack sufficient vitamin D.

“Records did not show you had a previously documented Vitamin D deficiency,” stated a denial letter issued by Cigna in April. How was van Terheyden supposed to document a vitamin D deficiency without a test? The letter was signed by a Cigna medical director named Barry Brenner.

Brenner did not respond to requests for comment.

Then, as allowed by his plan, van Terheyden took Cigna’s rejection to an external review by an independent reviewer.

In late June — seven months after the blood test — an outside doctor not working for Cigna reviewed van Terheyden’s medical record and determined the test was justified.

UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.

The blood test in question "confirms the diagnosis of Vit-D deficiency," read the report from MCMC, a company that provides independent medical reviews. Cigna eventually paid van Terheyden's bill. "This patient is at risk of bone fracture without proper supplementations," MCMC's reviewer wrote. "Testing was medically necessary and appropriate."

Van Terheyden had known nothing about the vagaries of the PXDX denial system before he received the $350 bill. But he did sense that very few patients pushed as hard as he had done in his appeals.

As a physician, van Terheyden said, he's dumbfounded by the company's policies.

"It's not good medicine. It's not caring for patients. You end up asking yourself: Why would they do this if their ultimate goal is to care for the patient?" he said.

"Intellectually, I can understand it. As a physician, I can't. To me, it feels wrong."

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Doris Burke contributed research.

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