

Prior authorization

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The Cigna Group

- **The Cigna Group** – Working to improve health care by delivering greater affordability, predictability, and simplicity
 - 190M+ customer and patient relationships globally
 - 1.5M relationships within global network of providers, clinics, and facilities
 - 70k employees serve our communities worldwide
- **Cigna Healthcare** – Health benefits provider offering U.S. Commercial (employer-sponsored health plans), U.S. Government (Medicare and individual/family health plans), and International Health (individual and employer-sponsored health plans)
- **Evernorth Health Services** – Broad range of coordinated and point solution health services and capabilities, including pharmacy benefits, home delivery pharmacy, specialty pharmacy, distribution, and care delivery and management solutions.



Benefits of prior authorization

- Medical knowledge is growing at unprecedented rates and accelerating every year. In 1950, it took 50 years to **double medical knowledge**. In 2020, it took just 73 days.
- **Evidence-based clinical guidelines are applied** to providers' requests to make sure they're in line with current medical science and best medical practices, which helps make sure patients receive optimal treatment at the optimal site based on their individual diagnosis and prognosis.
- The percentage of covered services and procedures that typically require prior authorization is small—**less than 15%**.
- By 2031, \$1 out of every \$5 is projected to be spent on health care. Average health care costs per worker reached about **\$17,200 in 2023**, up from \$15,862 in 2022—a nearly 8.5% increase.
- A 2023 study by Milliman found that eliminating of prior authorization would increase commercial premiums by approximately **\$600-\$1,500** per member annually, and Medicaid capitation rates would increase between **\$270 and \$1,100** per beneficiary annually.

Express Scripts' Utilization Management

- Utilization management services include:
 - > Prior authorization program
 - > Exception reviews for coverage of non-covered benefits
 - > Clinical overrides for step therapy programs
 - > Prescriptions exceeding preset quantity limits
 - > Brand name drugs when mandatory generic programs are in place
 - > Non-formulary medications

Extent to which prior authorization is used in North Dakota—2023

Review Type	Volume
Denied Coverage Determinations	642
Approved Coverage Determinations	1590
Denied Appeals	52
Approved Appeals	50

Initiating the UM process

- The following are typical scenarios in which prior authorization or exception review is required:
 - > The clinical review criteria for the prescribed product may require confirmation of a specific diagnosis.
 - > The clinical review criteria for the prescribed product may require specific test results, concurrent medical condition(s) or other medical circumstances.
 - > The member's benefit for the prescribed product requires the member to have tried one or more formulary pharmaceuticals.
 - > In the case of a mandatory generic program, coverage for a brand name drug may require evidence that a generic product is not clinically appropriate for the member. For example, the member has a sub-therapeutic response to the generic prescription product.
 - > The clinical review criteria may require the member to have used other product prior to coverage of the prescribed product. This is typically referred to "step therapy".

Clinical criteria and medical necessity

- Cigna has publicly accessible documents that are generally updated twice a month (1st and 15th)
 - > Cigna national formulary policy A-Z index
 - Here you can search alphabetically by a drug that is part of the Cigna National Formulary. Note – Multiple coverage policies may apply based on the customer’s benefit plan (for example: prior authorization, step therapy, quantity limitations): [CHCP - Resources - Cigna National Formulary Policies A-Z Index](#)
 - > Drug policy A-Z index (commercial)
 - Here you can search alphabetically for a drug name to see Cigna coverage position: [CHCP - Resources - Drug Policy A-Z Index \(Commercial\) \(cigna.com\)](#)

Retroactive denials

- All denial determinations are approved by a North Dakota licensed medical director.
- There are few instances in which a pharmacy prior authorization will be retroactively denied. These limited circumstances include:
 - > Evidence of fraud, waste, or abuse
 - When notification of potential FWA is received, coverage determinations may be revoked to permit proper investigation. This investigation is frequently conducted by the Cigna Special Investigations unit.
 - > A new authorization is granted for modified strength and/or dosing
 - When a coverage determination has previously been granted AND a new request for authorization of a modified dosage or strength is received and authorized, the original authorization will be activated to ensure that only the currently authorized strength/dosage is payable through the claim system.
 - > A request has been received from the Healthcare Professional to reverse authorization
 - Example: a change in the patient's therapy regiment.
 - > An approved drug's formulary status has changed
 - A change in the drug's status may modify the duration of a previous approval. A re-review against the new formulary requirements will then take place and a new decision will be issued.

Appeal Process

- A Customer can request, orally or in writing, an appeal of any adverse benefit determination, including both initial medical necessity and claim payment-related issues, that the Customer believes is not adequately addressed or resolved by Customer Service. The internal appeal process is provided at no cost to the Customer or the Customer's authorized representative.
- North Dakota allows a Customer to request an internal appeal at any time within 180 days from the date Cigna issued its last adverse benefit determination.
- Timeframes for resolution of the appeal:
 - > Pre-service appeals: Within 30 calendar days of receipt of appeal request.
 - > Post-service medical necessity: Within 30 calendar days of receipt of appeal request.
 - > Post-service administrative appeal: Within 60 calendar days of receipt of appeal request.
 - > Expedited/urgent appeals: Within 72 hours of receipt of appeal.