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

by Patrick Rucker, Maya Miller and David Armstrong
March 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.

Co-published with The Capitol Forum

ProPublica is a nonprofit newsroom that investigates abuses of power. Sign up to receive our biggest stories as soon as they're published.
Do you have experiences with health insurance denials? Please get in touch.

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 calcium 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.

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.

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.

Read the article online here.