Maine Inter-Agency Council on HMO Quality
Review of
CIGNA HealthCare of Maine, Inc.

Findings and Recommendations

The Bureau of Insurance (DPFR) and the Bureau of Medical Services (DHHS) completed a joint triennial examination of CIGNA HealthCare of Maine, Inc., hereafter "CIGNA", for compliance with 24-A M.R.S.A., Chapters 56 and 56A, Bureau of Insurance Rule Chapter 850, and Department of Human Services Rule Chapter 109. This report represents the finding of State surveyors as of November 15-16, 2006. CIGNA scored a **"Pass"** for this triennial examination.

Acknowledgement of cooperation and assistance extended to the examiners by all CIGNA representatives is hereby expressed.

This section highlights the findings associated with the examination of CIGNA:

I. Quality Management Program was determined to be in full compliance with Rule 109.
II. Credentialing Program was determined to be in full compliance with Rule 850.
III. Utilization Review Program was determined to be in full compliance with Rule 850 except for UR 23 (File Review). UR 23 received a “significant” rating, because 7 of 8 (29/30) UR denial files contained determinations within the time limit, had clinical peer reviews, had all pertinent clinical information, contained the reason for denial, information on the appeal process, information re: clinical rationale, and phone number. CIGNA is encouraged to ensure that all files meet all Maine requirements.
IV. Six of the eight elements re: Grievance and Appeals policies were determined to be in full compliance with Rule 850.

    Recommendation, GA 1, “UR Appeals Procedure:” CIGNA received a “significant” rating re: reviewing adverse utilization review determinations because in cases involving CIGNA Behavioral Health (“CBH”), the covered person may not appeal directly to CIGNA rather than through CBH at the first level. CIGNA is encouraged to modify their policies to allow appealing directly to CIGNA rather than its delegate.

    Recommendation, GA 1, “UR Appeals Procedure:” CIGNA was given credit for its description of the second level process in the adverse determination notification, in spite of the fact that the policy did not refer to review by clinical peers (instead using the term “physician”), because clinical peers were mentioned in the letters. CIGNA is encouraged to modify their policies from “physicians” to “clinical peers.”

    Recommendation, GA 3, “First Level Non-UR Procedures,” CIGNA itself received credit for all 7 requirements. However, CBH did not provide the covered person with a written explanation of the grievance process within 3 working days of receiving the grievance. CBH is encouraged to modify relevant policies to decrease the acknowledgement time from 5 calendar days to 3 working days.

Recommendation, GA 3, "First Level Non-UR Procedures," CIGNA was given credit for including the Superintendent of Insurance's contact information, in spite of the fact that the policy did not mention this, because it was mentioned in the letters. CIGNA is encouraged to modify their policies to include this information.

Recommendation, GA 4, "Second Level Procedures:" CIGNA was given credit for including the Superintendent of Insurance's contact information, in spite of the fact that the policy did not mention this, because it was mentioned in the letters. CIGNA is encouraged to modify their policies to include this information.

Recommendation, GA 6, "File Review 2nd Level UR:" CIGNA received a "significant" rating for this element because 1 file did not meet the requirements that the majority of panel consisted of appropriate clinical peers, and that at least one clinical peer was not previously involved. CIGNA is encouraged to ensure that all files meet all Maine requirements.

V. Seven of the eight elements re: Access, Availability, and Continuity of Care policies were determined to be in full compliance with Rule 850.

Recommendation, AC 7, "Appointment/Waiting Times:" CIGNA received a "partial" rating for this element because it did not demonstrate compliance with the following requirements:

- Steps to ensure that its members could obtain symptomatic primary care services within 7 days
- Steps to ensure that its members could obtain urgent primary care services within 24 hours. Note: CIGNA had such a policy, but CBH's policy had a 48 hour deadline. CBH has drafted a new policy reflecting the 24-hour deadline; it will go before the appropriate committee for ratification at its 12/8/06 meeting.
- Steps to ensure that its members were not kept waiting longer than 45 minutes for a scheduled appointment with a primary care or specialty provider.

CIGNA is encouraged to modify its policies to comply with these requirements.