Health Law & Business
July 24, 2023, 1:06 PM; Updated: July 24, 2023, 3:00 PM

Cigna Sued Over Alleged Automated Patient Claims Denials (1)

By Sara Hansard

- **COURT:** E.D. Cal.
- **TRACK DOCKET:** 2:23-at-00698 (Bloomberg Law subscription)

A class action was filed Monday against health insurer Cigna alleging that it illegally used advanced technology to automatically deny patients' claims without opening their files.

The suit was filed in the US District Court for the Eastern District of California by public interest law firm Clarkson Law Firm P.C. It alleged that Cigna Corp. and Cigna Health and Life Insurance Co., which cover about 18 million people in the US, denied more than 300,000 requests for payments using the method over two months in 2022, spending an average of 1.2 seconds reviewing each request.

The suit alleged that Cigna engaged in a scheme "to systematically, wrongfully, and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them by California law and, ultimately, the payments for necessary medical procedures owed to them under Cigna's health insurance policies."

The suit said Cigna developed an algorithm known as PXDX "to enable its doctors to automatically deny payments in batches of hundreds or thousands at a time for treatments that do not match certain preset criteria, thereby evading the legally-required individual physician review process."

The software used by Cigna to review claims, PXDX, "is a simple tool to accelerate physician payments that has been grossly mischaracterized in the press," Cigna Healthcare said in an email. "The facts speak for themselves, and we will continue to set the record straight."

The company said it couldn't comment on active litigation, "but this complaint appears to repeat and further inflate previous media mischaracterizations of PXDX," it said.

PXDX "is only used on the most common, low-cost procedures to verify that the codes are submitted correctly, which helps expedite physician reimbursement," Cigna said.

The review takes place after patients have received treatment, “so it does not result in any denials of care. It is a standard review, and is similar to processes that have been used by CMS and many other industry peers for years. There is no use of AI or algorithms to review claims where the code is incorrect or inappropriate,” it said.

ProPublica published an article in March about Cigna doctors and the software.

‘Unexpected Bills’

The suit alleges the rejections leave “thousands of patients effectively without coverage and with unexpected bills.”

The PXDX system saves Cigna money by allowing it to deny claims it previously paid and by eliminating the costs of doctor and employee time from individual manual review, the suit said.

Cigna “utilizes the PXDX system because it knows it will not be held accountable for wrongful denials,” the suit said. Only about 0.2% of policyholders will appeal denied claims and most will either pay the costs of the service themselves or forgo the procedures, it said.

“Cigna failed to use reasonable standards in evaluating the individual claims of Plaintiffs and Class members and instead allowed its doctors to sign off on the denials in batches,” it said.

Cigna breached its fiduciary duties, the lawsuit charges, and it seeks to remedy Cigna’s past unlawful conduct through damages, and by being enjoined from continuing to engage in the practice.

The suit cites two plaintiffs whose claims were denied. Thousands of Californians insured by Cigna submitted reasonable medical expense bills, which Cigna refused to pay, it said.

The suit alleges that Cigna violated its duties under insurance contracts and California law, that it violated California’s unfair competition law and the business and professional code, that it interfered with contractual relations against defendants, that it engaged in unjust enrichment against defendants, and that it violated the state’s health and safety code.

Increase in Denials

The lawsuit adds to health-care providers’ concerns over an increase in denials.

“While we cannot speak to the specifics of this litigation, we are deeply concerned that some insurers appear to be putting patients’ well-being in the hands of algorithms, Molly Smith, group vice president of public policy for the American Hospital Association.

“Over the past several years, hospitals and health systems have experienced substantial growth in insurer denials of both prior authorizations and payment for patients’ care that defy medical expertise and best practice. We have long urged additional oversight of these denials to ensure that patients are getting the care they need,” Smith said.

“The problem is that we don’t know how many of these have been appealed, how many have been overturned, and that’s very important information we need to know,” Wendell Potter, who leads two non-profit organizations, the Center for Health and Democracy and Business Leaders for Health Care Transformation, that focus on health-care reform, said in an interview. Potter was formerly head of Cigna’s corporate communications, but has since been critical of the health insurance industry.

“At the very least it adds a great deal of additional burden to physicians, because they’re having to deal with these denials” in “larger numbers than ever,” he said.

The case is Kisting-Leung v. Cigna, E.D. Cal., No. 2:23-at-00698, complaint filed 7/24/23.

(Updates with additional reporting throughout.)

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