

2026 Nonquantitative Treatment Limitation (NQTL) Submission Template

Instructions: This NQTL reporting submission form includes the required six information elements or Required Steps as specified by the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations, including 42 USC Section 300gg-26(a)(8)(A) and 45 CFR 146.137. The comparative analyses to be performed must be reported using this submission form and should comply with MHPAEA, its regulations, federal guidance, and the instructions, both separately provided and set forth herein.

A separate reporting form should be prepared and completed for each NQTL requested by the BOI in each benefits classification/sub-classification. For example, the comparative analysis for prior authorization for the Inpatient, In-Network benefits classification should be provided on its own reporting submission form, and the comparative analysis for prior authorization for the Inpatient, Out-of-Network classification should be provided in a separate reporting submission form. Similarly, the comparative analyses for prior authorization for Outpatient benefits should be reported separately, with a form used for In-Network and a form to be used for Out-of-Network. If there are questions about how to properly report using this form, please contact the BOI.

Post-Payment Retrospective Review

Post-Payment Retrospective Review is considered a non-quantitative treatment limitation (“NQTL”) under the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) and its implementing regulations and sub-regulatory guidance.

This document represents an NQTL comparative analysis for Post-Payment Retrospective Review applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services and benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company (“CHLIC”)

Note: this NQTL comparative analysis applies to all benefit classifications.

In the review and analysis of the Post-Payment Retrospective Review NQTL, Cigna assessed its policies, procedures, protocols, and conducted multiple discussions with the Special Investigation Unit (“SIU”).

No third parties or separate related entities played a role in developing the NQTL, comparative analysis, policies and procedures contained in this response.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See [45 CFR 146.137\(c\)\(1\)](#). Step 1 must include the following:

- (i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;
- (ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and
- (iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also [FAQ 45](#) (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

The Post-Payment Retrospective Review NQTL concerns retrospective or retroactive review of services where the claims have already been paid.

Cigna utilizes various forms of post-payment retrospective review, which include the following:

- Fraud, waste, and abuse investigations that occur post-claim payment (“FWA”); and
- Other post-payment retrospective review concepts Cigna applies, such as overpayment recovery (“Other”).

Cigna conducts post-service, pre-payment reviews which are addressed within the Retrospective Review Non-Quantitative Treatment Limitation document.

Cigna does not incorporate language related to fraud detection in its certificate or benefits booklet. There are no terms related to post-claim payment retrospective review contained in the Group Service Agreement (GSA). Information related to Health Care Fraud is posted online including how to report health care fraud on the Cigna website: <https://www.cigna.com/legal/members/report-fraud>.

Glossary:

1. Abuse: Actions that may, directly or indirectly, result in unnecessary costs such as paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment

2. Anomaly - Diagnosis Code: A significant amount of revenue generated from unusual diagnosis codes.
3. Anomaly - Procedure Code: A significant amount of revenue generated from an unusual procedure code.
4. Anomaly – Procedure Combination: A significant amount of revenue generated from unusual combinations of procedures codes.
5. Anomaly – Revenue Code: A significant amount of revenue generated from unusual revenue codes .
6. Billing Error: Unintended billing mistake made by the provider.
7. Customer: anyone covered by a plan, including the person who signed up for the plan and any dependents. Customer may also be referred to as: member, patient, or enrollee.
8. Data Mining: The process of sorting through large data sets to identify patterns and relationships that can help solve business problems through data analysis.
9. Density: Services and payments are unusually concentrated within certain types of procedures
10. Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
11. Frequency: An abnormal frequency of services visits and/or units.
12. Intensity: The level of service provided is abnormal when considered against defining attributes that include, without limit, age, gender and diagnoses.
13. Internal Investigations: The Unit within Cigna's Compliance organization that is responsible for investigating violations related to the Code of Ethics and Principles of Conduct.
14. Red Flag: Observed anomalies in either paper or electronic transaction environments whose unusual pattern or characteristics are essential for generating additional reviews or investigations.
15. Special Investigations Unit: The Unit within Cigna's Risk and Affordability Outcomes Organization tasked with the responsibility for conducting investigations of potential fraudulent, wasteful, or abusive activities.
16. Spike: Sudden increases in paid volume.
17. Trend: The direction in activity is increasing over time.
18. Waste: Practices that, directly or indirectly, result in unnecessary costs to plans, such as overusing services. Waste is generally considered a misuse of resources.

Supporting Documents:

Document/Policy Name	Description
Anti-Fraud Plan 2025 ("Plan")	This document summarizes the corporate anti-fraud plan for the Cigna Corporation.

Vendors:

Vendor Type	Vendor Name	Service Summary
Post-Pay Recovery	Cotiviti	Cotiviti performs overpayment research, COB research, recovery, and reconciliation.
Post-Pay Recovery	Optum	Optum/AIM is a sweeper credit balance recovery vendor. Optum/AIM also does overpayment identification and recovery.
Post-Pay Recovery	Conduent Credit Balance Solutions	Conduent is Cigna's primary credit balance recovery vendor.
Post-Pay	End-Game	End-Game Strategy identifies overpayments.

Recovery	Strategy (EGS)	
Post-Pay Recovery	Change Healthcare	Change Healthcare performs Overview Diagnosis-Related Groups (DRG) and post-pay Hospital Bill Audits. Change Healthcare also reviews medical implants, high-cost pharmacy claims for overpayments.
Post-Pay Recovery	Johnson & Rountree Premium (JRP)	Johnson & Rountree Premium collects dollars identified by End-Game Strategy and MultiPlan.
Post-Pay Recovery	Rawlings	The Rawlings Company researches COB with Medicare and commercial carriers.
Post-Pay Recovery	Conduent Payment Integrity Solutions	Conduent performs subrogation investigation and recovery to identify claims that are potentially accident related or there is some other third-party liability.
Post-Pay Recovery	MultiPlan	MultiPlan identifies overpayments.
Post-Pay Recovery	TREND Health Partners	TREND is a sweeper credit balance recovery vendor.

List of Services Subject to the NQTL:

Cigna's fraud, waste, and abuse efforts apply to all services, both MH/SUD and M/S, that are covered under the plan. Therefore, the list of specific Current Procedural Terminology (CPT) or revenue codes potentially subject to an SIU investigation encompasses all codes payable under the plan.

Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only. Cigna defines Post-Payment Retrospective Review as a claim audit and recovery efforts to ensure sound financial administration. These efforts are unrelated to medical necessity and focused on the accuracy of provider billing and ensuring that Cigna acted as the appropriate primary payer, i.e., coordination of benefits.

All M/S and MH/SUD services and providers are subject to fraud, waste and abuse compliance. Reviews of potential FWA are not determinations benefits or coverage, but rather a claims accuracy audit. Nevertheless, out of an abundance of caution Cigna has included this component of its operations here, despite the fact that there is no limitation on the scope or duration of services, and thus no NQTL to be compared or analyzed. Finally, all providers are subject to Cigna's overpayment recovery policies which seek to ensure accurate application of plan terms like subrogation, coordination of benefits, and eligibility. All of these efforts are conducted without regard to whether the underlying service is a MH/SUD or M/S service.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See [45 CFR 146.137\(c\)\(2\)](#). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

- (i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the

- sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and
- (ii) A definition of each factor, including:
- (A) A detailed description of the factor;
 - (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
 - (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

The table below reflects the factors which Cigna utilizes in the application of the M/S and MH/SUD Post Payment Retrospective Review NQTL. In the development of the Post Payment Retrospective Review NQTL there were no additional factors considered and rejected. These factors are applied uniformly and without weighting and do not operate in a systematically discriminatory manner, as they are not based on data, sources, or evidence that disfavor MH/SUD, including outdated, non-objective, or biased medical guidelines.

Factors	Sources for Each Factor
FWA 1. Internal Referrals: Notification within Cigna's SIU of suspected fraudulent behavior of a provider or customer	1. Internal Referrals Sources: • Cigna SIU Internal Analytics • Vendor partner identification via algorithms • Frontline claim and call team • Cigna account manager notification of a client concern • SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Evernorth.com
2. External Referrals: Notification	2. External Referral Sources:

by an individual or organization outside of Cigna SIU of suspected fraudulent behavior of a provider or customer.	• SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Evernorth.com • https://www.cigna.com/legal/members/report-fraud • Federal and state law enforcement agencies • Vendor identification via algorithms • NHCAA (SIRIS database) https://www.nhcaa.org/ • HFPP (Healthcare Fraud Prevention Partnership) https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership
3. Analytics: Analytics is the overarching process and programs utilized to identify suspect billing behavior and identify fraudulent claims by reviewing over a billion pieces of data, which is identical for both M/S and MH/SUD services.	3. Analytics Sources: • Claims data • SIU Internal analytics team • Vendor analytics: ○ Dedicated Data-Mart (Healthcare Fraud Shield) Claim detail for over 12 million medical customers (over 1 billion claim lines) are loaded on a weekly basis for risk scoring based on over 1,200 rules-based alerts. In addition, unsupervised learning, also referred to as Artificial Intelligence (AI), is used to identify aberrant behavior that may not be overtly detected in a rules-based approach. ○ Geospatial Analytics (ArcGIS) Data is modeled for probability risks, i.e., events that are unlikely to be appropriate. Examples in this space include billing from disaster zones (wildfires, hurricanes, etc.), and prescribing from long distances. ○ Link Analysis (i2) Public record information for subjects of investigations, coupled with internal data points, are loaded to IBM's i2 link analysis software to more clearly identify the extent of fraud activity. Examples include linkages of registered agents, telephone numbers, addresses, relationships, etc. This software is often used to expand an investigation through finding additional individuals or entities of interest. ○ Multiple Control Models (Python, R, SAS EG, SQL) Many models are run on an ongoing basis. Examples in this space include tracking all data elements associated with individuals or entities suspected of inappropriate billing, and monitoring claim activity for any potential data matches. ○ RatStats - Statistical sampling software. ○ Other Enabling Technologies - Teradata Studio, Toad, CA Workstation, Tableau, Cognos, etc. ○ Prest & Associates - Performs medical reviews for investigations focused on behavioral services. A medical doctor with a behavioral focus reviews full medical records for a number of customers of a particular provider/facility to validate services are appropriate and consistent with standards. Results

	are aggregated and reviewed in detail as a part of the investigative process. ○ Tata Consultancy Services (“TCS”) - Reporting and data acquisition is supported in part by TCS as a vendor. A total of eight outsourced FTE supports this body of work.
--	--

In choosing these factors, Cigna focuses solely on best practices for identifying suspect patterns of behavior regardless of specialty (M/S or MH/SUD), whereby analytics reviews data for risk.

Cigna does not establish thresholds for any one of these factors whether for M/S or MH/SUD.

In establishing the factors used to determine post-payment retrospective review, Cigna considers the following sources and evidentiary standards:

Factor	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
FWA:		
1. Internal Referrals: Notification within Cigna’s SIU of suspected fraudulent behavior of a provider or customer	1. Irrespective of specialty (M/S or MH/SUD), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider’s billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted.	1. Cigna claim data
2. External Referrals: Notification by an individual or organization outside of Cigna SIU of suspected fraudulent behavior of a provider or customer	2. Irrespective of specialty (M/S or MH/SUD), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider’s billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted.	2. Cigna claim data Vendor data
3. Analytics: Analytics is the overarching process and programs	3. Evidentiary Standards for Internal Analytics	3. Sources for red flags are claims data, internal analytics, and vendor analytics.
	Red Flags non-exhaustive list:	

utilized to identify suspect billing behavior and identify fraudulent claims by reviewing over a billion pieces data, which is identical for both MH/SUD and M/S services.	Cigna's Special Investigations Unit (SIU) identifies the following "red flags" as potential indicators of fraud, waste, and abuse. Red flags are also known as anomalies and may cover procedure codes, revenue and diagnosis: • Treatment does not match diagnosis. • Treatment is inconsistent with patient's age or gender. • Same or like diagnosis for all health care professionals' patients. • A large geographic difference in the location of the patient's home and the health care professional's office. • Treatment dates closely follow enrollment period. • Claimant/individual customer's address matches the health care professional's address. • Immediate claimant/individual customer pressures for payment of claims. • Resubmission of previously denied claim with modified information. • Unusual delay in submission of claims. • Multiple health care professional claims for the same patient on the same date of service. • Information on the claim form does not match eligibility information in claim system. • Unusually high number of patients coded as new patients to gain higher reimbursement. • Call history that customer has frequently requested overrides • Physician, pharmacy or family member calls concerned about individual customer's prescription drug abuse • Customer calls frequently regarding controlled substances • Multiple pharmacies used to fill controlled substances for one customer • Multiple physicians prescribing controlled substances for one customer • Customer calls about medications billed against his account that he does not take
Evidentiary Standards for Vendor Analytics M/S Non-exhaustive list of examples of dashboards and alerts that assess M/S codes are as follows:	Source is Healthcare Fraud Shield
AIShield/FWA360Leads The AI Models are anomaly detection models across all lines of business, services and claim types	
Non-par Dashboard Aggregates all out of network claims by dollars, claims and % of claims by Provider, Member and Group	
Facility Dashboard Aggregates any hospital admission and readmission in 4 data panels: ER Admission Rate, Average Length of Stay, 1 Day Admission and 30-Day Readmission	
Provider Dashboard Aggregates top risk scoring and dollars at-risk across all providers	
Code Analysis Code Analysis report can be used to identify any medical or surgical code or other key codes on all claim types (using CPT, HCPCS, Modifier, Diagnoses, Bill	

Type, DRG, Revenue, Place of Service) or group of codes and displays metrics and peer comparisons surrounding the code(s) selected

Alert Dashboard

The Alert Dashboard contains all alerts related to all services and all claim types. The alerts are a combination of outlier detection, anomalies and known patterns of concern to be further vetted by HCFS clients. Examples of alerts are as follows:

[2291-01] - Impossible Day: Time for professional claims for provider on single date of service exceeds 18 hours.

[1021-01] - Outlier, Excessive Procedures Per Day: This rule reviews providers billing for excessive # of procedures/services performed per day (peer comparison)

[1024-01] - Payment Spike: Substantial increase in net Payment for a single Member (200%) in the past 12 weeks

[1016-02] - Billed Amount Spike: Substantial increase in billed amount by provider (200%) in the past 12 weeks

[1019-01] - Procedure Code Spike: Increase of 200% or more in # claims with a procedure code and procedure code start date is not w/in 90 days

[2305-01] - Payment Spike-Watchlist Provider - Substantial increase in net payment to provider (200%) in the last 4 weeks.

[2107-20j] - Upcoding-E/M, Emergency Room: This rule reviews providers billing high frequencies of level 4 and 5 E/M codes out of the CPT range of codes 99281-99285. (Peer Comparison)

[2009-01] - Services Not Rendered, Multi-State Provider Npi Billing: This Alert identifies provider NPI's that are billing for services in 3 or more states on the same date of service.

[3068-20] - outlier, V24 - HCC 12, Breast, Prostate and Other Cancers and Tumors: This Alert identifies providers excessively billing the most clinically severe diagnosis related to v24, HCC 12, possibly to obtain a higher risk score for a larger reimbursement, when compared to their peers. (peer comparison)

[2001-20] - Outlier, COVID-19 Diagnosis: This Alert identifies providers billing a COVID-19 diagnosis code excessively when compared to their peers. (Peer Comparison)

[2230-20] – Services Not Rendered/Misrepresentation Of Service, Modifier 25: This rule reviews providers excessively billing Modifier 25 – significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service. (peer comparison)

[2221-20] – Services Not Rendered, Physical Therapy: This rule reviews providers billing for excessive Physical Therapy services.

[2107-20b] – Upcoding-E/M, Established Patient: This rule reviews providers billing high frequencies of level 4 and 5 E/M codes out of the CPT range of codes 99211-99215. (peer comparison).

[2191-06] – Unbundling, Global Surgery: This rule reviews providers billing for evaluation and management services within the global periods. Global periods are typically 0, 10 or 90 days as defined by the CMS Physician Fee Schedule. This rule looks at claims that do have modifiers appended to the codes.

[2097-02] – Unbundling, Medical And Surgical Supplies, Ambulatory Surgical Centers (ASC) and Outpatient Facilities: This Alert identifies the unbundling of medical and surgical supplies, using revenue code 270, as it is considered included in the payment for the primary service.

	Provider View Ability to see any medical or surgical alert flagging on this provider	
	Member View Ability to see medical or surgical alert flagging on this member (if member is suspect)	
	Group View Ability to see any medical or surgical alert flagging on this group	
	Evidentiary Standards for Vendor Analytics MH/SUD Non-exhaustive list of examples of dashboards and alerts that assess MH/SUD codes are as follows:	Source is Health Care Fraud Shield
	AIShield/FWA360Leads The AI Models are anomaly detection models across all lines of business and services.	
	Non-par Dashboard Aggregates all out of network claims by dollars, claims and % of claims by Provider, Member and Group.	
	Facility Dashboard Aggregates any inpatient behavioral health data by ER Admission Rate, Average Length of Stay, 1 Day Admission and 30-Day Readmission	
	Provider Dashboard Aggregates top scoring and at-risk providers with the ability to drill down on specialties specific to behavioral health	
	Code Analysis Code Analysis report can be used to identify any code or group of codes (including behavioral health) and displays metrics and peer comparisons surrounding the codes	
	Alert Dashboard [2083-01] - Billing For Services Not Rendered-Mental Health: This rule reviews mental health providers billing for patients who have a diagnosis that indicates it would be impossible for a patient to be communicative which would be necessary to report psychotherapy. [2071-20] - Upcoding-Psychotherapy: This rule reviews providers only billing CPT codes 90808-90809 out of CPT codes 90804-90909, only billing CPT codes 90814-90815 out of CPT codes 90810-90815, only billing CPT codes 90828-90829 out of CPT codes 90823-90829, only billing CPT codes 90821-90822 out of CPT codes 90816-90822. Starting 1/1/2013, the rule will look for CPT codes 90837-90838 out of 90837-90838,90832-90838 due to the changes in the codes. (individual tier) [2071-21] - Upcoding-Psychotherapy: Provider billing highest levels of psychotherapy [2292-01] - Unbundling Family / Group Therapy [2290-01] - Unbundling: Behavior Assessment and Psychotherapy [2303-01] - Upcoding, Psychological Testing - This rule reviews providers upcoding the time spent for psychological testing.	
	Provider View Ability to see any behavioral health alerts flagging on this provider, and any behavioral related diagnoses, procedure codes or revenue codes.	
	Member View Ability to see any behavioral health alerts flagging on this member (if member is suspect), and any behavioral related diagnoses, procedure codes or revenue	

	codes.
	Group View Ability to see any behavioral health alerts flagging on this member (if member is suspect), and any behavioral related diagnoses.
	Other alert examples: 1) [2298-01] - Unbundling, Partial Hospitalization: Flag claims where providers bill CPT 99201-99215 while patients are being treated for partial hospitalization and detox. Partial Hospitalization is defined as: Partial hospitalization refers to a comprehensive, short-term, intensive, clinical treatment program. This rule reviews providers also billing evaluation and management codes during the same time that a patient is treated for partial hospitalization. Individuals in partial hospitalization programs attend structured programming throughout the day, three to five days a week and return home in the evenings. To ensure client safety, many of the inpatient hospitalization rules apply (i.e. no phones, no shoelaces) to partial hospitalization programs. Each payer has different guidelines on the requirements for partial hospitalization and whether or not prior authorization is required. Healthcare Fraud Shield recommends to refer your respective plan's policies for more information. The rule evaluates the billing based on Revenue codes and CPT codes. 2) [2291-01] - Impossible Day: Time for professional claims for provider on single date of service exceeds 18 hours. This rule identifies any code with time components in the description, many of which are behavioral health related. 3) [1021-01] - Outlier, Excessive Procedures Per Day: This rule reviews providers billing for excessive # of procedures/services performed per day (peer comparison) Rules such as this one identify providers billing for an excessive number of services per patient. Some of the providers identified may be billing for behavioral health related codes. 4) Spike Rules have identified new behavioral health providers and those ramping up their billing. These rules include: [1024-01] - payment spike: Substantial increase in net payment for a single member (200%) in the past 12 weeks [1016-02] - Billed Amount Spike: substantial increase in billed amount by provider (200%) in the past 12 weeks [1019-01] - Procedure Code Spike: increase of 200% or more in # claims with a procedure code and procedure code start date is not w/in 90 days [2305-01] - Payment Spike-Watchlist Provider - substantial increase in net payment to provider (200%) in the last 4 weeks.

Healthcare Fraud Shield's alerts and aggregated statistics in dashboards are designed to detect potentially suspect Fraud, Waste, Abuse and/or Errors.

The alerts and dashboards have a variety of components including, but not limited to, patterns of behavior that detect aberrancies in all claims data, targeted known schemes that mirror industry standard guidelines, as well as external data providing information on potential adverse actions (sanctions, exclusions). There are 1,413 active alerts which include M/S and MH/SUD lines of business.

Cigna does not rely on any specific threshold in determining whether one or more of the factors results in the opening of an SIU investigation. Rather, these factors within Step 3 are considered in

determining whether any anomalous behavior has occurred that warrants further investigation or inquiry by SIU.

Importantly, these factors apply without regard to whether the underlying service is considered a mental health or substance use disorder (MH/SUD) service or medical/surgical (M/S) service.

Step 3: Description of how factors are used in the design and application of the NQTL.

See [45 CFR 146.137\(c\)\(3\)](#). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

- (1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;
- (2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;
- (3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;
- (4) If more than one factor is identified and defined in Step 2, an explanation of:
 - (A) How all of the factors relate to each other;
 - (B) The order in which all of the factors are applied, including when they are applied;
 - (C) Whether and how any factors are given more weight than others; and
 - (D) The reasons for the ordering or weighting of the factors.
- (5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of

benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].

- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Design and Application:

SIU Processes reflect the collective knowledge of highly trained and experienced healthcare anti-fraud professionals:

Major areas of responsibility and direct report focus within the SIU are summarized as follows:

- **Managing Director of the SIU**
 - Reports to Cigna's SVP of Risk & Affordability Outcomes
- **Investigations:**

Lead teams of investigators. Components of this role include the actual investigation, partnership with law enforcement, and working with external business partners. Direct report alignment is based on major books of business as follows:

 - Sr. Director of Healthcare Investigations
 - Director of Pharmacy Investigations
 - Sr. Director of Prescriber/Customer Investigations
- **Analytics Sr. Director:**

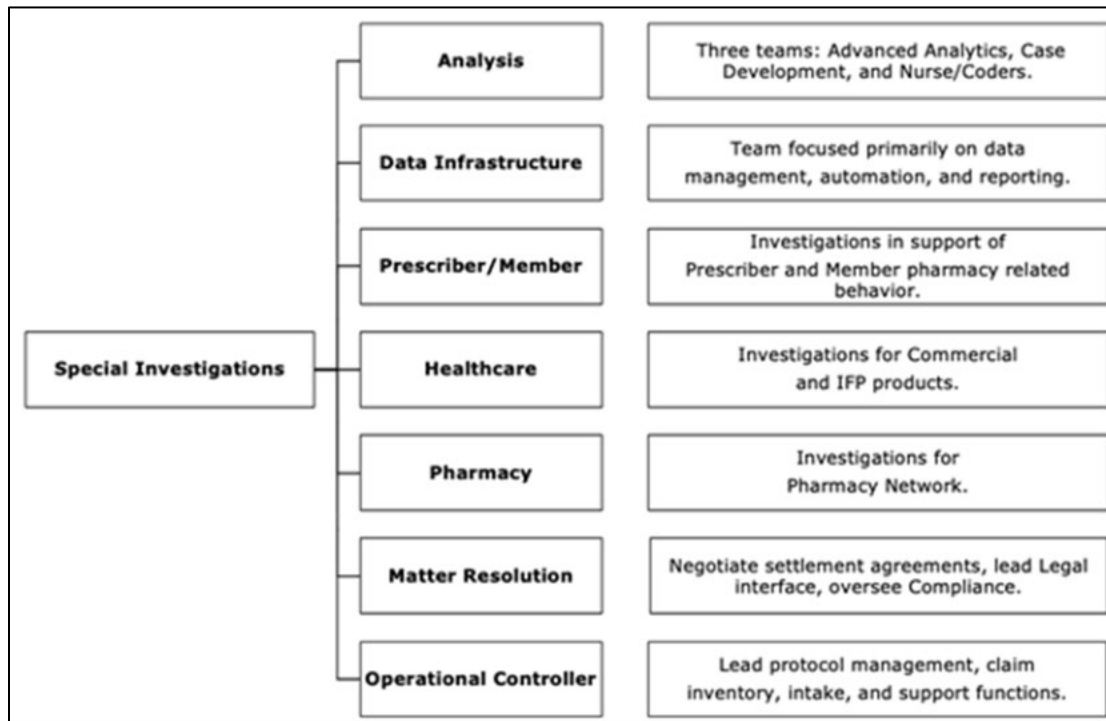
Leads "Case Development", which does rich data analysis and related investigative work to prepare the case for swift and effective resolution upon transfer to the Investigations team. In addition, the Analytics team leads proactive analysis including use of artificial intelligence and rules-based analytics.
- **Data Infrastructure Director** – The data infrastructure director supports investigative and analytic work through acquiring and working with large data sets, develops and maintains internal management reporting, supports efficiency-driven automation initiatives, and works on ad hoc analytic projects.
- **Operations Sr. Manager:**

Ensures claims are moving appropriately through the systems (inventory control) and leads team responsible for the SIU hotline and email box.
- **Matter Resolution Director:**

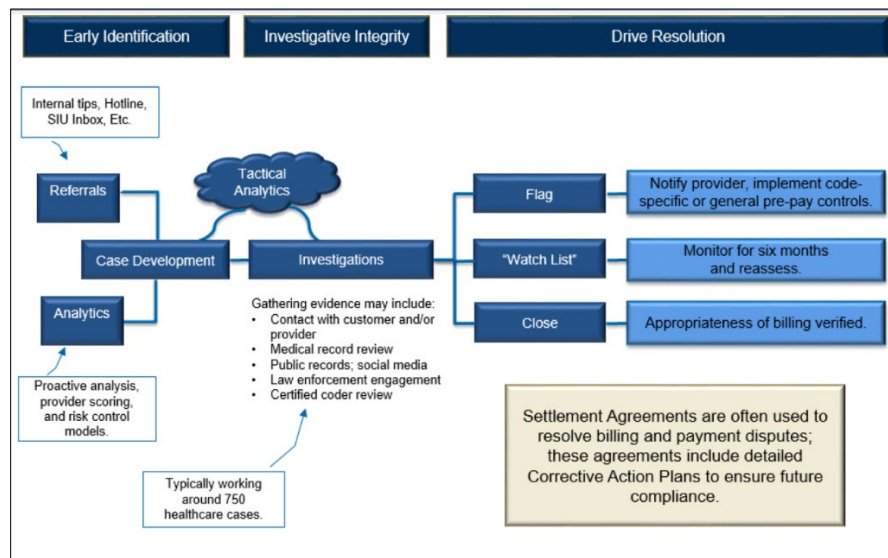
Ensures ongoing compliance with state and federal regulations and internal policies and facilitates resolutions with providers. Negotiates Corrective Action Plans with providers, partners with Legal in cases of litigation, and provides internal advice regarding risk

management and compliance advice. Oversees litigation interface to facilitate delivery of appropriate documentation, and partners with Director of Investigations to support strong case development and documentation. Also oversees booking of recovered dollars and associated allocation of funds to clients.

The below organizational chart provides additional detail on the structure of the SIU.



The below process flow provides perspective on how investigations are sourced, worked, and resolved. “Flagging” is not the goal; the goal is to modify billing to be appropriate and representative of industry standards.



The detailed investigative process is outlined in step 4. The procedural steps include an initial review and information gathering. Potential outcomes of an investigation may include:

- **Issue Closure** when appropriate billing is verified
- **Watch List** when determined additional monitoring may be required
- **Provider Education** when a small variance is identified
- **Prepay Review** when material fraud concerns are validated

The Overpayment Recovery Team Roles and Responsibilities:

The **Senior Operations Manager of Post Payment, Payment Integrity** collaborates with matrix partners to develop, execute and manage Cigna's internal overpayment program.

Leads, develops and expands programs/teams focused on medical cost savings, managing post payment internal and external overpayment recovery activities.

- Manages external post payment recovery vendors. Partners with Sourcing and internal teams to optimize program results and negotiate competitive contract terms. Manages the contractual relationship and monitors vendor performance by ensuring all Service Level Agreements (SLAs) and turnaround timeframes are met. Defines plan and coordinates corrective action and training with Vendors as necessary.
- Expand and integrate overpayment vendor programs across new or under-represented products or lines of business to increase financial effectiveness and impact key business objectives. Includes reviewing industry offerings, competitive vendor environment, client needs and provider expectations to ensure best in class programs.
- Consistently work to improve vendor recovery success. Includes expansion of auto-recoupment program, ensure vendor recovery best practices and partnership/focus groups with provider services to facilitate recovery with resistant providers.

Workgroups or committees responsible for vendor review/approval and oversight

Vendor Strategy is driven by the Senior Leadership - **Senior Director of Payment Integrity** and **Senior leaders in Procurement and Finance**.

Vendor Management - Department Functions

Business Project Advisors

- Arbitration Support, Vendor Quality and Training
- New vendor implementation, vendor analysis/reporting and special projects

Business Project Analysts

- Vendor Fee Process, Reconciliation and Audit
- Client Support, Education, Communication and Reports.
- Liaison between Contracting and Vendors
- Vendor system access, general vendor support

Vendor review and oversight is supported by:

- Post Payment, Payment Integrity Operations
- Cigna Information Protection (CIP)
- Legal and Privacy
- Procurement
- 3rd Party Management
- Finance

Step 4: Demonstration of comparability and stringency as written.

See [45 CFR 146.137\(c\)\(4\)](#). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant:
 - (A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and
 - (B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;
- (2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;
- (3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and
- (4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [\[Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits\]](#):
 - (A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;
 - (B) In the design of the factors or evidentiary standards; or
 - (C) In the application or design of the NQTL.

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [\[Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review\]](#).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Special Investigations Unit

Cigna Healthcare and Evernorth Behavioral Health maintain one Anti-Fraud Plan and one Special Investigations Unit ("SIU"), which is part of the Risk and Affordability Outcomes organization. The SIU provides our clients with anti-fraud detection and investigation, prepayment savings, and post payment recovery services. The SIU has approximately 180 employees who investigate suspected healthcare, dental and pharmacy fraud. Employees are concentrated in Connecticut, Missouri, and Florida, as well as various work-at-home locations nationwide. All services including medical, behavioral, and pharmacy are subject to potential review under this NQTL when the appropriate conditions are met.

Cigna's SIU is responsible for:

- conducting investigations and analyzing cases to determine the scope of potential fraud
- flagging providers/facilities/members in the claim systems to ensure payments suspected of fraud are addressed prior to releasing funds
- obtaining evidence for referrals to law enforcement, regulatory agencies, and associations
- pursuing civil recoveries
- delivering antifraud training and communication of current fraud schemes to Cigna employees
- using advanced technology and data-mining techniques to identify suspect behavior or patterns of possible fraudulent providers/facilities

- serving as a founding member of the National Health Care Anti-Fraud Association (NHCAA), an organization consisting of health care experts from both the public and private sectors
- working with clients and customers who inform us of discrepancies that may reveal potential fraud

The SIU works in partnership with dedicated resources within Cigna Claim, Legal, Data Infrastructure and Clinical Management teams to establish guidelines and controls to assist in the fight against fraud and abuse. While SIU leads Cigna's anti-fraud activities, their efforts are complemented by individual standards-based [National Council on Compensation Insurance ("NCCI"), Center for Medicare and Medicaid Services ("CMS"), ("ASA")] claim edits incorporated as a part of the claim adjudication process, as well as multiple targeted pre-payment programs to address areas of potential risk (Diagnosis Related Groups, Implantable Devices, Complex Claims, and Specialties, including cardiac, orthopedic, and neonatal).

Conducting Investigations and Analyzing Cases

As Written Fraud Waste and Abuse Process

The overall process for identifying potentially fraudulent claims is identical for both M/S and MH/SUD services. As made clear in the attached Cigna Anti-Fraud Plan for 2025 and associated policies, different approaches may be taken for certain types of benefits that reflect the variance in the manner in which fraud, waste, and abuse might occur in any given setting. For example, overbilling related to intensive outpatient program (IOP) treatment might be investigated in a manner that differs from the way in which non-routine laboratory work is investigated. Despite differences that arise from the particular modality of care, the approach to red-flagging services as potentially fraudulent, wasteful, or abusive is identical and does not consider whether the underlying service is for an MH/SUD or M/S condition.

Analytics are designed to identify potential bad actors by reviewing over a billion pieces of data which include:

- Claims
- Purchased public records
- Industry anti-fraud databases; and
- Social network

The data is modeled for risks by utilizing artificial intelligence, link analysis, geospatial analytics and predictive analytics. The results of this process will yield instances of potential fraud which will require further review and possible investigation.

There is not a set value of aberrant claims. Analytics identifies areas of risk and those areas are reviewed for potential investigation. Analytics assesses the risk to the portfolio and risk to individual clients. All referrals to the hotline or similar intake capability are assessed. As for the order-of-magnitude of the risk assessment, it is reasonable to see portfolio spend levels below \$100,000 where there is no client-specific concentration. In this case, it would be more likely to go onto the 'Watchlist' for monitoring rather than immediately opening a case. In terms of client-specific risk, tolerance levels for proactive analytics can be as low as \$10,000.

The investigative process includes the following procedural steps:

- The Investigator will perform an initial review to gain a thorough understanding of the allegation or flag.

- Review Post Shield risk score and understand related alerts.
- Identifying any potential Customer / Client issues or escalating factors.
- Create Healthcare Fraud Shield (HCFS) activity
 - The Allegation(s)
 - Source of the Allegation (customer complaint, data mining, etc.)
 - Summary of steps taken to date
 - Escalating factors.
- Evidence gathering may include:
 - Contact with customer/provider
 - Tax Identification Number (TIN) search
 - Reviewing the Contract status of health care provider (HCP) and requesting a copy of any current or historical agreements, if applicable.
 - Special Investigation Resource and Intelligence System (SIRIS) review.
 - Federal Employee Health Benefit Program (FEHBP) review (Special Agents Mutual Benefit Association (SAMBA) and National Association of Letter Carriers (NALC)).
 - Vendor review - CareCentrix, American Specialty Health (ASH) or eviCore.
 - Online research and review of public records (ex. Thomson Reuters CLEAR® system, License / Clinical Laboratory Improvement Amendments (CLIA) search, Office of the Inspector General (OIG) Exclusions, State Regulations, HCP, procedures codes, and diagnosis codes).
 - Reviewing Coverage/Reimbursement policies.
 - Researching Internal Special Investigation Unit (SIU) Investigative guidelines
 - Perform in-depth analysis of claim data using multiple sources (PostShield Alerts, Tactical Analytics)
 - PostShield is the name of the main analytics module within Healthcare Fraud Shield. The alerts are the individual rules, i.e., evidentiary standards, and the scores represent how alerts are aggregated to reflect a level of risk.
 - Tactical analytics go deeper on case-specific details to identify and understand the full scope of risk. Tactical analytics often identifies additional parties that may link other entities or individuals to an existing case.
 - Medical Record Review
 - Non-Clinical/Clinical Review
 - A non-clinical medical records review is performed when records are requested for claims during prospective or retrospective audits. A non-clinical review outlines the issues that need to be addressed by the clinician.
 - The investigator performs a non-clinical review and document findings on at least twenty-five percent (25%) of the records received before deciding if the records require additional clinical review.
 - A clinical review is a procedure to assist SIU when there is a need for a clinical assessment of medical records pertaining to the case in question and engage with SIU Registered Nurses (RNs), Independent Review Organization(s) (IRO), and/or Medical and Dental Directors for clinical record reviews. Medical record reviews may either be prospective (review of open claims and prepay correspondence) or retrospective (review of paid claims and/or appeals).
 - Public records; social media
 - Law enforcement engagement
 - Certified coder review
 - Investigations may include tracking:
 - Provider billing codes, patient relationship, prescribing patterns

- Pharmacy dispensing patterns
- Customer having similar prescriptions/different providers, no history of diagnosis

Potential Outcomes as previously mentioned in Step 3 may include:

- Issue Closure when appropriate billing is verified
- Watch List when determined additional monitoring may be required
- Provider Education when a small variance is identified
- Prepay Review when material fraud concerns are validated

Flagging Risks

Determining the Risk

The Intake Team will look for any “red flags” or evidence of known schemes. The Intake Team is the frontline of Special Investigations. The intake team is responsible for screening new allegations of fraud, reviewing information submitted on existing cases and responding to inquiries from both internal and external customers. The Intake Team will check the type of service and location to determine if the referral is indicative of an emerging issue or is from a high-risk county. The intake team will check HCFS to determine the subject’s risk score, check for any alerts, and determine network status.

The intake team will also refer to state licensing websites to determine if the provider is licensed, to verify CLIA certifications, or if there are any disciplinary actions. Overall exposure can be determined by reviewing the TIN Paid Summary for excessive, abusive, or ‘questionable value’ claim billing. The team looks for payment trends that may target a client or specific health plan.

If the Intake Analyst determines that there is potential fraud, they will write up the referral with specific details regarding the allegation. In the review, they will list all findings or observations about the allegation or issue. A final assessment of the total risk will be completed to determine if the referral warrants further review by the SIU or any other area.

When the final assessment is complete, they will determine whether to close the referral without action, place the provider on the watchlist, or send to Case Development or CRG for further review.

Red Flags

As noted in the definitions section, red flags are observed anomalies in either paper or electronic transaction environments whose unusual pattern or characteristics are essential for triggering additional reviews or investigations. An anomaly is an unusual pattern. The SIU uses red flags to educate claim processors and underwriting personnel to identify potential fraud for all lines of business. Within Step 2 there is a non-exhaustive list of potential red flags to help guide identification of potential FWA.

Clinical Review

Investigators may send Verification of Services (VOS) letters to customers to confirm whether services were performed. When the VOS letters are returned, the Investigator will interview the customers to substantiate the irregularities or identify additional allegations.

The random number generator is used within RAT-STATS to provide the sampling of customers that verification of services letters will be sent.

The Special Investigations Unit is tasked with identifying, investigating, and recouping damages, and may utilize the method of statistical sampling in order to calculate the damages. Sampling allows one to make a statement about the entire population based on findings of a smaller, representative group. A Statistically Valid Random Sample (SVRS) will be obtained during the retrospective review phase of an investigation. When requesting medical records, a SVRS may be obtained using RAT-STATS.

Medical Records

Cigna may request and receive the customer's complete medical record that would support the claims billed by the provider. These requests are not itemized; contents of a medical record will vary depending on the specialty and procedure. Therefore, Cigna's request letters ask for the patient's complete medical file that supports the billing submitted to Cigna. This applies to both M/S and MH/SUD claims.

Investigators may also send letters to providers/facilities to request medical records, patient payment ledgers, and/or billing policies using the Retrospective Review Process and the Guideline for Use of Statistically Valid Random Sampling Using RAT-STATS listed above.

Once the records are received, the Investigator will conduct an in-depth, non-clinical review to outline the issues that need to be addressed by the clinician. The Investigator is required to perform a non-clinical medical record review when records are requested for claims during prospective or retrospective audits. For retrospective reviews, it is the Investigator's responsibility to perform a non-clinical review and document findings on at least twenty-five percent (25%) of the records received before deciding if the records require additional clinical and/or coding review.

When the non-clinical review is complete, Investigators may partner with SIU Registered Nurses (RNs), Independent Review Organizations (IRO), and/or Internal Medical Directors for clinical record reviews. In addition to performing clinical records reviews, the SIU RNs are also Certified Professional Coders (CPCs) and can perform coding reviews.

Investigators are responsible for performing a review of the clinician's medical record review upon completion. The intent of this review is to ensure that all non-clinical findings were addressed and that the clinician's findings were complete and accurate based on the records and claim information reviewed.

Internal Medical Directors

Depending on the case and specialty, a Medical Director may be required to perform the clinical review. SIU partners with internal Medical Directors to perform retrospective and some perspective review of records.

Independent Review Organization(s) (IRO)

SIU may use a combination of both internal medical directors and Independent Review Organization (IRO) depending on the investigation. Specifically for MH/SUD, Cigna may use an internal Evernorth Behavioral Health Clinician and an IRO, sometimes on the same case.

Prest & Associates, Inc. (Prest), an IRO, is used to perform retrospective clinical reviews for behavioral health cases only. Prest employs a large number of Board-Certified psychiatrists, psychologists, and other behavioral health clinicians.

Prest is the oldest and one of the largest independent review organizations specializing in psychiatry, addiction medicine, and behavioral healthcare; it is accredited by the Utilization Review Accreditation Commission (URAC).

If Cigna's SIU investigation finds evidence of Fraud, Waste and Abuse the following actions may be taken:

- **Damages Letter**
 - Estimated overpayment calculated
 - Refund requested
- **Remediation Discussions**
 - Phase often engages owners and/or attorneys
 - Face-to-face or virtual site visits may be initiated
- **Corrective Action Plans**
 - Based on findings, Corrective Action Plans are often used to formalize go-forward standards
- **Settlement Agreements**
 - Financial resolutions with goal to make client whole again.
 - Litigation may be pursued

Driving resolution often leads to settlement agreements that include targeted Corrective Action Plans (CAPs), if applicable, for providers and allocating recovered funds to our clients. Investigators partner with Legal to ensure compliance with state and federal regulations and internal policies in order to facilitate resolution with providers. These agreements and associated plans are developed based on extremely detailed communication and documentation of concerns. Settlement meetings are scheduled to resolve outstanding damages, denied claims, work towards flag removal and behavioral change. A typical settlement meeting involves the provider presenting their program, the Special Investigations Unit (SIU) Investigator presenting investigative findings and the Attorneys discussing a financial settlement.

Using Advanced Technology and Data Mining Techniques to Identify Suspect Behavior

The methodology of when to apply post payment retrospective review through the use of analytics is as follows:

Cigna employs two full and complementary analytics teams, one team of Data Scientists employed directly by Cigna, and another contracted through Healthcare Fraud Shield (HCFS). Each of these teams include a full suite of relevant capabilities including advanced analytics in the form of AI and rules-based modeling, as well as aligned clinical and coding resources to refine risk identification. Further, Cigna has invested heavily in the latest technology including a dedicated data mart of over a billion claim lines that are scored to drive independent risk profiles for providers, clients, and customers. A few of the technologies employed to detect fraud or suspicious activity includes:

- Dedicated Data-Mart (Healthcare Fraud Shield)
- Claim detail for over 12 million medical customers (over 1 billion claim lines) are loaded on a weekly basis for risk scoring based on over 1,200 rules-based alerts. In addition, unsupervised learning, also referred to as Artificial Intelligence (AI), is used to identify aberrant behavior that may not be overtly detected in a rules-based approach.

- **Geospatial Analytics (ArcGIS)**
Data is modeled for probability risks, i.e., events that are unlikely to be appropriate. Examples in this space include billing from disaster zones (wildfires, hurricanes, etc.), and prescribing from long distances.
- **Social Media Monitoring (Pipl)**
Key word monitoring is in place to identify social media traffic related to potential fraud schemes.
- **Link Analysis (i2)**
Public record information for subjects of investigations, coupled with internal data points, are loaded to IBM's i2 link analysis software to more clearly identify the extent of fraud activity. Examples include linkages of registered agents, telephone numbers, addresses, relationships, etc. This software is often used to expand an investigation through finding additional individuals or entities of interest.
- **Multiple Control Models (Python, R, SAS EG, SQL)**
Many models are run on an ongoing basis. Examples in this space include tracking all data elements associated with individuals or entities suspected of inappropriate billing, and monitoring claim activity for any potential data matches.

General Analytics and Partnership - Partnership across the Cigna enterprise, as well as leadership within the National Health Care Anti-Fraud Association (NHCAA), allows the SIU to rapidly leverage learnings from both Cigna's portfolio and the industry in general. Examples in this category include researching movement in Cigna's Non-Par spending for particular services or regions, ongoing monitoring of industry schemes, and leveraging key industry data sources (Obituary data, Heat Zone list, CMS spending, List of Excluded Individuals/Entities (LEIE), NPI/eCARE etc.).

Healthcare Fraud Shield Process

As noted under Step 2, evidentiary standards, Cigna Partners with Healthcare Fraud Shield to generate aggregate statistics designed to detect potentially suspect Fraud, Waste, Abuse and/or Errors. The alerts and dashboards include a variety of components including, but not limited to, patterns of behavior that detect aberrancies in claims data, targeted known schemes that mirror industry standard guidelines, as well as external data providing information on potential adverse actions (sanctions, exclusions). There are 1,413 active alerts which include M/S and MH/SUD lines of business. An example of a rule monitored by this vendor is the Outlier, Excessive Procedures Per Day: This rule reviews providers billing for excessive # of procedures/services performed per day (peer comparison).

Associated Vendors and Programs of Use

Cigna's anti-fraud analytics uses the below software and tools, which include vendor partners and the use of commercially available software:

- **Healthcare Fraud Shield** - Data-mart generating a risk score for all providers, clients, and customers. Loads include claims for 12 million medical customers. HCFS also hosts the case management system, which is integrated with the data-mart analytics engine.
- **ArcGIS** - Geospatial analysis identifying events that are unlikely to be appropriate. Examples in this space include billing from disaster zones (wildfires, hurricanes, etc.), and prescribing from long distances.
- **IBM i2** - Link analysis software leveraging Thompson Reuters CLEAR public record information, together with proprietary investigative work and data to identify additional parties of interest of interest.

- RatStats - Statistical sampling software.
- SAS Miner, SAS EG, SQL - Multiple models are run on an ongoing basis to ensure early identification of risk factors. These models are incremental to controls built into the HCFS data-mart.
- Other Enabling Technologies - Teradata Studio, Toad, CA Workstation, Tableau, Cognos, etc.

As for the Special Investigations Unit, key vendor partners and related software partnerships are summarized as follows:

- Healthcare Fraud Shield (HCFS) - HCFS is a critical partner in Cigna's anti-fraud efforts. HCFS hosts a data-mart that leverages paid claim data for 11 million medical customers to generate risk scores for literally every claim. These scores aggregate to identify risk by provider, by customer, and by client. We also employ HCFS to provide proactive analytics as a supplement to our dedicated advanced analytics team. This dual approach effectively puts two talented and experienced teams on proactive analytics to ensure risks are identified quickly.
- Prest & Associates - Performs medical reviews for investigations focused on behavioral services. An MD with a behavioral focus reviews full medical records for a number of customers of a particular provider/facility to validate services are appropriate and consistent with standards. Results are aggregated and reviewed in detail as a part of the investigative process.
- TCS - Reporting and data acquisition is supported in part by TCS as a vendor. A total of eight outsourced full-time employee (FTE) supports this body of work.
- Thompson Reuters - While not strictly a vendor partner, Thompson Reuters' CLEAR is an enabler leveraged to further research individual customers, physicians, registered agents, etc.

Overpayment Recovery Efforts

Cigna relies on a number of external vendors to implement its overpayment recovery efforts. Cigna's overpayment recovery vendor programs are primarily focused on medical claims. The only MH/SUD overpayments that vendors pursue would involve duplicates, termination of benefits, non-covered dependent, coordination of benefits (COB), processing errors, billing errors, payee errors, incorrect assignment of benefits, incorrect copay, incorrect deductible, incorrect fee schedule, case rate reduction, and failure to follow claim check guideline. Specific to MH or SUD, none of the vendors are contracted to review for clinical medical necessity, fraud or perform coding edits.

Cotiviti represents one of Cigna's primary vendors and the largest overpayment recovery partner in identifying overpayments for a broad number of reasons, as specified below. Hence the analysis relies heavily on Cotiviti's information. The process utilized by Cotiviti does not vary based on whether the underlying service is for a MH/SUD or M/S condition.

While being listed as a vendor, Cotiviti, specifically handles overpayment research, COB research, recovery, and reconciliation. Cotiviti is contracted in a first pass capacity for overpayment data mining (includes COB), meaning that Cotiviti has the opportunity to identify overpayments before the other data-mining vendors. Cotiviti pursues overpayments that have been identified internally by Cigna. Since Cotiviti is Cigna's largest partner (80+% of data-mining activity), Cigna relies heavily on Cotiviti's analytics and reporting staff.

Cotiviti does not have edits that target MH/SUD related claims. These types of claims would be subject to the same edits as the rest of the medical claims for items such as duplicates, termination of benefits, non-covered dependent, COB with Medicare, COB with group insurance, COB calculated incorrectly, processing error, billing errors, payee errors, assistant surgeon reduction, multiple surgical reduction,

incorrect assignment of benefits, incorrect anesthesia allowance, incorrect copay, incorrect deductible, incorrect fee schedule, case rate reduction, and failure to follow claim check guideline.

The chart below lists each of the post-payment recovery vendors with a brief summary of the services they render to Cigna:

Vendor Type	Vendor Name	Service Summary
Post-Pay Recovery	Cotiviti	Cotiviti performs overpayment research, COB research, recovery, and reconciliation.
Post-Pay Recovery	Optum	Optum/AIM is a sweeper credit balance recovery vendor. Optum/AIM also does overpayment identification and recovery.
Post-Pay Recovery	Conduent Credit Balance Solutions	Conduent is Cigna's primary credit balance recovery vendor.
Post-Pay Recovery	End-Game Strategy (EGS)	End-Game Strategy identifies overpayments.
Post-Pay Recovery	Change Healthcare	Change Healthcare performs Overview Diagnosis-Related Groups (DRG) and post-pay Hospital Bill Audits. Change Healthcare also reviews medical implants, high-cost pharmacy claims for overpayments.
Post-Pay Recovery	Johnson & Rountree Premium (JRP)	Johnson & Rountree Premium collects dollars identified by End-Game Strategy and MultiPlan.
Post-Pay Recovery	Rawlings	The Rawlings Company researches COB with Medicare and commercial carriers.
Post-Pay Recovery	Conduent Payment Integrity Solutions	Conduent performs subrogation investigation and recovery to identify claims that are potentially accident related or there is some other third-party liability.
Post-Pay Recovery	MultiPlan	MultiPlan identifies overpayments.
Post-Pay Recovery	TREND Health Partners	TREND is a sweeper credit balance recovery vendor.

The factors relied upon in determining whether an overpayment has occurred rely on coding algorithms that are both voluminous and deeply proprietary to Cigna's external vendors. These algorithms have demonstrated effectiveness in applying plan and contract terms related to coordination of benefits (COB), plan cost-shares, and provider billing/ negotiated rate criteria. While not easily distillable into a discrete analysis, these vendor standards are designed to apply in a manner that reduce provider abrasion and ensure accurate application of plan/contract terms. As a result, these efforts are not considered a non-quantitative treatment limitation (NQTL), but the means of implementing given factors, strategies or other evidentiary standards that support a given NQTL. A review of the results of applying these standards, however, demonstrates that they are applied no more stringently to MH/SUD benefits than to M/S benefits.

Cigna's U.S. Employer segment provides post payment claim review services designed to identify claim overpayments for Cigna's clients and customers. Cigna works in partnership with various vendors, who apply proprietary processes, algorithms or tools to identify claim overpayments for both in-network and out-of-network provider claims.

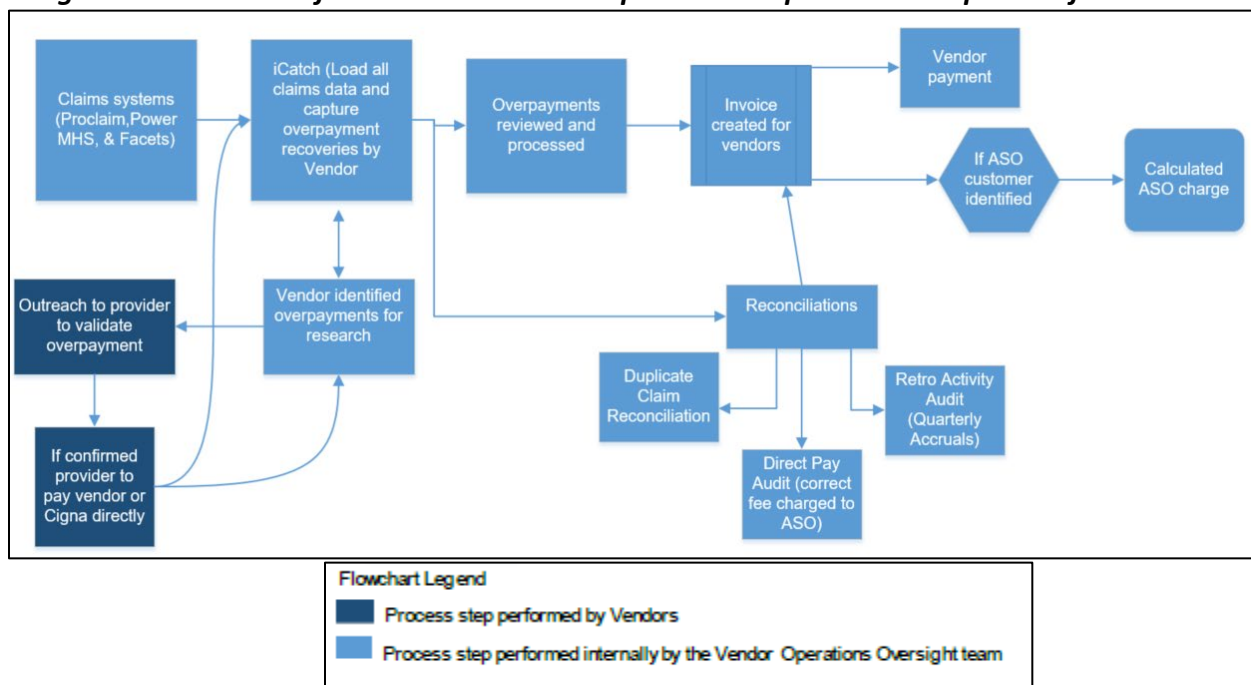
Cigna leverages several different vendors in the recovery process for claim overpayments, each

specializing in its own type of recovery such as subrogation, hospital bills, coordination of benefits, medical implants, or high-cost pharmacy claims. The Vendor Operations Oversight team in partnership with Global Procurement, manages the oversight of each vendor relationship. Vendor oversight includes monitoring adherence to established Service Level Agreements (SLAs) and day-to-day administration of claim overpayment recoveries utilizing the iCatch system. The iCatch system is utilized by Cigna to transmit claim data to vendors, calculate vendor fees and calculate cost containment fees to be charged to Cigna's self-funded ("ASO") clients. Approximately 70-75% of claim overpayments identified are recovered. Vendor fees range from 6.5-18% of the amounts recovered and cost containment fees charged to ASO clients range from 29-35% of the recovery amounts with the balance of the amount recovered passed through to the ASO client or retained by Cigna if the claim was self-insured or fully-insured, respectively.

Reconciliations are performed by the Vendor Operations Oversight team leveraging a combination of manual and automated controls. These reconciliations are designed to detect duplicate overpayment recovery fees, and verify the reasonableness and accuracy of overpayment recoveries, vendor fees, and cost containment fees.

The top three vendors, Cotiviti, Conduent, and Change Healthcare, accounted for approximately 81% of the \$753 million in overpayments recovered in 2022. Approximately 85% of these overpayments is applicable to our ASO book of business. The majority of overpayments is driven by subrogation research, coordination of benefits research and post pay hospital bill audits. The vendors do not identify M/S versus MH/SUD claims. Through the oversight process Cigna has learned that behavioral claims recoupment volume is low typically relate to specific administrative reasons such as retrospective terminations, coordination of benefits or duplicate payment.

A high-level overview of the cost containment process is captured in the process flow below:



Cigna's SIU regularly pursues overpayment recoveries. Settlement agreements, including targeted Corrective Action Plans, often serve as the means to resolution. These agreements appropriately balance documented overpayments versus claim denials to reach resolution. As is implied, the Corrective Action Plan focuses on resolving the issue(s) related to billing and/or services. Recovered

funds are distributed to clients based on their proportional loss associated with the provider. Cigna's SIU, partnering with Cigna Legal, drives the recovery process. No recovery fees are charged to clients.

In cases where a SIU investigation has identified money paid because of fraudulent activity, the SIU initiates the recovery process. Upon recovery, the money is allocated back to the individual client bank account based on proportional exposure to the specific case. Cigna does not use a third-party recovery vendor; recoveries are pursued through settlement agreements, including Corrective Action Plans, as well as engagement with both internal and external legal counsel. While these procedures do not vary for in-network and out-of-network claims, if parties fail to agree on appropriate settlement, the contract prevails for an in-network health care provider. This translates to arbitration for an in-network provider versus litigation for an out-of-network provider.

The possible actions from overpayment recovery are that Cigna's vendors pursue recoveries through outreach to providers (letters, phone calls, faxes, emails, etc.). Providers refund the vendor by check and the vendors send Cigna those funds for processing. Cigna may ask Contracting/Provider Relations to facilitate recovery discussions with uncooperative or unresponsive providers. Those discussions may lead to corrective actions (moving a provider to pre-payment review, initiating mediation or legal action or even terminating a provider's contract). Cigna Provider Contracting frequently requests overpayment inventory and issues prior to beginning re-contracting discussions. This information may be useful as they design their contracting strategy with the provider.

Cigna's overpayment recovery vendors operate without regard to whether a given service is for an MH/SUD or an M/S condition. As such, their written policies and procedures applicable to MH/SUD benefits are comparable to (in this case, identical to) and no more stringent than the policies and procedures applicable to M/S benefits. For example, hospital billing audits apply generally to all facilities and do not differentiate between MH/SUD providers and M/S providers. In fact, some of Cigna's overpayment recovery processes, such as DRG audits, apply only to M/S services, as Cigna does not reimburse facilities for MH/SUD services on a DRG basis.

Recoupment Vendors, not specifically SIU

Cotiviti receives claim spend from Cigna based on the contractual agreements in place related to process, data and frequency. Cotiviti intakes the applicable data fields required to perform agreed services, including but not limited to member information, service information, and billing details. Cotiviti then applies exclusions as directed by Cigna where applicable, including certain claim types, providers, and/or employer groups.

Cotiviti then applies proprietary analytics and algorithms in an effort to identify claims to be most likely overpaid based on the reasons outlined above. These processes are established based on approved concepts with Cotiviti's experience over more than 20 years with more than 40 plans.

Based on these data analyses, Cotiviti then groups claims with potential overpayments by reason code such as Coordination of Benefits, Data Mining, and Pharmacy. Additional detail is also identified such as the overpayment being related to a Duplicate Payment, Provider Billing, Contract concern or High-Cost Drug. These algorithms are applied across claims deemed in scope by Cigna and a single claim can be found across one or more overpayment reason types at the same time. Cotiviti ensures overpayments are only pursued for a singular reason based on the most appropriate term (e.g., Cotiviti would not pursue a contract reason if it also determined that Cigna should not have paid as primary due to coordination of benefits). From an overpayment recovery contract, Cotiviti performs data

mining and recovery. Cotiviti looks for billing, eligibility (benefit related), COB, billing/processing or contractual payment errors for Cigna. Cotiviti does not review for clinical medical necessity, fraud or perform coding edits on any Cigna business. Cotiviti's overpayment edits and algorithms are proprietary. When Cotiviti wants to implement a new edit, it must submit the concept to Cigna for approval.

As our expert partners, they are tasked with achieving maximum savings. The expert partners are paid on a contingency basis, incenting them to recover maximum dollars. All of the vendors have monthly and yearly recovery targets. Variances to those targets are discussed monthly.

Cotiviti then deploys expert resources to review claims to identify if and to what amount a claim was overpaid. Cotiviti's overall prioritization of review occurs based probability of overpayment and of highest value to Cigna. If Cotiviti identifies an overpayment based on a new concept, the applicable details such as claim examples, policy, etc. are shared with Cigna to ensure that the approach meets Cigna's approval. Once an overpayment has been identified via the data provided by Cigna accompanied by any applicable sourced data required, Cotiviti performs various quality assurance efforts. Cotiviti then follows the applicable submission processes established in partnership with Cigna.

Submissions to providers begin by sending a letter to providers notifying them of overpayment. After an initial letter is sent, manual follow-up from Cotiviti's recovery team begins. Manual follow-up to include emails, faxes, and phone calls. The frequency of communication varies depending on the provider preferences.

Determining factors to frequency include, but are not limited to, the total outstanding overpaid balance or for high recovery participating providers, an agreed-upon schedule that drives their successful performance. Some examples include:

- A number of providers will only communicate through spreadsheets and emails
- Some providers will only speak to Cotiviti on certain days of the week
- Monthly calls with providers to discuss their top 5-10 overpayments

Cotiviti prioritizes outbound efforts based on value to Cigna as well as limiting abrasion to providers. An example of this would be that Cotiviti makes calls at the provider level, not the claim level, to maximize recoveries while reducing the need for multiple calls to the provider for each individual claim.

High-level Cigna Vendor Process Overpayment Recovery/Recoupment

Cigna vendors do not use diagnosis codes when data mining and do not store diagnosis codes data field, meaning the vendor does not know when claims are M/S or MH/SUD.

Cigna has a database that all vendors use to submit overpayments. The database ensures that multiple vendors are not pursuing the same overpayment. All vendors receive files of all claims that were paid the previous week. The claim files include all necessary information to identify potential overpayments. Cigna vendors specialize in different types of overpayments and may have special skill sets to identify overpayments specific to their contractual relationship with Cigna.

All of the vendors initially apply automated proprietary edits to identify "potential" overpayments. Those overpayments are manually reviewed/validated by highly qualified analysts using information in Cigna claim systems, provider contracts, member eligibility and other relevant applications.

Validated overpayments proceed to the vendor's recovery staff. The actual recovery process can vary significantly based on such criteria as provider relationship, age of overpayment, amount, and type of overpayment. Typically, the recovery process begins with a mailed refund request letter. Follow-up may include additional letters and phone calls to the provider.

Cigna vendors have found that customizing the recovery approach to meet a particular provider's needs has worked effectively and many of Cigna's larger providers are set up with a customized approach. See below for items considered when determining follow-up dates and outreach methods:

- Size of overpayment - On large overpayments, our vendors may call or fax the provider on the same day that the first letter is released.
- Type of overpayment - With certain types of overpayments (Coordination of Benefits or retro terms), a provider will not refund until they have billed the correct party and been paid. This takes several months, and overly frequent follow-ups can frustrate the provider and decrease cooperation.
- Relationship or arrangement with provider – vendors may partner with large providers to customize recovery procedures. Some providers do not want letters and instead want to get a weekly or monthly spreadsheet of overpayments needing resolution. Other providers will only work overpayment requests on a certain day of the week or month.

If our vendor and Cigna have exhausted all reasonable efforts to recover an overpayment, the file is closed without recovery. If recovery is achieved, our vendor sends refunds to Cigna for processing.

Notably, the recovery team does not differentiate between claims that are considered MH/SUD vs M/S, nor is there an indicator for MH/SUD vs M/S in the recovery system.

Hospital Bill Audits and Overpayment Recovery

Cigna is contracted with Change Healthcare to perform Hospital Bill Audits and recover associated overpayments.

Process

Change Healthcare verifies that facility reimbursement is based on actual services rendered by comparing the medical documentation against the itemized bill. Audits are performed by licensed Registered Nurses. Any overpayments discovered during the audit are documented and recovery is pursued by Change Healthcare.

Claim Types and Criteria:

- Inpatient hospital/facility claims over \$10,000
- In-network or out-of-network providers with percent off charge reimbursements

Average Hospital Bill Audit Reduction: 3-5% average savings per audit

Inpatient hospital/facility claims means related to hospital stays (patient is admitted to the hospital and is considered "inpatient"). Hospital and facility are the same thing. Claims over \$10,000 is billed charges over \$10,000 (the hospital bills Cigna charges for the member's hospital stay and those charges are over \$10,000). Some hospitals are contracted with Cigna to pay a % of what the hospital bills/charges, for example, hospital contract requires Cigna to pay 60% of billed charges. Hospital bills \$100,000, Cigna payable would be \$60,000. Our vendor reviews various factors associated with a hospital stay to choose certain claims for audit. The 3-5% average savings is calculated as what % of the

Cigna payment can be overturned as incorrect/overpaid and recovery pursued.

Diagnostic Related Groups (DRG) Audit and Recovery

Cigna is also contracted with Change Healthcare to perform DRG audits and recover associated overpayments. It is worth noting that DRG audits are specific to M/S services given there are no MH/SUD DRG arrangements.

Process

The vendor audits medical documentation to ensure that the diagnosis and procedure codes which generate the DRG, and therefore, the hospital invoice, are accurate, valid and sequenced in accordance with national coding standards. Any overpayments discovered during the audit are documented and recovery is pursued by the vendor.

Claim Types and Criteria

- Inpatient hospital / facility claims
- Claims paid based on DRG reimbursements.

Average DRG audit reduction: 41% average reduction per DRG audit. Average savings per claim is greater than \$5,000.

The 41% average reduction would be the amount that the paid claim should be reduced by after the audit findings.

Credit Balance Recovery

Credit balance recovery vendors perform on-site reviews of the credit balance ledgers at hospitals to ensure that hospitals collect appropriate amounts of cost-share and other revenue related to claims paid by Cigna. These audits are conducted with respect to in-network providers who have contractually agreed to provide Cigna with access to conduct such audits to ensure the payment integrity of benefits insured by Cigna. Vendor services include initial contact with provider, scheduling of audits, review of credit balance for accuracy, and collection of overpayments.

A credit balance vendor represents multiple payors during their process of performing regularly scheduled audits at hospitals throughout the country. The credit balance vendor service augments our internal and other vendor initiatives by identifying overpayment opportunities that may not be identified without access to provider data (e.g., provider billing errors). Many times, Cigna does not have access to information that a provider has. Cigna pays claims based on information on the provider's bill which is prepared by the provider, with the information that the provider has at the time of billing. When the provider receives payment, the amount received may no longer match exactly what the provider is expecting (new or corrected information may have been received). The vendor reviews the provider information, reconciles the payment and presents findings to the provider. These findings can include the need for various adjustments, including a change in the member liability, overpayments or even underpayments. The vendor requests the overpayment from the provider and routes the refund back to Cigna for processing.

A billing error occurs when the provider inaccurately codes a bill for services. This can occur for many reasons. The error can be a billing analyst error (typo, knowledge deficit, unclear or incomplete medical service notes, etc.). Also common, additional information becomes available which changes components of the charges on the bill.

Cigna is contracted with three vendors for this service. Each vendor is assigned specific facilities. Cigna's vendors are Optum/AIM HealthCare, Conduent (formerly known as CDR Associates), and Trend Health Partners.

Coordination of Benefit Recoveries

While Cigna conducts an initial review, a secondary recovery vendor specializes in custom-tailored identification programs. They focus on areas that may require special analysis. These vendors identify overpayments not identified by our internal baseline efforts by performing a "secondary sweep" of our claim data. They operate on a 60–90-day lag, giving Cigna's internal teams the opportunity to identify overpayments first.

A secondary sweep means that Cigna currently contracts with two vendors who investigate customers for other insurance (Medicare or other commercial insurance). The second vendor is a safety net, looking for COB opportunities/overpayments not identified by the first vendor. Both vendors have proprietary edits that focus on different triggers that might mean that a customer has other insurance. Investigation is completed by the vendor verifying the other insurance and primacy. Overpayments identified during that process are pursued for recovery. Vendors send Cigna updated eligibility and primacy so that we are able to coordinate claims correctly going forward.

Cigna does not perform any recovery functions.

Cigna is contracted with Cotiviti (Accent/HMS), End-Game Strategy, Optum/AIM Healthcare and Multiplan to act as secondary overpayment identification vendors. Recovery for End-Game Strategy and Multiplan is handled by Johnson & Rountree Premium (JRP). Cigna is also contracted with Rawlings to identify coordination of benefits with Medicare and other commercial payers.

Step 5: Demonstration of comparability and stringency in operation.

See [45 CFR 146.137\(c\)\(5\)](#). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

- (A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;
 - (B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;
 - (C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and
 - (D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);
- (2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);
 - (3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:
 - (A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];
 - (B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);
 - (4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:
 - (A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

- (B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH and SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and
- (5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:
- (A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and
- (B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

SIU

In Operation:

On an annual basis, Cigna reviews applicable operational data with Subject Matter Experts to assess ongoing relevance and makes updates as necessary. Cigna applies general policies without regard to whether a given service is a MH/SUD or M/S service. In operation, the SIU has investigated a significantly larger number of potentially fraudulent M/S claims as compared to MH/SUD claims.

FWA Investigations	2025	
M/S	806	85.20%
MH/SUD	140	14.80%
Grand Total	946	

Based on the data, it is evident that the majority of claims reviewed by the SIU pertain to M/S claims. The 2025 data indicates that M/S claims constituted 85.20 percent of claims subject to SIU activity, clearly demonstrating that the factors and processes applied to MH/SUD benefits are no more stringent than those applied to M/S benefits.

The fraudulent schemes come to SIU via an internal, external and or analytics referral/alert process regardless of MH/SUD or M/S. SIUs analytics, processes, and the decision to investigate are applied in a manner that addresses the level of risk to our clients and customers. There is no disparity in the identification of SIU activity applied to MH/SUD as compared to M/S.

Overpayment Recovery

In operation:

To ensure appropriate tracking, all data files to and from vendors are sent using secure transfers. Vendor operations then maintain a list of file transfers which may be used to identify and address issues. Cigna is responsible for ensuring access to appropriate/updated training resources and hold monthly operational calls to address questions.

Given the broad scope of overpayment recovery efforts and the fact that Cigna's vendors are not permitted to differentiate between MH/SUD and M/S benefits, demonstrating operational parity requires reliance on statistical sampling. As such, the charts below demonstrate the relative impact on MH/SUD claims versus M/S claims.

Evidence to support MHPAEA compliance is demonstrated in the table below. MH/SUD claims make up

approximately 11% of Cigna’s total claim spend. Cotiviti’s identification rate is just below that at 9.7% and 9.6% for 2024 and 2025 respectively and recovery rates are 9.4% and 8.3% for the same time periods.

	2024		2025	
% of Claim Spend	MH/SUD	M/S	MH/SUD	M/S
Total Spend %	11.3%	88.7%	11.4%	88.6%
Total ID %	9.7%	90.3%	9.6%	90.4%
Total Recovery%	9.4%	90.6%	8.3%	91.7%

*Data represented herein is based on the eligible Cotiviti data, as provided by Cigna. Data specific to Overpayment Findings and Recoveries are only representative of results delivered by Cotiviti. Cotiviti determined MH/SUD claims in this analysis by identifying claims containing diagnosis codes within the F01-F99 CPT Code Range.

Similar ratios appear when the identification and recovery data is viewed as a percentage of total claims dollars:

	2024		2025	
As a % of Claim \$	MH/SUD	M/S	MH/SUD	M/S
Total ID %	0.56%	0.67%	0.60%	0.74%
Total Recovery%	0.11%	0.13%	0.19%	0.27%

And for total claims volume:

	2024		2025	
As a % of Claim Count (#)	MH/SUD	M/S	MH/SUD	M/S
Total ID %	0.18%	0.18%	0.23%	0.23%
Total Recovery %	0.03%	0.04%	0.06%	0.08%

As is clear from the above, the agnostic criteria utilized by Cotiviti results in a lower percentage of MH/SUD claims being subject to overpayment recovery, as compared to the total amount of Cigna’s claims spend that is made up of MH/SUD claims. This presents an overall favorable view of the impact on MH/SUD versus M/S claims with respect to application of the overpayment recovery processes.

Step 6: Findings and conclusions.

See [45 CFR 146.137\(c\)\(6\)](#). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

- (1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or

- intends to take to address any potential areas of concern or noncompliance;
- (2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;
 - (3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;
 - (4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and
 - (5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the [FAQ 45](#) guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Cigna applies the same processes and factors with respect to identifying and investigating potentially fraudulent, wasteful, or abusive provider claims practices, without regard to whether the provider is considered an MH/SUD or M/S provider or facility. The operation of Cigna's Special Investigations Unit (SIU), which results in post-payment retrospective review of claims, is identical for both MH/SUD and M/S claims and therefore meets the comparability requirement.

In operation, the SIU program is applied no more stringently to MH/SUD benefits as it is to M/S benefits, as evidenced by the significantly higher number of claims investigated for M/S services as compared to MH/SUD services. The investigative activity is driven by those engaged in fraudulent schemes. The fraudulent schemes come to SIU through an internal, external and or analytics referral/alert process regardless of MH/SUD or M/S benefits. SIUs analytics, processes, and the decision to investigate are applied in a manner that addresses the level of risk to our clients and customers which is applied comparably to MH/SUD and M/S benefits.

Similarly, with respect to overpayment recovery efforts, Cigna and its vendors apply the same factors and processes when evaluating whether or not a provider was paid an inaccurate amount for any number of reasons. As evidenced by the relative proportion of MH/SUD recoveries as compared to M/S recoveries, which are roughly equivalent to Cigna's total book of business in terms of proportion

between MH/SUD and M/S claims, the application of those factors and processes do not result in a more stringent application of the overpayment recovery processes to MH/SUD benefits than to M/S benefits, and in fact are more stringent with respect to M/S benefits than to MH/SUD benefits.

In conclusion, this comparative analysis performed for application of post-payment retrospective review processes demonstrates compliance with the NQTL requirement in-writing and in-operation. Cigna's analysis of the applicable processes and factors governing the application of post-payment retrospective review and overpayment recovery across MH/SUD and M/S benefits demonstrates comparability and equivalent stringency of any such processes in-writing. Not only is the written process identical, but the application of those identical processes results in comparable, and often less stringent application of those processes to MH/SUD benefits as compared to M/S benefits.

This version of the analysis was drafted and performed in 2026 based upon Cigna's 2025 book-of-business data, by members of the legal, compliance, and various business teams, including the following individuals:

Mental Health Parity Legal Team including:

Managing Counsel;
Associate Senior Counsel; and
Legal Compliance Senior Advisor

Mental Health Parity Compliance team including:

Legal Compliance Senior Manager;
Legal Compliance Senior Advisor

M/S and MH/SUD subject matter experts including:

Director, Corporate Audit Data & Analytics;
Managing Director, Business Analytics; and
Senior Director – Special Investigations