

I. Appeal Item Number Nine (9)

Cigna's non-production and/or failure to identify requested documents denied Mr. XXXX the opportunity to a "full and fair" review of the evidence for a second time during the appeal process.

Cigna has once again failed to produce numerous relevant documents pursuant to ERISA claim procedure 29 C.F.R. § 2560.503-1(g)(1), (h)(2), (i)(5), (j)(5), and (m)(8) and the DOL Frequently asked Questions on ERISA Procedure:

Relevant Documents (29 C.F.R. § 2560.503-1(g)(1), (h)(2), (i)(5), (j)(5), and (m)(8)):

A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

- (i) Was relied upon in making the benefit determination;
- (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
- (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Department of Labor Question C-17 states: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v) (A) and (j)(5)(i); 65 FR at 70251. §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).

The following "relevant" documents, which were clearly and unequivocally requested by Mr. XXXX, have never been produced:

1. Cigna "Claim -handling" Manual pursuant to 29 C.F.R. § 2560.503-1(g)(1), (h)(2), (i)(5), (j)(5), and (m)(8) and DOL Frequently asked question C-17
2. TSA/LSM referral document or any correspondence sent to Ms. XXXX. There is no correspondence in the file sent to Mr. XXXX by Cigna. How did Cigna communicate and correspond with Ms. XXXX? How did Ms. XXXX learn about the earning threshold? What were her instructions regarding "theories"? Getting back and forth to work? Oxycontin? Judgment? Standing?
3. Any "independent medical review" documents and the identification of the physician performing the "Independent medical review" as required by ERISA. (Both Ms. Johnson and Mr. Person mentioned an "independent medical review" in numerous correspondences dated November 10, 2006, November 13, 2006, December 27, 2006 and January 30, 2007). Dr. XXXX works for Intracorp, as the Acclaim notes indicate, thus he is not "independent". The word "independent" is in part defined as - not affiliated with a larger controlling unit. Intracorp is a fully owned subsidiary of Cigna. Mr. XXXX has a right to know the physician's name that performed the "independent" medical review and to see all documents associated with it.
4. Correspondence between Cigna and XXXX notifying the Plan Sponsor (UTC) of Cigna's decision.
5. Invoices "generated in the course of making the benefit determination" for the services rendered by XXXX, Dr. XXXX and any "independent medical reviewer". Their absence indicates Cigna does not get billed for services rendered by employees of the company and that an "independent medical review" never took place.