# Quality Review Tips!

Logically Contact Information:

- Business Hours (Monday through Friday 8:00am-5:00pm ET) 1-(866)-946-9638 option 1, Access Pin 221
- After Hours, Holidays & Weekends 1-(919) 856-2300 option 1

Vacation Requests: Please send to referralteam@bbabsence.com

Concerns/Comments/Requests: Please send to referralteam@bbabsence.com

As you may have seen, we have had a recent uptick in referrals for Cigna cases, more specifically, Cigna Core. A lengthy discussion around the expectation for their template took place and we have developed this month's tip for you to use as a guide.

**Cigna Tips**

- Use template provided from Cigna that is imbedded into the referral. Per Cigna's Medical Director, do not change the order of the template.

**Cigna Template-**

**Reason for Referral:**

- The primary area of disagreement identified in referral, including any RLs from the AP
- If you copy and paste from the referral, please use quotations
- The time frame under review may also be added here

**File Review:**

- For both CORE and APPEAL cases: This should be documented the same as a Medical History section of a report
- Ensure ALL records that were received are noted here
- Your review should include AP names, dates and pertinent information from each OVN, imaging, testing, forms, etc. **that would come into play in your analysis.** Symptoms, complaints, medications, injections, whether it is normal or abnormal findings that is supportive of your rationale

**My Assessment:**

"All of the customer's conditions have been assessed to determine which conditions may independently or collectively impact the customer's functionality (co-limiting). My medical analysis has determined that the following are co-limiting conditions, with respective associated limitations and restrictions <identify each co-limiting condition considered and list any stated or identified L(s)/R(s) for each>:"

- Identify each impairing condition and list any stated or identified L(s)/R(s) for each

- If no impairment is supported by the medical evidence, then indicate “none”

**Attestation Section-**

I have reviewed and conducted a separate analysis of the issue or issues upon which there is disagreement and I conclude that the position of the internal medical resource, which is in disagreement with the treating provider, is **<correct/incorrect>.** [OR I **<disagree/agree>** with the treating provider]. The treating provider’s opinion **<is not/is>** well supported by medically acceptable clinical or laboratory diagnostic techniques and is **<inconsistent/consistent>** with the other substantial evidence in the claim file because: ***<provide a statement of the issue or issues upon which you disagree with the customer’s HCP(s) and a detailed rationale/analysis supporting your conclusions>*:**

- What is the AP/IMR opinion and the date of the opinion (this should be documented in your file review section)
- Respond to this opinion
- Reiterate these opinions. Do you agree? Do you disagree? Provide your rationale
- The IMR opinion may be found in the referral
- Point out any evidence that is consistent or inconsistent

**<Complete the below section only where you disagree with the treating provider’s opinion>**

**Is the customer functionally limited? If so, describe how the customer is functionally limited.**

**Considering the customer’s functional limitations and the treatment(s) required for their condition(s), what medically necessary activity restrictions are appropriate?**

- This is for the time period under review
- Do not comment on IF the condition is permanent or if the customer is at MMI
- Do not focus on what was not done or recommend treatment.
- Do not opine on additional diagnosis or suggest additional diagnosis. Rather comment only on what the provider has addressed

***<Complete the below section only where applicable>***

The following conditions are out of my area of expertise, and I have not included consideration of them in my analysis:

- List conditions out of scope of reviewer.

**In the rare instance you opine that there is a lack of exam findings/ medical records to render a decision, please remove the last 2 bullets from the template (below) and insert this statement:**

“Considering all the current available medical records/ documentation, I am unable to certify the presence of continuous functional limitations or necessity of activity restrictions and limitations. Should additional records become available, re- assessment may be reasonable”.

- Is the customer functionally limited? If so, describe how the customer is functionally limited.
- Considering the customer’s functional limitations and the treatment(s) required for their condition(s), what medically necessary activity restrictions are appropriate?

**AP Calls if required:**

- 2 calls on 2 separate days, 24 hours apart.

**Cigna has very specific terminology that would like used in the reports:**

- *Customer* rather than Claimant/Patient/Employee
- *Symptom Complaints* rather than subjective complaints
- *Exam Findings/testing* rather than Objective Findings/ Clinical Evidence
- Global Impairment in functional capacity or no functional capacity rather than cannot work/ cannot perform job duties
- *Activity restrictions* rather than the claimant can work with RLs
- Suggest stating something to the effect of “based on the medical evidence reviewed” “it is reasonable to conclude….” Some examples to avoid are: “it is in my opinion”, “it is likely”, “I believe”, “it could be”, “it is possible”.
- Omit terms “at risk”, “more likely than not”, and at “high risk for.”
- Stay within your scope of practice
- Abbreviations: define word initially, then can use abbreviation

Please feel free to reach out to any of the Quality Review Nurses with questions on the QR Tips Qrteam@bbabsence.com

We hope this has been helpful and we welcome your feedback and questions.

Thank you,

The QR Team