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Lack of Information (LOI) Pre-Service

Table of Contents

Scope	1
General Background	1
Definitions.....	1
State/Federal Guidelines	2
Standard Procedure.....	3

Scope

The purpose of this policy is to establish a consistent process for “pending” pre-service decisions due to lack of clinical information reasonably necessary to make a decision.

General Background

Requests for service are reviewed to determine if reasonably necessary clinical information is available to make a utilization management (UM) medical necessity decision. When reasonably necessary clinical information is not provided, the request is pended for additional information as permitted by state mandates.

Timeline requirements for the return of requested information is based upon ERISA and/or state regulations. Customers and providers (acting as the customer’s authorized representative) are notified that a medical necessity decision has been pended while seeking additional information from the provider. The specific information needed for review is detailed in the written and verbal requests.

Definitions

For purposes of this policy “customer” means an individual participant or member.

Urgent:

- Could seriously jeopardize the patient’s life, health, or the member’s ability to regain maximum functionality, based on a prudent layperson’s judgment, or

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

State/Federal Guidelines

Mandated turnaround time requirements may apply for several states (i.e. Federal law and ERISA requirements also apply in most cases).

Reviewer qualifications for peer review and licensing may apply for several states.

- California (CA) If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information. If no additional information is received, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.
- New York (NY) All prior authorization denials for lack of information must be medical necessity denials whether a provider is in-network or out-of-network.
 - Request for additional information for "Standard" Pre-Service decisions must be made within 3 business days of receipt of request.
- Rhode Island (RI) requires we notify the customer and provider of the specific information required to complete the review within: 72 hours of receipt of request of urgent/emergent health care services; 15 business days of receipt of request to complete a review of non-urgent/non-emergent health care services; and prior to the expected date of service.
 - Requires the customer and provider be allowed a 72 hour extension for urgent/emergent cases to respond to request for additional information.
 - All Lack of Information denials are medical necessity denials
- Texas (TX) law requires medical necessity decision to be made if any clinical information is received. This information can include diagnoses, procedure codes, provider/facility medical charts or any type of document that contains clinical language (i.e. DO NOT deny for lack of information)
- Vermont (VT) law requires if matters beyond Cigna's control require an extension, customers will be notified prior to the expiration of the 30 day period.

Note: State mandates supersede Cigna standard

Standard Procedure

- A. Initial request for service is received which requires a medical necessity decision.
- B. Request is evaluated by a nurse to determine if reasonably necessary information is available to make a medical necessity decision.
 1. If reasonably necessary information IS available to make a medical necessity decision, the nurse adheres to established medical necessity review processes and timeline requirements. The Medical Director makes the decision on all medical necessity reviews which cannot be approved by the nurse. A resulting denial is based on medical necessity and NOT lack of information.
 2. If reasonably necessary information is NOT available to make a medical necessity decision, the request is pended for additional information and the specific information needed for review is requested from the provider.
 3. For non-urgent cases, this period may be extended one time by the organization for up to 15 calendar days:
 - Provided that the organization determines that an extension is necessary because of matter beyond the control of the organization.
 - Notifies the patient prior to the expiration of the initial calendar period, of the circumstances, requiring the extension and the date when the plan expects to make a decision
- C. Specific information needed for review is requested from the provider. The type of review and associated urgency of care drive the timeline requirements for requesting additional information, making a decision and providing customer/provider notification.
 1. A pre-service review is a review for care or service requiring an authorization prior to the care or service being received. Pre-Service reviews have an associated urgency of care: **Urgent or Non-Urgent.** The review is considered "urgent" if the timeline requirement for making a "non-urgent" decision could result in the following:
 - Could seriously jeopardize the patient's life, health, or the member's ability to regain maximum functionality, based on a prudent layperson's judgment, or
 - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
 - In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

D. The following action steps are taken based on the type of review and associated urgency of care (if applicable):

1. **“Urgent” Pre-Service:**

- a. Provider is informed of the specific information needed for review and the timeline requirement of forty-eight (48) hours to provide the information. A decision and notification is made within 48 hours from receipt of the requested information from the provider for authorization. If the requested additional information is not provided to Cigna within the allotted timeline, a decision is made within 48 hours or less from the deadline for submission of the requested information. Consider following wording: Provider is informed of the specific information needed for review and the timeline requirement for final decision to be made. If the requested additional information is not provided to Cigna within the allotted timeline, a decision would be made consistent with the UM-39 Timeliness Policy, Urgent Pre-Service requirements.
- b. UM system is documented to reflect the specific information needed for review, the timeline requirement for receiving the information and the name of the individual/department from which the additional information was requested.

The decision and notification would be made consistent with the UM 39 Timeliness of UM Decisions Policy for prospective, urgent cases.

2. **“Non-Urgent” Pre-Service**

- a. Provider is informed of the specific information needed for review. Decision is made within ten (10) Calendar days or less from receipt of all supporting information reasonably necessary.
- b. UM system is documented to reflect the specific information needed for review, the timeline requirement for receiving the information and the name of the individual/department from which additional information was requested.
- c. Unless otherwise required by state law, "Pending Request for Additional Information Letter" is sent to the provider, with a copy to the customer, if sufficient clinical was not received with request. If no response is received, the letter is sent again on calendar day fifteen (15) from the first letter requesting for additional information. The letter includes a request for additional information and the date the information must be received. The date the information must be received is forty-five (45) calendar days from the date of the initial

request plus five (5) calendar days to allow for mail delivery (i.e. the date is at least fifty (50) calendar days from the date of the initial request for additional information). If reasonably necessary information is not received by calendar day fifty-one (51), the applicable LOI denial and notification* or MD review, decision and notification* process is followed.

E. A request may be denied for lack of information if reasonably necessary information is not received within the timeline requirement. The following action steps are taken when additional information has been requested and is needed to make a medical necessity decision:

- a. If reasonably necessary clinical information is received within the timeline requirement, the nurse adheres to established medical necessity review processes and timeline requirements. *The Medical Director makes the decision on all medical necessity reviews which cannot be approved by the nurse. A resulting decision is based on medical necessity and NOT lack of information.
- b. If additional information is received within the timeline requirement but is limited or insufficient to make a medical necessity decision, any clinical information available is reviewed by the MD for a decision and notification*. A resulting decision and notification is based on medical necessity and NOT lack of information.
- c. If additional information is NOT received within the timeline requirement, any clinical information available is reviewed by the MD for a decision. The MD may outreach to the treating physician to obtain reasonably necessary information to make a medical necessity decision and notification*. A resulting denial is based on medical necessity and NOT lack of information.

* For all the above, the decision and notification would be made consistent with the UM 39 Timeliness of UM Decisions Policy for prospective, non-urgent cases.

- d. If NO clinical information is received within the timeline requirement, Only non- participating provider requests require an MD review when no clinical information is available and has been requested.

Denial notice must contain reference to clinical criteria that have not been met because of lack of information.

- If there is insufficient clinical information to reference a specific clinical guideline, the organization must state its inability to reference the specific criteria and must describe the information needed to render a

decision in a manner that is specific enough for a customer or their authorized representative to understand what is needed.

Example:

We cannot approve your request for [procedure] because we have not received the necessary clinical information [specify missing info (e.g. diagnosis, labs)]

- F. Product type and provider participation assist in determining customer/provider liability for resulting denials. Customer/provider liability is also contingent upon provider contracts and state regulatory requirements.
- **Participating provider** - customer may be held harmless for payment
 - **Non-participating provider**– customer may be responsible for payment and billed by the provider

***NOTE:** For the legacy PPO and indemnity products, the customer may be responsible for payment regardless of provider participation.