Policy Name	Policy Number
Lack of Information (LOI) Pre-Service	UM-49
Business Segment HealthCare	
Initial Effective Date: 08/2009	**Policy Committee Approval Date(s):** 6/23/20; 4/27/21; 3/8/22; 2/28/23
Replaces Policies: CGUM-III-8 Lack of Information CM-TP-01 LOI Failure to Respond to Transplant Zones; UM-US-013 Administrative Denial Following Non-Receipt of Requested Clinical Information	

Purpose:
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.

Policy Statement:
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.

If requested clinical information is not received within timeline requirements, the applicable denial/review process is engaged based on the following:

PROVIDER	NO CLINICAL	LIMITED OR INSUFFICIENT CLINICAL
* Participating	Denied for LOI	MD Review
**Non-participating	MD Review	MD Review

Definitions:
For purposes of this policy "customer" means an individual participant or member.

State/Federal Compliance:

- 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
- 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.
- 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
- Rhode Island 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

Note: State mandates supersede Cigna standard

Procedure(s):

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 (if applicable) 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:

   a. seriously jeopardize the life or health of the customer or the customer's ability to regain maximum function, based on a prudent layperson's judgment; or;
   b. In the opinion of a practitioner with knowledge of the customer's medical condition, would subject the customer to severe pain that cannot be adequately managed 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.

   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.

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 denial 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 denial 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 (a), (b), (c) 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,** the intake team determines if the requesting provider is participating or non-participating. If it is a participating provider, an administrative lack of information letter is sent by the Care Associate. Non-participating provider's requests are sent to the Prior Authorization nurse who determines if a MD review is required. 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.

G. The following action steps are taken based upon product type and provider participation when additional information is required to make a medical necessity decision and the request for service results in a denial:

- **Participating Provider**:

  a. If any clinical information is reviewed by the MD and results in a medical necessity denial, a medical necessity denial letter is generated. An Initial Medical Necessity denial letter is sent to the customer with a copy to the provider.
  b. If NO clinical information is received within the timeline requirement to make a decision, the request is denied for lack of information. The denial is administrative and MD review is not required. A Customer Held Harmless Lack of Information (MHHLOI) denial letter is sent to the requesting provider with a copy to the customer.

  c. If requested information is received after a denial has been rendered but prior to receipt of an appeal, a peer to peer reconsideration may occur in accordance with established processes. If the requested procedure has already been done, this would be considered a retrospective review.

Non-participating Provider

a. If any clinical information is reviewed by the MD and results in a medical necessity denial, a medical necessity denial letter is generated. An Initial Medical Necessity denial letter is sent to the customer with a copy to the provider. The customer may be responsible for payment if

services are rendered.

b. If NO clinical information is received within the timeline requirement to make a decision, a medical necessity denial letter is generated. An Initial Medical Necessity denial letter is sent to the customer with a copy to the provider. The customer may be responsible for payment if services are rendered.

c. If requested information is received after a denial has been rendered but prior to receipt of an appeal, a peer to peer reconsideration may occur in accordance with established processes.

Applicable Enterprise Privacy Policies:

https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
Adverse Decision Notification Elements Policy
Interact and Medical Director Case Review Policy
Peer to Peer Reconsideration of Medical Necessity Decisions Policy
Pre- certification of Inpatient, Outpatient and Ambulatory Services Policy
Timeliness of Health Services Decisions Policy

Links/PDFs: Attachment 1: Cigna Standard – LOI Timeline Requirements for Pre-Service

ATTACHMENT 1: Cigna STANDARD – LOI TIMELINE REQUIREMENTS FOR PRE-SERVICE

Last Revised: August 2009

Type of Review	Urgency of Care	Timeline to Request Additional Information	Diary Date for Follow-Up	NO Clinical Available	Limited or Insufficient Clinical (MD Review)	Timeline for Making a LOI Decision
PRE-SERVICE	**URGENT**	Verbal notification within 24 hours or less where required by state regulation	**48 hours** from receipt of request to allow for submission of additional information.	MHHLOI denial letter is sent for participating providers. "Additional Information Not Received-Par Provider" is selected. **Non-participating provider** requires MD review. A resulting denial is medical necessity, not LOI. "Additional Information Not Received-Non Par Providers" status reason code is selected.	Medical necessity decisions will be made with the information available.	If additional information is received, **decision must be made and verbal/written notification provided within 48 hours or less** from receiving additional information OR If additional information is NOT received, **decision must be made and verbal/written notification provided within 48 hours or less** from the time allowed for submission of additional information.

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Type of Review	Urgency ofCare	Timeline to Request Additional Information	Diary Date for Follow-Up	NO Clinical Available	Limited or Insufficient Clinical (MD Review)	Timeline for Making a LOI Decision
PRE SERVICE	**NON-URGE NT**	"Pending Request for Additional Information Letter" is sent on the day of the request for authorization. NOTE: ERISA allows 15 calendar days from receipt of the request. Some states require less.	**15 calendar days** from date of initial request for additional information; the additional information letter is regenerated with a new date. **Then, 36 calendar days** to allow for submission of additional information.	MMHHLOI denial letter is sent for participating providers. "Additional Information Not Received-Par Provider" is selected. Non-participating provider requires MD review. A resulting denial is medical necessity not LOI. "Additional Information Not Received-Non par Providers" status reason code is selected.	Medical necessity decisions will be made with whatever information is available.	If additional information is received, **decision must be made and verbal/written notification provided within 10 calendar days** of receiving additional information OR If additional information is NOT received, **decision must be made and verbal/written notification provided within 10 calendar) days** from the time allowed for submission of additional information

STATE VARIATIONS to Cigna STANDARD

Illinois:

- "Urgent" Pre-Service decisions related to post stabilization care must be made within 1 hour of receipt of the request using information available.

Kentucky:

- Prospective Inpatient (i.e. Pre-Service Inpatient) decisions must be made within 48 hours of receipt of the request regardless of information available.

New Mexico:

- For HMO and Network plans, "Urgent" Pre-Service decisions must be made within 24 hours of receipt of the request regardless of information available

New York:

- Request for additional information for "Standard" Pre-Service decisions must be made within 3 business days of receipt of request

Oklahoma:

- For HMO and Network plans, all Pre-Service decisions must be made within 5 business days of receipt of the request regardless of information available

Rhode Island:

- Pre-Service "Urgent" allows 3 days for written notification after verbal notification of decision

Vermont:

- "Urgent" Pre-Service decisions must be made and communicated within 24 hours from the receipt of additional information or within 24 hours from the time allowed for the submission of additional information.

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