Policy Name Lack of Information (LOI) Retrospective Review		Policy Number: UM-47
Business Segment HealthCare, Payer Solutions		
Initial Effective Date: 08/2009	**Policy Committee Approval Date(s):** 4/27/21; 3/8/22; 11/15/22; 9/12/23; 8/13/24	
Replaces Policies: CGUM-III-8 Lack Information CM-TP-01 LOI Failure to Respond to Transplant Zones		

Purpose:
The purpose of this policy is to establish a consistent process for "pending" retrospective (i.e., post service) decisions due to lack of clinical information reasonably necessary to make a decision.

Policy Statement:
Requests for services 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. Unique medical needs of the customer are also evaluated such as complications and co-morbidities to ensure that decisions are clinically appropriate to the individual customer. Review decisions are based on the information available to the provider at the time the services/medical care was provided.

Retrospective reviews are defined as requests for care or service that has already been received *(i.e., Post Service)*; or discharge order was written at the time the request was received. Retrospective does not have an associated urgency of care.

Timeline requirements for the return of requested information is based upon ERISA and/or state regulations. Customers and provider *(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 times 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) law specifies Cigna must notify customer and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information. If additional information is received, complete or not, decision and notification must be made within 15 calendar days of receipt of information. If no additional information is received within the calendar days given to the practitioner and customer to supply the information, decision and notification must be made with the information that is available within an additional 15 calendar days.
- Rhode Island requires we notify the customer and provider of the specific information required to complete the review within 30 business days of receipt of a request for payment. All lack of information denials are medical necessity denials.
- New York law requires that request for additional information for urgent post service requests be completed immediately by phone or fax and followed by a written request. Additional information requests for standard post service requests be completed within 30 days. This period may be extended one time for up to 15 days. Written notification will follow within 2 days from decision date.

  Note: State mandates supersede Cigna standard

Procedure(s):

A. Initial request for service is received which requires a medical necessity decision.

B. A nurse evaluates request to determine if reasonably necessary information is available to make a medical necessity decision.

   - 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.

- 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.

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

- Provider is informed of the specific information needed for review. Timeline requirement of making a decision may be shared with the provider. Decision and notification is made within thirty (30) days from receipt of all supporting information reasonably necessary.

- 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.

- "Pending Request for Additional Information Letter" is sent to the provider with a copy to the customer. The letter is sent on the day of the request and again on calendar day fifteen (15) if no response is received. The letter includes the specific information needed for review 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 or MD review process is followed.

NOTE: Inpatient Case Managers (IPCMs) who perform on-site reviews and receive a request for a review of service or care after the customer has discharged with days pended or discharged prior to notification of admission will make the facility aware of the need for medical records and review requested records, as necessary. "Pending Request for Additional Information Letter" is not generated. If the necessary medical records are not made available within 48 hours, the on-site IPCM will follow the LOI process.

C. 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:

i. **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 and notification* is based on medical necessity and NOT lack of information.

ii. **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. A resulting decision and notification* is based on medical necessity and NOT lack of information.

iii. **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. A resulting decision and notification is based on medical necessity and NOT lack of information.

iv. **If NO clinical information is received within the timeline requirement**, the nurse determines if an MD review is required. Only non-participating provider requests require an MD review when no clinical information is available and has been requested. Participating provider requests are denied for lack of information.

* For (i)(ii)(iii) above, the decision would be made consistent with the UM 39 Timeliness of UM Decisions for retrospective review.

D. 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

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)

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

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

- **Participating Provider:**

  - 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.

  - If NO clinical information is received within the timeline requirement to make 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.

  - 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.

- **Non-participating Provider:**

  - 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 were rendered.

  - If NO clinical information is received within the timeline requirement to make 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.

- 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 Retrospective

ATTACHMENT 1:
Cigna STANDARD - LOI TIMELINE REQUIREMENTS FOR RETROSPECTIVE
Last Revised: August 2011

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
RETROS PECTIVE	**NON-URGENT**	"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 may 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	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 whatever information is available.	**Decision must be made, and written notification provided by calendar day 51** from the initial request for additional information.

State Variations to Cigna Standard

Kentucky:

- Retrospective *(i.e., Post Service)* decisions must be made within 30 business days of receipt of the request regardless of information available.

Vermont:

- Retrospective decisions must be made and communicated in writing within 15 calendar days from the receipt of additional information or within 15 calendar days from the time allowed for the submission of additional information.

Virginia:

- Retrospective decisions must be made within 30 calendar days of receipt of request regardless of information available.