Cigna

Policy Name: Behavioral Lack of Information (LOI)	**Policy Number:** HM-CLN-45
Business Segment: Behavioral Health	
Initial Effective Date: 12/10/24	**Policy Committee Approval Date(s):** 12/10/24; 3/11/25
Replaces Policies:	

Purpose: The purpose of this policy is to establish a consistent process for "pending" decisions to address timeliness standards when there is not sufficient information to reasonably make a medical necessity determination.

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 clinical 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/care was provided.

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.

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

Lack of Information: Behavioral Health's care management staff review requests for service to determine if the necessary clinical information is available to make a decision based on medical necessity. If the request lacks sufficient information, the medical necessity determination may be pended until additional clinical information can be provided. Timeline requirements for the return of requested information are based on ERISA and/or state mandates. Customers and/or providers (acting as the customer's authorized representative) will be notified that the coverage decision has been pended due to lack of information. If the requested clinical information is not received within the extended timeline deadline, the coverage request will be reviewed by the appropriate MD or PhD to make a determination based on the available clinical information.

State/Federal Compliance: Please refer to Appendix A for State Specific information.

Procedure(s):

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

B. Request is evaluated to determine if reasonably necessary information is available to make a medical necessity decision.

1. If Behavioral Health has all reasonably necessary information to make a medical necessity decision, staff adheres to established medical necessity review processes and timeline requirements.
2. If Behavioral Health does not have all necessary information:
   A. Authorization is pended and additional information is requested from the provider.
      i. If additional information is not received after outreach, the LOI letter will reference the criteria and additional clinical information which may be required to conduct a medical necessity review. The provider will need to include the following elements as appropriate:
         a. Current symptoms and functional impairments including history of substance use/mental health,
         b. risk of harm, and/or self-injurious behavior
         c. Relevant inpatient and/or outpatient treatment history
         d. Relevant psychotropic medication history

C. For non-urgent preservice and concurrent cases, this period may be extended one time by the organization for up to 15 calendar days:
   1. Provided that the organization determines that an extension is necessary because of matter beyond the control of the organization.
   2. 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.

D. Non-urgent levels of care include partial, intensive outpatient and outpatient. Lack of Information will be applicable when all of the following criterion are met:
   1. Authorization is required
   2. Lack of Information is allowed per the UM mandate

E. Behavioral Health will make three initial attempts to obtain clinical. Once clinical is obtained and customer meets medical necessity, the Lack of information process is stopped. The Lack of Information process would not be considered an active request if in our attempts to obtain concurrent clinical we do not receive a response.

F. **Pre-service Review:**

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

1. **Urgent" Pre-Service**:

A. For urgent pre-service requests, Behavioral Health shall complete the determination, verbal notification and written notification within 72 hours of receipt of the request.
   i. If additional information is required, Behavioral Health shall notify the claimant of required information within 24 hours of receipt of request.
   ii. The claimant must be afforded 48 hours to provide the information. The decision is pended while waiting for the additional information.
   iii. A decision and notification shall occur within 48 hours after earlier of:
      a. response from claimant, or
      b. end of period afforded to claimant to respond.

B. Documentation must reflect:
   i. the specific information needed for review,
   ii. the timeline requirement for receiving the information and
   iii. 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. Documentation must reflect:
   i. the specific information needed for review,
   ii. the timeline requirement for receiving the information and
   iii. the name of the individual/department from which the 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. 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 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 MD review, decision and notification process is followed.

G. **Concurrent Review:**

1. A concurrent review is a (a) review of services when the customer is actively receiving services; or (b) review for an extension of a previously approved number of treatments or ongoing course of treatment over a period of time. "Concurrent" may apply to inpatient or ongoing ambulatory care.

2. **"Urgent" Concurrent (Inpatient)**:

   A. "Lack of information" or extending timeframes is not permitted for urgent concurrent review requests where the request was received at least 24 hours prior to the end of the current authorization period.
   B. Documentation is entered in the UM system 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
   C. If requested information is not received within timeframe necessary to make the determination, a denial is made. However, if the requested information is received after the denial, but before a claim has been presented and an appeal has not been received, the request will be reconsidered.

3. **"Non-Urgent" Concurrent:**

   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.
   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. 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 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 MD review, decision, and notification process is followed.

H. **Retrospective Review:**

1. 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)*:

   A. 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.
   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. For non-urgent cases, this period may be extended one time by the organization for up to 20 calendar days.
   D. Unless otherwise required by state law, "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 MD review, decision and notification process is followed.

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
HM-CLN-035 Timeliness of Utilization Management Decisions and Notifications.
HM-CLN-CA-035 Timeliness of Utilization Management Decisions & Notifications – California Addendum
HM-CLN-NY-002 Timeliness of Utilization Management Decisions and Notifications – New York Addendum – Substance Use Disorder
HM-CLN-NY-003 Timeliness of Utilization Management Decisions and Notifications – New York Addendum – Mental Health
Links/PDFs:

APPENDIX A – STATE SPECIFIC REQUIREMENTS

RHODE ISLAND

A. In any instance where Behavioral Health has not received sufficient clinical information to determine medical necessity, Behavioral Health shall review the available information and make a determination.
   1. If medical necessity cannot be determined based of available information, Behavioral Health will follow the medical necessity denial process.
      a. Behavioral Health shall not issue an administrative denial due to lack of information for either in network or out of network providers.

TEXAS

A. Urgent and Non-Urgent Preservice and Concurrent Requests:
   1. Texas (TX) law requires medical necessity decisions 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 ofinformation)