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Lack of Information (LOI) Retrospective Review

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Scope

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.

General Background

Requests for services are evaluated to determine whether sufficient clinical information is available to support a utilization management (UM) medical necessity decision. If the necessary information is not provided, the request will be pended while additional details are sought, in accordance with applicable state mandates. The unique medical needs of each customer-including complications and co-morbidities-are considered to ensure decisions are clinically appropriate for the individual. Review decisions are based on the information available to the provider at the time the service or care was delivered.

Retrospective Reviews:

Retrospective reviews refer to requests for care or services that have already been rendered (post-service), or where a discharge order was issued at the time the request was received. Retrospective reviews do not carry an associated urgency of care.

Timelines and Notifications:

The timeline for submitting requested information is determined by ERISA and/or relevant

state regulations. Customers and providers (acting as authorized representatives) are notified when a medical necessity decision is pended pending additional information. Written and verbal requests will specify the exact information required for review.

Definitions

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

State/Federal Guidelines

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

- **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.
- **New York (NY)** 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.
- **Rhode Island (RI)** 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.
- **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 Evaluation

- Initial Request for Service is received which requires a medical necessity decision.
- A nurse reviews each request to determine if sufficient information is available to make a medical necessity decision.
- If all necessary information is present, the nurse follows established review processes and timeline requirements.
- If all necessary information is NOT present to make a decision, the request is pended for additional information (see Procedure C)
- If the nurse cannot approve the request, the Medical Director reviews it. Any denial is based on medical necessity, not lack of information.

B. Request for Additional Information

- If information is insufficient, the request is pended, and the provider is asked for specific details needed for review.
- For non-urgent cases, the organization may extend the review period once, for up to 15 calendar days, if circumstances are beyond its control.
- The patient is notified before the initial period expires, including the reason for extension and the expected decision date.

C. Provider Notification

- Providers are informed of the specific information required and the timeline for submission.
- Decisions and notifications are made within 30 days of receiving all necessary information.

D. Documentation

- The UM system records the requested information, timeline requirements, and the individual/department contacted.

E. Pending Request Letter

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- A "Pending Request for Additional Information Letter" is sent to the provider and customer on the day of the request and again on day 15 if no response is received.
- The letter specifies the required information and the deadline, which is 50 calendar days from the initial request (45 days plus 5 days for mail delivery).
- If information is not received by day 51, the LOI MD review process is followed.

F. Special Cases: Inpatient Case Managers (IPCMs)

- IPCMs conducting on-site reviews after discharge do not generate a pending request letter.
- If medical records are not provided within 48 hours, the IPCM follows the LOI process.

G. Denial for Lack of Information

- If the necessary information is not received within the required timeline, the request may be denied for lack of information.

H. 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)]