



Troy Medicare Policy and Procedure

Title: Lack of Clinical Information				Policy Number: UM-009	
Primary Department: Utilization Management		LOB: Medicare Advantage & DSNP		Author:	
Effective Date: 2022	Approval Date:	Original Date:	Review Date(s):	Archive Date:	
Interactive Related Department(s)					
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing		<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Customer Service <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input type="checkbox"/> Utilization Management		<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other _____	

POLICY PURPOSE

The purpose of the Lack of Clinical Information policy is to describe the process for handling medical necessity determinations for requested health care services when requested clinical information is not received. This policy is written to ensure that physicians or attending health care professionals and members are notified in a timely manner that a request for authorization of services has insufficient information to complete a medical necessity review and additional information should be submitted. This policy outlines the procedural time frames that are appropriate to the clinical circumstances of the review, the resolution of requests in which the necessary information is not provided within the specified time frames, and processes by which Health Plan issues a non-certification.

Troy Medicare and Troy Health are hereby referred to as "Troy" for the purpose of this policy. **SCOPE**

This policy applies to the Utilization Management Department.

REFERENCES

CMS. Medicare managed Care Manual. Chapter 13- Medicare Managed Care Enrollee Grievances, Organization Determinations, and Appeals Guidance.

URAC: HUM 32

NCQA: UM9 (a) and (c)

RESPONSIBLE PARTIES

- Utilization Management Staff

DEFINITIONS

Requests for authorization of services must include clinical information sufficient to demonstrate medical necessity. Sufficient clinical information is defined as a diagnosis code, procedure code, and one (1) additional piece of relevant clinical information; Health Plan will consider the request to have

sufficient clinical information and the request will be reviewed for medical necessity. If requests for services are not accompanied by sufficient information to verify if the clinical criteria have been met, the request for the information will be issued to the referring physician or attending health care professional, and the case will be pended until the information is received, or for a specified period of time as required by law.

- **Lack of Information** - not having the clinical data needed to make a medical necessity determination based on nationally recognized criteria sets.
- **Organization Determination** – any determination made by a health plan organization with respect to any of the following:
 1. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
 2. Payment for any other health services furnished by a provider other than the Health Plan organization that the enrollee believes –
 - a. Are covered under Medicare or the commercial health plan benefits; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the health plan.
 - c. The health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan.
 - d. Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.
 - e. Failure of the Medicare health plan benefits to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

POLICY

Lack of Clinical Information or Insufficient Information

1. Requests for prior authorization that do not include any clinical information are placed in pend or hold status/activity pending the necessary clinical information to make a determination.
2. Requests that include some clinical information are evaluated by a Clinical Reviewer:
 - a. If the information received is adequate to render a medical necessity determination and meets medical necessity criteria, the request is approved by the Clinical Reviewer and appropriate notification issued within two (2) business days of the request.
 - b. If the information received is not sufficient to satisfy the medical necessity criteria, additional information is requested from the referring provider with two (2) outreach attempts.
3. Requests with insufficient information are placed in a pended or hold status/activity and notice is sent to the provider informing them of the specific additional information that must be received to complete the request.
 - If additional information is submitted, the request is processed, and a determination issued within the applicable timeframe.
 - If additional information is not submitted, up to two (2) additional outreach attempts will be made by telephone and/or fax to contact the provider to obtain the necessary information required to complete the case.
- a. Routine/Standard requests, the calls are placed during normal working hours every

other business day, starting the day after the case enters hold status. · The requestor will be notified of the information needed within two (2) business days of the request

b. Urgent/Expedited requests and part B drugs, up to two (2) calls will be placed within twenty-four (24) hours during normal working hours.

- Outreach attempts will be thoroughly documented in the record and continue unless one of the following occurs:
 - o the provider responds to the request, or
 - o outreach attempts are exhausted

c. Concurrent Review Requests

- The requestor will be notified of the information needed upon receipt of notification. The case is pended only within the timeframe required to issue a determination.

Additional attempts will be made on the second (2nd) and third (3rd) business day after receipt of admission notification.

- If no response is received by 2pm EST on the third (3rd) business day, the case is referred for determination.

d. Post Service Reviews Requests

- The plan does not review services already provided prior to obtaining authorization. For these cases, the plan will administer an administrative denial.

4. If the additional information is received within the time limitations, a medical necessity determination will be timely issued. If no clinical information is received within the time limitations, the review determination will be made based on the information originally provided in the request.

- Medicare: members and providers will be notified as expeditiously as the enrollee's health condition requires but no later than fourteen (14) calendar days after the date the request was received for a standard organization determination, or if a formal extension was initiated, no later than fourteen (14) calendar days from the date of the extension.

5. If the decision is to administratively deny the services due to lack of information, written notification shall be sent to the facility, patient, and the physician within one day of the determination to administratively deny, specifying it is an administrative denial for Lack of Information. The written notification includes information regarding the basis for denial, necessary information, and appeal rights and processes.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

•None

APPROVALS



CEO

DATE: 11/28/22