Fulcrum Health, Inc.

Policy Title:	Lack of Clinical Information		
Policy Number:	UM031	Effective Date:	11/01/2018
		Last Revision Date:	10/29/2020
		Last Review Date:	10/29/2020
Responsible Area/Individual:	UR staff, Clinical Review Staff, Clinical Peer Reviewers		
Purpose:	This policy outlines the lack of clinical information process.		
Regulation/ Reference (if applicable):	NCQA UM 5 and UM 6 Minn. Stat. § 62M.04 Subd.4 and § 62M.05, Subd.4 Medicare Managed Care Manual		

Policy:

Review decisions will be made on the clinical information obtained by Fulcrum at the time of the review determination. Fulcrum will request additional clinical information from the requesting provider when it is necessary to render a medical decision. Providers and members shall be notified in a timely manner that a request for authorization of services includes insufficient information to complete a medical necessity review and additional information should be submitted. The policy outlines procedural time frames, what occurs when necessary information is not provided within the specified time frames, and processes by which an adverse determination occurs due to lack of information.

Process:

Requests for authorization of services must include clinical information sufficient to demonstrate medical necessity. If requests for services are not accompanied by sufficient information to verify that clinical criteria have been met, a request for additional information will be issued to the attending health care professional/provider, and the case will be pended for a specified period of time.

A. Requesting Additional Clinical Information for a Medical Necessity Review
    a. When additional information is required to enable completion of the medical necessity review, Fulcrum attempts to contact the provider at least three (3) times by multiple methods and on multiple dates.
        i. For MN Fully Insured & Self-Insured Commercial Plans
            1. Web and fax on calendar day 1 (attempt 1)
            2. RFI Letter (attempt 2)
            3. Phone call on calendar day 3 (attempt 3)
            4. Due date stated in the communication shall be as soon as possible but no later than calendar day 3.
        ii. For Medicare, Commercial Fully Insured and Self-Insured (Non-MN) and MN Medicaid:
            1. Web and fax on calendar days 1 – 4 (attempt 1)

2. RFI Letter (attempt 2)
3. Phone call on calendar days 5– 7 (attempt 3)
4. Due date will be stated in the communication as soon as possible but no later than calendar day 10.

b. Providers can submit the requested information through the provider portal, by fax, or by phone.

c. When making requests for information, staff will:
   i. Identify self by name, title and organization
   ii. Identify member by name, date of birth and insurance identification number
   iii. Describe the information that is needed for completion of the review
   iv. Provide the date that the information is needed
   v. Provide a call back number if questions arise
   vi. Provide instructions for provider portal entry or a fax number for submission of the information
   vii. Staff will document in the QConnect system:
      1. Information requested to complete the clinical review
      2. Documentation of each contact made to request additional information, including date and time, phone number, person contacted, and date information is needed
      3. Letters, electronic notification, and faxes will be date/time stamped

B. Review Classification
   a. Authorization
      i. Non-urgent
         1. For MN Fully Insured & Self -Insured Commercial Plans,
         2. non-urgent authorization decisions must be made within five (5) business days the request. When additional information is needed, staff contacts the provider by the 3rd calendar day.
         3. For Medicare, non-MN Commercial Fully Insured and Self-Insured, and MN Medicaid, non-urgent authorization decisions must be made within ten (10) business days of the request. When additional information is needed, staff contacts the provider by the 7th calendar day.
      ii. Urgent
         4. For MN Fully Insured & Self -Insured Commercial Plans, urgent authorization must be made within 48 hours and must include at least one business day after the initial request.
         5. For Medicare, non-MN Commercial Fully Insured and Self-Insured, and MN Medicaid, non-urgent authorization decisions must be made within 72 hours of the request.
      iii. If additional information is not received, the request will be sent to the clinical reviewer with available information prior to expiration of the decision timeframe.

b. Post Service Medicare and Commercial reviews are performed and completed within 30 Calendar days.
c. Review determination:
    i. Upon receipt of additional information, the reviewer completes the medical necessity review and authorizes the request if criteria are met.
    ii. When requested information is not received, a determination is made by the clinical peer reviewer based on the available information. If denied, the UM Coordinator sends the adverse determination letter to the member and provider, with denial reason as lack of information. The letter must indicate the specific information needed in the adverse determination notice.
d. RFI audit validation

RFI received validation is defined as follows: (occurring after the RFI receipt date but on or before decision date):

1. Assessments entered in whole
2. Assessment entered in part
3. Verbal or web note from provider stating that they do not have the information requested
4. Medical records attached to the episode
5. Incorrect clinical information that was not available on the initial submission

References:

CMS Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance

Medicare Initial Determinations (Organizational Determinations)

Document History:

Date	Update
10/03/2018	Approved by the UM Subcommittee
10/09/2018	Approved by the UM Subcommittee
11/15/2018	Approved by the Quality Committee of the Board
10/9/2019	Approved by the UM Subcommittee
10/17/2019	Approved by the Quality Committee of the Board
10/20/2020	Approved by UM Subcommittee
10/29/2020	Approved by UM Subcommittee