Cigna Medical Coverage Policies – Preface

Effective December 20, 2021

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

Preface to the Comprehensive Musculoskeletal Guidelines

Prior Authorization Requirements

eviCore applies an evidence-based approach to evaluate the most appropriate medically necessary procedure or service for each individual. Specific elements of an individual's medical records commonly required to establish medical necessity include, but are not limited to, the following:

- Recent virtual or in-person consultation with the treating provider.
- Prior to any procedure or service, the provider is required to confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This evaluation includes, but is not limited to, the following:
  - Detailed history with recent relevant physical examination findings (as outlined in the specific guidelines)
  - Details of relevant past and current treatment response
  - Diagnostic testing (as outlined in the specific guidelines) includes, but is not limited to ultrasounds, x-rays, or advanced diagnostic imaging studies (e.g. CT, MRI, Myelography) which must include the interpretation by an independent radiologist.
    - **Please note**: Clinically significant discrepancies in interpretations between the ordering provider and the radiologist need to be reconciled in the documentation submitted for prior authorization.
- Reports from other providers and/or specialists participating in treatment of the relevant condition
- For requests that fall outside of guideline requirements, submission of medical records is needed to document an individual's current clinical status and why an exception to policy is being requested. Without this information, medical necessity for the request cannot be established.

Similar or Duplicate Requests

- Requests that are similar or duplicative to a procedure or service recently approved will require additional individual clinical information to determine medical necessity. Duplicate requests (by the same or another provider) require documentation to support that the prior procedure or service was never performed or establish the medical necessity of performing a duplicate procedure or service simultaneously. Similar requests (by the same or another provider) require medical records to establish the medical necessity of performing all of the procedures or services simultaneously or in close time proximity.

Sequential Requests for the Same Procedure or Service

- In general, requests for sequential procedures or services, for the same condition in the same anatomic area, will require documentation in the medical records that the therapeutic benefit of the prior procedure or service proved effective and that the expected duration of relief has lapsed. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Out of Scope Requests for a CPT®/ HCPCS Code

- At times, a procedure code (CPT® or HCPCS) may be used to represent more than one clinical indication. In these instances, eviCore reviews only for the clinical indications listed in the associated guideline. Procedure code requests for a clinical indication not reviewed by eviCore will be directed to the health plan.

Benefits, Coverage Policies, and Eligibility Issues

- Benefits, coverage policies, and eligibility issues pertaining to each Health Plan may take precedence over eviCore's guidelines. There may be certain procedures or services that are considered investigational by the payor. Providers are urged to obtain written instructions and requirements directly from each payor.
- For Medicare and Medicare Advantage enrollees, the coverage policies of CMS (Centers for Medicare and Medicaid Services) supersede eviCore's guidelines.

Experimental, Investigational, and/or Unproven (EIU) Procedures or Services

- Certain procedures or services are considered experimental, investigation, and/or unproven (EIU) when the effectiveness has not been demonstrated by required scientific evidence and properly authorized by governing entities in order to be acknowledged as medically effective for the improvement of function for specific conditions or treatment.

Clinical and Research Trials

- Clinical trial requests will be considered to determine whether they meet health plan coverage and/or if required, do they meet eviCore's evidence-based guidelines.
- For Medicare and Medicare Advantage enrollees, CMS (Centers for Medicare and Medicaid Services) requires coverage for procedures requested as part of a CMS approved clinical trial through the CMS CED program. A list of the currently approved procedures is available at the following link:
  - http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Index

Legislative Mandate

- State and federal legislations may need to be considered in the review of certain musculoskeletal procedures or services.

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References

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2. Coverage of Clinical Trials under the Patient Protection and Affordable Care Act; 42 U.S.C.A. §300gg-8.
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4. Prospective Payment Systems - General Information. CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen.

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