CIGNA MEDICAL COVERAGE POLICIES-SUPPLEMENTAL INFORMATION:

CMS Hierarchies and Application Guidelines

Effective Date: April 15, 2025

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.

These guidelines include procedures EviCore does not review for Cigna. Please refer to the **Cigna CPT code list** for the current list of high-tech imaging procedures that EviCore reviews for Cigna.

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Medicaid

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Medicaid Hierarchy

1. Medicaid state-specific policy
2. These evidence-based guidelines or the appropriate alternative guideline utilized by a program/health plan in place of these guidelines
3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines should also be reviewed for individuals under 21 years of age as applicable for coverage determination

Application of Medicaid Policy

The state Medicaid policy will be reviewed first to determine if the information provided is instructive to the clinical case at hand. For the purpose of this policy, sufficient clinical criteria to render a medical necessity decision is defined as the presence of a state Medicaid policy that addresses the service/procedure/test/equipment and the member condition (indication) and supplies sufficient clinically relevant detail to be instructive to the case. See the numbered items below for specific guidance:

1. State Medicaid policy addresses clinical scenario: (service/procedure/test/equipment AND member condition AND Medical Necessity criteria):
   a. Medicaid policy will be utilized and cited for determining medical necessity
   b. If specific medical necessity criteria are present in the state policy, but are limited or less detailed than eviCore or alternative guideline, the state policy would still be applied and cited, as this would be considered sufficient information to render a decision
2. State Medicaid policy addresses service/procedure/test/equipment, but does NOT cover member condition in question or provide specific medical necessity criteria for this indication and does not contain relevant clinical information to be instructive to the case/clinical scenario, eviCore guidelines or alternative guidelines, as appropriate, will be utilized and cited
3. State policy exists for service/procedure/test/equipment AND member condition but NO medical necessity criteria exist for this indication. The state policy would still be instructive to the case clinical scenario and Medicaid will be utilized and cited.
4. (Example: Service is requested to address a member condition and the state policy indicates that the service is indicated for this member condition without providing specific criteria regarding under which circumstances the service would be indicated for this condition. This is considered instructive, and the state policy would be applied/cited.)

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5. If no clinical information is provided with a request, the above hierarchy is still applied. If there is an applicable state-specific Medicaid policy, the Medicaid policy would be utilized and cited to request clinical information/documentation. If there is no applicable state-specific Medicaid policy, eviCore guidelines or alternative guidelines, as appropriate, will be utilized and cited

Note: The scope of this policy is to outline the default order in which policy sources will be used during a delegated medical necessity determination. The Medicaid hierarchy outlined here may be superseded by Plan- and State-specific Hierarchy policies, where applicable, based on contracts with a state Medicaid entity.

Application and citation of policy

State Medicaid Policy exists	State Medicaid policy addresses service/ procedure/test/ equipment	State policy addresses member condition and/ or is instructive to the case	State Medicaid Policy provides specific medical necessity criteria relevant to service and member condition	Application and Citation of Policy
Y	Y	Y	Y	State Medicaid policy applied and cited
Y	Y	Y	N	State Medicaid policy applied and cited
Y	Y	N	N	EviCore criteria applied and cited
Y	N	N	N	EviCore criteria applied and cited

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Medicare Policy

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CMS Coverage Hierarchy: Medicare Advantage Medical Policy Development and Application

Medicare Advantage medical policies identify the clinical criteria for determining when medical services are considered 'reasonable and necessary' (medically necessary). Medicare Advantage plans are required by CMS to provide the same medical benefits to Medicare Advantage members as original Medicare.

Medicare Advantage plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in traditional Medicare laws. This includes criteria for determining whether an item or service is a benefit available under traditional Medicare. When coverage criteria are not fully established in Medicare statute, regulation, NCD, or LCD, Medicare Advantage organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature.

If additional criteria are needed to interpret or supplement generalized provisions within an NCD, LCD or other Medicare coverage policy, or there is flexibility allowed in the NCD/LCD, or there is no applicable NCD, LCD, or LCA (used in concert with an LCD) available to determine medical necessity, then other evidence-based criteria may be applied.

Coverage criteria are not fully established when (42 CFR 422.101(6) (i) :

(i) Coverage criteria not fully established. Coverage criteria are not fully established when:

(A) Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services;

(B) NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or

(C) There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

The following hierarchy is used to determine Medicare Advantage Medical Policy:

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1. CMS Coverage Manuals or other CMS-Based Resource: Coverage provisions in interpretive manuals are instructions that are used to further define when and under what circumstances items or services may be covered (or not covered)
2. National Coverage Determinations (NCD)
3. Local Coverage Determinations (LCD)
4. Local Coverage Articles (LCA), when used in conjunction with LCD
5. EviCore's evidence-based guidelines or the appropriate alternative guideline utilized by a program/health plan in place of EviCore's guidelines.

- Rationale supporting the adoption and use of internally developed coverage guidelines: When coverage criteria are not fully established (as defined in 42 CFR 422.101(6) (i)) in Medicare policy, an NCD, or an LCD, CMS allows a Medicare Advantage Organization (MAO) to create and use internally developed coverage criteria. See 'Coverage criteria are not fully established when (42 CFR 422.101(6) (i) above on page 3 for the full definition of 'not fully established'.
- EviCore will exhaust all traditional Medicare policies, NCDs, and LCDs prior to using internal criteria policies. When an internally created coverage policy is utilized for a specific condition where a Medicare policy, an NCD, or LCD is not fully established, the general provisions supplemented by the internal criteria will include when the specific clinical presentation of the enrollee, for the request under review is not addressed in the Medicare coverage policy; or there are no specific coverage criteria included in a Medicare policy because the policy provides broad provisions, which may be instructive, but are not detailed enough to be used to determine the medical necessity of the request. Additionally, internal coverage policy may be used when Medicare policy includes statements within the policy that allow for coverage beyond what is written in the Medicare policy.
- Under the guidance outlined above EviCore's evidence-based guidelines or the appropriate alternative guideline utilized by a program/health plan in place of EviCore's guidelines, EviCore may apply internally developed clinical coverage guidelines to the request under review. Each EviCore clinical coverage policy is developed following an objective, evidence-based process based on scientific evidence, generally accepted and current standards of medical practice, and authoritative clinical practice guidelines. Each coverage policy developed and used outlines clinical benefits, addresses any clinical harm, and access to services. In addition, each member's unique clinical situation is considered in conjunction with current CMS guidelines and EviCore clinical coverage policy, as applicable.

Note: Where a Medicare Administrative Contractor (MAC) has adopted the Palmetto GBA MolDX® Program's criteria for the LCDs governing molecular and genomic tests within their jurisdiction, EviCore's Laboratory Management program will follow the MolDX criteria published by the MACs for those jurisdictions.

Medicare/Medicaid Dual Membership

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Hierarchy and Application for dual eligible Medicare/Medicaid

Individuals enrolled in both Medicare and Medicaid are considered to be dually eligible. For individuals with both Medicare and Medicaid, the following hierarchy should be applied.

1. CMS Coverage Manuals
2. National Coverage Determinations (NCD)
3. Local Coverage Determinations (LCD)
4. Local Coverage Articles (LCA) – when used in conjunction with an LCD
5. Medicaid Coverage Policies (if Medicare/Medicaid (MMP) or Medicare/Medicaid Special Needs plans)
6. Evidence based clinical policies (EviCore) or the appropriate alternative guideline utilized by a program/health plan in place of EviCore's guidelines

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