Cigna Medical Coverage Policies – Musculoskeletal
Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines

Effective November 1, 2024

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.

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Prior Authorization Requirements

The Cigna-EviCore co-branded guidelines apply 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 perform 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 specific guidelines)
  - Details of relevant past and current treatment response
  - Diagnostic testing (as outlined in specific guidelines) includes, but is not limited to ultrasounds, x-rays, or advanced diagnostic imaging studies (e.g., CT, MRI, Myelography).
    - **Note**: Advanced imaging must include the interpretation by an independent radiologist. 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.

Sequential, Similar, or Duplicate Requests

Similar or duplicate requests are for treatment of the same clinical condition using the same or similar procedure(s) or service(s) that were recently requested (by the same or another provider). Similar or duplicate requests for procedures or services may be either part of ongoing treatment **or** in lieu of previously authorized treatment that was not performed. These types of requests require the following:

- Requests for sequential (same or similar) procedures or services, as part of ongoing treatments included in a comprehensive treatment plan, require documentation of the effect of the previous authorized procedure or service (as outlined in specific guidelines).
- Requests for procedures or services (same or similar) that were authorized (for the same or another provider), but not performed, require documentation of non-performance.

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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 re-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 these 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 the Cigna-EviCore co-branded guidelines.

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

Certain studies, treatments, procedures, or devices may be considered **experimental, investigational, or unproven** for **ANY** condition, illness, disease, or injury being treated if one of the following is present:

- if there is a paucity of supporting evidence;
- if the evidence has not matured to exhibit improved health parameters;
- if clinical utility has not been demonstrated in any condition; OR,
- the study, treatment, procedure, or device lacks a collective opinion of support.

Supporting evidence includes standards that are based on credible scientific evidence published in peer-reviewed medical literature (such as well conducted randomized clinical trials or cohort studies with a sample size of sufficient statistical power) generally recognized by the relevant medical community. Collective opinion of support includes physician specialty society recommendations and the views of physicians practicing in relevant clinical areas when physician specialty society recommendations are not available.

Unlisted Codes and CPT® Category III Codes

The Current Procedural Terminology (CPT®) Manual requires providers to report the procedure or service with the code that most accurately reflects the procedure or service as typically performed.

- Category III CPT® codes are temporary codes used to report emerging technologies, procedures, or services.
  - According to the American Medical Association (AMA), a Category III CPT® code should be reported in place of an unlisted code if the Category III code accurately reflects the service performed.
- Unlisted codes do not describe a specific procedure or service.
  - Unlisted codes should only be used when no specific Category I, Category lll CPT® code or HCPCS code exists for the procedure, service, or device.

Unlisted Code Determinations

- An unlisted code may be used appropriately to represent **ANY** of the following scenarios:
  - A procedure or device that is entirely new, unproven, or investigational;
  - An established procedure performed by a different method or approach;
  - An established procedure using a different device than what is described by standard available codes
  - A procedure performed at a different anatomical location than those described by standard available codes
- The purpose of the coding category (CPT® or HCPCS) is to represent the procedure, service, or device. The appropriate coding use of an unlisted code does not equal medical necessity.
  - Unless otherwise noted in a procedure-specific guideline, requests for unlisted codes are considered **experimental, investigational, or unproven (EIU)**.
    - See **Experimental, Investigational, or Unproven (EIU) Procedures or Services**

Clinical and Research Trials

- Clinical trial requests will be considered to determine whether they meet health plan coverage and/or if required, if they meet the Cigna-EviCore co-branded 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 Coverage with Evidence (CED) program. A list of the currently approved procedures is available at the following link:
  - https://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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