CIGNA MEDICAL COVERAGE POLICIES - MUSCULOSKELETAL

Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines

Effective Date: December 18, 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.

Table of Contents

Prior Authorization Requirements

Guideline Page

Prior Authorization Requirements

CMM.PRF
v2.0.2025

The Comprehensive Musculoskeletal Management (CMM) 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 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.

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Sequential, Similar, or Duplicate Requests

Guideline Page

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Sequential, Similar, or Duplicate Requests

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v2.0.2025

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.

Out of Scope Requests for a CPT®/HCPCS Code

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Out of Scope Requests for a CPT®/ HCPCS Code

CMM.PRF
v2.0.2025

- At times, a procedure code (CPT® or HCPCS) may be used to represent more than one clinical indication. The Comprehensive Musculoskeletal Management (CMM) Guidelines only apply to the indications listed within the guidelines. Procedure code requests for a clinical indication that is not in the guidelines may be re-directed to the health plan.

Benefits, Coverage Policies, and Eligibility Issues

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CMM.PRF

v2.0.2025

- Benefits, coverage policies, and eligibility issues pertaining to each health plan may take precedence over the Comprehensive Musculoskeletal Management (CMM) 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 Comprehensive Musculoskeletal Management (CMM) Guidelines.

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

Guideline Page

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CMM.PRF
v2.0.2025

For information related to experimental, investigational, or unproven (EIU) procedures or services, see **Guidelines Definitions** document.

Clinical and Research Trials

Guideline Page

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Clinical and Research Trials

CMM.PRF
v2.0.2025

- Clinical trial requests will be considered to determine whether they meet health plan coverage and/or, if required, if they meet the evidence-based Comprehensive Musculoskeletal Management (CMM) 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

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Legislative Mandate

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

Coding for Utilization Management (UM) Requests

Guideline Page

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Coding for Utilization Management (UM) Requests

CMM.PRF
v2.0.2025

The information that follows is based on the Current Procedural Terminology (CPT®) Manual as well as the methodologies of the National Correct Coding Initiative (NCCI). The Current Procedural Terminology (CPT®) Manual requires providers to request the procedure or service with the code(s) that most accurately reflect(s) the planned procedure(s) or service(s) as typically performed (not contingent procedure[s] or service[s]]).

- **Note**: This section information is for **UM purposes only**. Additional claims rules may apply.

CPT® Category III Codes

Category III CPT® codes are temporary codes used to reflect emerging technologies, procedures, or services.

- According to the American Medical Association (AMA), a Category III CPT® code should be requested in place of an unlisted code if the Category III code accurately reflects the service performed.

Unlisted Codes

For information related to unlisted codes, see **Management of Unlisted Codes** document.

Improper Coding

- HCPCS/CPT® codes are considered **not medically necessary** if the requested codes improperly reflect the planned procedure or service as typically performed due to ANY of the following reasons:
  - The medical information provided supports that a different code or code combination (other than the one requested) would most accurately represent the procedure or service (planned or performed).
    - Any changes to the requested code (or code combination) that may be needed as a result of a discovery made during the course of the procedure or service (e.g., intra-operative discovery), must be documented in medical records. The medical information submitted must support the procedure or service represented in the coding change.

The requested code is explicitly limited to one unit. (See also)

- The requested code (or code combination) does not align with or fully support the procedure or service (planned or performed) as noted in the medical information provided
  - Example: the requested code (or code combination) lacks one or more additional codes that would represent the planned procedure or service
- The requested code (or code combination) is obsolete or can be replaced with a more accurate code (or code combination).
- The requested code combination is not appropriate and can be replaced with a single code. (See also)
- The requested code is considered integral to another procedure. (See also)

Mutually Exclusive Codes

- HCPCS/CPT® codes are considered mutually exclusive if, based on the code descriptor, the planned procedures are not procedures that can be reasonably performed at the same time on the same individual due to anatomic considerations or due to the nature of the procedure themselves.
  - Examples include codes representing two different surgical techniques to be performed at the same anatomical location on the same date of service.
- If the codes are considered mutually exclusive codes and requested for the same date of service, the code that does not most accurately reflect the procedure or service (as typically performed) is considered **not medically necessary**.

Quantity of Units/Levels

According to the AMA Current Procedural Terminology (CPT®) coding instructions, the planned procedure or service should be requested using the code that most accurately reflects the planned procedure or service as typically performed. This may involve requesting more than one unit of a HCPCS/CPT® code or requested HCPCS/CPT® codes representing additional levels of where a procedure was performed.

- HCPCS/CPT® codes are considered **not medically necessary** if the requested codes (or code combination) improperly reflect the procedure or service as typically performed due to ANY of the following reasons:
  - The medical information provided does not support the number of units requested.
  - The requested code is explicitly limited to one unit. (See also)
  - The medical information provided does not support the number of levels requested.

Primary Procedure Not Authorized

- HCPCS/CPT® codes are considered “primary” codes when, based on the code descriptor, the following apply:

  - The code represents the procedure that is considered the main reason for the encounter.
  - The code represents the most significant medical procedure performed on an individual during a given encounter.
- HCPCS/CPT® codes that are considered “add-on” codes represent procedures or services that must be associated with an allowed primary procedure code as specified by AMA CPT and that are always provided “in addition to” other, related services or procedures. Add-on codes cannot stand alone as separately reportable services and are typically identified as “add-on” codes by the “+” preceding the numeric code as well by the parenthetical inclusion of “*each additional*” or “*list separately in addition to code for primary procedure*” at the end of the code description. The authorization of an “add-on” code will follow the criteria required for and the decision of the primary procedure code.
  - An “add-on” code is considered **not medically necessary** when the associated primary procedure code is considered **not medically necessary**.
  - An “add-on” code requested without a primary code is considered **not medically necessary**.
- A “separate procedure” code designation identifies a procedure that may be performed independently or as part of a more extensive procedure.
  - HCPCS/CPT® codes designated as "separate procedure" and representing a procedure performed independently and distinctly from the primary procedure may be requested on its own would be reviewed on its own merit.
  - HCPCS/CPT® codes designated as "separate procedure" **should not be requested in addition to** the code for the more complex procedure or service (i.e., primary code) of which it is considered an integral component. (See also and)

Unbundling Codes

HCPCS/CPT® codes may describe complex procedures with several components and these “component procedures” may have their own HCPCS/CPT® code. When a more comprehensive code exists, the code for the more complex procedure should be requested. In this scenario, the codes for the component procedure are considered bundled (or combined) into the comprehensive code for the more complex procedure.

- If two or more procedure codes are used to reflect a procedure or service when a single, more comprehensive code exists that more accurately represents the procedure or service performed, then the codes are considered as unbundled. Typically, this is identified by the CPT® code description for each code and in these coding scenarios the following determinations apply:
  - Unbundled codes are considered **not medically necessary** when a single, more comprehensive code exists that more accurately represents the procedure or service performed. (See also)

  - Unbundled codes are considered **not medically necessary** when requested in addition to the more comprehensive code.
- It is appropriate to separately request the code for the component procedure when it is necessary to perform the individual component procedure as an independent and distinct procedure during a separate encounter.
  - In this scenario, the code for the component procedure is considered as unbundled (or separate) from the more complex procedure and will be reviewed individually for medical necessity.

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References

CMM.PRF
v2.0.2025

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