Prominence Gastroenterology Provider Information Tips

A common reason for the denial of a procedure request is that the information submitted is incomplete or inadequate for our medical reviewers to make an informed decision regarding the appropriateness of the procedure. This is often frustrating to the provider as well as the peer reviewer. In an effort to reduce this source of friction, we have created a Provider Information Packet designed to instruct providers on the type of information that our reviewers need to adjudicate a particular case. This is not meant to be all-inclusive, but rather can be used as a guide. Further and more specific information is available by reading the actual evidence-based guidelines.

General Background Information

- eviCore's Gastrointestinal Endoscopy Program applies an evidence-based approach to evaluate the most appropriate care for each patient.
- This evaluation requires collection of clinical information pertinent to the treatment and/or services being requested by the provider.
- If the clinical information provided does not include sufficiently detailed information to understand the patient's current clinical status, then medical necessity for the request has not been demonstrated and the request cannot be approved.
- Specific elements of a patient's medical records commonly required to establish medical necessity include, but are not limited to:
  - Recent virtual or in-person clinical evaluation which includes a detailed history and physical examination
  - Relevant Laboratory studies
  - Relevant Imaging studies
  - Relevant Pathology reports
  - Relevant Procedure reports
  - Reports from other providers participating in treatment of the relevant condition
    - Note: It is important to keep in mind that the information provided be relevant to the intended procedure. Sending many pages of irrelevant material may contribute to delays in adjudication for your patients.

Specific clinical information helpful for commonly requested indications.

- This section provides the type of clinical information that our medical reviewers would need in order to properly adjudicate the case. It is most helpful to look at this in concert with our evidence-based guidelines.
- EGD (Esophagogastroduodenoscopy), Medicare Members
  - Documentation including, but not limited to:
    - Red flag symptoms
    - Prior EGD results
    - Pathology results
    - Treatment with anti-secretory therapy, when appropriate as per guideline criteria
    - Specific purpose of the study
    - Results of prior work up by other disciplines if relevant, such as prior a pulmonary or allergy evaluation if an EGD is being requested to assess extraesophageal reflux
    - Risk factors, when relevant (e.g., relevant family or smoking history, for an EGD to screen for Barrett's esophagus)

- Prior authorization is required for add-on EGDs when planned at the time of EUS (endoscopic ultrasound) and/or ERCP (endoscopic retrograde cholangiopancreatography). Routine requests to bundle add-on EGD with EUS or ERCP will not be approved. Approval of add-on EGD requires:
  - The specific purpose of the study must be unique (e.g., not for an endoscopic service that otherwise may be accomplished through the ERCP or EUS instrument) and;
  - The study must meet the same eviCore guideline criteria as for stand-alone EGD

- Colonoscopy, Medicare Members
  - Screening colonoscopy
    - Average risk. (CPT code G0121) No preauthorization is required if the individual meets average risk criteria for screening as defined in Medicare Benefit Policy Manual, Chapter 15, Section 280.2.2.
      - Medicare Benefit Policy Manual, Chapter 15, Section 280.2.2: Individuals not meeting the criteria for being at high risk for developing colorectal cancer, at a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed); and If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above (see §§280.2.2.D.1 and 2) but has had a covered screening flexible sigmoidoscopy (code G0104), then the individual may have a covered G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.
    - High risk. Requests for high-risk screening colonoscopies (CPT code G0105) as defined in Medicare Benefit Policy Manual, Chapter 15, Section 280.2.2 and 280.2.3 require preauthorization.
      - Medicare Benefit Policy Manual, Chapter 15, Section 280.2.2 and 280.2.3: The A/B MAC (B) must pay for screening colonoscopies (code G0105) when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed). Refer to §280.2.3 for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.
        - §280.2.3: Characteristics of the High Risk Individual: An individual at high risk for developing colorectal cancer has one or more of the following:
          - A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
          - A family history of familial adenomatous polyposis;
          - A family history of hereditary nonpolyposis colorectal cancer;
          - A personal history of colorectal cancer;
          - A personal history of adenomatous polyps;
          - Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

  - Non-screening colonoscopy (Diagnostic or Therapeutic colonoscopy)
    - Prior colonoscopy and pathology results as indicated, that require follow up
    - Recent lab and prior workup, as well as information regarding particular risk factors (e.g., family history, etc.)
    - Notation of alarm symptoms, if present (see Guidelines).

- Diarrhea - Notation of acute vs. chronic is helpful, prior relevant lab and stool studies, if present
- The nature of any bleeding, if present (e.g. positive stool occult blood, melena, bright red blood, etc.)
- Results of any prior or abnormal radiologic study results, when relevant
- BBPS Score or prior colonoscopy report if early repeat is requested for inadequate preparation
- Details of any genetic syndromes (e.g., gene mutations, etc.)

- Capsule Endoscopy, Medicare Members
  - Crohn's Disease
    - Clinical features of your patient that are consistent with Crohn's Disease (e.g., diarrhea, abdominal pain, etc.)
    - Previous imaging and endoscopic procedure results
  - Gastrointestinal Bleeding
    - Documentation of the type and nature of the suspected bleeding (e.g., melena, observed blood per rectum, etc.)
    - Previous EGD and colonoscopy findings