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)
  - 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 extra-esophageal 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 or performed 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
- Capsule Endoscopy
  - 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.
- Colonoscopy (Commercial)
  - Screening colonoscopy
    - Average risk. Specify if the primary and intended purpose of the planned colonoscopy is for asymptomatic average risk screening, defined as no previously diagnosed colorectal cancer, colonic adenomas, or inflammatory bowel disease involving the colon.

- High risk. Specify if the primary and intended purpose of the planned colonoscopy is for asymptomatic high-risk screening, defined as:
  - one or more first-degree relatives with CRC or an advanced adenoma diagnosed at age ≤ 60 years
  - two first-relatives with CRC or documented advanced adenomas at any age
  - one or more first-degree relatives with a documented advanced serrated lesion or a sessile serrated polyp with cytologic dysplasia or
  - one first-degree relative diagnosed at age > 60.

- Non-screening colonoscopy (Diagnostic or Therapeutic colonoscopy)
  - Prior colonoscopy and pathology results as indicated, that require follow up
  - Surveillance after polypectomy - size, number, and histologic findings of the initial baseline colonoscopy in which the polyp was detected.
    - In addition, the results of the most recent colonoscopy in the case of subsequent surveillance requests should be submitted, and should include the above information relevant to the most recent polyp findings.
  - Surveillance after a diagnosis of colorectal cancer - the most recent colonoscopy findings and the date of diagnosis and/or resection
  - Inflammatory bowel disease - state of disease (e.g., active, chronic, etc.), current symptoms, and the reasons why the current colonoscopy is being requested (e.g., surveillance for dysplasia, monitoring of response to therapy of active disease, etc.).
  - Recent lab and prior workup, as well as information regarding particular risk factors (e.g., family history, etc.)
  - Notation of alarm symptoms is helpful (see Guidelines).
  - Diarrhea - Notation of acute vs. chronic is helpful, prior relevant lab and stool studies are helpful.
  - The nature of any bleeding is helpful (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.)

- Colonoscopy, Medicare
  - Screening colonoscopy - Medicare Advantage program members are subject to different criteria with respect to screening colonoscopy. Medicare has established 2 specific G-codes, G-0121 and G-0105, which reflect screening colonoscopies being performed in average and high-risk individuals, respectively. The criteria for payment for procedures performed using these G-codes are as follows.
    - G-0121 (colorectal cancer screening in average-risk individuals)
      - Can be performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer at a frequency of once every 10 years.

- G-0105 (colorectal cancer screening; colonoscopy on an individual at high risk)
  - May be paid when performed at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer
    - Characteristics of the High Risk Individual: 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 adenomatous polyps
      - A personal history of colorectal cancer; or 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.)