Musculoskeletal Site of Care Frequently Asked Questions (FAQs)

What is the musculoskeletal (MSK) site-of-care program?

The MSK site-of-care program supports our efforts to provide Cigna customers with the right care at the right place and right time. As a part of this program, precertification for certain MSK procedures will include a medical necessity review of both the requested service(s) and the service location.

How will requesting providers know if a customer is included in the site-of-care program?

Providers do not need to do anything. If a customer is included in the site-of-care program, the precertification pathway will seamlessly recognize the customer without any effort from the provider. There is no change to the process for initiating precertification requests for customers whose benefit plans include a site-of-care medical necessity review. If a provider requests an outpatient hospital setting for one of these affected customers, he or she will need to provide clinical rationale for the hospital setting; otherwise; we will deny the site of service

How will the program impact ordering providers?

There will be no change when ordering providers refer patients to an ambulatory surgery center. If a provider directs a patient to an outpatient hospital setting and there is an alternative ambulatory surgery center available, he or she will need to identify the clinical condition that warrants the need for the service to be performed there. If there is no clinical rationale, EviCore will deny coverage for the service at the outpatient hospital setting.

How will the program impact service locations?

Hospitals may see a reduction in the number of outpatient MSK procedures approved at their facilities. Ambulatory surgery centers may see an increase in the number of MSK procedures approved at their facilities.

How will the program impact customers?

Cigna customers may receive a denial of coverage for MSK procedures if their provider requests the service to be performed at an outpatient hospital setting, unless that setting is determined to be medically necessary. EviCore will attempt to contact customers who have approved procedures but the site of service denied to explain the reason for the denial.

What procedures will require site-of-care precertification through EviCore?

The site-of-care program will apply to the following EviCore-managed MSK services:

- Knee arthroscopy
- Hip arthroscopy
- Shoulder arthroscopy
- Epidural steroid injections
- Facet injections

- Radiofrequency joint ablation/denervation
- Regional sympathetic blocks
- Sacroiliac joint injections
- Spinal cord stimulation

Where can providers view the site of care coverage policy?

The Site of Care: Outpatient Hospital for Select Musculoskeletal Procedures coverage policy is available at www.eviCore.com/Cigna -->Comprehensive Musculoskeletal Management Guidelines.

Will the precertification process change?

There will be no changes to the current precertification process when requesting coverage for services provided at an ambulatory surgical center or another preferred location. When requesting coverage for an outpatient hospital setting, providers will need to provide clinical rationale. Providers may continue to request precertification for MSK services by logging in to the EviCore website (eviCore.com) or by calling EviCore at 888.693.3297, Monday through Friday from 7:00 a.m. to 7:00 p.m. ET.

Will urgent requests require site-of-care review?

No. Urgent requests will not be subject to site-of-care review. Services performed in an emergency room setting are already excluded from all precertification.

What if the requested procedure is approved but the site is denied or the site is approved and the procedure is denied?

In either of these cases, services rendered in the requested place of service will not be covered. Providers can follow the directions in the denial letter for post-decision options. If the site is denied and the procedure is approved, providers can also resubmit the request with an ambulatory surgery center.

Will claims be paid if the site of service is denied and the procedure is performed at the denied site?

If the procedure is performed without an approved precertification, including the site of service, the claim will not be paid.

What is reconsideration?

Providers and/or staff may be able to request a reconsideration of a site denied/procedure approved (or vice versa) by submitting additional clinical information without the need for a provider to participate. Reconsideration must be requested on or before the anticipated date the services will be performed. The reconsideration option is only applicable to commercial benefit plans.

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What is a peer-to-peer clinical consultation (P2P)?

A P2P clinical consultation is a discussion between a provider and an EviCore medical director in which the provider can provide additional clinical information. We welcome these consultation requests, and in certain instances, additional clinical information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval. A clinical consultation can only be performed by a requesting provider, nurse practitioner, or physician assistant.

If a requested procedure is approved but the site is denied and the requesting provider wishes to change the site of care to a preferred site, what should he or she do?

The ordering provider will need to contact EviCore to request a new precertification.

How should providers submit an appeal for the site of care?

Appeal options, including a reconsideration or clinical consultation (if applicable), will be explained in the denial letter.

Will claims be paid if a service is performed at a denied site of care?

If the procedure is performed without an approved precertification for the site of service, the claim will not be paid.

Will the requested site be notified if the request is denied?

If a request for precertification is denied, we will notify the ordering provider, requested site, and customer.

If a rendering provider has questions about becoming a preferred site, who should they contact?

Providers may contact their Cigna contracting representative.

How does an ordering provider know what ASC(s) are in network, and if they have surgical privileges at that facility?

It is up to the provider to know at which facilities they have privileges and what covering physicians they will be using at the Cigna in-network facility.

To confirm the ASC is in-network, prior to rendering services, it is required that the provider either utilize Cigna for Health Care Professionals, or contact Cigna Provider Services. The telephone # is 1-800-88Cigna, then select network participation.