Clinical Policy: Breast Surgeries

Reference Number: WNC.CP.104 Coding Implications
Last Review Date: 08/24 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy describes the medical necessity requirements for breast surgeries including mastectomy/breast conserving surgery, male gynecomastia, prophylactic mastectomy, reduction mammoplasty and breast reconstructive surgery.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that ***mastectomy*** **or** ***breast conserving surgery*** is covered when it is medically necessary.

II. It is the policy of WellCare of North Carolina® that mastectomy for ***male gynecomastia*** is medically necessary when the following criteria are met:

- **A.** **One** of the following:
  1. An adult member has a history of gynecomastia that persists for more than three (3) months after pathological causes are ruled out; **OR**
  2. An adolescent's gynecomastia persists more than 6 months after pathological causes are ruled out;
- **B.** The excessive tissue is glandular and not fatty tissue as confirmed by clinical exam, **AND** either ultrasound or mammogram;
- **C.** Other causes of gynecomastia such as obesity, adolescence, and drug treatments (gynecomastia resolves with the discontinuation of the medication) have been ruled out;
- **D.** The excessive breast tissue development is not caused by medications, non-covered therapies, alcohol, or use of illicit drugs such as marijuana or anabolic steroids, etc. (gynecomastia resolves with the discontinuation of the illicit drug usage);

NOTE*: Exception can be made for gynecomastia caused by psychotropic medication which the prescribing physician has documented cannot be discontinued.*

- **E.** The member's body mass index (BMI) is less than or equal to than 30 (http://www.halls.md/ideal-weight/body.htm) **OR** has participated in a clinically supervised weight loss and exercise program for more than 6 consecutive months;
- **F.** The member has a documented history of significant medical symptoms due to the gynecomastia that are not resolved by conservative treatments.
- **G.** The following medical documentation has been submitted:

1. Height (in inches), weight (in pounds), and age;
2. Unclothed pre-operative photographs from the chin to the waist (or lowest extent of breasts, if lower), including standing frontal and side views with arms straight down at the sides;
3. Medical record documentation of objective signs and symptoms and their duration; prior medical management, including the member's current medications; endocrine study results; and confirmation that the excessive tissue is glandular;
4. A list of subjective symptoms caused by breast enlargement with supporting medical record documentation of significant medical symptoms;
5. Evidence of exclusion of other medical problems that may cause or contribute to the significant medical symptoms as documented in the medical record; **and**
6. Medical record documentation by the requesting surgeon that the excessive breast tissue is not caused by medications, non-covered therapies, alcohol, or usage of illicit drugs such as marijuana or anabolic steroids.

III. It is the policy of WellCare of North Carolina® that ***prophylactic mastectomy*** is medically necessary when **all** of the following apply:

A. **One** of the following:
1. **One** of the following applies:
   a. Breast biopsy indicates that the member is at high risk for breast cancer, that is, has atypical hyperplasia or lobular carcinoma-in-situ (LCIS), which may also be an indication for bilateral mastectomy;
   b. Personal history of breast cancer (invasive ductal, invasive lobular, or ductal carcinoma-in-situ) in the contralateral breast;
   c. Personal positive BRCA1or BRCA2 genetic testing;
   d. Personal history of contralateral breast cancer in a pre-menopausal woman
2. **Two or more** of the following apply:
   a. Family history strongly suggestive of an autosomal dominant pattern of inheritance of a genetic mutation predisposing to breast cancer and or ovarian cancer;
   b. Immediate family history of breast cancer (mother, sister, daughter, brother, father);
   c. Personal history of ovarian cancer or history of a first-degree relative with ovarian cancer;
   d. Severe benign disease (such as fibrocystic disease or post-traumatic fat necrosis) that interferes with the ability to read mammograms as documented by a radiologist or extensive mammographic abnormalities (such as calcifications) that adequate biopsy or excision is impossible

B. The following documentation has been submitted:
1. History and physical;
2. Diagnoses;
3. Medical records to demonstrate the above criteria is met;
4. Plan of treatment, containing any planned reconstruction

IV. It is the policy of WellCare of North Carolina® that ***unilateral reduction mammoplasty*** is covered in cases of congenital absence or loss of significant female breast tissue of the contralateral breast subsequent to trauma or medically necessary (cancer or high cancer risk) mastectomy.

V. It is the policy of WellCare of North Carolina that ***reduction mammoplasty*** is medically necessary when the criteria in A **OR** B below are met:

A. ***Macromastia,*** **all** of the following*:*

1. Member is ≥18 years of age;
2. Member is <18 years of age and both of the following:
   a. Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging).
   b. No breast growth equivalent to a change in cup size for at least 6 months;
3. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the member's body surface area (BSA) per Appendix B listed below, adapted from the Schnur Sliding Scale.

Note: *The DuBois and DuBois body surface calculator (found here: http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm) may be used to calculate BSA if only height and weight are given; If the weight of resected tissue falls below the 22nd percentile of weight to be removed per BSA (the minimum cutoff in the Schnur Sliding Scale in Appendix B), a medical director will review the request on a case-by-case basis;*

4. Member has **at least two** (2) of the following persistent symptoms, affecting activities of daily living for at least one year:
   a. Headaches associated with neck and upper back pain;
   b. Pain in neck, shoulders, arm or upper back not related to other causes (e.g., poor posture, acute strains, poor lifting techniques);
   c. Breast pain;
   d. Painful kyphosis documented by X-rays;
   e. Pain/discomfort/ulceration/grooving from bra straps cutting into shoulders;
   f. Paresthesia of upper extremities due to brachial plexus compression syndrome;
   g. Intertrigo;
   h. Significant discomfort resulting in severe restriction of physical activities.
5. Physician evaluation has determined **ALL** of the following:
   a. Pain is unresponsive to conservative treatment as evidenced by physician documentation of therapeutic measures including at least **two** of the following:
      i. Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs);
      ii. Physical therapy/exercise when skeletal pathology is present;
      iii. Supportive devices (e.g., proper bra support, wide bra straps);
      iv. Medically supervised weight loss program;
      v. Chiropractic care or osteopathic manipulative treatment;
      vi. Orthopedic or spine surgeon evaluation of spinal pain;

b. Symptoms are not associated with another diagnosis, (e.g., arthritis);
c. One of the following:
   i. ≥ 40 years of age and mammogram negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure.
   ii. < 40 years of age with symptoms of breast cancer or high-risk factors for breast cancer and mammogram negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure;
   iii. < 40 years of age with no symptoms of breast cancer and no high-risk factors for breast cancer;

B. *Gigantomastia of Pregnancy*
The member has gigantomastia of pregnancy, accompanied by *any* of the following complications, and delivery is not imminent:
1. Massive infection;
2. Significant hemorrhage;
3. Tissue necrosis with slough;
4. Ulceration of breast tissue.
5. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.

VI. It is the policy of WellCare of North Carolina® that ***breast reconstructive surgery of the affected breast*** is reasonable and medically necessary when documentation (including photographs) confirms severe disfigurement resulting from surgical complications, trauma, disease, or Poland Syndrome. Reduction, mastopexy, and/or augmentation of the contralateral breast as reasonable and medically necessary when documentation demonstrates that procedure is necessary for the repair of breast asymmetry caused by mastectomy or medically necessary lumpectomy in association with the primary mastectomy procedure for the following conditions:

A. Member requires reconstruction due to **one** of the following:
1. Malignant neoplasm of the breast;
2. Secondary malignant neoplasm of the breast;
3. Carcinoma in situ of the breast, either lobular or ductal; or
4. Congenital absence of the breast (Poland's syndrome).
5. Prophylactic mastectomy when the applicable criteria are met.

B. If required, breast implants, including tissue expanders and implant materials, are covered when surgically placed in the area where the natural breast tissue has been removed for a medically necessary mastectomy or to achieve symmetry after medically necessary breast surgery.

C. Nipple reconstruction and/or tattooing are also covered when criteria in V.A. above are met.

D. If needed, periprosthetic capsulotomy or capsulotomy procedures are covered for contractions or adhesions following reconstruction surgery when the contractions or adhesions are caused by medically necessary chemotherapy or radiation treatments for breast cancer.

VII. It is the policy of WellCare of North Carolina® that the breast surgeries listed below are **not covered**:

- **A.** Breast implants when used for breast enlargement for cosmetic purposes;
- **B.** Removal of mammary implants or mammary implant material for cosmetic purposes;
- **C.** Augmentation mammaplasty with or without prosthesis for cosmetic purposes;
- **D.** Correction of inverted nipples;
- **E.** Preparation of moulage for custom breast implants;
- **F.** Periprosthetic capsulotomy and periprosthetic capsulectomy procedures following augmentation;
- **G.** Breast reduction except when the medical necessity criteria are met;
- **H.** Mastopexy except when the medical necessity criteria are met.

Background[1]

A. ***Mastectomy/Breast Conserving Surgery***

Mastectomy is the surgical removal of part, or all of the breast tissue. Breast conserving surgery is removal of part of the breast and can be called lumpectomy, tylectomy, quadrantectomy, or segmentectomy.

B. ***Male Gynecomastia***

Mastectomy for gynecomastia is the surgical removal of breast tissue from adult males. Male gynecomastia is the excessive development of the male mammary glands. During puberty, enlargement of the male breast is normal and is usually transient.

C. ***Prophylactic (Risk reducing) Mastectomy***

Prophylactic mastectomy is the removal of the breast(s) to prevent development of cancer in members considered to be at high risk of developing or redeveloping breast cancer. Fibrocystic disease is not a legitimate reason for mastectomy in the absence of documented risk factors.

D. ***Reduction Mammaplasty***

Reduction mammaplasty is surgery to remove substantial breast tissue, including the skin and glandular tissue, to reduce the size of the breast.

E. ***Breast Reconstructive Surgery***

Breast reconstructive surgery is performed following a mastectomy to establish symmetry with the contralateral breast or following bilateral mastectomy. It includes the surgical creation of a new breast mound and the nipple-areolar reconstruction, which is accomplished with small local flaps for the nipple and either tattooing or a skin graft for the areola. Reconstructive breast surgery may also include reduction mammaplasty, mastopexy, or augmentation on the contralateral breast to establish symmetry. Breast implants, tissue flaps, or both are surgically placed in the area where natural breast tissue has been removed.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
19300	Mastectomy for gynecomastia
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myo cutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myo cutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myo cutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents

CPT®* Codes	Description
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less

Appendices

Appendix A

- Criteria for distinguishing Tanner stages 1 to 5 in those with a female reproductive system[11]:

Tanner Stage	Breast	Pubic Hair
1 (Prepubertal)	No palpable glandular tissue or pigmentation of areola; elevation of areola only	No pubic hair; short, fine villus hair only
2	Glandular tissue palpable with elevation of breast and areola together as a small mound; areola diameter increased	Sparse, long pigmented terminal hair chiefly along the labia majora
3	Further enlargement without separation of breast and areola; although more darkly pigmented, areola still pale and immature; nipple generally at or above mid-plane of breast tissue when individual is seated upright	Dark, coarse, curly hair, extending sparsely over mons
4	Secondary mound of areola and papilla above breast	Adult-type hair, abundant but limited to mons and labia
5 (Adult)	Recession of areola to contour of breast; development of Montgomery's glands and ducts on the areola; further pigmentation of areola; nipple generally below mid-plane of breast tissue when individual is seated upright; maturation independent of breast size	Adult-type hair in quantity and distribution; spread to inner aspects of the thighs in most racial groups

Appendix B

- Adapted from Schnur Sliding Scale – body surface area and estimated minimum cutoff weight for breast tissue per breast to be removed[12]:

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.35	199
1.40	218
1.45	238

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.50	260
1.55	284
1.60	310

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
2.00	628
2.05	687
2.15	819
2.20	895
2.25	978
≥ 2.30	1000

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	01/21	05/21
Revised Criteria in Sections I and V.2. Added note to Section II.D. Reviewed CPT codes. Added additional references.	01/22	02/22
Revised Criteria in Section I. "mastectomy or breast conserving surgery is covered when it is medically necessary"	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Added Criteria V.B. "gigantomastia of pregnancy.".	05/23	05/23
Annual review. Criteria V.A.1. and Criteria V.A.2, updated for criteria for members/enrollees ≥ 18 years of age and members/enrollees < 18 years of age. Criteria V.A.3. updated to include note regarding medical director review on case-by-case basis when weight of tissue to be resected is less than the 22nd percentile minimum based on the Schnur Sliding Scale. Criteria I.A.4.b. updated to include pain in arm. Added Appendix A Tanner Stage and Appendix B Schnur Sliding Scale. HCPCS table removed.	05/24	05/24
Criteria II.A.1. Changed 'three to four' to 'three.' Verbiage updated in criteria V.removed "in females for non cosmetic indications" Criteria A.5.b. Changed 'the pain' to "Symptoms are." Removed criteria I.A.5.c. and d. Updated to include mammogram requirement for members/enrollees < 40 years of age with symptoms of breast cancer or high-risk factors for breast cancer in what is now I.A.5.c.i. through iii. Removed the 'Medicaid and health choice' verbiage from the References.	08/24	08/24

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North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.