Clinical Policy: Surgery for Clinically Severe or Morbid Obesity

Reference Number: WNC.CP.228 Coding Implications
Last Review Date: 05/2025 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]

Surgery for clinically severe or morbid obesity is performed for long-term surgical weight loss management. This may result in improvement of the co-morbidities of obesity. The goal of the surgery is to reduce the morbidity associated with obesity and to improve metabolic and organ function.

Morbid obesity is defined as a body-mass index (BMI) greater than or equal to 40 kg/m2.

Clinically severe obesity is defined as a BMI of 35-39.9 kg/m2 with comorbid conditions.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover a bariatric surgical procedure for clinically severe or morbid obesity when health records substantiate that a Member has met **ALL** the following criteria (A through F) for the past **12** calendar months prior to the request for surgery:

- **A.** A diagnosis of morbid obesity (BMI) ≥ 40 kg/m2 **OR**
- **B.** Clinically severe obesity BMI of 35-39.9 kg/m2 with at least **ONE** of the following conditions:
  1. Arteriosclerosis, Type 2 diabetes mellitus, heart disease, cardiomyopathy, heart failure, pseudotumor cerebri; **OR**
  2. Gastroesophageal reflux disease with secondary asthma or erosive esophagitis, not controlled despite maximum dosages of proton pump inhibitors; **OR**
  3. Limitation of motion in any weight-bearing joint or lumbosacral spine as documented by the health record, including x-ray findings of degenerative osteoarthritis or severe osteoarthritis; **OR**
  4. Significant respiratory insufficiency as evidenced by partial pressure of carbon dioxide (PCO^2) greater than 50 mmHg, hypoxemia at rest, as evidenced by PCO^2 less than 55 mmHg on room air; forced expiratory volume in 1 second (FEV1), forced vital capacity (FVC) less than 65%, or carbon monoxide diffusion in the Lung (DLCO) less than 60% (such as Obesity Hypoventilation Syndrome); or

sleep apnea documented by respiratory function studies, blood gases, sleep studies; **OR**

5. Significant circulatory insufficiency such as peripheral vascular disease documented with arteriography or ultrasound and brachial and ankle pressure before and after exercise. Documented coronary artery disease by stress test or previous need for angioplasty or coronary bypass. Carotid artery disease documented by ultrasound with greater than 70% blockage. Aortic disease documented by CT or MRI. Severe valvular disease documented by doppler echo; **OR**
6. Pulmonary Hypertension **OR**
7. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and greater than 90 mmHg diastolic measured with appropriate size cuff) that has not responded to medical management including at least two anti-hypertensive drugs at maximum tolerated dosages; **OR**
8. Hypercholesterolemia greater than 240 mg/dL or hypertriglyceridemia greater than 400 mg/dL or low-density lipoprotein (LDL) greater than160 mg/dL or high-density lipoprotein (HDL) less than 40 mg/dL; despite appropriate medical therapy defined as at least one appropriate drug at maximum dosage. **OR**
9. Metabolic syndrome, nonalcoholic steatohepatitis (NASH).

C. Member has demonstrated evidence of attempts to lose weight through non-surgical means such as follow up with medical provider for weight-related comorbid conditions, nutritional counseling, and physical activity through a professional qualified to provide these services or through a proprietary weight loss program

D. Documentation in the health record substantiates **ALL** of the following (1- 4) criteria:

1. The Member has been unsuccessful with medical treatment for clinically severe or morbid obesity for the past 12 calendar months prior to the request for a bariatric surgical procedure, of at least three (3) calendar months duration, provided or supervised by a medical provider.
2. The monthly encounter notes must document **ALL** the following:
   a. Body weight greater than 100 pounds or 45kg above ideal weight with at least one height documented;
   b. Caloric requirements, and eating behaviors being modified; **AND**
   c. Measurable activity prescribed relevant to the Member's medical condition(s) (Such as: type of exercise, frequency, duration.)

   Note: A statement in the encounter note to "increase activity" or failure to prescribe a measurable activity does not meet this requirement;
3. The Member has no correctable cause for obesity, such as an endocrine disorder; **AND**
4. The treatment of any medical condition(s) listed in Section B.

E. Dietician or Nutritionist Evaluation

1. Evaluation by a registered dietician or nutritionist experienced in the issues associated with bariatric surgery procedures, documenting diet history, problem areas, obstacles, eating disorders, or need for dietary behavior modifications, reduced calorie, and dietary recommendations in the past **six (6)** calendar months prior to the request for surgery. The required evaluation must be conducted face-

to-face, and not in a group setting. This documentation, at a minimum, must substantiate the Member's suitability for a bariatric surgical procedure;
   a. History of weight loss management;
   b. History of weight loss attempts with supervised diets and exercise programs as well as independent attempts; and
   c. Their ability to comply with postoperative medical care, dietary restrictions, and the lifetime commitment required for a successful outcome.

F. Psychological Evaluation
1. Evaluation by a licensed psychologist, psychiatrist, or licensed medical clinical social worker, documenting the absence of significant psychopathology in the past **six (6)** calendar months. This documentation must substantiate the Member's suitability for a bariatric surgical procedure, and their ability to comply with postoperative medical care, dietary restrictions, and the lifetime commitment required for a successful outcome. Inability to comply will result in denial of the surgery.
2. The psychological evaluation must document, at a minimum the following, to substantiate suitability for surgery:
   a. Psychiatric history;
   b. Current psychological function;
   c. Weight and dieting history;
   d. Current eating behaviors;
   e. Level of physical activity; and
   f. History of substance use and dependence (as well as any current use).
3. During the psychological evaluation, a Member is educated on the behavioral changes necessary to ensure good post-operative results, as well as any psychological changes that can be anticipated after surgery.

G. The requesting surgeon shall (with the prior approval request) submit **ALL** health records that meet the following requirements:
1. Conducts the Initial Assessment, face to face, to determine medical or surgical alternatives. If a covered bariatric surgical procedure is recommended and mutually agreed upon, the surgeon shall inform and evaluate the Member's understanding of the procedure to be performed, including the procedure's risks and benefits; behavioral changes required prior to and after the bariatric surgical procedure (including pre and post operative dietary and increasing exercise requirements); psychological changes, and commitment for following the surgeon's post-surgical program.
2. Make the appropriate referrals to the dietician or nutritionist and psychological professional for evaluations if they have not been completed or treatment has not resolved contraindicated issues.
3. If the surgeon prescribes additional pre-surgical requirement(s), not all inclusive of specified weight loss or smoking cessation, the surgeon shall either provide treatment or make a referral to assist the Member in meeting additional requirement(s) before a prior approval is submitted. Health records substantiating that the requirement(s) have been met must be submitted with the prior approval request.

4. If the surgeon deems the primary mutually agreed upon procedure is no longer medically appropriate, another face-to-face assessment must be conducted.
5. When **ALL** pre-surgical requirements are met, the requesting surgeon, group associate, or group physician extender shall perform a complete History & Physical examination, which must document current weight, height, BMI, laboratory values (that includes thyroid levels) and a list of current medication(s).
6. Appropriate medical work up may consist of a chest x-ray, upper gastrointestinal series, endoscopy, appropriate pre-op labs and ECG.

Note: Routine pre-admission work-up must be held pending approval to prevent repeating time-sensitive services.

H. The bariatric surgical procedure is **ONE** of the following procedures:
1. Gastric bypass with Roux limb 150 cm or less (Roux-en-Y);
2. Adjustable gastric banding, for members with a BMI of less than 50 kg/m^2. Members with a BMI greater than or equal to 50 kg/m^2 are considered on a case-by-case basis when information is provided as to the medical necessity of this procedure for the specific Member.
3. Biliopancreatic diversion with or without duodenal switch, for Members with a BMI greater than or equal to 50 kg/m^2, to be considered on an individual basis with appropriate documentation of the indications for this procedure under current standards of care;
4. Gastric bypass, with small intestine reconstruction to limit absorption, with roux limb greater than 150 cm (long-limb Roux-en-Y) for a Member with a BMI greater than or equal to 55 kg/m^2 , to be considered on an individual basis; **or**
5. Laparoscopic sleeve gastrectomy (LSG) as a stand-alone procedure.

I. Provider Certifications:
Effective November 1, 2023, facilities will be required to have the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Proof of accreditation must be submitted with each prior approval request. PA requests not submitted with proof of accreditation will be denied effective November 1, 2023

II. WellCare of North Carolina® shall cover revision of a primary bariatric surgical procedure for a ***documented perioperative or late complication*** for a Member who meets **ONE** of the below conditions:
A. Weight loss of 20% or more below the ideal body weight;
B. Esophagitis unresponsive to nonsurgical treatment;
C. GERD unresponsive to at least 3 months of non-surgical treatment
D. Hemorrhage or hematoma complicating a procedure;
E. Excessive bilious vomiting following gastrointestinal surgery;
F. Complications of the intestinal anastomosis and bypass;
G. Stomal dilation, confirmed by endoscopy;
H. Slippage of adjustable gastric band that cannot be corrected with manipulation or adjustments;
I. Stricture;
J. Obstruction;

K. Erosion;
L. Staple-line failure; **or**
M. Non-absorption (such as hypoglycemia or malnutrition following gastrointestinal surgery).

NOTE: Covered bariatric surgical procedures may be performed in the most clinically appropriate setting at the discretion of the surgeon. Appropriate places of service for bariatric procedures include hospital inpatient, outpatient, and ambulatory surgery center, as determined by the Member clinical condition, comorbidities, etc. if prior authorization for the procedure is obtained.

III. WellCare of North Carolina® shall cover revision of a primary bariatric surgical procedure that has failed when ***pouch dilation*** is confirmed by upper gastrointestinal examination or endoscopy, producing weight gain of 20% or more, provided that:
A. The primary procedure was successful in inducing weight loss prior to the pouch dilation; **and**
B. The Member has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement of compliance with diet and exercise).

IV. WellCare of North Carolina® **shall not** cover the following:
A. Jejunoileal bypass;
B. Biliopancreatic diversion with or without duodenal switch for a Member with a BMI < 50 kg/m^2;
C. Gastric wrapping;
D. Adjustable gastric banding for a Member with a BMI > 50 kg/m^2
E. Jejunocolostomy;
F. Mini-gastric bypass;
G. Open sleeve gastrectomy;
H. Gastric bypass with roux limb greater than 150 cm for a Member with a BMI less than 55 kg/m^2.;
I. Bariatric surgical procedures for a Member with a BMI less than 35 kg/m^2
J. Gastric electrical stimulation;
K. Revision of a primary bariatric surgical procedure when the Member does not meet the criteria above;
L. Staged procedures; **or**
M. Cosmetic surgery: Weight loss following bariatric surgical procedures can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is **not covered**.

V. Medicaid shall not cover a bariatric surgical procedure or a Member who is:
A. A preadolescent child,

B. A pregnant or breast-feeding adult or adolescent
C. Planning to become pregnant within two years of surgery; or
D. Not demonstrating mastery of the principles of healthy dietary and activity habits.

VI. The following conditions are contraindications to a bariatric surgical procedure, and approval cannot be granted until there is health record documentation that the conditions are resolved:
A. Untreated major depression or psychosis,
B. Binge-eating disorders, or
C. Current drug and or alcohol abuse.

***NOTE**: A provider's summary letter alone is not considered a health record. Encounter notes must document the following:*
- Member's name on each page;
- Date of service;
- Exclusive purpose for pre-surgical bariatric evaluation or treatment, assessments, and findings;
- Individualized intervention; and
- Member's response to the treatment plan.

Background[1]

Body Mass Index (BMI) is considered to represent the most practical measure of a recipient's body fat. It is calculated by dividing the weight in kilograms by the height in meters squared (kg/m^2). Weight gained during pregnancy cannot be used to meet the presurgical requirements for this policy.
Clinically Severe Obesity is defined as a BMI 35-39.9 kg/m^2 with co-morbid conditions.
Morbid Obesity is defined as a BMI greater than or equal to 40 kg/m^2.
Surgery for clinically severe or morbid obesity (referred to as a bariatric surgical procedure for the purposes of this policy) falls into two general categories:
- Gastric-restrictive procedures which create a small gastric pouch, resulting in weight loss by producing early satiety and thus decreasing dietary intake because the amount of food that can be eaten at one time is greatly reduced; and
- Malabsorptive procedures, which produce weight loss due to malabsorption by altering the normal transit of ingested food through the intestinal tract. Following a malabsorption procedure, the number of calories, fats and nutrients that can be absorbed during digestion is reduced.

Some bariatric surgical procedures may include both a restrictive and a malabsorptive component.

Lifetime Limitation: One (1) primary bariatric surgical procedure from those listed in *Section I.H.* is allowed per Member per lifetime. When a Member had a previous primary bariatric

surgical procedure, other than as a Medicaid Member, then the Member may have an additional primary bariatric surgical procedure, if all prior approval requirements are met.

A primary bariatric surgical procedure may be revised if all prior approval requirements are met.

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 2025, 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
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only

CPT®* Codes	Description
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Reviewed CPT codes.	02/22	05/22
Annual Review. Added "> OR=" to I.A. & I.B.1. Added conditions to I.A.1. DM2/cardiomyopathy/HF I.A.2. GERD, I.A.3. Severe OA, I.A.6. Pulmonary HTN, I.A.9. NASH. 1.C. Added "Member has demonstrated evidence of attempts to lose weight…" I.D.2.a. changed verbiage to "Body weight greater than 100 pounds or 45kg above ideal weight with at least one height documented." I.E.,1. and I.F.1. Added requirements for Evaluation & for Documentation, under Dietician or Nutritional & Psychological evaluations. I.G.5 added verbiage "laboratory values (that includes thyroid levels)." I.G.6. added verbiage "Appropriate medical work up may consist of a chest x-ray, upper gastrointestinal series, endoscopy, appropriate pre-op labs and ECG." I.I. added Provider Certification requirements effective 11/1/2023. II. Added "NOTE: "Covered bariatric surgical procedures may be performed in the most clinically appropriate setting at the discretion of the surgeon…" Section IV.I. added verbiage ""Bariatric surgical procedures for a Member with a BMI less than 35kg/$m^{2.}$ Section V. added. verbiage for "shall not cover." Section VI added. "NOTE: "A provider's summary letter alone is not considered a health record." Added Encounter notes requirements. In Background added verbiage w/no effect on criteria for gastric-restrictive and malabsorptive procedures.	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. Removed ICD-10-PCS table.	11/23	11/23
Annual Review. Added Criteria II.C. "GERD unresponsive to at least 3 months of non-surgical treatment" Removed HCPCS code box.	05/24	05/24
Annual Review. CPT codes reviewed. Removed "Medicaid and health choice" text from References. Under NC Guidance/Claims related information, updated state web address.	05/25	05/25

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1A-15 Surgery for Clinically Severe or Morbid Obesity. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published October 1, 2024. Accessed February 12, 2025.

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/meetingsnotices/medicaid-state-plan-public-notices

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.