Clinical Policy: Gender-Affirming Procedures

Reference Number: HIM.SC.CP.MP.95
Date of Last Revision: 09/25

Coding Implications
Revision Log

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

Description

Services for gender affirmation most often include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. Not every individual will require each intervention, so necessity needs to be considered on an individualized basis. The criteria in this policy outline the medical necessity criteria for gender-affirming medical and surgical treatment (GAMST) *when such services are included under the member/enrollee's benefit plan contract provisions.*

Policy/Criteria

I. It is the policy of Ambetter from Absolute Total Care that gender-affirming surgeries are considered **medically necessary** for members/enrollees when diagnosed with gender dysphoria or gender incongruence per section A. and when meeting the eligibility criteria in section B.

Note: Intersex individuals are not subject to the criteria in this policy.

A. Gender Dysphoria or Gender Incongruence Criteria:
   1. Marked and sustained incongruence between the member/enrollee's experienced/expressed gender and assigned gender, as *indicated by two or more* of the following:
      a. Marked incongruence between the member/enrollee's experienced/expressed gender and primary and/or secondary sex characteristics;
      b. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender;
      c. A strong desire for the primary and/or secondary sex characteristics of the other gender;
      d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
      e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);
      f. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender);
      g. The condition is associated with impairment in social, occupational, or other important areas of functioning;

B. Eligibility criteria, all of the following:
   1. Member/enrollee must be ≥ 18 years of age;
   2. Capacity to make a fully informed decision (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment;

3. If significant medical or mental health concerns are present, they are reasonably well controlled;
4. Other possible causes of apparent gender dysphoria, gender incongruence, or gender diversity have been identified and excluded;
5. Minimum of one written statement with signature recommending gender-affirming medical and surgical treatment (GAMST) from a health care provider competent to independently assess and diagnose gender incongruence;
6. Assessment for GAMST from a provider who meets both of the following:
   a. Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider);
   b. Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;
7. The documented assessment for GAMST meets all of the following:
   a. Identifies any mental or physical health conditions that could negatively impact the outcome of GAMST, with risks and benefits discussed;
   b. Notes the member/enrollee's capacity to understand the effect of GAMST on reproduction and includes a discussion of reproductive options with the member/enrollee prior to the initiation of GAMST;
8. Member/enrollee remains stable on their gender affirming hormonal treatment regime (which may include at least six months of hormone treatment or longer if required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated).

C. Gender-affirming surgeries are considered **medically necessary** when meeting above criteria and additional criteria as listed below for specific procedures:
   1. For members/enrollees ≥ 18 years of age, any of the following:
      a. Penectomy;
      b. Urethroplasty;
      c. Mammoplasty;
      d. Mastectomy, and the member/enrollee has been assessed for risk factors associated with breast cancer;
      e. Clitoroplasty;
      f. Vulvoplasty;
      g. Labiaplasty;
      h. Vaginectomy;
      i. Vulvectomy;
      j. Scrotoplasty;
      k. Testicular prosthesis;
      l. Breast augmentation, and the member/enrollee has been assessed for risk factors associated with breast cancer;

m. Phalloplasty;
n. Metoidioplasty;
o. Vaginoplasty;
p. Gonadectomy (i.e., hysterectomy, salpingo-oophorectomy, orchiectomy; at least six months of hormone therapy may be considered prior to procedure, as appropriate for the member/enrollee's goals).

II. It is the policy of Ambetter from Absolute Total Care that gender affirming facial procedures will be considered for medical necessity on a *case-by-case* basis when meeting the following:
A. Criteria has been met in section I.A. and I.B.;
B. Requested procedure intends to correct existing facial appearance that demonstrates significant variation from standard appearance for the experienced gender. Possible procedures include, but are not limited to, the following:
1. Blepharoplasty;
2. Face lift/mid-face lift/brow lift;
3. Facial implants and bone reconstruction;
4. Hair removal/electrolysis;
5. Drugs for hair loss or growth;
6. Hair transplantation or hairline advancement;
7. Prosthetic or filler substances to alter contour;
8. Rhinoplasty;
9. Thyroid chondroplasty;
10. Removal of redundant skin;
11. Upper lip shortening and lip augmentation;
12. Chondrolaryngoplasty;
13. Voice modification surgery, therapy, or lessons.

III. It is the policy of Ambetter from Absolute Total Care that per the General Assembly of the State of South Carolina A203, R219, H4624, gender-affirming procedures are considered **medically necessary** for *members < 18 years of age*, when at least one of the following criteria is met:
A. A minor requiring treatment for precocious puberty, prostate cancer, breast cancer, endometriosis, or other procedure unrelated to gender transition, or who was born with a medically verifiable disorder of sexual development including, but not limited to, a person with external biological sexual characteristics that are ambiguous including, but not limited to, people who were born with forty-six XX chromosomes with virilization or forty-six XY chromosomes with under virilization or having both ovarian and testicular tissue;
B. A minor diagnosed with a disorder of sexual development, if a health care provider has determined, through genetic or biochemical testing, that the minor does not have a sex chromosome structure, sex steroid hormone production, or sex steroid hormone action, that is normal for a biological male or biological female;

C. A minor needing treatment for an infection, injury, disease, or disorder that has been caused or exacerbated by the performance of gender transition procedures, whether or not the gender transition procedure was performed in accordance with state or federal law;
D. If prior to *August 1, 2024*, a health care provider initiated a course of treatment for a minor that includes the prescription, delivery, or administration of a puberty-blocking drug or a cross-sex hormone, and the health care provider determines and documents in the minor's medical record that immediate termination would cause harm to the minor, the health care provider may institute a period during which the minor's use of the drug or hormone is systematically reduced. That period may not extend beyond **January 31, 2025.**
E. A minor requiring a procedure due to a physical disorder, physical injury, or physical illness that would, as determined and documented by the health care provider, place the minor in imminent danger of death or impairment of a major bodily function unless treated by the physician.

IV. It is the policy of Ambetter from Absolute Total Care that for members < 18 years of age, surgical gender transition procedures for any other reasons than those listed in Section III. are *prohibited* per the General Assembly of the State of South Carolina A203, R219, H4624.

V. It is the policy of Ambetter from Absolute Total Care that revision procedures for affirming gender are **medically necessary** when the revision is required to address complications of a prior gender affirming procedure (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.).

VI. It is the policy of Ambetter from Absolute Total Care that procedures used solely to improve appearance, and unrelated to gender expression, are not medically necessary, as they are considered cosmetic in nature.

VII. It is the policy of Ambetter from Absolute Total Care that detransition procedures by gender-related hormone intervention, surgical intervention, or both, will be considered for medical necessity on a case-by-case basis.

Background

The World Professional Association for Transgender Health (WPATH) is an international professional society dedicated to promoting the highest level of evidence-based principles for transgender and gender diverse (TGD) individuals.[3] Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of two through three years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.[4] *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).[4,5] Per WPATH, the focus of gender dysphoria is not

on the individual's gender identity, but on any of the distress or discomfort related to being TGD.[3] WPATH states that gender incongruence is considered a condition with a focus on the TGD person's experienced identity and any need for gender-affirming treatment that arises from this identity.[3]

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may not involve gender-affirming surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless of whether they differ from the sex assigned to them at birth.

WPATH's Standards of Care (SOC) are a series of flexible guidelines for clinical practice published by the society and are based on evidence and expert consensus.[3] Version 8 of WPATH's SOC were published in 2022, and these guidelines offer clinical guidance to health care professionals caring for TGD people and are intended to be adaptable to meet the diverse health care needs of this population.[3]

WPATH recommends that the assessment for GAMST in adults ≥ 18 years of age be completed by a provider who is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider). The provider(s) working with gender diverse adults should additionally meet all of the following[3]:

1. Identify co-existing mental health or other psychosocial concerns, distinguishing these from gender dysphoria, incongruence, and diversity;
2. Assess capacity to consent for treatment (capacity to consent is required for GAMST assessment);
3. Have experience or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity and is able to liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required;
4. Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments;
5. Ensure any mental or physical health conditions that could negatively impact the outcome of GAMSTs are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
6. Assess the member/enrollee's capacity to understand the effect of GAMST on reproduction and discuss reproduction options with the member/enrollee prior to the initiation of GAMST;
7. Assess and discuss the role of social transition with the member/enrollee requesting GAMST.

*** Per the General Assembly of the State of South Carolina A203, R219, H4624, Section 44-42-320, "A physician, mental health provider, or other health care professional shall not knowingly provide gender transition procedures to a person under eighteen years of age".* The bill also explains allowable exceptions as well as penalties for violations.[2]

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 that may be considered part of gender-affirming surgery.
This code list does not indicate if a procedure is or is not considered medically necessary.

CPT® Codes	Description
11950 through 11954	Subcutaneous injection of filling material (e.g., collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent implant
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

CPT® Codes	Description
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 through 15783	Dermabrasion
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820 through 15823	Blepharoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832 through 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876 through 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19316	Mastopexy

CPT® Codes	Description
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty reconstruction female urethra
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

CPT® Codes	Description
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular) with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy complete removal vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction artificial vagina; without graft
57292	Construction artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

CPT® Codes	Description
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

CPT® Codes	Description
58940	Oophorectomy, partial or total, unilateral or bilateral
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	10/24	12/24
Annual review. Updated verbiage in Criteria VI. to state that procedures used solely to improve appearance, and unrelated to gender expression, are not medically necessary and removed list of procedures considered cosmetic in nature. Coding and descriptions reviewed. References reviewed and updated.	09/25	

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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/enrollee. 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.

Note: For Medicaid members/enrollees, 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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.