Clinical Policy: Endometrial Ablation

Reference Number: WNC.CP.120 Coding Implications
Last Review Date: 05/24 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 This policy describes the medical necessity guidelines for an endometrial ablation. Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal abnormal uterine bleeding.[2,12,21,] Although this procedure preserves the uterus, endometrial ablation is indicated for those who have no desire for future fertility.[11] The two major classifications of endometrial ablation procedures are first generation resectoscopic techniques and second generation nonresectoscopic methods. Quality of life resulting from reduced bleeding and amenorrhea, may improve following endometrial ablation procedures.

Policy/Criteria

I. It is the policy of WellCare of North Carolina® that Endometrial Ablation using an FDA approved device, is medically necessary when **all** the following criteria are met:
- **A.** **One** of the following indications:
  1. Menorrhagia unresponsive to at least 3 months of hormonal or medical therapy (unless contraindicated to such therapy); [25]
  2. Abnormal uterine bleeding, including residual menstrual bleeding after at least 6 months of androgen therapy in a member/enrollee with a female reproductive system undergoing treatment for gender affirmation;[23]
- **B.** Cervical cytology or HPV testing and gynecological exam excludes significant cervical disease;[25]
- **C.** Endometrial sampling prior to the procedure has excluded malignancy or hyperplasia;[25]
- **D.** No structural anomalies, such as fibroids or polyps that require transmural surgery or represent a contraindication to an ablation procedure
- **E.** If anatomic or pathologic conditions exist that may result in a weakened myometrium, only a resectoscopic endometrial ablation is appropriate;[81]
- **F.** Thyroid disorders have been treated or ruled out.
- **G.** Does **NOT** have any of the following contraindications:
  1. Premenopausal with future desire for fertility;
  2. Untreated disorders of hemostasis;[81]
  3. Pregnancy at time of procedure;
  4. Intrauterine device at time of procedure;
  5. Active pelvic infection.

II. It is the policy of WellCare of North Carolina® that there is insufficient scientific evidence to support effectiveness for the following:

A. Photodynamic endometrial ablation procedures;
B. Endometrial ablation for the treatment of all other conditions than those specified above.

Background
Menstrual disorders are among the most prevalent gynecological health problems in the United States, and abnormal menstrual bleeding affects up to 30% of people at some time during their reproductive years.[4]

Traditionally, medication therapy has been the initial treatment of choice, followed by hysterectomy, when medication does not provide the desired outcome. The levonorgestrel releasing intrauterine device (e.g., Mirena or Liletta; referred to as LNG 52 mg IUD) is an option in patients who do not desire pregnancy. Both the LNG 52 mg IUD and endometrial ablation are effective in reducing menstrual blood loss. The decision to use the LNG 52 mg or endometrial ablation depends on a patient's preferences regarding treatment factors, such as plans for fertility and contraception, convenience, and risks of anesthesia.[21,24,29] Endometrial ablation can offer an alternative to the more invasive hysterectomy treatment option.[9]

Endometrial ablation can also be used to treat residual menstrual bleeding in transgender men.[23] Generally, masculinizing hormones cause cessation of menses within 2 – 6 months of initiation. The addition of a progestational agent or endometrial ablation may be considered for those wishing to completely cease menses.[17]

Endometrial ablation encompasses several techniques of targeted destruction of the endothelial surface of the uterine cavity through a vast array of energy sources. While hysterectomies provide permanent relief from abnormal uterine bleeding, they are associated with longer recovery times, higher rates of postoperative complications, substantial convalescent time and morbidity.8,[9] Although endometrial ablation has a high success rate, there are specific cases of endometrial ablation failures in which the patient will return for repeat care, often for a hysterectomy.[90] The effectiveness of endometrial ablation was demonstrated in a report of 26 patients who underwent ablation. After one year, 25 of the 26 patients reported reduced bleeding with no further medical or surgical interventions; one patient required a hysterectomy due to persistent uterine bleeding related to a leiomyoma.[30] Among patients who return for hysterectomy after failure of endometrial ablation, adenomyosis, leiomyomata and endometriosis are the most common contributing diagnoses.[20,31]

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used. Endometrial ablation is predominately indicated for patients who have no desire for future fertility.[20] Post-operative complications from endometrial ablation include: (1) pregnancy after endometrial ablation; (2) pain-related to obstructed menses (hematometra, post ablation tubal sterilization syndrome); (3) failure to control menses; (4) risk from preexisting conditions (endometrial neoplasia, cesarean section; and (5) infection.[13,21] Uterine perforation has been reported in 0.3 percent of nonresectoscopic endometrial ablation procedures and 1.3 percent of resectoscopic ablations or resections. [21]

Table 1: FDA-Approved Techniques Approved For Endometrial Ablation

Procedure[1,2,3]	System[1,2,13]	Device Size[1] (mm)	Treatment Time[1,13](min)	Amenorrhea Rate[2]
Resectoscopic Ablation				
Laser Vaporization				37%
Electrosurgical Rollerball				25 to 60%
Transcervical resection of endometrium				26 to40%
Radiofrequency Vaporization				N/A
Non-Resectoscopic Ablation				
Cryotherapy	Cerene	4.5	10 to 8	53%
Heated Free Fluid	Hydro ThermAblator	7.8	~ 14 *	71%
Vapor ablation	Mara		2.0	
Radiofrequency Electricity	NovaSure	7.2	1.5	41%
Combined thermal and bipolar radiofrequency ablation device	Minerva		2.0	

* 3 minutes to heat the fluid to 90°C, 10 minutes to maintain that temperature to ablate the endometrium, and approximately 1 minute for the fluid to cool down allowing the device to be 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
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle
N92.4	Excessive bleeding in the premenopausal period
N92.5	Other specified irregular menstruation
N92.6	Irregular menstruation, unspecified
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	02/21	05/21
Added "HPV testing" to Section I.B. Updated investigational verbiage in Section II. Revised Table 1 to add ThermaChoice. References reviewed and updated.	04/22	05/22
Annual Review. Criteria I.A.2, reworded portion pertaining to abnormal bleeding in transgender members from "female to male transgender person" to "member/enrollee with a female reproductive system undergoing treatment for gender affirmation." Changed Criteria I.D. from "no structural anomalies, such as fibroids or polyps that require surgery or represent a contraindication to an ablation procedure, or previous transmyometrial uterine surgery (including classical cesarean)" to "no structural anomalies, such as fibroids or polyps that require transmural surgery or represent a contraindication to an ablation procedure." Added contraindication criteria I.F.6. "Previous classical cesarean or other transmural surgery." Added to Background w/no change to criteria "Traditionally, medication therapy has been the initial treatment of choice, followed by hysterectomy, when medication does not provide the desired outcome. The levonorgestrel (LNG)-releasing intrauterine device (e.g., Mirena or Liletta; referred to as LNG 52) is an option in patients who do not desire pregnancy. Both the LNG 52 IUD and endometrial ablation are effective in reducing menstrual blood loss. The decision to use the LNG 52 or endometrial ablation depends on a patient's preferences regarding treatment factors, such as plans for fertility and contraception, convenience, and risks of anesthesia.[22,25] Endometrial ablation can offer an alternative to the more invasive hysterectomy treatment option.[10] NCHC verbiage removed from NC Guidance Verbiage. Added requirement in I.F. that thyroid disorders have been treated or ruled out. Removed contraindication "previous classic cesarean or other transmural surgery" from I.G. Background and Table 1 updated. Added requirement in I.F. that thyroid disorders have been treated or ruled out. Removed contraindication "previous classic cesarean or other transmural surgery" from I.G. Background and Table 1 updated. Minor rewording with no clinical significance. References reviewed and updated.	05/23	05/23

Annual Review. Under Description, added verbiage "resulting from reduced bleeding and amenorrhea," Under Criteria I. added "using an FDA approved device," Under Background, paragraph 3, added "adenomyosis, leiomyomata and" Removed HCPCS table.	05/24	05/24

References

1. Apgar BS, Kaufman AH, George-Nwogu U, Kittendorf A. Treatment of menorrhagia. *Am Fam Physician*. 2007;75(12):1813 to1819.
2. Sharp HT. Endometrial ablation or resection: resectoscopic techniques. UpToDate. www.uptodate.com. Updated November 8, 2022. Accessed January 27, 2023.
3. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 557: Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women. www.acog.org Published April 2013 (reaffirmed 2020). Accessed January 27, 2023.
4. Matteson KA, Boardman LA, Munro MG, Clark MA. Abnormal uterine bleeding: a review of patient-based outcome measures. *Fertil Steril*. 2009;92(1):205 to 216. doi:10.1016/j.fertnstert.2008.04.023
5. Frick KD, Clark MA, Steinwachs DM, et al. Financial and quality-of-life burden of dysfunctional uterine bleeding among women agreeing to obtain surgical treatment. *Womens Health Issues*. 2009;19(1):70 to 78. doi:10.1016/j.whi.2008.07.002
6. American College of Obstetricians and Gynecologists. Committee on Practice Bulletins—Obstetrics. ACOG Practice Bulletin No. 128. Diagnosis of Abnormal Uterine Bleeding: in Reproductive-Aged Women. www.acog.org Published July 2012 (reaffirmed 2021). Accessed January 27, 2023.
7. Munro MG, Critchley HO, Broder MS, et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in non-gravid women of reproductive age. *Int J Gynaecol Obstet*. 2011 Apr;113(1):3 to 13.
8. Sowter MC. New surgical treatments for menorrhagia. *Lancet*. 2003;361(9367):1456 to 1458. doi:10.1016/S0140-6736(03)13140-6
9. Bofill Rodriguez M, Lethaby A, Fergusson RJ. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2021; 2(2):CD000329. Published February 23, 2021. doi:10.1002/14651858.CD000329.pub4
10. Laberge P, Leyland N, Murji A, et al. Endometrial ablation in the management of abnormal uterine bleeding. *J Obstet Gynaecol Can*. 2015;37(4):362 to 379. doi:10.1016/s1701-2163(15)30288-7
11. Bofill Rodriguez M, Lethaby A, Grigore M, Brown J, Hickey M, Farquhar C. Endometrial resection and ablation techniques for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2019;1(1):CD001501. Published 2019 Jan 22. doi:10.1002/14651858.CD001501.pub5
12. Sharp HT. Endometrial ablation: non-resectoscopic techniques. UpToDate. www.uptodate.com Updated October 17, 2022. Accessed January 27, 2023.
13. Sharp HT. Endometrial ablation: postoperative complications. *Am J Obstet Gynecol*. 2012;207(4):242 to 247. doi:10.1016/j.ajog.2012.04.011
14. El-Nashar SA, Hopkins MR, Creedon DJ, St Sauver JL, Weaver AL, McGree ME, Cliby WA, Famuyide AO. Prediction of treatment outcomes after global endometrial ablation. *Obstet Gynecol*. 2009 Jan;113(1):97 to 106. doi: 10.1097/AOG.0b013e31818f5a8d. Erratum in: *Obstet Gynecol*. 2010 Mar;115(3):663. PMID: 19104365; PMCID: PMC2977517.

15. Food and Drug Administration. Class 2 Device Recall Gynecare Thermachoice III. www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRes/res.cfm?ID=142341 Accessed January 27, 2023.
16. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of GenderDysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759]. *J Clin Endocrinol Metab*. 2017;102(11):3869 to 3903. doi:10.1210/jc.2017-01658
17. The World Professional Association for Transgender Health Inc. (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 8th version. https://www.wpath.org/publications/soc Accessed January 27, 2023.
18. Kalampokas E, McRobbie S, Payne F, Parkin DE. Long-term incidence of hysterectomy following endometrial resection or endometrial ablation for heavy menstrual bleeding. *Int J Gynaecol Obstet.* 2017;139(1):61 to 64. doi:10.1002/ijgo.12259.
19. Al-Shaikh G, Almalki G, Bukhari M, Fayed A, Al-Mandeel H. Effectiveness and outcomes of thermablate endometrial ablation system in women with heavy menstrual bleeding. *J Obstet Gynaecol*. 2017;37(6):770 to 774. doi:10.1080/01443615.2017.1292228.
20. Riley KA, Davies MF, Harkins GJ. Characteristics of patients undergoing hysterectomy for failed endometrial ablation. JSLS. 2013;17(4):503 to 507. doi:10.4293/108680813X13693422520602.
21. Sharp HT. Overview of endometrial ablation. UpToDate. www.uptodate.com. Updated November 28, 2022. Accessed January 27, 2023.
22. National Institute for Clinical Excellence (NICE). Photodynamic endometrial ablation. Interventional Procedure Guidance 47. London, UK: NICE; 2004.
23. Obedin-Maliver J. Pelvic pain and persistent menses in transgender men. UCSF Transgender Care. https://transcare.ucsf.edu/guidelines/pain-transmen Published June 17, 2016. Accessed January 27, 2023.
24. Kaunitz AM. Abnormal uterine bleeding: Management in premenopausal patients. UpToDate. www.uptodate.com Updated January 11, 2023. Accessed January 27, 2023.
25. Practice Committee of American Society for Reproductive Medicine. Indications and options for endometrial ablation. *Fertil Steril*. 2008;90(5 Suppl):S236 to S240. doi:10.1016/j.fertnstert.2008.08.059
26. Kumar V, Chodankar R, Gupta JK. Endometrial ablation for heavy menstrual bleeding. *Womens Health (Lond).* 2016;12(1):45 to 52. doi:10.2217/whe.15.86
27. Food and Drug Administration (FDA). Endometrial ablation for heavy menstrual bleeding. https://www.fda.gov/medical-devices/surgery-devices/endometrial-ablation-heavymenstrual-bleeding Published October 25, 2021. Accessed January 27, 2023.
28. European Society of Human Reproduction and Embryology (ESHRE). ESHRE Guideline Endometriosis. https://www.eshre.eu/Guidelines-and Legal/Guidelines/Endometriosisguideline.aspx . Published February 2, 2022. Accessed January 30, 2023.
29. Bofill Rodriguez M, Dias S, Jordan V, et al. Interventions for heavy menstrual bleeding; overview of Cochrane reviews and network meta-analysis. *Cochrane Database Syst Rev*. 2022;5(5):CD013180. Published 2022 May 31. doi:10.1002/14651858.CD013180.pub2

30. Zacur H. Managing an episode of acute uterine bleeding. UpToDate. www.uptodate.com Updated November 14, 2022. Accessed February 10, 2023.
31. Stevens KYR, Meulenbroeks D, Houterman S. et al. Prediction of unsuccessful endometrial ablation: a retrospective study. *Gynecol Surg* 16, 7 (2019). https://link.springer.com/article/10.1186/s10397-019-1060-1 Accessed February 10, 2023.

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.