Clinical Policy: Excimer Laser Therapy for Skin Conditions

Reference Number: WNC.CP.136 Coding Implications
Last Review Date: 04/2026 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

Targeted phototherapy utilizes non-ionizing ultraviolet radiation with therapeutic benefit. Phototherapy is an efficacious local therapy that provides several advantages to traditional and biologic systemic therapies. Excimer lasers are monochromatic 308nm xenon chloride lasers that are approved to treat certain inflammatory skin diseases. This policy describes the medical necessity requirements for excimer laser based targeted phototherapy.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that excimer laser based targeted phototherapy is medically necessary for the following indications after the failure of topical treatments:
- **A.** Localized plaque psoriasis with <10% body surface area (BSA) involvement, individual lesions, or more extensive disease;
- **B.** Vitiligo;
- **C.** Atopic dermatitis;
- **D.** Cutaneous T-cell lymphoma (e.g., mycosis fungoides/ Sézary Syndrome).

II. It is the policy of WellCare of North Carolina® that the evidence is insufficient to draw conclusions regarding the efficacy of excimer laser targeted phototherapy for the following indications.
- **A.** Patients with photosensitivity disorders;
- **B.** For the treatment of all other conditions not specified above.

Background[1]

Targeted phototherapy uses a localized delivery of ultraviolet light to facilitate therapeutic relief of certain conditions. Ultraviolet light is predominantly absorbed by skin DNA, leading to the generation of pyrimidine dimers, pyrimidine, and (6-4)-photoproducts which are either repaired or marked for arrest or cell death through the cell's checkpoint machinery.[1] Various spectra of ultraviolet A (UVA) and ultraviolet B (UVB) wavelengths are utilized to treat a varying array of inflammatory skin disorders, including narrowband, broadband, and excimer lasers, as well as combinations of UVA and UVB with topical, systemic, biologic, and chemotherapeutic

regimens.[2] Additionally, phototherapy is cost effective and avoids the immunosuppressive effects that often accompany traditional and biologic based systemic therapies.

Excimer lasers are monochromatic 308nm xenon chloride lasers that provide a safe and selective approach to treating dermatological conditions. Excimer lasers are associated with significant T-cell depletion, alterations in apoptosis-related molecules, reductions in proliferation indices, and immunomodulatory mechanisms.[3] An early study by Feldman *et al* assessed the efficacy of excimer lasers for the treatment of mild to moderate psoriasis in a multicenter study. The authors noted that 84% of the patients reached the primary outcome of at least 75% improvement after 10 or fewer treatments.[4]

According to a joint updated guideline from the American Academy of Dermatology, National Psoriasis Foundation, the excimer laser is recommended for use in adults with localized plaque psoriasis (including palmoplantar psoriasis) <10% body surface area (BSA), for individual lesions, or in patients with more extensive disease (recommendation based on consistent, good quality patient oriented evidence.) Excimer laser is also recommended in the treatment of scalp psoriasis in adults (based on inconsistent or limited-quality patient-oriented evidence).[5]

The initial treatment dose of the excimer laser depends on the individual's skin type, plaque characteristics, and thickness, with subsequent doses adjusted in accordance to the patient's clinical response and side effects.2,5 Treatment takes place two to three times per week until a patient is clear of symptoms. According to a separate guideline on children from the American Academy of Dermatology, National Psoriasis Foundation, excimer laser may be used in children with psoriasis and may be efficacious and well tolerated, but these options have limited supporting evidence.[6]

The European Academy of Dermatology and Venereology published a position statement giving worldwide expert recommendations for diagnosis and management of vitiligo. Their findings indicated that detection and treatment of vitiligo at an early stage is essential for optimal management and to improve prognosis. Early aggressive treatment in rapidly progressive vitiligo to limit irreversible damage to pigment cells is appropriate. In active vitiligo, topical treatment, phototherapy and/or in rapidly progressive vitiligo systemic treatment are recommended. Varying treatment algorithms were cited in the position statement. Phototherapy remains an essential in the treatment of vitiligo and can be given with excimer devices which are more suited for localized forms of vitiligo.[7,8]

Notably, Alhowaish et al documented the effectiveness of excimer laser treatments in vitiligo in 23 separate articles that included case studies, randomized controlled studies, retrospective analyses, randomized blinded studies, and controlled comparative studies.[9] Although the response time and the duration of response varied, the excimer laser therapy was generally effective across all of the studies.[9] While several treatment options are available for vitiligo, targeted laser therapy delivers high intensity light to the desired depigmented area to avoid exposure to surrounding neighboring healthy skin.[10]

Atopic dermatitis (eczema) is a chronic, pruritic, inflammatory skin disease with clinical presentation of dry skin, severe pruritus and cutaneous hyperreactivity to various environmental stimuli. Skin hydration with emollients and moisturizers is a key component of first-line therapy. Other topical treatments, i.e., anti-inflammatory therapy with topical corticosteroids or calcineurin inhibitors can be effective in controlling pruritus. When topical therapy alone is not enough, narrowband ultraviolet B (NBUVB) or ultraviolet A1 (UVA1) phototherapy can be added. Patients with moderate to severe disease despite topical therapy may require systemic treatment such as dupilumab. Narrowband ultraviolet B (NBUVB) phototherapy is also an alternative. However, phototherapy is not suitable for infants and young children. Phototherapy can be administered in the office two to three times weekly.

Mycosis fungoides (MF) and Sézary syndrome (SS) are common subtypes of cutaneous T cell lymphoma (CTCL). MF is a mature T cell non-Hodgkin lymphoma that presents in the skin but has potential involvement of the lymph nodes, blood, and viscera. Skin lesions include patches or plaques, localized or widespread, along with tumors, and erythroderma. SS is an inflammatory skin disease with leukemic involvement by malignant T cells. Diagnosis of both MF and SS is made through skin biopsy, blood studies, or nodal biopsy.

The TNMB systems is the standard method for staging MF and SS. The TNMB staging is based on evaluation of skin (T), lymph node (N), visceral (M), and blood (B). For MF, early stages (IA to IIA) consist of papules, patches, or plaques, with limited, if any, lymph node involvement, and no visceral involvement. Skin-directed therapies can include topical corticosteroids, mechlorethamine, retinoids, imiquimod, localized radiation, or phototherapy (narrowband ultraviolet B [NBUVB] or psoralen plus ultraviolet A [PUVA]).[11] SS Stage IVA1 involves no significant lymph node or visceral involvement, Stage IVA2 is demonstrated by lymph node involvement, but no visceral involvement and Stage IVB includes visceral involvement, with or without nodal involvement. Although no standard initial therapy for patients with SS, systemic therapy can be given alone, with skin directed therapy, or with other systemic therapies.[12]

The NCCN generally recommends skin-directed therapies as above, and systemic therapy regimens, which can be tolerated for longer periods of time with lower rates of cumulative toxicity, before moving on to treatments that carry a higher risk of cumulative toxicity and/or immunosuppression. The FDA has approved bexarotene, brentuximab vedotin, mogamulizumab, vorinostat, and romidepsin for treatment of MF and SS. Further suggested regimens by staging can be found in the NCCN guidelines.[13]

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 2026, 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
96920	Excimer laser treatment for psoriasis; total area less than 250 sq cm
96921	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm
96922	Excimer laser treatment for psoriasis; over 500 sq cm

ICD-10-CM CODE	Description
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L40.0	Psoriasis vulgaris (plaque psoriasis, nummular psoriasis)
L80	Vitiligo
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05	Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06	Mycosis fungoides, intrapelvic lymph nodes
C84.07	Mycosis fungoides, spleen
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
C84.10	Sezary disease, unspecified site
C84.11	Sezary disease, lymph nodes of head, face, and neck
C84.12	Sezary disease, intrathoracic lymph nodes
C84.13	Sezary disease, intra-abdominal lymph nodes
C84.14	Sezary disease, lymph nodes of axilla and upper limb
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites

Reviews, Revisions, and Approval	Reviewed Date	Approval Date
Policy developed.	04/26	04/26

References

1. Feldman SR. Targeted phototherapy. UpToDate. www.uptodate.com. Updated January 24, 2025. Accessed February 03, 2025.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 5. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy [published correction appears in J Am Acad Dermatol. 2021 Feb;84(2):586]. *J Am Acad Dermatol*. 2010;62(1):114 through 135. doi:10.1016/j.jaad.2009.08.026
3. Specchio F, Carboni I, Carnnarozzo G, Tamburi F, Dattola E, Nistico S. Excimer UV radiation in dermatology. *Int J Immunopathol Pharmacol*. 2014;27(2):287 through 289. doi: 10.1177/039463201402700217
4. Abrouk M, Levin E, Brodsky M, et al. Excimer laser for the treatment of psoriasis: safety, efficacy, and patient acceptability. *Psoriasis (Auckl).* 2016;6:165 through 173. Published 2016 Dec 12. doi:10.2147/PTT.S105047
5. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780. doi: 10.1016/j.jaad.2019.11.024.]. *J Am Acad Dermatol*. 2019;81(3):775 through 804. doi:10.1016/j.jaad.2019.04.042
6. Menter A, Cordoro KM, Davis DMR, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis in pediatric patients [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):574. doi: 10.1016/j.jaad.2020.01.061.]. *J Am Acad Dermatol*. 2020;82(1):161 through 201. doi:10.1016/j.jaad.2019.08.049
7. Van Geel N, Speeckaert T, Taïeb A, et al. Worldwide expert recommendations for the diagnosis and management of vitiligo: Position statement from the International Vitiligo Task Force Part 1: towards a new management algorithm. *J Eur Acad Dermatol Venereol*. 2023;37(11):2173 through 2184. doi:10.1111/ jdv.19451
8. Senechal J, Speeckaert R, Taïeb A, et al. Worldwide expert recommendations for the diagnosis and management of vitiligo: Position statement from the international Vitiligo Task Force—Part 2: Specific treatment recommendations. *J Eur Acad Dermatol Venereol*. 2023;37(11):2185 through 2195. doi.10.1111/jdv.19450
9. Alhowaish AK, Dietrich N, Onder M, Fitz K. Effectiveness of a 308-nm excimer laser in treatment of vitiligo: a review. *Lasers Med Sci*. 2013;28(3):1035 through 1041. doi: 10.1007/s10103-012-1185-1
10. Kuroda Y, Yang L, Lai S, et al. A Lower Irradiation Dose of 308 nm Monochromatic Excimer Light Might Be Sufficient for Vitiligo Treatment: A Novel Insight Gained from In Vitro and In Vivo Analyses. *Int J Mol Sci*. 2021;22(19):10409. Published 2021 Sep 27. doi:10.3390/ijms221910409
11. Hoppe RT, Kim TH, Horwitz S. Treatment of early stage (IA to IIA) mycosis fungoides.UpToDate. www.uptodate.com. Updated October 24, 2023. Accessed February 2, 2024.
12. Kim EJ, Rook AH. Treatment of Sézary syndrome. UpToDate. www.uptodate.com. Updated January 20, 2022. Accessed February 2, 2024.

13. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology:Primary Cutaneous Lymphomas. Version 1.2025. https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1491 Published November 11, 2024. Accessed February 07, 2025.
14. Feldman SR, Soung J. Chronic plaque psoriasis in adults: Treatment of disease requiring phototherapy or systemic therapy. UpToDate. www.uptodate.com. Updated November 21, 2024. Accessed February 07, 2025.
15. Sidbury R, Davis DM, Cohen DE, et al. Guidelines of care for the management of atopic dermatitis: section 3. Management and treatment with phototherapy and systemic agents. *J Am Acad Dermatol*. 2014;71(2):327 through 349. doi:10.1016/j.jaad.2014.03.030
16. Nicolaidou E, Antoniou C, Stratigos A, Katsambas AD. Narrowband ultraviolet B phototherapy and 308-nm excimer laser in the treatment of vitiligo: a review. *J Am Acad Dermatol*. 2009;60(3):470 through 477. doi:10.1016/j.jaad.2008.07.053
17. Sung JM, Bae JM, Kang HY. Comparison of cyclic and continuous 308-nm excimer laser treatments for vitiligo: A randomized controlled noninferiority trial. *J Am Acad Dermatol*. 2018;78(3):605 through 607.e1. doi:10.1016/j.jaad.2017.09.048
18. Elsaadany AE, El-Khalawany M, Elshahid AR, Seddeik Abdel-Hameed AK. Comparison between 308-nm excimer light alone versus 308-nm excimer light and platelet-rich plasma in the treatment for localized vitiligo. *J Cosmet Dermatol*. 2022;21(7):2826 through 2831. doi:10.1111/jocd.14582
19. National coverage determination: treatment of psoriasis (250.1). Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=88&ncdver=1&. Published January 01, 1966. Accessed February 07, 2025.
20. Grimes PE. Vitiligo: Management and prognosis. UpToDate. www.uptodate.com. Updated February 21, 2024. Accessed February 03, 2025.
21. Paller AS, Butala S, Howe W. Treatment of atopic dermatitis (eczema). UpToDate. www.uptodate.com. Updated January 22, 2025. Accessed February 20, 2025.
22. Salah Eldin MM, Sami NA, Aly DG, Hanafy NS. Comparison between (311-312 nm) Narrow Band Ultraviolet-B Phototherapy and (308 nm) Monochromatic Excimer Light Phototherapy in Treatment of Vitiligo: A Histopathological Study. *J Lasers Med Sci*. 2017;8(3):123 through 127. doi:10.15171/jlms.2017.22
23. Health Technology Assessment. Comparative effectiveness review of laser therapy for psoriasis. Hayes. www.hayesinc.com. Published April 25, 2019 (annual review April 07, 2022). Accessed February 06, 2025.
24. Paller AS, Lund EB. Psoriasis in children: Management of chronic plaque psoriasis. UpToDate. www.uptodate.com. Updated April 08, 2024. Accessed February 17, 2025.
25. Taieb A, Alomar A, Böhm M, et al. Guidelines for the management of vitiligo: the European Dermatology Forum consensus. *Br J Dermatol*. 2013;168(1):5 through 19. doi:10.1111/j.1365-2133.2012.11197.x
26. Gawkrodger DJ, Ormerod AD, Shaw L, et al. Guideline for the diagnosis and management of vitiligo. *Br J Dermatol.* 2008;159(5):1051 through 1076. doi:10.1111/j.1365-2133.2008.08881.x

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. 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

- 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:

I. that is unsafe, ineffective, or experimental or investigational.
II. 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

- 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.
- **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:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. 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:

- 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.
- 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.

- 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
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- 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.