Clinical Policy: Opioid Treatment Program Service

Reference Number: WNC.CP.277 Coding Implications
Last Review Date: 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]
The Opioid Treatment Program (OTP) Service is an organized, outpatient treatment service for a Member with an opioid use disorder (OUD). The OTP service utilizes methadone, buprenorphine formulations, naltrexone or other drugs approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorders.

Definitions:

I. The ASAM Criteria
The American Society of Addiction Medicine Criteria is a comprehensive set of treatment standards for addictive, substance-related, and co-occurring conditions. The ASAM Criteria uses six dimensions to create a holistic, biopsychosocial assessment to be used for service planning and treatment. The six dimensions are:
- **A.** Acute Intoxication and Withdrawal Potential;
- **B.** Biomedical Conditions and Complications;
- **C.** Emotional, Behavioral, or Cognitive Conditions and Complications;
- **D.** Readiness to Change;
- **E.** Relapse, Continued Use, or Continued Problem Potential; and
- **F.** Recovery and Living Environment.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® shall cover the OTP Service when the Member meets the following specific criteria:

A. The Member has a current opioid use disorder (OUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference manual **and**

B. The Member meets the American Society of Addiction Medicine (The ASAM Criteria) Third Edition for OTP (Opioid Treatment Program specific) level of care.

C. Admission Criteria - Due to the nature of this OTP service, a comprehensive clinical assessment (CCA) or diagnostic assessment (DA) is not required prior to admission. An

initial abbreviated assessment, physical exam and service plan must be completed by a physician or approved medical provider(nurse practitioner or physician assistant with a midlevel exemption from SAMHSA) to establish medical necessity for this service as a part of the admission process. The initial assessment must contain the following documentation in the member's service record:

1. Presenting problem;
2. Needs and strengths;
3. A provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a Member admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;
4. A pertinent social, family, and medical history; and
5. Evaluations or assessments, such as psychiatric, substance use, medical, and vocational, as appropriate to the client's needs.

The program physician can bill Evaluation and Management (E/M) code separately for the admission evaluation and physical exam.

A licensed professional shall complete a CCA or DA Within **ten (10**) calendar days of the admission, to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment can be utilized as part of the current CCA. Relevant diagnostic information must be obtained and contained in the treatment or service plan.

The licensed professional may update the initial assessment or a recent CCA or DA from another clinician if a substantially equivalent assessment is available and reflects the current level of functioning. Information from that assessment can be used as part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and contained in the treatment or service plan.

D. Continued Stay Criteria - The Member is eligible to continue this service if there is documentation of the Member's current status based on the six (6) dimensions of the ASAM Criteria for OTP that indicates a need for continued stay. Justification must be provided based on current level of functioning in each of the six (6) Dimensions of the ASAM Criteria. Documentation must contain details of the assessment of the six (6) dimensions.

1. In addition to the above, the Member shall meet one of the following:
   a. The Member has achieved current Person-Centered Plan (PCP) goals and additional goals are indicated as evidenced by documented symptoms;
   b. The Member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service is effective in addressing the goals outlined in the PCP; OR
   c. The Member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the Member's pre-morbid or potential level of functioning are possible.

2. If the Member is functioning effectively with this service and discharge would otherwise be indicated, this service must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on ANY ONE of the following:
   a. A history of regression in the absence of opioid treatment is documented in the Member's service record;
   b. A presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a chronic disease management approach, in the event that there are medically sound expectations that symptoms persist and that ongoing treatment interventions are needed to sustain functional gains; or
   c. There is a lack of a medically appropriate step down.

E. Transition and Discharge Criteria - The Member meets the criteria for transfer or discharge if the following applies:
1. Documentation of the Member's current status based on the ASAM Criteria Six (6) dimensions for OTP that indicates a need for transfer or discharge. Justification must be provided based on current level of functioning in the Six (6) dimensions of the ASAM Criteria. Documentation must contain details of the assessment of the six (6) dimensions; and
2. The Member meets one of the following:
   a. The Member's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care, including a coordinated transition to Office Based Opioid Treatment (OBOT), as medically necessary, and there are no medical expectations that symptoms persist without ongoing medication or change in medication;
   b. The Member has achieved positive life outcomes that support stable and ongoing recovery, there is low potential for regression, there is no medical expectation that symptoms persist, and ongoing treatment interventions are not needed to sustain functional gains at this level of care, there is a transition plan to step down to a lower level of care, including a coordinated transition to OBOT, as medically necessary, and the Member is no longer in need of the OTP Service; or
   c. The Member or legally responsible person requests a discharge from OTP Service or other Medication Assisted Treatment.

II. It is the policy of WellCare of North Carolina® shall **NOT COVER** the following:
A. Any services in the OTP Service per diem as separate billable services unless otherwise indicated in this clinical coverage policy;
B. Transportation for the Member or member's family is not billable under OTP program. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina's Non-Emergency Medical Transportation benefit. See related policy, Non-Emergency Medical Transportation: WNC.CP.262, available at WellCare NC Clinical Coverage Guidelines WNC.CP.262 NEMT for prior authorization

information. Information for WellCare of North Carolina members is available at WellCare NC Medicaid Transportation Services

C. Any habilitation activities;
D. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
E. Clinical and administrative supervision of OTP Service staff, which is covered as an indirect cost and part of the rate;
F. Covered services that have not been rendered;
G. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
H. Services provided to teach academic subjects or as a substitute for education personnel;
I. Interventions not identified on the Member's PCP;
J. Services provided to children, spouse, parents or siblings of the eligible Member under treatment or others in the eligible Member's life to address problems not directly related to the eligible Member's needs and not listed on the PCP; and
K. Payment for room and board.

III. Requirements for and Limitations on Coverage

A. Prior Approval

1. WellCare NC does not require prior approval for the OTP Service.
2. A service order must be signed prior to or on the first day service is rendered. Refer to Background III.C. of this policy.
3. Provider shall collaborate with Member's existing provider to develop an integrated PCP.

B. Additional Limitations or Requirements

1. A Member can receive OTP Service from only one provider organization at a time.

C. Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the Member's needs. A signed service order must be completed by a physician, physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for 12 months. Medical necessity must be revisited, and the service must be ordered at least annually, based on the date of the original service order.

ALL the following apply to a service order:

1. Backdating of the service order is not allowed;
2. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; **and**
3. A service order must be in place prior to or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the Member is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

D. Documentation Requirements

The service record documents the nature and course of a Member's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid.

Service notes must meet the requirements of the Department of Health and Human Services (DHHS) Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (C)(4).

E. Provider Eligibility, Provider Certifications, Clinical Supervision Requirements, and Staff Training Requirements:

Please refer to North Carolina Medicaid State Policy Site for Opioid Treatment Program Service Clinical Coverage Policy No: 8A-9 at https://medicaid.ncdhhs.gov/media/12302/download?attachment

NOTE: Services noted in this policy must be delivered by practitioners employed by a mental health or substance use provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G.

F. Program Requirements:

The OTP service is delivered by an interdisciplinary team of professionals trained in the treatment of opioid use disorders. An interdisciplinary team shall provide person-centered and recovery-oriented individualized treatment, case management, and health education to the member. Treatment with methadone, buprenorphine formulations, or other medications approved by the FDA are designed to address the Member's need to achieve changes in their level of function. A Member who is admitted to treatment shall be evaluated for specific objective and subjective signs of opioid use disorder as defined in 42 CFR 8.12.

Agonist, partial agonist, or antagonist medications are administered to address the physiological aspects of opioid use disorder, such as cravings and withdrawal symptoms.

Person-centered substance use disorder and co-occurring disorder therapy, counseling, supports, and intervention are offered to address the emotional, psychological, and behavioral aspects of opioid use disorder. To accomplish this, the PCP must address major lifestyle issues that have the potential to undermine the beneficiary's recovery-oriented goals and inhibit their ability to cope with major life tasks.

1. **Program Services:** Access to timely services within the OTP are the following:

a. Clinical staff available five (5) days per week to offer and provide counseling, as needed (either in person or telehealth);
b. Medical provider staff available five (5) days per week to provide methadone and buprenorphine inductions and patient care, as needed.
c. In-Clinic Dosing Services available at least six (6) days per week, 12 months per year, for a Member who is in the induction phase or who is not stable enough for unsupervised take home doses. Daily, weekend and holiday medication dispensing hours must be scheduled to meet the needs of the Member.
d. When the supervising RN, physician, NP or PA is not on site, an on-call RN, physician, NP or PA shall be continuously available to the LPN whenever providing Member care. Continuous availability is the ability to be available by phone immediately and physically arrive within one hour and be present on site in a timely manner as much as needed to address Member assessment and care needs.

2. **Program Support Systems:** Necessary support systems within the OTP include:
   a. Linkage with or access to psychological and psychiatric consultation;
   b. Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care;
   c. Linkage with or access to evaluation and on-going primary and preventative medical care;
   d. Ability to conduct or arrange for appropriate laboratory and toxicology tests;
   e. Behavioral health crisis response (de-escalation or coordination of care), when clinically appropriate, 24-hours a day, 7 days a week telephonically or via telehealth.

   These supports and interventions need to address co-occurring issues (mental health disorders, infectious diseases, and other co-occurring illnesses), based on a person-centered, multi-dimensional assessment and Member's recovery goals. Integrated concurrent care for the Member's various conditions is recommended, and where possible these services need to be provided across different settings with appropriate direct coordination of care.

3. **Program Therapies:** Therapies within the OTP Service are the following:
   a. Individualized, person-centered assessment and treatment;
   b. Assessing, ordering, administering, supplying, monitoring, and regulating medication and dose levels appropriate to the Member;
   c. Supervising withdrawal from opioid analgesics, including methadone and buprenorphine;
   d. Monitoring drug testing, to be conducted at least one time per month;
   e. A range of cognitive, behavioral, and other substance use disorder focused evidenced-based therapies, reflecting a variety of treatment approaches, provided to the Member on an individual, group, or family basis;

f. Service coordination activities, consist of coordination with care management entity, medical monitoring, and coordination of on and off-site treatment services and supports; and
g. Health education, reproductive and life planning education consisting of education about HIV, tuberculosis, hepatitis C, pregnancy and sexually transmitted infections.

4. **Program Assessments:** Ongoing assessments and person-centered plan reviews must occur regularly; and be completed based on changes with Member needs or goals to ensure progress and improve Member's response to treatment; and at a minimum completed annually.

Assessment and treatment planning within the OTP Service consists of the following:
a. A comprehensive medical history, physical examination, and laboratory tests provided in accordance with 42 CFR § 8.12;
b. A biopsychosocial assessment;
c. An appropriate regimen of methadone or buprenorphine, as required by the Center for Substance Abuse Treatment (CSAT) regulation, at a dose established by a physician or appropriately licensed medical provider at admission and monitored carefully until the Member is stable and an adequate dose has been established. The dose is then reviewed as indicated by the Member's course of treatment;
d. Continuing evaluation and referral for care of any biomedical problems;
e. An individualized, recovery-focused PCP, consisting of problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve these goals. PCPs are developed collaboratively with the Member, are reflective of their personal goals for recovery, and are updated regularly, as specified by the plan.

NOTE: OTP providers shall have the ability to admit a Member at least five (5) days per week. OTP providers shall ensure that all programs have access to naloxone, or other Federal Food and Drug Administration approved opioid antagonist, on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses. OTP programs must develop policies that detail the use, storage and education provided to staff regarding naloxone.

5. **Program Bundled Rates:** Activities in the bundled rate for this service are:
a. Managing medical plan of care and medical monitoring;
b. Individualized recovery focused person-centered plan;
c. A minimum of Two (2) required counseling or therapy sessions per Member per month during the first year of opioid treatment services and one required counseling session per Member per month thereafter;
d. Nursing services related to administering medication, preparation, monitoring and distribution of take-home medications;
e. Cost of the medication;
f. Presumptive drug screens and definitive drug tests;

g. Pregnancy tests;
h. TB tests;
i. Psychoeducation consisting of HIV and AIDS education and other health education services; and
j. Service coordination activities consisting of coordination with care management entity and coordination of on and off-site treatment and supports.

6. **In addition**, to the bundled rate activities, providers can bill separately for:
   a. Evaluation and Management (E/M) billing codes;
   b. Diagnostic assessments or comprehensive clinical assessments;
   c. Laboratory testing (excluding pregnancy test, TB test, & drug toxicology);
   d. Individual, group, and family counseling (provided beyond the minimum Two (2) counseling of therapy sessions per month during the first year or one counseling or therapy session per month thereafter) (licensed professionals only); and
   e. Peer Support Services.

Background[1]
The Opioid Treatment Program (OTP) Service is delivered by an interdisciplinary team of professionals trained in the treatment of opioid use disorders. The team provides person-centered, recovery-oriented treatment, case management, and health education. A range of cognitive, behavioral, and substance use disorder (SUD) focused therapies are provided to address substance use that could compromise recovery.

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 2023, 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.

HCPCS ®* Codes	Description	Unit Limitations
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	1 Unit = 1 weekly bundle

- At least one service included in Section 6.3 Program Requirements (e.) must be provided to the Member within the weekly service payment unit to bill the bundled rate.

- Providers may provide and bill for more than one week of take home doses to meet Member need.

- Licensed professionals LCAS, LCAS-A, CSAC, CSAC-I, CADC, CADC-I, LCSW, LCSWA, LCMHC, LCMHCA, LMFT, LMFTA, LPA or LP can bill separately for eligible CPT code services beyond the two (2) **required** counseling or therapy sessions per Member per month during the first year of opioid treatment services and one (1) required counseling session per Member per month thereafter.
- **Place of Service - Opioid Treatment Services are provided in a licensed Opioid Treatment Facility (10A NCAC 27G .3601)**

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	10/23	10/23
Under Criteria III.E. added "Note: Services noted in this policy must be delivered by practitioners employed by a mental health or substance use provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G."		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No:8A-9 Opioid Treatment Program Service. https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies. Published October 15, 2023. Accessed March 14, 2024.

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);
a. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
b. 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.