Clinical Policy: Outpatient Oxygen Use

Reference Number: LA.CP.MP.190c
Date of Last Revision: 11/24

Coding Implications
Revision Log

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

Description

Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxemia.[1]

Note: If a medically necessary, lesser cost item exists and will suit the member/enrollee's medical needs, a higher cost item will be denied.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that initial approval of oxygen concentrators and oxygen systems (for indications other than cluster headaches; for stationary oxygen systems for cluster headaches, see section V) for members/enrollees are **medically necessary** when meeting all of the following[8]:

A. The attending physician, or a consultant physician who has personally examined the beneficiary at the request of the attending physician, must have seen the beneficiary within 30 – 60 days of prescribing oxygen therapy.;

B. A prescription which is signed and dated by the treating physician and includes:
   1. Oxygen flow rate;
   2. Frequency and duration of use;
   3. Estimate of the period of need; and
   4. Results of a current blood gas laboratory report done at rest and at room air (performed no more than 30 days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

C. The blood gas study or pulse oximetry measurement meets one of the following:
   1. Member/enrollee qualifies for Group I by meeting any of the following[3,8]:
      a. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation (or pulse oximetry) at or below 88 percent taken at rest (awake), breathing room air;
      b. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation (or pulse oximetry) at or below 88 percent, taken during sleep, for a beneficiary who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation (or pulse oximetry) at or above 89 percent while awake;
      c. A decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation (or pulse oximetry) more than five percent from baseline saturation, taken during sleep and associated with symptoms (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis) reasonably attributable to hypoxemia;
      d. An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation (or pulse oximetry) at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation

(or pulse oximetry) at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air;

2. Member/enrollee qualifies for Group II by meeting both of the following[1,8]:
   a. An arterial PO_2 of 56 through 59 mm Hg or an arterial blood oxygen saturation of 89 percent or less at rest (awake), during sleep, or during exercise (as described under Group I criteria);
   b. Any of the following:
      i. Dependent edema suggesting congestive heart failure;
      ii. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF);
      iii. Erythrocythemia with a hematocrit greater than 56 percent

D. If the request is for a portable oxygen system, the following[8] must be met:
   1. Member/enrollees need continuous oxygen and require portable units while in route to a doctor's office, hospital, or medically necessary appointment.
   2. Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the members/enrollees treating physician with the prior authorization request.

E. If the request is for a portable oxygen system, The portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

II. It is the policy of Louisiana Healthcare Connections that reauthorization of oxygen concentrators and oxygen systems for members/enrollees ≥ 21 years of age are **medically necessary** when meeting the following[1,7,9]:

A. Evaluation by the treating physician within 90 days prior to the date of recertification, and one of the following:
   1. Chronic hypoxemia is not expected to improve or is expected to worsen, as documented in an explanatory letter of medical necessity (LOMN);
   2. Treatment is for nocturnal hypoxemia in a member/enrollee who qualifies for Group I (as defined in criteria section I), and two oxygen requests have already been authorized;
   3. A new arterial blood gas (ABG) or pulse oximetry result documents that member/enrollees still meets the criteria in section I above (initial approval criteria), and one of the following:
      a. For Group I (as defined in section I), the measurement is obtained within 90 days of the recertification date, and by the physician or designee, or by an independent diagnostic testing facility (IDTF). O_2 levels obtained by DME providers do not qualify. Home oxygen companies are permitted to coordinate with an IDTF for the purpose of obtaining needed overnight oximetry saturation testing;
      b. For Group II (as defined in section I; rare cases where initial certification was for three months with PO_2 56 through 59 or O_2 sat 89%), a repeat ABG or oximetry must be obtained within 30 days of recertification date;

B. If the request is for a portable oxygen system, the following[8] must be met:

1. Member/enrollees need continuous oxygen and require portable units while in route to a doctor's office, hospital, or medically necessary appointment.
2. Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the members/enrollees treating physician with the prior authorization request.

C. If the request is for a portable oxygen system, The portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

III. It is the policy of Louisiana Healthcare Connections that reauthorization of oxygen concentrators and other supplemental oxygen delivery systems for members/enrollees < 21 years of age (including medically fragile members/enrollees and those covered by EPSDT) are medically necessary when meeting all of the following:

A. Evaluation by the treating physician within 30 days prior to the date of recertification; and one of the following:
   1. A new recorded (overnight recommended) pulse oximetry tracking, sleep study report, or blood gas result documents that the member/enrollee still meets the initial authorization criteria in Section II above, and the measurement meets both of the following:
      a. Obtained within 30 days of the recertification date;
      b. Obtained by the physician or designee, or by an independent diagnostic testing facility (IDTF). DME companies are prohibited from obtaining the O_2 levels unless they are also home oxygen providers. Home oxygen companies are permitted to coordinate with an IDTF for the purpose of obtaining needed overnight oximetry saturation testing;
   2. Chronic hypoxemia is not expected to resolve or is expected to worsen, as documented in an explanatory letter of medical necessity (LOMN);

B. If the request is for a portable oxygen system, the following[8] must be met:
   1. Member/enrollees need continuous oxygen and require portable units while in route to a doctor's office, hospital, travel to and from school or medically necessary appointment.
   2. Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the members/enrollees treating physician with the prior authorization request.

C. If the request is for a portable oxygen system, The portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

IV. It is the policy of Louisiana Healthcare Connections that reauthorization of oxygen concentrators and other supplemental oxygen delivery systems for members/enrollees shall not be denied in the event reevaluation of the treating physician has not occurred prior to the pertinent recertification date criteria if any of the following exist:

A. There is a pending scheduled appointment by and between the member/enrollee and their treating physician at the time of the recertification date though reevaluation has not occurred; or

B. there is good cause why the member/enrollee could not schedule and/or attend the reevaluation appointment due to good cause. "Good cause" exists in the event the member/enrollee was physically or mentally unable to schedule and/or attend his/her appointment due to unforeseen circumstances and the member/enrollee has a historically used the oxygen concentrators and other supplemental oxygen delivery systems.

V. It is the policy of Louisiana Healthcare Connections that oxygen concentrators **are not medically necessary** for the following indications[1,3,8]:
- A. Angina pectoris in the absence of hypoxemia;
- B. Breathlessness without cor pulmonale or evidence of hypoxemia;
- C. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia;
- D. Shortness of breath or dyspnea in a pediatric patient without evidence of hypoxemia;
- E. Terminal illnesses that do not affect the ability to breathe.[1,8]

VI. It is the policy of Louisiana Healthcare Connections that stationary gaseous oxygen systems (i.e. cylinder of liquid or gaseous oxygen) and related delivery equipment for the treatment of cluster headaches are **medically necessary** when meeting the following:
- A. Diagnosis of cluster headache as evidenced by all of the following[7,10,11,12,13];
  1. At least five severe to very severe unilateral headache attacks lasting 15 to 180 minutes when untreated;
  2. The headaches are accompanied by at least one of the following:
     - a. Ipsilateral conjunctival injection and/or lacrimation;
     - b. Ipsilateral nasal congestion and/or rhinorrhea;
     - c. Ipsilateral eyelid edema;
     - d. Ipsilateral forehead and facial sweating;
     - e. Ipsilateral miosis and/or ptosis;
     - f. A sense of restlessness or agitation;
  3. Frequency of headache attacks occur between one every other day and eight per day.[11]

Background

Oxygenation is the process of oxygen diffusing passively from the alveolus to the pulmonary capillary, where it binds to hemoglobin in red blood cells or dissolves into the plasma.[2] A low partial pressure of oxygen in the blood is termed hypoxemia. Hypoxemia can have multiple causes including hypoventilation, ventilation-perfusion (V/Q) mismatch, right-to-left shunts, diffusion limitation, and reduced inspired oxygen tension. Common tests to determine if oxygenation is impaired and at risk of being insufficient include arterial oxygen saturation (SaO_2), arterial oxygen tension (PaO_2), alveolar to arterial (A-a) oxygen gradient, and the PaO_2/fraction of inspired oxygen (FiO_2) ratio.[2]

Indications for continuous long-term oxygen therapy (LTOT) for those with chronic lung disease include[3]:

- Resting arterial oxygen tension (PaO_2) less than or equal to 55 mmHg (7.32 kPa), or a pulse oxygen saturation (SpO_2) less than or equal to 88 percent;
- PaO_2 less than or equal to 59 mmHg (7.85 kPa), or an SpO_2 less than or equal to 89 percent, if there is evidence of cor pulmonale, right heart failure, or erythrocytosis (hematocrit >55 percent);
- PaO_2 of 55 mmHg (7.32 kPa) or lower, or an SpO_2 of 88 percent or lower, during exercise or sleep.

Prescribed oxygen flow rates may vary throughout the day with activity or sleep or during acute exacerbations of disease. For patients with nocturnal oxygen desaturation, clinical evaluation for sleep-disordered breathing utilizing polysomnography are often appropriate.[3]

The American Association for Respiratory Care
According to the American Association for Respiratory Care LTOT in the home or alternate site health care facility is normally indicated for the treatment of hypoxemia and has been shown to have a significant positive impact on hypoxemic patients with chronic obstructive pulmonary disease (COPD). LTOT has also been shown to reduce hospitalizations and lengths of stay. Laboratory indications for LTOT include documented hypoxemia in adults, children, and infants older than 28 days as evidenced by $PaO_2 \leq 55$ mm Hg or $SaO_2 \leq 88\%$ in subjects breathing room air or PaO_2 of 56 to 59 mm Hg or SaO_2 or $SpO_2 \leq 89\%$ in association with specific clinical conditions such as cor pulmonale, congestive heart failure, or erythrocythemia with hematocrit > 56. Some patients may not demonstrate a need for oxygen therapy at rest but will be hypoxemic during ambulation, sleep, or exercise. Oxygen therapy is indicated during these specific activities when the SaO_2 is demonstrated to fall to $\leq 88\%$. The initial need for LTOT is determined by measurement of inadequate arterial blood oxygen tensions and/or saturations and/or the presence of clinical indicators. Ongoing evaluation or reassessment of arterial blood gas tensions and/or saturations by invasive or noninvasive methods may be indicated whenever there is a change in clinical status that may be cardiopulmonary related.[1]

The American Thoracic Society
Per the American Thoracic Society Clinical Practice Guidelines for Home Oxygen Therapy (HOT) in Adults, HOT is recommended for the following:[4]

- For patients with severe resting hypoxemia, the prescription of LTOT to improve survival is supported by historical trials in patients with COPD;
- The expert panel strongly recommends prescribing oxygen for patients with interstitial lung disease (ILD) with severe resting hypoxemia;
- Existing evidence and panel consensus suggest not prescribing LTOT for patients with COPD with moderate resting hypoxemia;
- This review confirmed scarce and inconclusive data to support the prescription of oxygen in patients who have normoxia at rest but desaturate (sometimes markedly) with exertion;
- Emerging evidence suggests that ambulatory oxygen therapy may improve health-related quality of life in patients with ILD in the short term but longer-term data are needed;
- The panel unanimously agreed that liquid oxygen (LOX) should be offered to active patients on high-flow oxygen;

- Finally, the minimal standard of care for all patients receiving home oxygen therapy must include education and training related to their oxygen equipment, oxygen safety, and self-management.

The American Thoracic Society Clinical Practice Guidelines for Home Oxygen Therapy in Children states that, despite widespread use of home oxygen therapy (HOT) in children for various lung and pulmonary vascular diseases, there is a striking paucity of data regarding its implementation, efficacy, monitoring, and discontinuation. With limited evidence, the panel provides recommendations based on expert opinion and experiences associated with patient-important outcomes, which will aid clinicians in the management of complex pediatric patients requiring HOT.[5]

HOT for children is recommended for the following situations[5]:

- Cystic fibrosis complicated by severe chronic hypoxemia (strong recommendation, very low-quality evidence);
- Cystic fibrosis patients who have both mild chronic hypoxemia and dyspnea on exertion (conditional recommendation, very low-quality evidence);
- Bronchopulmonary dysplasia complicated by chronic hypoxemia (strong recommendation, very low-quality evidence);
- Sleep-disordered breathing complicated by severe nocturnal hypoxemia in those who cannot tolerate positive airway pressure therapy or are awaiting surgical treatment of sleep-disordered breathing (conditional recommendation, very low-quality evidence);
- Sickle cell disease complicated by severe chronic hypoxemia (conditional recommendation, very low-quality evidence);
- Pulmonary hypertension without congenital heart disease complicated by chronic hypoxemia (strong recommendation, very low-quality evidence);
- Interstitial lung disease complicated by severe chronic hypoxemia (strong recommendation, very low-quality evidence);
- Interstitial lung disease patients who have mild chronic hypoxemia and either dyspnea on exertion or desaturation during sleep or exertion (conditional recommendation, very low-quality evidence);
- Pulmonary hypertension with congenital heart disease complicated by chronic hypoxemia but not until there has been consultation with a pediatric pulmonologist or cardiologist who has expertise in the management of pulmonary hypertension in this clinical setting, regardless of previous reparative or palliative congenital heart surgery (strong recommendation, very low-quality evidence).

Additionally, the expert panel unanimously agreed that optimal implementation of the above HOT recommendations consists of all of the following[5]:

- Oxygen therapy to maintain an oxygen saturation as measured by pulse oximetry in an acceptable range according to age and respiratory condition outlined in the full guideline document;
- Use of oxygen equipment that is of the appropriate size, developmental stage, and flow rate to function properly;
- Oxygen therapy monitoring by pulse oximetry in the home.

Requirements for Medical Oxygen Providers and Retailers

In addition to meeting the general DME and medical supply provider requirements, oxygen providers and providers of oxygen-related equipment and services must also have a current and valid oxygen permit.

Pharmacy providers who also provide DME and bill Medicaid for oxygen must submit copies of their OPH pharmacy permits with their provider enrollment applications.

Oxygen providers must have a licensed certified respiratory therapist (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) under contract or on staff to provide management and consumer instruction at the provider's physical DME business location or in the beneficiary's home.

DME oxygen providers and providers of oxygen-related equipment and services must establish and implement written policies and procedures to ensure all new and used oxygen-related or respiratory equipment, including the internal filters purchased by the provider, are appropriately disinfected, sterilized, serviced, and properly stored according to manufacturer's specifications.

Prior to renting, delivering, or providing the equipment to any individual beneficiary, all licensure requirements and industry standards are applicable.

NOTE: Used equipment cannot be sold to a beneficiary; however, rental equipment may be provided.

Additionally, all providers of medical oxygen and oxygen-related equipment must have an updated contingency plan on file that ensures emergency oxygen, oxygen related equipment and services will be provided to beneficiaries 24 hours a day. Providers are responsible for ensuring that medical oxygen and oxygen-related equipment available during emergencies, if medically necessary. This may include the aftermath of a natural disaster. The department will not reimburse providers for unused equipment and supplies retrieved after an emergency. Pickup and delivery documentation must be maintained for all equipment. The provider of DME oxygen services and oxygen-related equipment and services must maintain beneficiary records. All beneficiary records must include equipment assessments, such as oxygen concentrator hour meter readings.

If the equipment has a patient compliance hour meter, that reading must also be documented and maintained in the beneficiary's record.

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 and may not support medical necessity. 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.

Note: To adhere to the CMS National Correct Coding Initiative (NCCI) edits, only one (1) unit per HCPCS for portable oxygen contents is allowed per claim line regardless of the date(s) of service. Multiple claim lines for the HCPCS for portable oxygen contents may be billed for the same dates of service.

HCPCS Codes	Description
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0425	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0430	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Stationary oxygen contents, gaseous, 1 month’s supply = 1 unit
E0442	Stationary oxygen contents, liquid, 1 month’s supply = 1 unit
E0443	Portable oxygen contents, gaseous, 1 month’s supply = 1 unit
E0444	Portable oxygen contents, liquid, 1 month’s supply = 1 unit
E0445	Oximeter device for measuring blood oxygen levels noninvasively
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
E1392	Portable oxygen concentrator, rental

HCPCS Codes	Description
E1405	Oxygen and water vapor enriching system with heated delivery
E1406	Oxygen and water vapor enriching system without heated delivery
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot
S8121	Oxygen contents, liquid, 1 unit equals 1 pound

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	08/15/20	
Annual review. References reviewed and updated. Background updated. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Added "may not support medical necessity" to coding implications. Edited portable oxygen criteria to include option for "mobile within community" in addition to "within the home." Reorganized portable oxygen criteria within sections I and III. Added criteria for portable oxygen systems for pediatrics in sections II and IV. In the over 21 auth and reauth sections regarding the qualifying blood gas study for portable oxygen and concentrators, removed "for the approved stationary concentrator" for clarity.	2/22	4/10/22
Annual review. Updated title from Oxygen Use and Concentrators to Outpatient Oxygen Use. Added "Note: If a medically necessary, lesser cost item exists and will suit the member/enrollee's medical needs, a higher cost item will be denied." Under the Description section. In I.A. updated "hypoxia" to "hypoxemia." Updated statement and included reference (based on CMS NCD 240.2)[8] to I.B.1. and I.B.2 for clarity. In II.A. updated "hypoxia" to "hypoxemia." In III.A.2. added "criteria" to (as defined in criteria section I) statement for clarity. In IV.B.2. changed Chronic hypoxemia is not expected to "improve" to "resolve." In VI. Added "(i.e. cylinder of liquid or gaseous oxygen)" and related "delivery equipment" ... for clarity and removed age criteria "≥ 21." Reformatted criteria in VI.A.1. and 2 for clarity. Removed VI.B. "Enrolled in clinical trial.." Minor rewording with no clinical significance. Background updated with no clinical significance. References reviewed and updated. Internal and external specialist reviewed.	4/23	7/10/23
Annual review. Updated all criteria instances of "blood gas study" to include "or pulse oximetry measurement" and all instances of "arterial oxygen saturation" to include "(or pulse oximetry)". Updated numbering throughout policy. Added Section B. in section I. Minor rewording in Criteria I. Added clarifying language to Criteria I.C.1.a. regarding	02/24	6/5/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date
breathing room air. In I. C..1.b., I.C..1.c., and I.C..2.a., removed the requirement that the measurement is taken after 5 minutes of sleep vs. during sleep. Removed I.C. and I.D. Removed I.E. regarding alternative treatments. Removed section II. Minor rewording in Criteria III.A.3.a. and Criteria III.A.3.b. Added B. and C sections to II. Regarding requests for portable oxygen systems Added B. and C sections to III. Regarding requests for portable oxygen systems. Added new section IV. Minor rewording to Criteria V.B.1. Clarifying language added to Criteria V.C. regarding the absence of systemic hypoxemia. Added Criteria V.E. to include terminal illnesses that do not affect the ability to breathe. Minor rewording in Criteria V. Added Criteria V.A.3. to include frequency of headache attacks. Background updated with no impact on criteria. References reviewed and updated.		
Added Requirements for Medical Oxygen Providers and Retailers under background per IB 24-41.	11/24	

References

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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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. 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.