

# Clinical Policy: Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Nerve Stimulation

Reference Number: LA.CP.MP.117

Date of Last Revision: 1/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

Peripheral nerve stimulation (PNS) is intended to decrease chronic and acute pain by stimulating peripheral nerves with leads placed adjacent or parallel to the affected nerve.<sup>1</sup> PNS can be used in a trial of pain relief effectiveness, or for permanent placement. In peripheral nerve field stimulation (PNFS), leads are placed in the region in which the pain is felt, stimulating smaller peripheral nerves and nerve endings.<sup>1</sup> PNFS is useful when one nerve does not clearly service the painful area.

Percutaneous electrical nerve stimulation (PENS) uses fine needles as electrodes, which are placed in the soft tissues or muscles at dermatomal levels consistent with pain or local pathology. It is similar to transcutaneous electrical nerve stimulation but bypasses the local skin resistance and delivers electrical current closer to the affected tissues. Percutaneous electrical nerve field stimulation (PENFS) is a variation of PENS that targets an area of pain instead of targeting a specific nerve.

The dorsal column stimulator (DCS), or spinal column stimulator (SCS) is a device that allows for electrical stimulation of the dorsal aspect of the spinal cord nerves in an effort to relieve pain in patients with a variety of chronic pain disorders. In most cases, neuropathic pain responds poorly to standard pharmacological and surgical therapies and can last indefinitely with increasing severity over time. It may result in severe disability. Stimulation in this area interferes with the conduction of pain impulses through adjacent sensory pathways and may stimulate endorphins. The technique does not alter the underlying pathological process. However, in selective patients with persistent and intractable pain of nerve origin, approximately 50% of patients will have pain relief, thereby decreasing the need for analgesic medication and at times obviating the need for further surgical procedures.

*Note: For other types of peripheral nerve stimulation, please refer to:*

- LA.CP.MP.40 Gastric Electrical Stimulation
- LA.CP.MP.137 Fecal Incontinence Treatments
- LA.CP.MP.133 Posterior Tibial Nerve Stimulation for Voiding Dysfunction
- LA.CP.MP.12 Vagus Nerve Stimulation
- LA.CP.MP.203 Diaphragmatic/Phrenic Nerve Stimulation

## Policy/Criteria

- I. It is the policy of Louisiana Healthcare Connections that there is insufficient evidence to support the efficacy of percutaneous electrical nerve stimulation, peripheral nerve stimulation *or* peripheral nerve field stimulation for any indication.

## CLINICAL POLICY

### Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Nerve Stimulation



**II.** It is the policy of Louisiana Healthcare Connections that there is insufficient evidence to support the efficacy of percutaneous electrical nerve field stimulation (PENFS) for any indication, including irritable bowel syndrome (IBS).

**III.** It is the policy of Louisiana Healthcare Connections that spinal cord stimulation (SCS) is **medically necessary** for the following indications:

A. A *trial of SCS for failed back surgery syndrome* when all the following criteria are met:

1. Prior lumbar surgery;
2. Neuropathic pain lasting  $\geq$  six months, is refractory and interferes with activities of daily living (ADLs);
3. Not a suitable candidate for or opposes additional surgery;
4. Failure of  $\geq$  six months of conventional multidisciplinary medical therapy including all of the following:
  - a. Chiropractic, physical therapy or prescribed home exercise program;
  - b. NSAIDs (non-steroidal anti-inflammatory drugs) unless contraindicated or not tolerated;
  - c. Activity modification;
5. Has demonstrated cognitive ability to manage stimulator;
6. Psychological evaluation and clearance by a qualified mental health professional reveals no evidence of an inadequately controlled mental health problem;
7. No untreated, existing drug or alcohol dependency.

B. A *trial of SCS for complex regional pain syndrome (CRPS)* when all the following criteria are met:

1. Pain is being managed by a pain management specialist with experience treating CRPS and pain/burning has persisted for  $>$  six months;
2. Has  $\geq$  two of the following symptoms limited to one extremity only:
  - a. Allodynia (pain sensation in response to a typically non-painful stimulus) or hyperalgesia;
  - b. Swelling/tenderness;
  - c. Cyanotic/red/pale digit/extremity;
  - d. Increased sweating;
  - e. Alteration of temperature;
  - f. Persistent loss of motion;
  - g. Trophic skin changes;
  - h. Flexion contractures;
3. Pain is chronic, refractory, and interferes with ADLs;
4. Failure of  $\geq$  six months of conventional multidisciplinary therapy including all of the following:
  - a. Physical therapy or occupational therapy;
  - b. Anticonvulsant or antidepressant medication;
  - c. Sympathetic block;
5. Has demonstrated cognitive ability to manage stimulator;
6. Psychological evaluation and clearance by a qualified mental health professional reveals no evidence of an inadequately controlled mental health problem;
7. No untreated, existing drug or alcohol dependency.

- C. *A trial of SCS for chronic ischemic leg pain due to peripheral vascular disease* when all of the following criteria are met:
1. Chronic, ischemic leg pain due to peripheral vascular disease and one of the following:
    - a. Not a candidate for revascularization;
    - b. Revascularization has failed to relieve painful symptoms and the pain has not responded to medical management;
  2. Pain lasting  $\geq$  six months, is refractory and interferes with ADLs;
  3. Has demonstrated cognitive ability to manage stimulator;
  4. Psychological evaluation and clearance by a qualified mental health professional reveals no evidence of an inadequately controlled mental health problem;
  5. No untreated, existing drug or alcohol dependency.
- D. *A trial of SCS for the following indications* has **limited evidence** to prove effectiveness of treatment and consideration will be made on a case-by-case basis. Medical necessity will be considered in members/enrollees based on the following information:
1. Chronic, intractable pain due to one of the following:
    - a. Lumbosacral adhesive arachnoiditis secondary to multiple myelographies or lumbar surgeries that has not responded to medical management, including physical therapy (the presence of arachnoiditis is usually documented by the presence of high levels of proteins in the cerebrospinal fluid and/or by myelography or magnetic resonance imaging);
    - b. Nerve root injuries, post-surgical or post traumatic (e.g., avulsion);
    - c. Phantom limb syndrome that has not responded to medical management;
    - d. Post-herpetic neuralgia;
    - e. Plexopathy;
    - f. Polyneuropathy;
    - g. Intercostal neuralgia that did not respond to medical management and nerve blocks;
    - h. Cauda equina injury/syndrome;
    - i. Incomplete spinal cord injury;
    - j. Diabetic peripheral neuropathy;
    - k. Failed neck surgery syndrome (FNSS);
    - l. Chronic, intractable back pain and/or lumbar radiculopathy;
  2. Pain lasting  $\geq$  six months, is refractory and interferes with ADLs;
  3. Specific goals have been established between the provider and the member/enrollee that include increased function, ADLs, return to work, and/or quality of life;
  4. Failure of  $\geq$  six months of conventional multidisciplinary medical therapy, including any of the following:
    - a. Physical therapy and/or chiropractic care;
    - b. Physician-directed home exercises;
    - c. Oral medications including opioids or non-opioids;
    - d. Life-style changes, including diet, smoking cessation, and/or daily exercise;
  5. Has demonstrated cognitive ability to manage stimulator;
  6. Psychological evaluation and clearance by a qualified mental health professional reveals no evidence of an inadequately controlled mental health problem;
  7. No untreated, existing drug or alcohol dependency.

- E. *A trial of SCS for refractory chronic stable angina pectoris* has **limited evidence** to prove effectiveness of treatment and consideration will be made on a case-by-case basis. It should be reserved only for carefully selected members/enrollees, if any. Medical necessity will be considered in members/enrollees based on the following information:
1. Continued angina after percutaneous coronary intervention or coronary artery bypass graft;
  2. Not a candidate for further revascularization;
  3. Angina is NYHA (New York Heart Association) III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest);
  4. Reversible ischemia documented at least by a symptom-limited treadmill exercise test;
  5. Has had optimal pharmacotherapy for at least one month that includes the maximal tolerated dose of at least two of the following:
    - a. Long-acting nitrates;
    - b. Beta-adrenergic blockers;
    - c. Calcium channel antagonists;
  6. Pain is chronic, refractory, and interferes with ADLs;
  7. Has demonstrated cognitive ability to manage stimulator;
  8. Psychological evaluation and clearance by a qualified mental health professional reveals no evidence of an inadequately controlled mental health problem;
  9. No untreated, existing drug or alcohol dependency.
- F. *Permanent placement of a SCS* is **medically necessary** following a trial of spinal cord stimulation for an indication listed above when all of the following criteria are met:
1. Disease specific criteria for spinal cord stimulation are met;
  2. Documented trial of  $\geq$  three days;
  3. Documented pain reduction of  $> 50\%$  from the trial associated with functional improvement;
  4. The same brand and model of the generator device used for the trial is used for permanent placement.

**IV.** It is the policy of Louisiana Health Care Connections that there is insufficient evidence to support the efficacy of dorsal root ganglion (DRG) stimulation.

### **Background**

#### *Peripheral nerve stimulation (PNS)*

Evidence supporting peripheral nerve stimulation (PNS) is limited. According to a systematic review by Xu et al., there is a lack of high-quality randomized control trials to recommend PNS for most pain management indications.<sup>2</sup> They cited wide variations in experimental design, research protocol, and heterogeneity of study population as limitations preventing a meta-analysis.<sup>17</sup> Xu et al. stated that PNS had level I and Level II evidence supporting its efficacy for migraine/chronic headache.<sup>2</sup> However, the large multicenter randomized clinical trial (RCT) included in the systematic review, conducted by Dodick et al. studying the effect of PNS for migraine headache, also noted adverse events among 70% of the study sample, with 48% of the patients with adverse events requiring hospitalization or further surgical intervention to treat the complication.<sup>3</sup> An additional systematic literature review noted moderate to strong evidence for peripheral nerves stimulation, but surveyed the literature as a whole for an array of pain

indications, noting that further research could help “further refine appropriate populations and pain diagnoses.”<sup>4</sup> Hayes notes that there is insufficient evidence to evaluate the efficacy of peripheral nerve stimulation for back pain, or chronic neck pain.<sup>1</sup>

*Peripheral nerve field stimulation (PNFS)*

Hayes notes two available RCTs addressing PNFS for chronic low back pain, stating they were of low quality due to inability to blind patients and/or researchers, low sample sizes, and short follow-up periods.<sup>5</sup> An additional RCT evaluated subcutaneous PNFS combined with spinal cord stimulation (SCS) for refractory low back pain, concluding that PNFS significantly decreased pain compared to SCS alone.<sup>6</sup> Study limitations included industry ties amongst investigators and small sample sizes.<sup>6</sup> There were too few high-quality studies to support the safety or efficacy of PNFS for other indications.

*Percutaneous electrical nerve stimulation (PENS)*

In 2013 the National Institute for Clinical Health and Care Excellence (NICE) published guidance for PENS for refractory neuropathic pain, noting evidence of short-term efficacy and no significant safety concerns. NICE guidelines cite evidence from two RCTs with 64 and 50 patients, respectively, demonstrating significant reduction in pain and favorable safety profiles.<sup>7</sup> Although studies are promising, evidence and guidance supporting the efficacy of PENS remain limited.

*Percutaneous electrical nerve field stimulation (PENFS)*

PENFS is a variation of PENS that targets a general area of pain as opposed to a specific nerve. PENFS is emerging as a promising noninvasive auricular neurostimulation therapy to treat disorders of gut-brain interaction (DGBI) with study populations including children and adolescents.<sup>8,9,10</sup> Although study findings are promising, additional studies are needed before PENFS can be routinely recommended for children and adolescents with functional abdominal pain (FAP).<sup>10</sup>

The IB-Stim (NeurAxis Inc.) is a PENFS designed to relieve functional abdominal pain and is cleared by the U.S. Food and Drug Administration (FDA) for the treatment of abdominal pain in adolescents with irritable bowel syndrome (IBS). According to a Hayes review, clinical studies suggest no or unclear support for the use of IB-Stim in the treatment of IBS in adolescents, and there are no professional guidelines that currently offer recommendations for PENFS in this population. In the Hayes review, only one fair quality trial was identified, and IB-Stim was not compared to other active treatments and did not report clear benefits in patient outcomes compared to sham past three to four weeks of study follow up.<sup>8</sup>

*Spinal cord stimulation (SCS)*

SCS is currently used to treat a wide variety of inoperable and intractable chronic pain syndromes, including failed back surgery syndrome and complex regional pain syndrome (CRPS). In patients with failed conservative and surgical treatment of lower-limb ischemia, SCS increases skin blood flow, decreases pain, and improves quality of life. Four studies used inferential statistics and found pain reduction to be significant. At least 50% pain reduction at follow-up was found in 78%, 80%, and 85% of patients in the three studies that reported this data. Follow-up ranged from six to 35 months.

According to recent systematic reviews, the most favorable results have been observed in patients with peripheral vascular disease, complex regional pain syndrome, and peripheral neuropathy (e.g., diabetic or causalgic origin). Of interest, the pain relief achieved with SCS in patients with complex regional pain syndrome is possible without vasodilation. The vasodilation found with SCS is attributed to an inhibitory effect on sympathetically maintained vasoconstriction. Diabetic patients with peripheral arterial occlusive disease who present with intractable pain have also been successfully treated with SCS, except those who have severe autonomic neuropathy. Recently, SCS has been successfully used to treat intractable angina pectoris and chronic mesenteric ischemia.

Spinal cord stimulation is proposed as a late or last resort treatment for chronic pain due to stable angina pectoris. Although most of the research reviewed used subjective outcome measures and some studies lacked prospective design, adequate sample size, and control groups, SCS was shown to alleviate pain and reduce myocardial ischemia in many of the study patients for whom pain relief was previously unobtainable. SCS has also been shown to reduce service utilization in aggregate among recipients. Side effects, while not infrequent, are rarely serious and can usually be resolved by the realignment or replacement of the device. Evidence indicates that the analgesic effect of SCS in angina does not mask the warning pain of myocardial infarction. Patients who have been treated with SCS have not been shown to be at increased risk for morbidity or mortality compared with their peers. Although a minority of patients receiving a trial of SCS ultimately experience prolonged pain relief, the significance of the alleviation of pain and suffering among those who do cannot be underestimated. Therefore, spinal cord stimulation for chronic stable angina pectoris secondary to demonstrable myocardial ischemia in patients who are refractory to treatment should be considered.

Slangen et al., performed a multicenter randomized clinical trial in 36 painful diabetic peripheral neuropathy (PDPN) patients with severe lower limb pain not responding to conventional therapy.<sup>11</sup> The authors concluded treatment success was shown in 59% of patients with PDPN who were treated with SCS over a six month period, although this treatment is not without risks. Two-year outcomes of the same study reported clinically significant improvements in pain and sleep in 53% of patients. Additionally, a randomized controlled trial of 60 patients, conducted by de Vos and colleagues, found that pain due to PDPN was significantly reduced from baseline at six months, and quality of life was improved.

#### *Dorsal Root Ganglion (DRG) Stimulation*

Hayes notes that currently there is insufficient evidence to determine the effectiveness and safety of DRG stimulation for adults with CRPS. According to Hayes, there is limited evidence suggesting that DRG stimulation for CRPS may result in successful outcomes for pain, quality of life, and mood, but conclusions could not be made due to the limited quantity of evidence, individual study limitations such as small sample sizes, and limited follow up. Additional high quality comparative studies are recommended to evaluate the benefits and risks of DRG stimulation for CRPS.<sup>12</sup>

#### **Coding Implications**

**CLINICAL POLICY**  
**Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Nerve Stimulation**



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 and may not support medical necessity. 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: Coverage is subject to each requested code’s inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (\*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

**CPT Codes That Do Not Support Coverage Criteria**

CPT® Codes	Description
0720T*	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation

**CPT Codes That Support Coverage Criteria**

CPT Codes	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64555*	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64575*	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64585*	Revision or removal of peripheral neurostimulator electrode array
64590 <sup>1</sup>	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595* <sup>2</sup>	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array

<sup>1</sup> For gastric electrical stimulation, refer to LA.CP.MP.40 Gastric Electrical Stimulation

<sup>2</sup> For gastric electrical stimulation, refer to LA.CP.MP.40 Gastric Electrical Stimulation

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CPT Codes	Description
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator
64999	Unlisted procedure, nervous system
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

**HCPCS Codes That Support Coverage Criteria**

HCPCS Codes	Description
L8678*	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month
L8679*	Implantable neurostimulator, pulse generator, any type
L8680*	Implantable neurostimulator electrode, each
L8681*	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682*	Implantable neurostimulator radiofrequency receiver
L8683*	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

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HCPCS Codes	Description
L8685*	Implantable neurostimulator pulse generator, single array, rechargeable includes extension
L8686*	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687*	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688*	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	8/15/20		
Revised I.A.6&7, B.6&7, C.4&5, D.5&6, and E.8&9, to strengthen criteria for psychological evaluation and drug abuse.	5/21	3/26/22	
Edited contraindications: Replaced “non-hepatic malignancy...” with malignancy with high risk of recurrence or death...”; added GFR restriction, added HIV infection with detectable viral load, added stroke, acute coronary syndrome, or MI; added acute renal failure...; added septic. Added “and may support medical necessity” to Coding Implications section	5/22	8/13/22	
Annual review. Criteria II.A. updated verbiage to include “diagnosis of” neuropathic pain. Added Criteria II.D. regarding PENS not being used to treat low back pain. Updated Criteria III.A.3. to state, “Not a suitable candidate for or opposes additional surgery.” Criteria III.D.1.j. added “peripheral.” Criteria III.D.1.l. updated to say “Chronic, intractable back pain and/or lumbar radiculopathy.” Added Criteria III.D.3. Criteria III.D.4. updated to include examples of conservative therapy. Criteria III.F.4. updated to include “...same brand and model...” Added criteria IV. Regarding insufficient evidence to support dorsal root ganglion (DRG) stimulation. Background updated to include information regarding DRG stimulation for complex regional pain syndrome. Added CPT codes 95971 and 95972. Removed ICD-10 codes. References reviewed and updated. Reviewed by internal specialists.	4/23	7/21/23	
Annual review. Updated description and background with no clinical significance. Coding reviewed. References reviewed and updated. Added note for non-covered codes.	02/24	4/26/24	
Description updated with no impact on criteria. Added Criteria III. stating that there is insufficient evidence to support the efficacy of PENFS for any indication, including irritable bowel syndrome (IBS). Background updated with information to support updated criteria regarding PENFS. Added CPT code 0720T as not covered. References reviewed and updated.	07/24	10/28/24	12/2/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Annual review. Coding reviewed and descriptions updated as needed. Added codes 64596, 64597, 64598, and L8678. References reviewed and updated.	2/25	4/28/25	5/29/25
Annual review. Added percutaneous electrical nerve stimulation (PENS) to Criteria I. for insufficient evidence to support efficacy. Removed medically necessary criteria II. for PENS. Removed “for a minimum of 60 days prior to request, as confirmed by lab testing” in Criteria IV.A.7., IV.B.7., IV.C.5., IV.D.7., and IV.E.9. Background updated to align with criteria updates. Coding and descriptions reviewed. References reviewed and updated. Reviewed by internal specialist and external specialist.	1/26	3/30/26	4/30/26

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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.

## **CLINICAL POLICY**

### **Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Nerve Stimulation**



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.

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