Clinical Policy: Corticosteroids for Ophthalmic Injection (Dextenza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq)

Reference Number: CP.PHAR.385
Effective Date: 09.01.18
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

Description

The following are corticosteroids for ophthalmic injection requiring prior authorization: dexamethasone intravitreal implant (Ozurdex®), dexamethasone ophthalmic insert (Dextenza®), fluocinolone acetonide intravitreal implant (Iluvien®, Retisert®, Yutiq®), and triamcinolone acetonide suprachoroidal injection (Xipere®).

FDA Approved Indication(s)

Dextenza is indicated for the treatment of:

- Ocular inflammation and pain following ophthalmic surgery in adults and pediatric patients
- Ocular itching associated with allergic conjunctivitis in adults and pediatric patients aged 2 years and older

Iluvien is indicated for the treatment of:

- Diabetic macular edema in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure
- Chronic non-infectious uveitis affecting the posterior segment of the eye

Ozurdex is indicated for the treatment of:

- Macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
- Non-infectious uveitis affecting the posterior segment of the eye
- Diabetic macular edema (DME)

Retisert and Yutiq are indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.

Xipere is indicated for the treatment of macular edema associated with uveitis.

Limitations of use: The use of Dextenza is not recommended for the treatment of ocular itching associated with allergic conjunctivitis in pediatric patients who require sedation for the insertion procedure.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that corticosteroids for ophthalmic injection are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Ocular Inflammation and Pain Following Ophthalmic Surgery (must meet all)**:**

1. Diagnosis of ocular inflammation and pain following ophthalmic surgery;
2. Request is for Dextenza;
3. Prescribed by or in consultation with an ophthalmologist;
4. Member has received or is scheduled to receive ophthalmic surgery within 30 days of this request;
5. Failure of a topical corticosteroid (*see Appendix B*), unless contraindicated, clinically significant adverse effects are experienced, or member is unable to manage regular eye drop use (e.g., due to age or comorbidities including visual impairment);*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Dose does not exceed 0.4 mg (1 insert) per eye every 30 days.

Approval duration: 1 month (one insert per eye)

B. Ocular Itching Associated with Allergic Conjunctivitis (must meet all)**:**

1. Diagnosis of ocular itching associated with allergic conjunctivitis;
2. Request is for Dextenza;
3. Prescribed by or in consultation with an ophthalmologist;
4. Age ≥ 2 years;
5. Failure of both of the following (a and b), unless clinically significant adverse effects are experienced or both are contraindicated (*see Appendix B*), or member is unable to manage regular eye drop use (e.g., due to age or comorbidities including visual impairment):*
   **For Illinois HIM requests, the step therapy requirements above do not apply per IL HB 5395*
   a. Topical mast cell stabilizer and topical antihistamine (as a single dual-acting product or as two products used in combination);
   b. Topical corticosteroid;
6. Dose does not exceed 0.4 mg (1 insert) per eye every 30 days.

Approval duration: 1 month (one insert per eye)

C. Macular Edema following BRVO or CRVO (must meet all)**:**

1. Diagnosis of macular edema following BRVO or CRVO;
2. Request is for Ozurdex;
3. Prescribed by or in consultation with an ophthalmologist;
4. Age ≥ 18 years;
5. Failure of both of the following (a and b), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*):
   a. Intravitreal corticosteroid injections, if available;
   b. Intravitreal anti-vascular endothelial growth factor (VEGF) agent;
   **For Illinois HIM requests, the step therapy requirements above do not apply per IL HB 5395*
6. Dose does not exceed 1 implant per eye.

Approval duration: 3 months (one implant per eye)

D. Non-Infectious Uveitis (must meet all)**:**
1. Diagnosis of non-infectious uveitis affecting the posterior segment of the eye;
2. Request is for Iluvien, Ozurdex, Retisert, or Yutiq;
3. Prescribed by or in consultation with an ophthalmologist;
4. Member meets one of the following (a or b):
   a. For Iluvien, Ozurdex, Yutiq: Age ≥ 18 years;
   b. For Retisert: Age ≥ 12 years;
5. Failure of one of the following (a or b), unless clinically significant adverse effects are experienced or both are contraindicated (*see Appendix B*):
   **For Illinois HIM requests, the step therapy requirements above do not apply per IL HB 5395*
   a. Systemic corticosteroid (e.g., prednisone);
   b. Non-biologic systemic immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, tacrolimus);
6. Dose does not exceed 1 implant per eye.

Approval duration: 3 months (one implant per eye)

E. Diabetic Macular Edema (must meet all)**:**
1. Diagnosis of DME;
2. Request is for Ozurdex or Iluvien;
3. Prescribed by or in consultation with an ophthalmologist;
4. Age ≥ 18 years;
5. Failure of both of the following (a and b), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix* B);
   a. Intravitreal corticosteroid injections, if available;
   b. Intravitreal anti-VEGF agent;*
   **For Illinois HIM requests, the step therapy requirements above do not apply per IL HB 5395*
6. Dose does not exceed 1 implant per eye.

Approval duration: 3 months (one implant per eye)

F. Macular Edema with Uveitis (must meet all)**:**
1. Diagnosis of macular edema associated with non-infectious uveitis;
2. Request is for Xipere;
3. Prescribed by or in consultation with an ophthalmologist;
4. Age ≥ 18 years;
5. Inadequate response to Triesence® intravitreal injection, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 4 mg (1 vial) per eye every 12 weeks.

Approval duration: 6 months (two injections per eye)

G. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. If request is for Dextenza, one of the following (a or b):
   a. Both of the following (i and ii):
      i. Request is for an ophthalmic surgery unrelated to the previous request;
      ii. Member has received or is scheduled to receive the new surgery within 30 days of this request;
   b. Member continues to experience ocular inflammation and pain/itching related to their ophthalmic surgery/allergic conjunctivitis as evidenced by findings on magnified examination;
4. Member meets one of the following (a, b, c, d, e, or f):
   a. For Dextenza: At least 1 month has passed since last treatment;
   b. For Ozurdex: At least 3 months have passed since last treatment;
   c. For Iluvien, one of the following (i or ii):
      i. For DME: At least 12 months have passed since last treatment;
      ii. For non-infectious uveitis: At least 36 months have passed since last treatment;
   d. For Retisert: At least 30 months have passed since last treatment;
   e. For Yutiq: At least 36 months have passed since last treatment;
   f. For Xipere: At least 12 weeks have passed since last treatment;
5. Dose does not exceed (a, b, or c):
   a. Dextenza: 0.4 mg (1 insert) per eye;
   b. Ozurdex, Iluvien, Retisert, Yutiq: 1 implant per eye;
   c. Xipere: 4 mg (1 vial) per eye.

Approval duration:
Ozurdex, Iluvien, Retisert, Yutiq, Xipere – 3 months (one implant or injection per eye)
Dextenza – 1 month (one insert per eye)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BRVO: branch retinal vein occlusion
CRVO: central retinal vein occlusion
DME: diabetic macular edema
FDA: Food and Drug Administration
VEGF: vascular endothelial growth factor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
anti-VEGF agents (e.g., bevacizumab†, Lucentis® [ranibizumab], Eylea® [aflibercept], Vabysmo®, Beovu®)	**Macular Edema** Refer to prescribing information	Refer to prescribing information
systemic corticosteroids (e.g., prednisone)	**Uveitis** prednisone 5 – 60 mg/day PO in 1 – 4 divided doses	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
non-biologic systemic immunosuppressive therapy (e.g., azathioprine†, Leukeran® [chlorambucil]†, cyclophosphamide†, cyclosporine [Sandimmune®, Neoral®]†, methotrexate [Trexall®]†, mycophenolate mofetil [Cellcept®]†, tacrolimus [Prograf®]†)	**Uveitis** Varies	Varies
topical dual-acting mast cell stabilizer/antihistamine (e.g., azelastine, bepotastine, epinastine, ketotifen, olopatadine)	**Allergic Conjunctivitis** 1 to 2 drops in affected eye(s) per day	Varies
topical mast cell stabilizer (e.g., cromolyn, lodoxamide, nedocromil)	**Allergic Conjunctivitis** 2 to 6 drops in affected eye(s) per day	Varies
topical antihistamine (e.g., alcaftadine, emedastine)	**Allergic Conjunctivitis** 1 to 4 drops in affected eye(s) per day	Varies
topical corticosteroids (e.g., loteprednol, dexamethasone)	**Allergic Conjunctivitis or Ocular Pain and Inflammation** Loteprednol: 1 to 2 drops in affected eye(s) QID Dexamethasone: 1 to 2 drops in affected eye(s) up to every hour for severe disease	Varies
intravitreal corticosteroids: Triesence (triamcinolone)	**Macular Edema, DME, Uveitis** 4 mg injected intravitreally per affected eye	4 mg/eye

† Off-label
Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications / Boxed Warnings

- Contraindication(s):
  - Dextenza: active corneal, conjunctival or canalicular infections, including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella; mycobacterial infections; fungal diseases of the eye, and dacryocystitis.
  - Retisert: patients with active viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in active bacterial, mycobacterial or fungal infections of the eye.

- Iluvien, Ozurdex, Xipere, Yutiq: patients with active or suspected ocular or periocular infections including most viral disease of the cornea and conjunctiva including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections and fungal disease.
- Iluvien, Ozurdex: patients with glaucoma with cup to disc rations of greater than 0.8
- Ozurdex: patients with posterior lens capsules that is torn or ruptured because of the risk of migration into the anterior chamber.
- Iluvien, Ozurdex, Yutiq, Xipere: hypersensitivity.

- Boxed warning(s): none reported

Appendix D: General Information

- Based on clinical trials with Retisert:
  - Within 3 years post-implantation, approximately 77% of patients will require intraocular pressure (IOP) lowering medications to control intraocular pressure and 37% of patients will require filtering procedures to control intraocular pressure.
  - Following implantation of Retisert, nearly all patients will experience an immediate and temporary decrease in visual acuity in the implanted eye which lasts for approximately one to four weeks post-operatively.
  - During the 3-year post-implantation period, nearly all phakic eyes are expected to develop cataracts and require cataract surgery.
- In one study, intravitreal bevacizumab (1.25 mg) and the dexamethasone (DEX) (0.7 mg) implant were compared in a randomized, Phase II trial called the BEVORDEX study. 79 Forty-two eyes received intravitreal bevacizumab every 4 weeks, and 46 eyes received an intravitreal DEX (0.7 mg) implant every 16 weeks, with a when necessary (PRN) regimen for 12 months. The primary outcome of the study was to gain ten or more letters in the best-corrected distance visual acuity (BCVA) at 12 months, which was achieved in 40% of the bevacizumab-treated eyes and 41% of the DEX implant-treated group (P = 0.99). The mean corneal refractive therapy (CRT) decrease was statistically significant between the groups, and the reduction was 122 µm in the bevacizumab group and 187 µm in the DEX implant group (P=0.015). The mean number of injections over 1 year was 8.6 for the bevacizumab group and 2.7 for the DEX implant group. Finally, in the DEX implant-treated eyes, 11% lost ten or more letters of the BCVA, which was due to cataracts in 4 of 5 cases; none lost ten letters in the bevacizumab-treated eyes.
- The Chart Review of Ozurdex in Macular Edema (CHROME) study evaluated the real-world use, efficacy, and safety of one or more dexamethasone intravitreal implant(s) 0.7 mg (DEX implant) in 120 eyes with macular edema (ME). The mean number of DEX implant injections was 1.7 ± 0.1 in all study eyes; 44.2% of eyes had repeat DEX implant injections (reinjection interval 2.3-4.9 months).
- According to Pommier et al., an average of 2.6 injections of Ozurdex were needed to obtain a 58.6% of patients who gained more than 15 letters, and 51.1% of patients showed macular edema resolution.
- The POINT trial by Thorne et al. found no significant difference between intravitreal triamcinolone acetonide injection and intravitreal dexamethasone implant in terms of safety and efficacy for the treatment of uveitic macular edema.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Dexamethasone (Dextenza)	Ocular inflammation and pain after surgery, ocular itching associated with allergic conjunctivitis	Insert into the lower lacrimal punctum and into the canaliculus. A single insert releases a 0.4 mg dose of dexamethasone for up to 30 days following insertion	1 insert per eye per 30 days
Dexamethasone (Ozurdex)	Macular edema, uveitis, DME	Inject the implant containing 0.7 mg dexamethasone intravitreally	One implant injection per eye every 6 months
Fluocinolone (Iluvien)	DME, uveitis	Inject the implant containing 0.19 mg fluocinolone intravitreally	DME: One implant injection per eye every 12 months Uveitis: One implant injection per eye every 36 months
Fluocinolone (Retisert)	Uveitis	Inject the implant containing 0.59 mg fluocinolone intravitreally	One implant injection per eye every 30 months
Fluocinolone (Yutiq)	Uveitis	Inject the implant containing 0.18 mg fluocinolone intravitreally	One implant injection per eye every 36 months
Triamcinolone (Xipere)	Macular edema associated with uveitis	4 mg (0.1 mL) administered as a suprachoroidal injection	One injection per eye every 12 weeks

VI. Product Availability

Drug Name	Availability
Dexamethasone (Dextenza)	Ophthalmic intracanalicular insert: 0.4 mg
Dexamethasone (Ozurdex)	Biodegradable intravitreal implant: 0.7 mg
Fluocinolone (Iluvien)	Non-biodegradable intravitreal implant: 0.19 mg
Fluocinolone (Retisert)	Non-biodegradable intravitreal implant: 0.59 mg
Fluocinolone (Yutiq)	Non-biodegradable intravitreal implant: 0.18 mg
Triamcinolone (Xipere)	Injectable suspension in a single-dose vial: 40 mg/mL

VII. References

1. Dextenza Prescribing Information. Bedford, MA: Ocular Therapeutix, Inc.; April 2025. Available at: www.dextenza.com. Accessed May 8, 2026.
2. Iluvien Prescribing Information. Baudette, MN: Alimera Sciences, Inc.; December 2025. Available at: www.iluvien.com. Accessed May 8, 2026.
3. Ozurdex Prescribing Information. North Chicago, IL: Abbvie, Inc.; March 2026. Available at: www.ozurdex.com. Accessed May 8, 2026.

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6. Xipere Prescribing Information. Bridgewater, NJ: Bausch & Lomb Americas Inc.; May 2025. Available at: www.xipere.com. Accessed May 8, 2026.
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Diabetic Retinopathy & Macular Edema

8. Solomon SD, Chew E, Duh EJ, et al. Diabetic retinopathy: a position statement by the American Diabetes Association. Diabetic Care 2017;40:412-418.
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11. Lam WC, Albiani DA, Yoganathan P, et al. Real-world assessment of intravitreal dexamethasone implant (0.7 mg) in patients with macular edema: the CHROME study. *Clin Ophthalmol.* 2015 Jul 10;9:1255-68. doi: 10.2147/OPTH.S80500. eCollection 2015.
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Retinal Vein Occlusions

13. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Retinal Vein Occlusions. San Francisco, CA: American Academy of Ophthalmology; September 2024. Available at: www.aao.org/ppp. Accessed May 8, 2026.

Uveitis

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17. Yeh S, Khurana RN, Shah M, et al. Efficacy and safety of suprachoroidal CLS-TA for macular edema secondary to noninfectious uveitis: Phase 3 randomized trial. *Opthalmology*. 2020; 127(7): 948-955.
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Conjunctivitis
19. American Academy of Ophthalmology Cornea/External Disease Committee. Preferred Practice Pattern® Guidelines. Conjunctivitis. San Francisco, CA: American Academy of Ophthalmology; November 2023. Available at: www.aao.org/ppp. Accessed May 8, 2026.

Coding Implications
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
J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
J7311	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg (Retisert)
J7312	Injection, dexamethasone intravitreal implant, 0.1 mg
J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg (Iluvien,)
J7314	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg (Yutiq)
J3299	Injection, triamcinolone acetonide (Xipere), 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications and continued therapy section.	09.22.22	
Added Dextenza to policy; revised dosing frequency for Ozurdex from q4 months to q3 months per literature review, market analysis, and specialist feedback; updated HCPCS code for Xipere.	01.23.23	05.23
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.14.23	08.23
3Q 2024 annual review: no significant changes; in Appendix B, updated commercially available branded therapeutic alternatives and clarified off label indications; in Section V, revised Ozurdex maximum dose from every 4 months to every 6 months per PI references reviewed and updated.	05.24.24	08.24
For DME, macular edema, and uveitis, removed required step through of intravitreal steroid injections due to lack of commercial availability (Triesence is the only intravitreal steroid injection on market, and it is currently on shortage without a known resolution date).	08.20.24	
RT4: for Iluvien, added newly approved indication for non-infectious uveitis affecting the posterior segment of the eye; for Appendix C, updated contraindications section for Iluvien, Ozurdex, and Yutiq to align with prescribing information; updated HCPCS code description for Retisert, Iluvien, and Yutiq.	03.20.25	
3Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; for allergic conjunctivitis, added bypass of redirection	05.01.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
for members unable to manage regular eye drop use; for macular edema following RVO and DME clarified failure of a single intravitreal anti-VEGF agent; for non-infectious uveitis, added examples of trial and failure agents and clarified non-biologic "*systemic"* immunosuppressive therapy; RT4: for Dextenza, removed age requirement for ocular inflammation per FDA pediatric expansion and updated age requirement for allergic conjunctivitis from ≥ 18 years to ≥ 2 years per FDA pediatric expansion; in Appendix B, consolidated non-biologic systemic immunosuppressive therapies; updated HCPCS code description for Xipere; in Section V, updated Ozurdex and Iluvien indications per PI and updated Ozurdex maximum dose from every 6 months to every 3 months; references reviewed and updated.		
In Section V, clarified maximum dose is every 6 months.	12.09.25	
3Q 2026 annual review: no significant changes; added ICHRA line of business; no significant changes; references reviewed and updated.	05.08.26	08.26
Added step through of intravitreal steroid injections back to all indications as Triesence is now available for macular edema and DME.	08.05.26	11.26

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. This clinical policy is not intended to recommend treatment for members. Members 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.

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Note:
For Medicaid members, 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.

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