Concert Genetic Testing: ~~Skeletal Dysplasia and Rare Bone Disorders~~Orthopedics

Reference Number: LA.CP.CG.21
Date of Last Revision ~~01/25~~03/26
Revision Log

Coding implications

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

OVERVIEW

~~Skeletal dysplasias are a category of rare genetic disorders that affect bones and joints and are estimated to affect 2.4 per 10,000 births, and some forms of skeletal dysplasia can be suspected based on prenatal ultrasound. There are more than 350 distinct skeletal disorders that have been described, and some skeletal dysplasias can be lethal, often due to a significantly small rib cage that restricts lung development. The osteogenesis imperfecta group of disorders are sometimes classified as skeletal dysplasias, while other times they are considered bone fragility disorders.~~

~~Genetic testing has allowed for gene identification in more than two thirds of the skeletal dysplasias. Testing allows for more precise diagnosis facilitating health care providers' care based on the established natural history of the individual disorder. For some skeletal dysplasias, knowing the specific disease causing variant or variants can impart prognostic information. A few skeletal dysplasias are currently amenable to pharmacologic therapy, though such therapies may be reserved for patients with confirmed genetic diagnosis. The familial recurrence risk and long term natural history differs based on the underlying genetic basis of disease.~~

~~Per GeneReviews*, osteogenesis imperfecta (OI) should be distinguished from child physical abuse/non-accidental trauma (NAT). The prevalence of physical abuse is much greater than the prevalence of OI, and on rare occasions, the two can be present concurrently. Patient history, family history, physical examination, radiographic imaging, fracture investigation, and the clinical course all contribute to distinguishing OI from NAT. The overlap in clinical features includes multiple or recurrent fractures, fractures that do not match the history of trauma, and the finding of fractures of varying ages and at different stages of healing. Rib fractures are much more common in NAT than in osteogenesis imperfecta.~~

~~*GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.~~

This policy addresses the use of tests for rare skeletal dysplasias and other bone disorders. Pre-test and post-test genetic counseling that facilitates informed decision-making, addresses the

possibility of secondary or incidental findings, and a plan for returning results before testing occurs is strongly advised.

For additional information see the Rationale section.

POLICY REFERENCE TABLE

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~~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 and may not support medical necessity. 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.

The tests, ~~associated laboratories,~~ CPT codes, and ICD codes ~~contained within~~referenced in this ~~document serve only as examples to help users navigate claims and corresponding criteria; as such, they~~policy are not comprehensive, and ~~are~~their inclusion does not represent a guarantee of coverage or non-coverage. Please see the ~~Concert Platform~~Concert Platform for ~~a comprehensive list of~~additional registered tests.

> **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. The non-covered codes will only be denoted in the table below and not throughout the policy. Please only reference the policy reference table for covered and non-covered codes.**

~~Criteria Sections~~ CRITERIA SECTIONS	~~Example Tests (Labs)~~EXAMPLE TESTS (LABS)	~~Common CPT Codes~~COMMON BILLING CODES	~~Common ICD Codes~~REF
Osteogenesis Imperfecta (OI)			

~~Osteogenesis Imperfecta~~ Osteogenesis Imperfecta	Osteogenesis imperfecta COL1A1 & COL1A2 NGS Panel (HNL Genomics)	81406*, 81408*, 81479, Q78.0, Z82.79	3
	Osteogenesis Imperfecta Panel (PreventionGenetics, part of Exact Sciences)		
	Osteogenesis Imperfecta NGS Panel - Dominant & Recessive (HNL Genomics)		
Skeletal Dysplasias and Rare Bone Disorders			
~~Multigene Panel Analysis for Skeletal Dysplasia or Rare Bone Disorder~~Multigene Panel Analysis for Skeletal Dysplasia or Rare Bone Disorder	Skeletal Disorders Panel (Invitae)	81400*, 81401*, 81402*, 81403*, 81404*, 81405*, 81406*, 81407*, 81408*, 81479, M85, Q77, Q78	1, 7, 8
	Skeletal Dysplasia Core & Extended NGS Panel (HNL Genomics)		
	Comprehensive Skeletal Dysplasias and Disorders Panel (Blueprint Genetics)		
Other Covered Skeletal Dysplasias and Rare Bone Disorders			
Other Covered Skeletal Dysplasias and Rare Bone Disorders	See list below	81400*, 81401*, 81402*, 81403*, 81404*, 81405*, 81406*, 81407*, 81408*, 81479, M85, Q77, Q78	2, 4, 5, 6

~~OTHER~~

RELATED POLICIES

This policy document provides criteria for ~~Genetic Testing for Skeletal Dysplasia and Rare Bone Disorders.~~testing related to skeletal dysplasia and rare bone disorders. Please refer to:

- ~~***Genetic Testing: Aortopathies and Connective Tissue Disorders*** for criteria related to Ehlers-Danlos syndrome and other connective tissue disorders.~~
- ~~***Genetic Testing: Multisystem Inherited Disorders, Intellectual Disability, and Developmental Delay***~~***Specialty Testing: Cardiovascular*** for criteria related to diagnostic ~~testing~~ tests for inherited and sporadic cardiovascular conditions.
- ***Specialty Testing: Multisystem Genetic Conditions*** for criteria related to diagnostic tests for genetic disorders that affect multiple organ systems~~.~~ (e.g. whole exome and genome sequencing, chromosomal microarray, and multigene panels for broad phenotypes).
- ~~***Genetic Testing:***~~ ***General Approach to*** ~~***Genetic and Molecular***~~***Laboratory Testing*** for criteria related to skeletal dysplasias and rare bone disorders, including known familial variant testing, that is not specifically discussed in this or another non-general policy~~, including known familial variant testing.~~.

~~back to top~~

back to top

CRITERIA

It is the policy of Louisiana Healthcare Connections that that the specific genetic testing noted below is **medically necessary** when meeting the related criteria:

OSTEOGENESIS IMPERFECTA (OI)

Osteogenesis Imperfecta

I. *COL1A1* and *COL1A2* variant analysis ~~(81408, 81479)~~ or multigene panel analysis ~~(81406, 81408, 81479)~~ that includes *COL1A1* and *COL1A2* to establish or confirm a diagnosis of osteogenesis imperfecta (OI) is considered **medically necessary** when:

A. The member/enrollee has any of the following:

1. Fractures with minimal or no trauma in the absence of other factors, such as ~~non-accidental trauma (NAT)~~non-accidental trauma (NAT) or other known disorders of bone, **OR**

2. Short stature, often with bone deformity, **OR**
3. Blue/gray scleral hue, **OR**
4. Dentinogenesis imperfecta (DI), **OR**
5. Progressive, postpubertal hearing loss, **OR**
6. Ligamentous laxity or other signs of connective tissue abnormality, **OR**
7. Family history of OI, **OR**
8. Fractures of varying ages and stages of healing (often of the long bones), **OR**
9. "Codfish" vertebrae, **OR**
10. Wormian bones, **OR**
11. Protrusio acetabuli, **OR**
12. Low bone mass or osteoporosis.

II. Current evidence does not support *COL1A1* and *COL1A2* variant analysis ~~(81408, 81479)~~ or multigene panel analysis ~~(81406, 81408, 81479)~~ that includes *COL1A1* and *COL1A2* to establish or confirm a diagnosis of osteogenesis imperfecta ~~is considered **investigational**~~ for all other indications.

~~back to top~~

~~MULTIGENE PANEL ANALYSIS FOR~~ view rationale

back to top

SKELETAL ~~**DYSPLASIA OR**~~DYSPLASIAS AND RARE BONE ~~**DISORDER**~~DISORDERS

Multigene Panel Analysis For Skeletal Dysplasia Or Rare Bone Disorder

I. Multigene panel analysis ~~(81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81479)~~ to confirm or establish a post-natal diagnosis of a skeletal dysplasia or a rare bone disorder may be considered **medically necessary** when:

A. The differential diagnosis includes more than one type of skeletal dysplasia or bone disorder, **AND**

B. The member/enrollee displays one or more of the following clinical features of a skeletal dysplasia:

1. Prenatal ultrasound that showed shortening of the bones of the arms and legs more than 3 standard deviations below the mean, **OR**
2. Prenatal ultrasound that showed head circumference greater than 75th percentile, **OR**
3. Prenatal ultrasound that showed bone irregularities (e.g., bowed, fractured, thickened, thin, undermineralized, etc.), **OR**
4. Prenatal ultrasound that showed abnormal ribs or a small chest circumference, **OR**
5. Postnatal short stature with height or length less than 3rd percentile.

II. ~~Multigene~~Current evidence does not support multigene panel analysis ~~(81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81479)~~ to confirm or establish a diagnosis of a skeletal dysplasia or a rare bone disorder ~~is considered **investigational**~~ for all other indications.

~~back to top~~

view rationale

back to top

OTHER COVERED SKELETAL ~~DYSPLASIA~~DYSPLASIAS AND RARE BONE DISORDERS

Other Covered Skeletal Dysplasias and Rare Bone Disorders

The following is a list of conditions that have a known genetic association. Due to their relative rareness, it may be appropriate to cover these genetic tests to establish or confirm a diagnosis.

I. Genetic testing to establish or confirm one of the following skeletal dysplasias or rare bone disorders to guide management is considered **medically necessary** when the member/enrollee demonstrates clinical ~~features*~~features[1] consistent with the disorder (the list is not meant to be comprehensive, see II below):

A. Achondroplasia Group
    1. Achondroplasia
    2. Hypochondroplasia
    3. Thanatophoric Dysplasia
B. Type II Collagenopathies
    1. Hypochondrogenesis
    2. Spondyloepiphyseal Dysplasia
C. Type XI Collagen Disorders
    1. Fibrochondrogenesis
    2. Otospondylomegaepiphyseal Dysplasia (OSMED)
D. Sulfation Disorders
    1. Achondrogenesis IB
    2. Atelosteogenesis II
    3. Diastrophic Dysplasia
    4. Chondrodysplasia with Congenital Joint Dislocations
E. Filamin Disorders and Similar Disorders
    1. Atelosteogenesis Type I
    2. Atelosteogenesis Type III
    3. Larsen Syndrome
    4. Spondylo-Carpal-Tarsal Dysplasia
F. Short-Rib Dysplasias (with and without Polydactyly)
    1. Chondroectodermal Dysplasia (Ellis-van Creveld (EVC))
    2. Short-Rib Polydactyly Syndrome I, II, III, IV including Asphyxiating Thoracic Dystrophy
G. Metaphyseal Dysplasias
    1. Cartilage-Hair Hypoplasia
H. Spondylo-Epi-(Meta)-Physeal Dysplasia
    1. SEMD, Short Limb Abnormal Calcification Type
I. Acromesomelic Disorders
    1. Acromesomelic Dysplasia, Type Maroteaux
J. Mesomelic and Rhizo-Mesomelic Dysplasias
    1. Langer Type (Homozygous Dyschondrosteosis)
K. Bent Bone Dysplasias
    1. Campomelic Dysplasia
    2. Stuve-Wiedemann Dysplasia
    3. Bent Bone Dysplasia FGFR2 Type
L. Slender Bone Dysplasia
    1. Microcephalic Osteodysplastic Primordial Dwarfism
    2. Osteocraniostenosis
M. Neonatal Osteosclerotic Dysplasias
    1. Bloomstrand Dysplasia
    2. Caffey Disease (Infantile)

3. Raine Dysplasia

N. Increased Bone Density Group
   1. Osteopetrosis

O. Abnormal Mineralization Group
   1. Hypophosphatasia

P. Multiple Epiphyseal Dysplasia and Pseudoachondroplasia Group
   1. Multiple Epiphyseal Dysplasia (MED) - Autosomal Dominant
   2. Multiple Epiphyseal Dysplasia (MED) - Autosomal Recessive
   3. Stickler Syndrome

Q. Hereditary Multiple Osteochondromas

II. Genetic testing to establish or confirm the diagnosis of all other skeletal dysplasias or rare bone disorders not specifically discussed within this or another medical policy will be evaluated by the criteria outlined in *General Approach to ~~Genetic and Molecular~~Laboratory Testing* (see policy for criteria).

~~*Clinical~~[1]Clinical features for a specific disorder may be outlined in resources such as GeneReviews, OMIM, National Library of Medicine, Genetics Home Reference, or other scholarly sources.

~~back to top~~

view rationale

back to top

~~DEFINITIONS~~

~~1. **Non-accidental Trauma (NAT)** refers to injury that is purposely inflicted upon a child (e.g., child abuse). NAT often occurs as injury to the skin and soft tissue, but approximately a third of NATs are fractures.~~

~~back to top~~

~~BACKGROUND AND~~ RATIONALE

Osteogenesis Imperfecta

GeneReviews: COL1A1/2 Osteogenesis Imperfecta

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

The recommended diagnostic testing for osteogenesis imperfecta is as follows:

COL1A1/2 osteogenesis imperfecta (OI) should be suspected in individuals with the following clinical, radiographic, and laboratory features.

- Fractures with minimal or no trauma in the absence of other factors, such as non-accidental trauma (NAT) or other known disorders of bone
- Short stature or stature shorter than predicted based on stature of unaffected family members, often with bone deformity
- Blue/gray scleral hue
- Dentinogenesis imperfecta (DI)
- Progressive, postpubertal hearing loss
- Ligamentous laxity and other signs of connective tissue abnormality
- Family history of OI, usually consistent with autosomal dominant inheritance

Radiographic features of OI change with age. -The major findings include the following:

- Fractures of varying ages and stages of healing, often of the long bones but may also rarely involve ribs and skull. Metaphyseal fractures can be seen in a very small number of children with OI. Rib fractures are much more common in NAT than in OI.
- "Codfish" vertebrae, which are the consequence of spinal compression fractures, seen more commonly in adults.
- Wormian bones, defined as "sutural bones which are 6 mm by 4 mm (in diameter) or larger, in excess of ten in number, with a tendency to arrange in a mosaic pattern." Wormian bones are suggestive of but not pathognomonic for OI.
- Protrusio acetabuli, in which the socket of the hip joint is too deep and the acetabulum bulges into the cavity of the pelvis causing intrapelvic protrusion of the acetabulum.
- Low bone mass or osteoporosis detected by dual energy x-ray absorptiometry (DEXA). Bone density can be normal, especially in individuals with OI type I, as DEXA measures mineral content rather than collagen.

“A multigene panel that includes *COL1A1*, *COL1A2*, and other genes of interest is most likely to identify the genetic cause of the condition at the most reasonable cost while limiting identification of variants of uncertain significance and variants in genes that do not explain the underlying phenotype.”

back to top

Multigene Panel Analysis ~~for~~For Skeletal Dysplasia ~~or~~Or Rare Bone Disorder

Krakow et al 2009

A guideline for prenatal diagnosis of fetal skeletal dysplasias (Krakow, Lachman, Rimoin, 2009) recommends the ~~follow~~following criteria:

- Fetuses with long bone measurements at or less than the 5th centile or greater than 3 SD below the mean should be evaluated in a center with expertise in the recognition of skeletal dysplasias. If the patient cannot travel, arrangements may be able to be made for evaluation of ultrasound videotapes or hard copy images.
- The following fetal ultrasound measurements should be visualized and plotted against normative values: fetal cranium (biparietal diameter and head circumference), facial profile, mandible, clavicle, scapula, chest circumference, vertebral bodies, all fetal long bones, and the hands and feet. Fetuses with long bone parameters more than 3 SD below the mean should be strongly suspected of having a skeletal dysplasia, especially if the head circumference is greater than the 75th centile
- Lethality should be determined by chest circumference to abdominal circumference ratio and/or femur length to abdominal circumference measurement ratio. A chest-to abdominal circumference ratio of less than 0.6 or femur length to abdominal circumference ratio of 0.16 strongly suggests a perinatal lethal disorder, although there are exceptions. The findings should be conveyed to the physicians caring for the patient and to the patient~~.~~ (p. 5~~)~~).

In addition, close attention should be paid to the shape and mineralization pattern of the fetal calvarium and fetal skeleton (poor or ectopic mineralization). Determining the elements of the skeleton that are abnormal, coupled with the findings of mineralization and shape of the bones can aid in diagnosis~~.~~ (p. 3~~)~~).

American College of Medical Genetics and Genomics (ACMG)

For diagnosis of genetic causes of short stature, the American College of Medical Genetics clinical practice resource for evaluation of short stature (Seaver et al, 2009) is as follows:

> "The definition most commonly used for short stature is height-for-age less than two standard deviations below average for gender, which is demonstrated on the standard growth curves as a length or height less than the 3rd centile~~.""~~ (p. 466~~)~~).

Scocchia, et al.

A 2021 study of the clinical utility of multigene panel testing for an unselected population of individuals with suspected skeletal dysplasia demonstrated a high diagnostic yield in individuals with a suspected skeletal dysplasia or growth disorder~~.~~ (p. 1~~)~~).

A molecular diagnosis was established in 42% of patients (228/543). Diagnostic variants were identified in 71 genes, with variation in nearly half of these genes contributing to a molecular diagnosis for a single patient in this cohort. Overall, the most common genes in which molecular diagnoses were identified included: *COL2A1* associated with type II collagenopathies; *FGFR3* associated with achondroplasia, thanatophoric dysplasia, hypochondroplasia, and other conditions such as FGFR-related craniosynostoses; and *COL1A1* or *COL1A2*, associated with osteogenesis imperfecta. Together, these four genes accounted for over one third of all molecular diagnoses across the cohort~~.~~ (p. 2-3~~)~~).

back to top

Other Covered Skeletal ~~Dysplasia~~Dysplasias and Rare Bone Disorders

International Skeletal Dysplasia Society

The International Skeletal Dysplasia Society published an updated categorization of skeletal dysplasias (Unger, 2023):

> "The 'Nosology of genetic skeletal disorders' has undergone its 11th revision and now contains 771 entries associated with 552 genes reflecting advances in molecular delineation of new disorders thanks to advances in DNA sequencing technology….As with the previous versions, the list of disorders and genes in the Nosology may be useful in considering the differential diagnosis in the clinic, directing bioinformatic analysis of next-generation sequencing results, and provide a basis for novel advances in biology and medicine~~."~~" (p. 1165~~)~~).

~~back to top~~

back to top

DEFINITIONS

1. **Non-accidental Trauma (NAT) -** This refers to injury that is purposely inflicted upon a child (e.g., child abuse). NAT often occurs as injury to the skin and soft tissue, but approximately a third of NATs are fractures.

back to top

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Converted corporate to local policy	09/23	11/27/23	
Semi-annual review. Updated title to reflect V1.2024 version. Overview, coding, reference-table, background and references updated. Throughout policy: replaced "coverage criteria" with "criteria. For Policy Reference Table: added "81401, 81402, 81403, 81404, 81405, 81406, 81407". For Other Related Policies: added "and Molecular". For Criteria; under Multigene Panel Analysis for Skeletal Dysplasia or Rare Bone Disorder Panel: added "post-natal"; for Other Covered Skeletal Dysplasia and Rare Bone Disorders Panel: under I.O.1. removed "(also in Metabolic Policy)"; under II. added "and Molecular".	12/23	2/27/24	
Semi-annual review. Updated title to reflect V2.2024 version. In Overview and Clinical Considerations, policy overview updated to include information from the Clinical Considerations section, which has been consolidated into the Overview section. Minor rewording for clarity throughout. Coding, reference-table, background and references updated.	06/24	9/4/24	10/4/24
Semi-annual review. Updated title to reflect V1.2025 version. Osteogenesis Imperfecta: Updated example tests in Policy Reference Table; Updated GeneReviews copyright dates in Reference list; Streamlined portions of Background and Rationale section for brevity. Multigene Panel Analysis for Skeletal Dysplasia or Rare Bone Disorder: Updated References; Streamlined portions of Background and Rationale section for brevity; Updated tests in Policy Reference Table. Other Covered Skeletal Dysplasias and Rare Bone Disorders: Updated Background and Rationale with information from newer version of reference; updated reference.	1/25	3/31/25	5/1/25
Annual review. Policy name changed from Concert Genetic Testing: Skeletal Dysplasia and Rare Bone Disorders to Concert Genetic Testing: Orthopedics. Policy reference table, rationale, background, and references updated. "Investigational" policy statements changed to state "current evidence does not support."	03/26		

REFERENCES

1. Seaver LH, Irons M; American College of Medical Genetics (ACMG) Professional Practice and Guidelines Committee. ACMG practice guideline: genetic evaluation of short stature [published correction appears in Genet Med. 2009 Oct;11(10):765]. Genet Med. 2009;11(6):465-470. doi:10.1097/GIM.0b013e3181a7e8f8
2. Unger S, Ferreira CR, Mortier GR, et al. Nosology of Genetic Skeletal Disorders: 2023 revision. American J of Med Genetics Pt A. 2023;191(5):1164-1209.
3. Steiner RD, Basel D. COL1A1/2 Osteogenesis Imperfecta. 2005 Jan 28 [Updated 2024 Mar 14]. In: Adam MP, Mirzaa GM Ardinger HH, Pagon RA, et al., editors.

GeneReviews [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2024. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1295/
4. Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2024. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1116/
5. Online Mendelian Inheritance in Man, OMIM. McKusick-Nathans Institute of Genetic Medicine, Johns Hopkins University (Baltimore, MD). World Wide Web URL: https://omim.org/
6. MedlinePlus [Internet]. Bethesda (MD): National Library of Medicine (US). Available from: https://medlineplus.gov/genetics/
7. Scocchia, A., Kangas-Kontio, T., Irving, M. *et al.* Diagnostic utility of next-generation sequencing-based panel testing in 543 patients with suspected skeletal dysplasia. *Orphanet J Rare Dis* 16, 412 (2021). https://doi.org/10.1186/s13023-021-02025-7
8. Krakow D, Lachman RS, Rimoin DL. Guidelines for the prenatal diagnosis of fetal skeletal dysplasias. ~~Genet Med.~~Genetics in Medicine. 2009;11(2):127-133. doi:10.1097/~~GIM~~gim.0b013e3181971ccb

back to top

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 member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/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, member/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, member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to member/enrollees and/or submitting claims for payment for such services.

©2026 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademarks exclusively owned by Louisiana Healthcare Connections.