BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:

Treatment of Cervicogenic Headache and Occipital Neuralgia

Policy #: 314
Category: Surgery

Latest Review Date: November 2019
Policy Grade: B

Background/Definition:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

POLICY:

Blue Advantage will treat the following treatments for **chronic headaches, including cervicogenic headache, occipital neuralgia and migraine** as a **non-covered** benefit and as **investigational**.

- Discectomy and spinal fusion
- Dorsal column stimulation
- Electrical stimulation of occipital nerve
- Ganglionectomy
- Implantable infusion pumps (refer to Medical Policy #442 for additional information)
- Injection of anesthetic
- Nerve root decompression
- Neurectomy
- Neurolysis of the great occipital nerve with or without section of the inferior oblique muscle
- Occipital nerve neurolysis
- Pulsed radiofrequency
- Radiofrequency denervation of cervical facet joints
- Radiofrequency ablation of the planum nuchale
- Radiofrequency ablation of peripheral nerves
- Rhizotomy
- Sphenopalatine Ganglion block
- Surgical release of the lesser occipital nerve within the trapezius

The safety and effectiveness of these treatments for this indication has not been established.

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

DESCRIPTION OF PROCEDURE OR SERVICE:

Headache

Headaches are common neurologic disorders and are among the top reasons that patients seek medical care. Headaches affect approximately 50% of the general population in a given year and over 90% of people have a lifetime history of headache. Several treatments or procedures for headache (e.g., chronic migraine, tension-type headache, chronic cluster or cervicogenic headache) and occipital neuralgia have been introduced with varying levels of success. The consensus on standard of care does not exist due to the variability in patient selection and clinical outcomes.

The International Headache Society (IHS), through expert consensus, has created a headache classification system to help diagnose and classify headaches. The IHS criteria are regarded as the gold standard for diagnosis of all types of headaches. The first edition was published in 1988, the second edition was published in 2004 and the third edition was released in early 2018. The third edition classifies headaches into 3 major groups:

- The first group, the primary headaches, includes migraine, tension-type headache, cluster headaches, other trigeminal autonomic cephalgias, and other primary headaches;
- The second group, the secondary headaches, includes headaches attributed to head and/or neck trauma, cranial or cervical vascular disorder, non-vascular intracranial disorder, a substance or its withdrawal, infection, disorder of homeostasis, disorder of cranial, cervical or facial structures, or psychiatric disorder; and
- The third group includes cranial neuralgias, central or primary facial pain, and other headache disorders.

Primary Headache Disorders

Migraines

Migraines are the second-most common headache disorder with 1-year prevalence of migraine in the United States of approximately 12% and can be categorized by headache frequency. Migraines are characterized by severe pain on one or both sides of the head, an upset stomach, and, at times, disturbed vision.

According to the Third Edition of the International Headache Classification (ICHD-3), migraine without aura (previously known as common migraine) is defined as at least 5 attacks per month meeting other diagnostic criteria. Chronic migraine is defined as attacks on at least 15 days per month for more than 3 months, with features of migraine on at least 8 days per month.

A variety of medications are used to treat acute migraine episodes. They include medications taken at the onset of an attack to abort the attack (triptans, ergotamines), and medications to treat the pain and other symptoms of migraines once they are established (nonsteroidal anti-inflammatory drugs, narcotic analgesics, antiemetic's). Prophylactic medication therapy may be appropriate for people with migraines that occur more than 2 days per week. In addition to medication, behavioral treatments such as relaxation and cognitive therapy are used in the management of migraine headache. Moreover, botulinum toxin type A injections are a U.S. Food and Drug Administration (FDA) –approved treatment for chronic migraine.

Tension-Type Headaches (TTH)

Tension- type headaches (TTH) have a prevalence range from 30% to 78%. They are diagnosed when patients report at least 2 of the following characteristics: bilateral headache location, non-pulsating pain of mild to moderate intensity and headache not aggravated by physical activity. Tension- type headaches tend to be mild in nature and are frequently self-diagnosed and self-treated.

There are three types of TTH: Infrequent episodic, frequent episodic and chronic. Infrequent episodic headache is identified in patients who experience headache episodes less than 1 day per

month. Frequent episodic TTH is classified as patients whom experience headache episodes 1 to 14 days per month and chronic TTH is diagnosed in patients who experience headache episodes for 15 days or more per month. Treatment for episodic TTH consists of simple analgesics, simple analgesics with caffeine, parenteral treatments, triptans, and muscle relaxants. Chronic TTH treatment consists of tricyclic antidepressants, behavioral therapies and physical therapy.

Cluster Headaches
Cluster headaches are less common than tension or migraine headaches, with an estimated prevalence of 0.1% of the population. Cluster headaches are characterized by severe unilateral orbital, supraorbital and/or temporal pain that also includes other symptoms in the eye and/or nose on the same side such as rhinorrhea, eyelid edema, or drooping. Cluster headaches occur in a series lasting for weeks to months. Approximately 10-15% have cluster, periods separated by remission periods which usually lasts for months or years. Due to the severity of pain associated with cluster headaches, patients may seek emergency treatment.

Severe acute cluster headaches may be treated with abortive therapy including breathing 100% oxygen and triptan medications. Other medications used to treat cluster headaches include steroids, calcium channel blockers and nerve pain medications.

Occipital Neuralgia
Occipital neuralgia is a specific type of headache that is located on one side of the upper neck, back of the head, and behind the ears, and sometimes extending to the scalp, forehead, and behind the eyes. The pain, which may be piercing, throbbing, or electric-shock-like, follows the course of the greater and lesser occipital nerves. Occipital neuralgia is believed to occur due to pressure or irritation to the occipital nerves, which may result from injury, entrapment by tight muscles, or inflammation.

Occipital neuralgia results in posterior occipital headaches when pressure occurs on the greater and/or lesser occipital nerves. It may be classified as intermittent (e.g., paroxysmal) or continuous, with an acute or chronic nature. Paroxysmal occipital neuralgia is pain that occurs only in the distribution of the greater occipital nerve. The attacks are unilateral, with sudden and severe pain prescribed as sharp, twisting or lancing. The attacks may occur spontaneously but can be provoked by specific maneuvers applied to the back of the scalp or neck regions. Acute continuous occipital neuralgia attacks can last for many hours, with duration of up to 2 weeks before remission. This type is not usually associated with radiating facial symptoms. In chronic continuous occipital neuralgia, the attacks are accompanied by localized muscle spasms. The pain is described as steady, sharp or aching, with referred pain into facial areas, especially above and behind the orbit. Unilateral pain is more common, but it can also be bilateral. Scalp tenderness is common. Pain may be increased or be provoked with postures that occur in reading or sleeping positions or with hyperextension or rotation of the head to the involved side. Physical findings include pain with palpation of the occipital nerves. Occasionally, there is hyperesthesia or allodynia in the distribution of the occipital nerve. Local muscle spasm is frequently found with palpable trigger points and taut bands. Cervical range of motion may be restricted, and neurological exams are typically normal. An anesthetic block given at the site of maximal tenderness or at the site of the occipital groove confirms the diagnosis of occipital neuralgia if

there is pain relief. Treatment may include massage, rest, muscle relaxants, nerve blocks, or injection of steroids directly into the affected area.

The IHS considers the diagnostic criteria for occipital neuralgia as follows:

- Paroxysmal, stabbing pain, with or without persistent aching between paroxysms, in the distribution of the greater, lesser, and/or third occipital nerves.
- Tenderness over the affected nerve.
- Pain eased temporarily by local anesthetic block of the nerve.

Secondary Headache Disorder
Cervicogenic Headache
Cervicogenic headache is a headache that is secondary to a disorder of the cervical spine. The pain may be referred from facet joints, intervertebral discs, or soft tissue. The pain is constant and may be aggravated by movements of the neck or pressure to certain areas on the neck. The first three cervical spinal nerves can refer pain to the head. The C1 suboccipital nerve innervates the atlanto-occipital joint; the C2 spinal nerve and the C3 dorsal ramus have close proximity to and innervate the C2-C3 facet joint. The C2-3 facet joint is the most frequent source of a cervicogenic headache. A diagnosis of a cervicogenic headache may be confirmed by an anesthetic block of the lateral atlanto-axial joint, the C2-3 facet joint, or the C3-4 facet joint.

Cervicogenic headache and occipital neuralgia are syndromes whose diagnosis and treatment have been reported as controversial in the medical literature due to lack of expert consensus regarding their etiology and treatment. The terminology refers to specific types of headache thought to arise from impingement or entrapment of the occipital nerves and/or the upper spinal vertebrae. Compression and injury of the occipital nerves within the muscles of the neck and compression of the second and third cervical nerve roots are generally thought to be responsible for the symptoms including unilateral and occasionally bilateral head, neck, and arm pain. The convergence of the afferents of the upper 3 cervical spinal nerves is thought to be responsible for this head pain that arises from the neck.

Generally accepted causes of head pain originating in the neck include:

- Developmental abnormalities, tumors, ankylosing spondylitis, rheumatoid arthritis, and osteomyelitis.

Controversial causes include:

- Cervical disc herniation, degenerative disc disease, and whiplash injuries.

The prevalence of cervicogenic headache in the general population is about 2.2% and is 4 times more prevalent in women. The clinical features of cervicogenic headache may mimic those associated with primary headache disorders, such as tension-type headache, migraine, or hemicrania continua, so it may be difficult to distinguish among headache types. Cervicogenic headache is characterized by continuous, unilateral head pain radiating from the occipital areas to the frontal area, with associated neck pain and ipsilateral shoulder or arm pain. The headache is non-throbbing and of moderate intensity. It is described as a dull, boring, dragging pain that can fluctuate in intensity. The headache may last from a few hours to several days and, in some cases, for several weeks. The pain is exacerbated by neck movements and is usually caused by

neck trauma. Associated symptoms, such as nausea, photophobia, phonophobia, dizziness, blurred vision, and dysphagia may be present, but are generally not pronounced.

The IHS considers the diagnostic criteria for cervicogenic headache as follows:

- Pain referred from a source in the neck and perceived in one or more regions of the head and/or face.
- Clinical, laboratory and/or imaging evidence of a disorder or lesion within the cervical spine or soft tissues of the neck, generally accepted as a valid cause of headache.
- Evidence that the pain can be attributed to the neck disorder or lesion, based on either clinical signs that implicate a source of pain in the neck or abolition of headache following diagnostic nerve block.
- Pain resolving within three months after successful treatment of causative disorder or lesion.

Sjaastad et al identified another type of CGH with bilateral head and neck pain, aggravated by neck positions and specific occupations such as: hair-dressing, carpentry, and truck/tractor driving. The neck pain precedes or co-exists with the headache, and is aggravated by specific neck movements or sustained postures.

In 2011, Vincent et al described several factors to differentiate CGHs, including:

•Unilateral pain with a facet 'lock' irradiating from the back of the head
•Evidence of cervical dysfunction presenting during manual examination
•May occur with trigger point palpation in the head or neck
•Aggravated by sustained neck positions
•Normal imaging

Because the diagnosis of CGH is relatively new, its particular etiology remains unclear. Treatment of cervicogenic headache (CGH) includes nerve blocks, physical therapy, and exercise.

KEY POINTS:

The most recent literature update was performed through November 4, 2019.

Summary of Evidence

For individuals who have chronic migraine who receive sphenopalatine ganglion blocks, the evidence includes 1 RCT and a case report. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The RCT was double-blind and placebo controlled, and provided a course of 12 SPG blocks over 6 weeks. It found significantly greater short-term (up to 24 hours) benefits of active treatment versus placebo. There were not significant longer-term effects (i.e., 1 and 6 months after a course of 12 treatments). The study was underpowered to detect longer term efficacy. Additional adequately powered RCTs demonstrating efficacy are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have severe acute headache treated in an emergency setting who receive sphenopalatine ganglion blocks, the evidence includes 1 RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The RCT was double-blind and placebo controlled, and provided a single SPG block. There was not a statistically significant difference between active treatment and placebo in the primary outcome, pain reduction 15 minutes post-intervention. The study did not collect pain data again while patients were in the emergency department (e.g., at 1 hour after treatment). At 24 hours after treatment, significantly more patients were headache-free in the active treatment versus placebo group. However, there is insufficient evidence that SPG blocks are an effective treatment in the emergency setting. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have cluster headache who receive sphenopalatine ganglion blocks, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Two small case series were available; the approach to intranasal SPG blocks differed from the intervention currently available in the United States. It is not clear how the safety or efficacy of the procedure used in the case series differs from an intranasal SPG block applying local anesthetics and using an FDA cleared device. In the series, 40-50% of patients experienced complete symptom relief for a variable length of time and about 20% had treatment-related complications. Additional studies, preferably RCTs are needed to evaluate SPG blocks for treating cluster headaches. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have occipital neuralgia or cervicogenic headache who receive RFA of peripheral nerves, the evidence includes systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. No RCTs of RFA for chronic occipital neuralgia have been identified. Three RCTs of RFA for a cervicogenic headache have been published, none of which were high quality. Pain is a subjective, patient-reported measure that is particularly susceptible to placebo effect. Randomized trials with sham or active-controls are needed to evaluate the efficacy of this treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Practice Guidelines and Position Statements
American Academy of Neurology et al
In 2013, the American Academy of Neurology and American Headache Society updated their joint practice guidelines on migraine prevention in adults; the use of biofeedback was not mentioned in the recommendations.

In 2000, the American Academy of Neurology's recommendations for the evaluation and treatment of migraine headaches stated that behavioral and physical interventions are used for preventing migraine episodes rather than for alleviating symptoms once an attack has begun. Although these modalities may be effective as monotherapy, they are more commonly used with pharmacologic management. Relaxation training, thermal biofeedback combined with relaxation training, electromyographic biofeedback, and cognitive-behavioral therapy may be considered treatment options for prevention of migraine. Specific recommendations regarding which to use for specific patients could not be made.

KEY WORDS:
Cervicogenic headache, occipital neuralgia, migraine headache, Sphenopalatine Ganglion (SPG), Sphenopalatine Ganglion Block, Tx360®, MiRx™ protocol, SpenoCath®, Allevio™, Radiofrequency Ablation (RFA), sphenopalatine ganglion pulsed radiofrequency (SPG-PRF), Pulsed Radiofrequency Ablation (PRFA), cluster headache and tension-type headache.

APPROVED BY GOVERNING BODIES:
The Tx360® Nasal Applicator (Tian Medical), the Allevio™ SPG Nerve Block Catheter (JET Medical), and the SpenoCath® (Dolor Technologies) are considered class I devices by the U.S. Food and Drug Administration (FDA) and are exempt from 510(k) requirements. This classification does not require submission of clinical data regarding efficacy but only notification of FDA prior to marketing. These 3 devices are all used to apply numbing medication intranasally.

U.S. Preventative Services Task Force Recommendations
Not applicable.

BENEFIT APPLICATION:
Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

CURRENT CODING:
CPT Codes:
There is no specific CPT for sphenopalatine ganglion block. Use the unlisted procedure codes 30999 or 64999.

The use of code 64505 would be inappropriate as the procedure is for a spray application.

30999	Unlisted procedure, nose
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; one interspace, cervical
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc,

	reexploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; cervical
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)
63050	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (list separately in addition to code for primary procedure)
63185	Laminectomy with rhizotomy; one or two segments
63190	Laminectomy with rhizotomy; more than two segments
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64405	Injection, anesthetic agent; greater occipital nerve
64450	Injection, anesthetic agent; other peripheral nerve or branch
64555	Percutaneous implantation of neurostimulator electrodes array; peripheral nerve (excludes sacral nerve)
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, intraorbital, mental,

	or inferior alveolar branch
64612	Chemo-denervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (e.g., for cervical dystonia, spasmodic torticollis)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
64716	Neuroplasty and/or transposition; cranial nerve (specify)
64722	Decompression; unspecified nerve(s) (specify)
64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)
64744	Transection or avulsion of; greater occipital nerve
64802	Sympathectomy, cervical
64804	Sympathectomy, cervicothoracic
64999	Unlisted procedure, nervous system
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g. rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e. cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

HCPCS:

E0745	Neuromuscular stimulator, electronic shock unit
J0585	Injection, Onabotulinumtoxin A, one unit
J0587	Injection, Rimabotulinumtoxin B, 100 units
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode (with any number of contact points), 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
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8695	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

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POLICY HISTORY:

Adopted for Blue Advantage, January 2008
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Medical Policy Group, August 2008
Available for comment August 28-October 12, 2008
Medical Policy Group, December 2008
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Medical Policy Group, October 2017
Medical Policy Group, December 2017
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Medical Policy Group, October 2018
Medical Policy Group, December 2018
Medical Policy Group, November 2019

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member's plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield's administration of plan contracts.