Name of Policy:
Transanal Endoscopic Microsurgery (TEMS)

Policy #: 313
Category: Surgery
Latest Review Date: October 2013
Policy Grade: B

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
**Description of Procedure or Service:**
Transanal endoscopic microsurgery (TEMS) is a minimally invasive surgical approach to local excision of rectal tumors. It has been used in benign conditions such as large rectal polyps (that cannot be removed through a colonoscope), retrorectal masses, rectal strictures, rectal fistulae, rectal pelvic abscesses, and in malignant conditions such as malignant polyps. Use of TEMS for resection of rectal cancers is more controversial. TEMS can avoid morbidity and mortality associated with major rectal surgery including fecal incontinence related to stretching of the anal sphincter.

This procedure has been available for nearly 20 years in Europe but had not been used widely in the United States. Two reasons for this slow diffusion are the steep learning curve for the procedure and the limited indications. For example, most rectal polyps can be removed endoscopically and many rectal cancers need a wide excision and are thus not amenable to local resection. TEMS involves the use of specialized equipment including an operating proctoscope, insufflation, and magnified stereoscopic views for resection of rectal tumors.

Complications specifically related to TEMS may include perforation into the peritoneal cavity and anal incontinence. TEMS is a sphincter-preserving procedure, but prolonged anal dilatation with the 40-mm rectoscope may induce sphincter function problems after surgery.

**Policy:**
**Effective for dates of service on or after October 6, 2009:**
Transanal endoscopic microsurgery (TEMS) meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for treatment of rectal adenomas, including recurrent adenomas that cannot be removed using other means of local excision.

Transanal endoscopic microsurgery (TEMS) meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for treatment of T1 rectal adenocarcinomas than cannot be removed using other means of local excision and that meet all of the following criteria:
- Located in the middle or upper part of the rectum
- Well or moderately differentiated (G1 or G2)
- Without lymphadenopathy or microscopic angiolymphatic invasion
- Less than 1/3 the circumference of the rectum

Transanal endoscopic microsurgery does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and is considered investigational for the treatment of rectal tumors that do not meet the previously listed criteria.

**Effective for dates of service prior to October 6, 2009:**
Transanal endoscopic microsurgery (TEMS) does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for treatment of rectal conditions including rectal cancers and rectal polyps and is considered investigational.
Blue Cross and Blue Shield of Alabama 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 Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate 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.

Key Points:
Transanal endoscopic microsurgery (TEM) is a minimally invasive surgical technique introduced in 1984 by Buess. It incorporates a high-quality binocular operating system and pressure-regulated insufflation with continuous suction. Compared with conventional transanal resection, TEM provides superior intraoperative visualization and the ability to perform full-thickness excision of the tumor with clear margins, together with perirectal fat and adjacent lymph nodes of tumors higher up in the rectum (4 to 18 cm from anal verge). The technique is not yet generally established because of the high cost, the necessary special instrumentation and tools, and the unusual technical aspects of the approach.

Currently, there are about 510 TEM systems in use worldwide. As expected, it is most frequently used in the United Kingdom and Europe, where approximately 110 units are present in Germany and 300 are in use in England and remaining areas of the continent. In Japan and Southeast Asia, approximately 58 units are in use. In the United States, approximately 50 systems are functional; however, usage has been slow to catch on for a variety of reasons.

Despite many years of experience using this device in Europe, comparative data are very limited. Middleton authored a systematic review of this procedure in 2005 based on published results through August 2002. Three comparative studies, including one randomized controlled trial (RCT) and 55 case series were included. The first area of study was the safety and efficacy in removal of adenomas. In the randomized controlled trial, no difference could be detected in the rate of early complications between transanal endoscopic microsurgery (10.3% of 98 patients) and direct local excision (17% of 90 patients). Transanal endoscopic microsurgery resulted in less local recurrence than direct local excision. The six percent rate of local recurrence for transanal endoscopic microsurgery in this trial is consistent with the rates found in case series of transanal endoscopic microsurgery.

The second area of study was the safety and efficacy of carcinomas. In the RCT of 53 patients, no difference could be detected in the rate of complications between transanal endoscopic microsurgery and direct local excision. No differences in survival or local recurrence rate between transanal endoscopic microsurgery and anterior resection could be detected in either the randomized controlled trial or the nonrandomized comparative study. There were two of 25 (8%) transanal endoscopic microsurgery recurrences in the RCT, but no figures were given for recurrence after anterior resection. In the case series, the median local recurrence rate for TEMS was 8.4%, ranging from 0% to 50%. The authors concluded that the evidence regarding TEMS is very limited, being largely based on a single relative small randomized controlled trial.
However, they also concluded that the transanal endoscopic microsurgery does appear to result in fewer recurrences that those with direct local excision in adenomas and thus may be a useful procedure for several small niches of patients, e.g., for large benign lesions of the middle to upper third of the rectum, for T1 low-risk rectal cancers, and for palliative use in more advanced tumors.

At the 1995 annual meeting of the American Society of Colon and Rectal Surgeons, the centers in the United States with TEM experience presented their pooled initial data. Of 153 TEM procedures, eight were converted to laparotomy because the lesion was not accessible in its entirety, and in one case, an inadvertent entry into the peritoneum necessitated a laparotomy. Approximately half of the lesions were considered beyond reach of conventional instruments. Of the 82 adenomas, mean size was 4cm. Recurrence rate following TEM was 11%, most were treated with cautery or snare excision, and repeat TEM was rarely required. Of the 54 cancers, mean size was 3cm; there were 30 T1 lesions, 15 T2, and six T3. Recurrence rate following TEM increased in relation to depth of invasion by the primary tumor; 10% for T1, 40% for T2, and 66% for T3 cancers.

Cataldo notes that complications of TEMS are rare but can be significant. Major complications rates are around 5% are reported in some series; these complications include intraperitoneal sepsis, rectovaginal fistula, and post-operative hemorrhage requiring reoperation.

**October 2009 Update**

Two comparative studies of transanal endoscopic microsurgery (TEMS) were identified on a recent literature search. Lezoche et al randomized 70 patients with T(2) N(0), G(1 to 2) rectal cancer to TEMS or laparoscopic resection (LR) via total mesorectal excision. All patients received chemoradiation prior to surgery. Median follow-up was 84 months (range, 72 to 96 months). Two local recurrences (5.7%) were observed after TEMS and one (2.8%) after LR. Distant metastases occurred in one patient in each group. The probability of survival for rectal cancer was 94% for TEMS and 94% for LR. Moore et al report on a retrospective review of patients who underwent transanal excision for rectal neoplasms and compared results for traditional transanal resection and TEMS. Of 296 patients identified, 76 were excluded because surgery was for abscess, fistulas, inflammatory bowel disease, or multiple lesions. Forty-nine patients were excluded because of incomplete or missing charts. Records of 171 patients were analyzed; 82 patients who underwent TEMS and 89 who had transanal resection (TA) were analyzed. For patients who received TEMS, those with T1 lesions without adverse histologic features (poor differentiation or lymphovascular invasion) received local excision alone. Patients with T1 lesions with adverse features or T2 lesions received postoperative chemoradiation. Local excision was performed for T3 lesions only in high-risk patients or those who refused radical resection. In the TEMS group there were 40 polyps, five carcinoma in situ, 21 T1, seven T2, eight T3, no indeterminate and one carcinoid, and in the TA group: 38 polyps, four carcinoma in situ, 20 T1, 19 T2, six T3, one indeterminate and one carcinoid. All patients treated before December 2001 received TA (seven surgeons), TEMS was performed by one surgeon. Since the introduction of TEMS, 20 TAs were performed. There were 12 (15%) postoperative complications (four major) in the TEMS group and 15 (17%) complications in the TA group (six major). In the TEMS group, 90% had negative tumor margins and none had
indeterminate margins 71% negative and 15% indeterminate in the TA patients. There were four recurrences in the TEMS group and 24 in the TA group. Local recurrence was less frequent after TEMS (2 vs 24%, P= 0.004). The difference between groups in distant recurrence was not significant. Three TEMS patients with malignant lesions underwent radical resection and were excluded from recurrence analyses. The recurrence rate among cancer patients was not statistically different from between groups. For patients with adenomas, the overall recurrence rate after TEMS was 3% versus 32% for TA. In patients with polyps, clear margins were achieved more frequently after TEMS (83%) than after TA (61%).

Doornebosch et al, in a systematic review, discuss weaknesses in the available evidence and still unanswered questions about the role of TEMS. They post three questions: “First, is there enough evidence to propagate local excision (LE) as a curative option in selected (T1) rectal carcinomas? Second, if LE is justified, which technique should be the method of choice? Third, can we adequately identify, pre-and postoperatively, tumors suitable for LE?” They note that selection bias in studies complicates answering the first question; and a significant portion of tumors recurred in all studies using various techniques for local excision (including TEMS), although it seemed not to influence survival rates. The authors note that the published case series reporting outcomes after TEMS for T1 rectal carcinomas utilized inclusion criteria that are not always clear and use of salvage procedures may introduce bias. TEMS was demonstrated to be a safe procedure in all series; complications rates vary between 5% and 26%, and complications were generally minor. Local recurrence rates for TEMS varied between 4% and 33% in the studies reviewed. Regarding the third question, the authors wonder if high recurrence rates can be improved by better tumor selection. The authors note that based largely on retrospective case series, TEMS has been incorporated in the surgical armamentarium. They also note that despite the lack of Level I evidence, its use seems justified in well-selected T1 rectal cancers. Some might view TEMS as an alternative for those with T1 lesion who are currently undergoing other methods of local excision such as local excision according to Parks, instead of radical surgery, for their T1 lesions.

The Blue Cross Association requested clinical input through Physician Specialty Societies and Academic Medical Centers. In response to their requests, input was received through two Academic Medical Centers while this policy was under review. While the various Physician Specialty Societies and Academic Medical Centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the Physician Specialty Societies or Academic Medical Centers, unless otherwise noted. Those providing input supported the policy statements as adopted in October 2009. One of the reviewers had specific comments that this technique should be limited to selected T1 rectal cancers.

In summary, based on review of the published data and clinical input, there is sufficient evidence to conclude that transanal endoscopic microsurgery (TEMS) is a safe and effective (low recurrence rates) procedure for excision of rectal adenomas that cannot be removed by traditional local approaches such as endoscopic removal. Similarly, based on review of the literature and clinical input, use of TEMS may be considered medically necessary in selected, low-risk T1 rectal cancers. These T1 cancers are those that are located in the middle or upper part of the rectum, are well or moderately differentiated (G1 or G2), there is no lymphadenopathy or
microscopic angiolymphatic invasion, and less than 1/3 the circumference of the rectum is involved. Thus, these applications may be considered medically necessary.

The data on use of TEMS in other rectal cancers are much more limited. There are still important questions about selection of other lesions for local excision. Thus, use of TEMS for rectal cancers that do not meet the criteria noted above, including T2 lesions, is considered investigational because the impact on net health outcome is uncertain.

Guidelines and Positions Statements
The National comprehensive Cancer Network (NCCN) guideline on treatment of rectal cancer states that when criteria for transanal resection are met, transanal endoscopic microsurgery can be used when the tumor can be adequately identified in the rectum. The guideline is based on level 2A evidence for T1 tumors and level 2B evidence for T2 tumors.

November 2010 Update
During the 2010 review, a number of articles were identified that begin to raise questions about disease recurrence following TEMS for T1 rectal cancer. In one of these studies, Doornebosch reported on treatment of recurrence following TEMS T1 rectal cancer. In that series of 88 patients, 18 (20.5%) patients had a local recurrence. Of those, 16 patients had salvage surgery. At three-year follow-up, overall survival was 31% and cancer-related survival was 58%. The authors concluded that further tailoring patient and tumor selection prior to a decision for local excision may improve survival.

In an editorial accompanying this study, Friel comments on issues concerning the use of local excision in the treatment of T1 rectal lesions. Friel notes that the reported recurrence rate should raise concerns and calls for additional studies of recurrence with local excision to verify the Doornebosch study. Friel also notes that local excision must still be considered as an oncologic compromise between lower surgical morbidity but higher disease recurrence, and that once fully informed, patients may find this compromise acceptable.

April 2012 Update
In 2011, Wu and colleagues published a meta-analysis on TEMS and conventional surgery for T1 rectal cancers. Five studies were included in the analysis including one prospective RCT and four retrospective, nonrandomized studies for a total of 397 (216 TEMS and 181 conventional rectal surgery) patients. Combined analyses were performed for mortality, postoperative complications, recurrence rate, and five-year survival. No deaths were reported from either procedure, and TEMS resulted in fewer postoperative complications than conventional surgery (16/196 vs. 77/163). On combined analysis the odds ratio (OR) for complications was 0.10 (95% CI: 0.05 to 0.18). There was a higher rate of local recurrence or distant metastasis at 40-months’ follow-up for the TEMS group versus conventional radical surgery (CRS (12% [26 of 216] vs. 0.5% [1 of 181]). On the combined analysis the odds ratio for recurrence in the CRS group was 8.64 (95% CI: 2.63 to 28.39). The five-year survival (not specified as disease specific or overall), as reported in four studies, was not significantly different between groups at 80.1% (157 of 196) in TEMS patients and 81% (132 of 163) in conventional surgery patients. These results support the conclusion that TEMS is associated
with less early complications but a higher rate of recurrence compared to standard resection, with no demonstrable differences in overall survival.

Sgourakis et al, in 2011, conducted a meta-analysis of T1 and T2 rectal cancer treatment with TEMS compared to standard resection and transanal excision (TAE). Eleven studies were included in the analysis and included three randomized controlled, one prospective, and 7 retrospective studies for a total of 1,191 (514 TEMS, 291 standard resection, and 386 TAE) patients. Numerous combined analyses were performed for measures of mortality, complications and recurrence rates. For postoperative complication rates, combined analysis showed a significantly lower rate of major complications for TEMS versus standard resection (OR: 0.24, 95% CI: 0.07 to 0.91). Minor complications were not significantly different between these groups. Overall postoperative complications were not significantly different between TEM versus TAE when T1 and T2 tumor data were pooled. Follow-up for all of the studies was a mean/median of more than 30 months (except for follow-up of more than 20 months in one treatment arm in two studies). For T1 tumors, local recurrence was significantly higher for the TEMS versus the standard resection group (OR: 4.92, 95% CI: 1.81 to 13.41), as was overall recurrence (odds ratio: 2.03, 95% CI: 1.15 to 3.57). Distant metastasis (OR: 1.05, 95% CI: 0.47 to 2.39) and overall survival (OR: 1.14, 95% CI: 0.55 to 2.34) were not significantly different between groups. Results were similar when data were analyzed with T1 and T2 tumors, except that disease-free survival was significantly greater with TEMS versus TAE. There was less evidence available for T2 tumors, and conclusions for that group of patients were less clear. The results of this review also support the conclusions that TEMS is associated with less postoperative complications compared with standard resection, a higher local and distant recurrence rate, and no difference in long-term overall survival.

March 2013 Update

Rectal Adenomas and Benign Rectal Conditions

In 2011, Barendse and colleagues reported on a systematic review to compare transanal endoscopic microsurgery (TEMS) to endoscopic mucosal resection (EMR) for rectal adenomas larger than 2cm. Included in the review were 48 TEMS and 20 EMR studies; all were treated as single-arm studies. No controlled trials were identified that compared TEMS to EMR directly. Early adenoma recurrence rates, within three months of the procedure, were 5.4% (95% confidence interval [CI]: 4.0-7.3) with TEMS versus 11.2% (95% CI: 6.0–19.9) with EMR (p=0.04) in pooled estimates. After three months, late adenoma recurrence rates in pooled estimates were 3.0% (95% CI: 1.3-6.9) with TEMS versus 1.5% (95% CI: 0.6-3.9) for EMR (p=0.29). Lengths of hospitalization and readmission rates were not significantly different between procedures. For TEMS, there was a mean hospitalization of 4.4 days versus 2.2 days for EMR (p=0.23). Hospital readmission rates were 4.2% for TEMS versus 3.5% for EMR (p=0.64). Complication rates after TEMS, for rectal adenomas only, were 13.0% (95% CI: 9.8-17.0) versus 3.8% (95% CI: 2.8-5.3) after EMR, for colorectal adenomas (p<0.001). Postoperative complications were found to increase significantly in studies with larger polyp size (p=0.04). However, postoperative complication rates remained higher in TEMS after adjusting for a larger mean polyp size in the TEMS studies (8.7% [95 %CI: 5.8–12.7]) than in EMR (4.2% [95 % CI: 2.9–6.3; p=0.007]). These results suggest that TEMS may be associated with less early recurrence compared to EMR but late recurrence (after three months) may not be significantly different between procedures. Complications in these studies were significantly higher with
TEMS for rectal adenomas larger than 2cm. This systematic review is limited by the low quality of the available studies, in particular the reliance on single-arm studies to compare the two techniques.

Rectal Adenocarcinomas
In 2012, E. Lezoche et al published an additional report of a similar RCT of 100 patients with T2 rectal cancers without evidence of lymph node or distant metastasis randomized to receive either TEMS or laparoscopic total mesorectal excision. All patients received neoadjuvant chemoradiation prior to surgery. All patients in the TEMS group were able to complete the procedure. However, with laparoscopic resection, five patients (10%) required conversion to open surgery (p=0.028), and 23 patients required a stoma. Postoperative complications were not significantly different between groups. Disease-free survival was also not significantly different between groups (p=0.686) after a median follow-up of 9.6 years (range 4.7-12.3 years for the laparoscopic resection group and 5.5-12.4 for the TEMS group). Local recurrence or metastases occurred in six TEMS patients and five laparoscopic patients. Overlap of patients from the 2008 and 2012 studies cannot be determined.

Summary
Transanal endoscopic microsurgery (TEMS) is a minimally invasive surgical approach for local excision (LE) of rectal lesions that cannot be directly visualized. It is an alternative to open or laparoscopic excision, and has been studied in the treatment of both benign and malignant conditions of the rectum.

In summary, based on review of the published data and clinical input, there is sufficient evidence to conclude that transanal endoscopic microsurgery (TEMS) is a safe and effective (low recurrence rates) procedure for excision of rectal adenomas that cannot be removed by traditional local approaches such as endoscopic removal.

For stage T1 rectal cancer, the evidence supports the conclusions that TEMS is associated with less postoperative complications but a higher local recurrence rate and possibly a higher rate of metastatic disease. There is no demonstrated difference in long-term overall survival in the available studies. Based on this evidence and clinical input, use of TEMS may be considered medically necessary in selected, low-risk T1 rectal cancers. These clinical-stage T1 cancers are those that are located in the middle or upper part of the rectum, are well or moderately differentiated (G1 or G2) by biopsy, without lymphadenopathy, and involving less than one-third of the circumference of the rectum. While additional follow-up studies are being completed, it is important that patients with T1 rectal cancer be fully informed of the tradeoffs (risks and benefits) with this procedure.

The data on use of TEMS in other rectal cancers are much more limited. There are still important questions about selection of other cancers for local excision. In comparison to more extensive resection, TEMS may have reduced adverse effects of fecal and bladder incontinence, but the overall effect on health outcomes is uncertain.
Practice Guidelines and Position Statements
The National Comprehensive Cancer Network (NCCN) guideline on treatment of rectal cancer states that, when criteria for transanal resection are met, transanal endoscopic microsurgery can be used when the tumor can be adequately identified in the rectum. It further states that TEMS for more proximal lesions (greater than 8cm from anal verge) may be technically feasible. The guideline is based on level 2A evidence.

The National Cancer Institute states that the surgical approach to treatment varies according to location, stage, and presence or absence of high-risk features (i.e., positive margins, lymphovascular invasion, perineural invasion, and poorly differentiated histology) and may include transanal local excision and transanal endoscopic microsurgery for select clinical staged T1/T2N0 rectal cancers.

The American Society of colon and Rectal Surgeons has published practice parameters for the management of rectal cancer. The guidelines state that curative local excision is an appropriate treatment modality for carefully selected well to moderately differentiated T1 rectal cancers. Tumor size must be less than 3cm in diameter and less than one third of the bowel lumen circumference. Additionally, patients must have lymphovascular or perineural invasion. The guidelines note visualization with transanal endoscopic microsurgery appears to be superior to the transanal approach, but randomized controlled trials on the issue are lacking. T2 lesions should be treated with radical mesenteric excision unless the patient is a poor candidate for a more extensive surgical procedure.

The American College of Radiology (ACR) has issued appropriateness criteria on local excision of early-stage rectal cancer. The ACR notes TEMS is an appropriate operative procedure for locally complete excision of distal rectal lesions and has been “evaluated for curative treatment of invasive cancer.” TEMS is noted to have “been shown to be as effective, and possibly better than, conventional transanal excision” and is considered safe after treatment with chemoradiation. These ACR guidelines are based on expert consensus and analysis of current literature.

Key Words:
Transanal endoscopic microsurgery, TEMS, TEM

Approved by Governing Bodies:
The Transanal Endoscopic Microsurgery (TEM) Combination System and Instrument Set (Richard Wolf Medical Instruments Corp) received 510(k) marketing from the US Food and Drug Administration in March 2001. The FDA determined that this device was substantially equivalent to existing devices for use in inflating the rectal cavity, endoscopically visualizing the surgical site, and accommodating up to three surgical instruments.

The Covidien SILS Port subsequently received 510(k) approval in 2011. The SILS Port is a similar instrument that can be used for rectal procedures including TEMS.
**Benefit Application:**
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
FEP contracts: FEP does not consider investigational if FDA approved. Will be reviewed for medical necessity.

**Coding:**
CPT Codes: 0184T Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full thickness)

**References:**
11. Lezoche G, Baldarelli M, Guerrieri M, et al. A prospective randomized study with a 5-year minimum follow-up evaluation of transanal endoscopic microsurgery versus laparoscopic...


19. Papagrigoriadis S. Transanal endoscopic micro-surgery (TEMS) for the management of large or sessile rectal adenoma: a review of the technique and indications. International Seminars in Surgical Oncology 2006;3(13).


Policy History:
Medical Policy Group, December 2007 (2)
Medical Policy Administration Committee, January 2008
Available for comment January 5-February 20, 2008
Medical Policy Group, November 2009 (1)
Medical Policy Administration Committee, November 2009
Available for comment November 6-December 21, 2009
Medical Policy Group, November 2010 (1): Key Points, Approved by Governing Bodies
updated, Verbiage update for coding update to 0184T, Reference Update.
Medical Policy Group, April 2012 (4): Updated Keypoints, Approved Govering Bodies and References.
Medical Policy Panel, November 2013
Medical Policy Panel, September 2013

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.