BLUE REVIEW℠

For Providers

JULY 2024

CLAIMS & ELIGIBILITY

New Coupe Health Plan: Update Your Member Records

Starting in October 2024, providers in the commercial Blue Choice PPO℠ and Blue High Performance Network® may see members of our new Coupe Health benefit plan. This plan streamlines the payment process for your office and our Coupe Health members.

Coupe Health is a copay-only plan, and members pay no deductibles or coinsurance. **You won't collect any copay from Coupe Health plan members.** Instead, Blue Cross and Blue Shield of Texas will reimburse you directly for the full allowed amount, including the member share. For reimbursement, follow the billing instructions on the member's ID card.

Check ID Cards to Identify Coupe Health Members

As with all our members, it's important to ask to see the member ID card before all appointments, and to check eligibility and benefits. **Update your records if member ID numbers have changed.** Use Availity® Essentials or a preferred vendor to check membership, coverage and prior authorization requirements, and to confirm that you are in-network for the member's policy. Emergency services are covered at the in-network benefit level.

If you have questions, call the customer service number on the member's ID card.

Prime Therapeutics Drug Claims Processed in Error Without Required Prior Authorization

A system error resulted in some Blue Cross and Blue Shield of Texas members, with **Prime Therapeutics LLC** as their pharmacy benefit manager, receiving paid claims without following the necessary prior authorization steps. The error has been fixed and letters are being sent to members whose benefits require them to go through the **Prime PA** process. Affected members may now need prior authorization approval for continued coverage of their drug.

Impacted Prime PA programs are:

- Acute Migraine
- GLP-1 Agonists
- Topiramate ER
- Winlevi

Next steps: Please submit the **Prime PA** request for your patient. Visit the Prior Authorization/Step Therapy Programs section for both forms and more information. The prior authorization program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for PA by reviewing U.S. Food and Drug Administration approved labeling, scientific literature, and nationally recognized guidelines.

Important reminders: If your patients have any questions about their pharmacy benefits, please have them call the number on their member ID card. Members may also visit and log into to Blue Access for Members or MyPrime.com for a variety of online resources.

As a reminder, treatment decisions are always between you and your patients. Coverage is subject to the terms and limits of your patients' benefit plans.

Coming Soon – New Learning & Training Center in Availity® Essentials

Starting in August 2024, some of the educational resources on our Provider website are moving to a new Learning & Training Center within Availity Essentials. All instructional user guides for Availity tools and instructor-led Availity trainings will be available in this new location.

To access the Learning & Training Center: Log in to Availity and go to the Blue Cross and Blue Shield of Texas-branded **Payer Spaces – Applications.** You must be a registered Availity user to view the information in the training center. If you haven't registered yet, go to Availity and get started today at no cost. For registration help, call Availity Client Services at **1-800-282-4548**.

Our Provider Tools and Training pages will continue to include detailed overviews of online options and training topics. You'll be redirected to Availity, when applicable, to view user guides, register for training and attend upcoming training sessions.

Claim Processing Enhancements for ERS Effective Sept. 1, 2024

Effective Sept. 1, the following updates will be made related to claim processing for **Employee Retirement System of Texas** participants:

- **Cotiviti**
  - **Diagnosis Code Guideline Policy** added to identify multiple scenarios where a diagnosis submitted for a procedure or service is reported in an inappropriate position on professional and/or facility claim line(s).
  - **Anatomical Modifiers** edit will focus on coding the appropriate modifier based on the area or part of the body the procedure is performed and will apply to professional claims and facility claims.
  - **Emergency Room Evaluation & Management** edits to identify miscoded facility and professional claims that were billed at high intensity levels (4 & 5).

- **MultiPlan out-of-area or out-of-network rate negotiations**
  - We will negotiate charges for covered health care services from out-of-network health care providers to reduce the amount a participant may be liable for and/or help protect participants from balance billing.

For additional information, contact your Blue Cross and Blue Shield of Texas Network Management office.

Electronic Claim Review and Ensuring the Correct Use of our Claim Review Form

Electronic claim review through Availity Essentials is fast and easy and is the preferred method of submission.

If you're unable to submit electronically, you can submit by paper, using our Claim Review Form, Blue Cross and Blue Shield of Texas must have all the information requested to complete a proper claim review. **Effective August 1, 2024, we'll return any incomplete form without conducting the claim review.**

Here are some **helpful tips** when submitting a claim review form:

- These requests are only to be used for **review of a previously adjudicated claim**.
- Don't attach the original claims to a review form, rather, you'll reference the claim number in the appropriate field on the form
- Don't use this form to submit a corrected claim, instead, use our Corrected Claim Form
- Don't use this form to respond to an additional information request. Use the Additional Information Form.
- If you submit this form as a request for a second review, you must provide information not previously submitted for the review to be eligible.

Reminder: Electronic submission is your fastest path to an efficient claim review at Availity® Essentials. Be sure to provide all required information as we won't review electronic inquiries received with incomplete information.

Submit a Claim Review Online, Fast
To submit an online claim review request via Availity Essentials:

- First, perform a **Claim Status** search utilizing the Member or Claim tab;
- Second, use the **Dispute Claim** or **Message This Payer** option to request a claim review;
- Third, complete all needed information.

More information: Learn more at our Claim Filing Tips web page.

ClaimsXten™ Quarterly Update Effective Aug. 19, 2024

Blue Cross and Blue Shield of Texas will implement its third quarter code updates for the ClaimsXten auditing tool on or after Aug. 19, 2024.

These quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology (CPT®) codes
- Healthcare Common Procedure Coding System (HCPCS) codes

When applicable, BCBSTX may also post advance notice of significant changes, like implementation of new rules, in the News and Updates section of our Provider website and the Blue Review monthly newsletter.

Use **Clear Claim Connection™ (C3)** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind our code-auditing software.

Please note that C3 doesn't contain all of our claim edits and processes. Its results don't guarantee the final claim decision.

For more information, refer to the Clear Claim Connection page in the Education and Reference/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

Clinical Payment and Coding Policy Updates

Our website's Clinical Payment and Coding Policies describe payment rules and methodologies for CPT, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies and does not address all reimbursement-related issues. We may add and modify clinical payment and coding policies. The following policy was added or updated:

- TXCPCP03 Surgical and Non-Surgical Services Updated, Effective 09/06/2024

EDUCATION & REFERENCE

Provider Learning Opportunities

We offer free webinars to contracted providers who service our members. These trainings focus on electronic options, and other helpful tools and resources. Review upcoming training sessions. Also, if you are a new provider or have new staff, please refer to our Provider Orientation Information.

Reminder: Update Your Demographic Information

If you've changed your location, phone number, email or other details, it's essential that you let us know so our members can locate you in our Provider Finder® tool. We suggest you periodically review yourself on Provider Finder to verify the accuracy of your information. Refer to the Verify and Update Your Information page for instructions on submitting changes.

HEALTH & WELLNESS

GLP-1 New to Therapy Optional Benefit Program Available for Select Commercial Members

As of April 1, 2024, there is a new optional pharmacy benefit program available for Administrative Services Only groups with Prime Therapeutics called **GLP-1 New to Therapy**. This new program aims to reduce the drug waste and cost of care associated with beginning GLP-1 drug therapy. It can also help members utilize the medication as intended, based on FDA labeling, until they find their maintenance dosage. GLP-1 drugs that are indicated for Type 2 Diabetes and indicated for Weight Loss/Weight Management may be included in the program.

How it works: GLP-1 New to Therapy limits an initial fill(s) to 30 days when members are new to GLP-1 drug therapy. After the initial fill(s), members may be eligible for up to a 90-day supply, per their pharmacy benefits.

- 30-day supply limit may continue to apply after the first fill if the member moves to a new dosing strength or changes to a different GLP-1 medication.
- Members may be impacted if they are new to GLP-1 therapy or have no claims history within the past 120 days.
- Members currently taking a GLP-1 drug on a maintenance dosage are not impacted.
- Drug products that can be included are: Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Saxenda, Trulicity, Victoza, Wegovy, and Zepbound. This list is subject to change.

The program categories and medications included, as well as any applicable prior authorization programs for GLP-1 and Weight Loss, would be based on the member's pharmacy benefits. Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

In-Home Test Kits for Colorectal Cancer Screening

We're providing in-home test kits this summer to certain members who, based on our data, need a colorectal cancer screening. We're working with vendors to send Fecal Immunochemical Test kits to select MyBlue Health℠ and Blue Advantage HMO℠ members at no additional charge.

As a trusted provider, you may want to **encourage our members who are your patients to take advantage of this opportunity** to learn more about their health with a FIT kit. In 2023 we provided 16,840 FIT kits to Blue Cross and Blue Shield of Texas members:

- 2,379 members returned their kits and closed this gap in their care.
- Test results were sent to the members and to their health care providers; 97 kits were abnormal or positive, meaning the sample contained blood when collected.

Why use FIT? The U.S. Preventive Services Taskforce recognizes annual FIT testing for **colorectal cancer screening starting at age 45**.

- FIT testing is appropriate screening for people with an average risk for colorectal cancer. Average risk means no family history of colorectal cancer, no personal history of inflammatory bowel disease, no previous polyps and no previous colorectal cancer.
- When compared to stool DNA tests, FIT kits have fewer false positives, which reduces unnecessary colonoscopies, according to the National Cancer Institute. Unlike stool DNA tests like Cologuard®, FIT kits require only a swab rather than a stool sample.

How In-Home Testing Works

The in-home testing process is quick and easy for members:

- ·Vendors send the kits to a sample of eligible members who have a gap in care for colorectal cancer screening. Completing the kit is voluntary.
- ·Members may take medications according to their normal schedule.
- Members complete the test kit at home, provide the name of their health care provider, if available, and **mail the test for processing to the vendor by Dec. 31, 2024**. An addressed, postage-paid envelope is included with the kit.
- The vendor sends results to the member and to their provider in three to four weeks.

How You Can Help

- Consider discussing the importance of colorectal cancer screening and healthy lifestyle choices with your patients. If one of your patients receives a kit and calls your office with questions, **discuss their screening options**.
- Document any test results in your patient's medical record and discuss the results with your patient.
- Texas resources include the Cancer Prevention & Research Institute of Texas, which is striving to reduce cancer incidence, morbidity, and mortality.

Encourage Routine Vaccines and Well-Care Visits for Children and Teens

The CDC recommends doctors and health care professionals encourage families to schedule vaccines and visits for their children. Check out our Children's Wellness Guidelines for a routine immunization schedule. Read more.

NETWORK PARTICIPATION

Provider Rights and Responsibilities

As a participating provider in our provider networks, you have certain rights and responsibilities that may affect your practice. Some of these are noted below. We publish this information for providers annually.

Your Credentialing Rights

If you're applying or reapplying to participate in our networks, you have the right to:

- Review information submitted to support your credentialing application
- Update incorrect and/or conflicting information

- Receive the status of your credentialing or recredentialing application upon request

To learn more about these rights: Visit the Credentialing page on our provider website.

Case Management Programs
You can help our members maintain or improve their health by encouraging them to participate in relevant case management programs. These may include:

- Condition management programs to support members with specific conditions like asthma or diabetes
- Complex case management services for members facing multiple or complicated medical or behavioral health conditions
- Programs to help members transition home after a hospital stay or navigate the health care system
- Wellness and prevention programs for members of all ages

Members can access applicable services for complex and condition case management by:

- Asking to enroll, or having their caregiver ask to enroll
- Referral from a primary care physician, practitioner, hospital or other discharge planner
- Referral through utilization management programs

To refer members to any case management programs: Call the number on the member's ID card. Our clinicians will collaborate with you to provide our members with available resources and additional support.

Utilization Management Decisions
It's BCBSTX's policy that licensed clinical personnel make all utilization management decisions according to the benefit coverage of a member's health plan, evidence-based medical policies and medical necessity criteria. Decisions are based on appropriateness of care and service, and existence of coverage.

BCBSTX prohibits decisions based on financial incentives. We do not reward practitioners or clinicians for issuing denials of coverage.

To obtain the criteria used for utilization management decisions: Call the number on the member's ID card. You can also refer to BCBSTX's medical policies, which are available for review online.

Learn more about Utilization Management on our provider website.

Blue Cross and Blue Shield Federal Employee Program® members: In addition to the details provided above, visit fepblue.org for more information about our FEP® members. Call 800-441-9188 for questions regarding FEP prior authorizations. For FEP expedited appeals only, the fax number is 972-766-9776.

Member Rights and Responsibilities

As a participating provider, it's important that you are aware of our members' rights and responsibilities. A summary is provided below. Additional information can be found in the members' benefit booklet and on our member website.

Member rights include the right to:

- Receive information about Blue Cross and Blue Shield of Texas, our services, participating providers and facilities, and member rights and responsibilities
- Be treated with respect and dignity with recognition of their right to privacy
- Participate with providers in making decisions about their health care
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Voice complaints or appeals about BCBSTX or the services we provide
- Make recommendations regarding our member rights and responsibilities policy

Member responsibilities include a responsibility to:

- Provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care
- Follow the plans and instructions for care that the member has agreed to with their provider
- Understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible

Blue Cross and Blue Shield Federal Employee Program® members: In addition to the details provided above, visit fepblue.org for more information about our FEP® members, including on rights and responsibilities.

To learn more about member/subscriber rights and responsibilities, see:

- Blue Choice PPO℠ and Blue High Performance Network℠ (Blue HPN℠) Provider Manual
- Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual
- Members' benefit booklet
- Member website, which has the HIPAA Notice of Privacy Practices

Texas Medicaid members: In addition to the details provided above, our Medicaid members have an expanded list of rights and responsibilities that can be found under Education and Reference on our website for Medicaid providers and also in our Medicaid STAR, CHIP and STAR Kids Provider Manual in Section 18.

STANDARDS & REQUIREMENTS

Updated PEAQ℠ Methodology Is Now Available

An updated methodology is now available for our Physician Efficiency, Appropriateness, and Quality℠ program. The methodology explains how PEAQ evaluates physician performance. It is titled PEAQ 4.0 on our PEAQ page.

What's new: We regularly evaluate PEAQ's three components (efficiency, appropriateness and quality) and refine the methodology based on new clinical data and input from practicing physicians. The updated methodology includes:

- Updated efficiency measurements
- New specialty (psychiatry)
- The Quality Practice Score, which indicates performance in certain specialties based on set measurements and indicators

How it's used: The updated methodology is the foundation for future **Physician Performance Insights** reports. PPI reports show how physicians compare to their peers and include information on improving performance. Beginning in August, Provider Finder® will include summaries of performance ratings from PPI reports to **help our members make informed care decisions**.

PPI reports are available in Availity® Essentials. If you don't yet have an Availity account, register here. For more details about PEAQ, visit our PEAQ page or email PEAQ Inquiries.

Physician Performance Insights Coming Soon from PEAQ℠

In July, physicians eligible for our Physician Efficiency, Appropriateness, and Quality Program can view their Physician Performance Insights in Availity Essentials. PPI reports show how physicians compare to their peers and include information on improving performance. Read more.

UTILIZATION MANAGEMENT

NICU Utilization Management Update Effective Sept. 1, 2024, for ERS Plans

What's changing: Effective Sept. 1, 2024, ProgenyHealth® is delegated for all neonatal intensive care unit (NICU) admissions and concurrent reviews for the Employees Retirement System of Texas (ERS) Plans. Providers have the option to notify ProgenyHealth pre-service to ensure medical necessity, level of care and other plan requirements are met prior to submitting claims.

ProgenyHealth for NICU Key Points

BCBSTX encourages providers to request Recommended Clinical Review (RCR) for all NICU admissions and concurrent reviews.

- ProgenyHealth's NICU UM program coordinates and monitors the appropriateness, cost-effectiveness and efficiency of the care being provided in the NICU while maximizing the quality of health care and services provided to the participant.
- Each family is matched with a ProgenyHealth case manager who provides support up to the first year of the newborn's life. Case managers connect with families to assess needs, optimize care and collaborate with hospital staff to support the baby's transition from the hospital to home.
- ProgenyHealth ensures continued care with the family's pediatrician by reducing unnecessary emergency department visits and unplanned readmissions and provides any additional mental or physical health needs.
- Providers are encouraged to notify ProgenyHealth directly of admissions via Sfax at **1 (855)732-8182**. ProgenyHealth's clinical staff will coordinate with providers to perform utilization management and discharge planning throughout the inpatient stay.

More information: Be sure to check eligibility and benefits through Availity® Essentials or your preferred vendor.

Watch for updates about ERS' RCR processes on the ERS Tools page and News and Updates on our provider website.

Changing Prior Authorization to Recommended Clinical Review Effective Sept. 1 for TRS Participants

What's changing: Effective Sept. 1, 2024, Blue Cross and Blue Shield of Texas will be moving prior authorization to **Recommended Clinical Review Option for outpatient services** for **Teacher Retirement System of Texas** participants as indicated below:

Outpatient Services previously requiring PA by **BCBSTX moving to RCR**: (As a reminder, inpatient services were changed to RCR effective 03/01/2024)

- Cardiology -Lipid Apheresis
- Ear, Nose and Throat
- Gastroenterology
- Neurology
- Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw)
- Pain Management
- Wound Care
- Home Health Services including but not limited to home private duty nursing (PDN), home infusion therapy (HIT)
- Home Hemodialysis
- Home Hospice
- Non-Emergent Air Ambulance
- Transplant Services, Transplant Evaluations and Transplants
- Durable Medical Equipment > $5000 applicable to medical necessity review per benefit language (less than $5000 medical necessity review not needed)
- Outpatient Physical Therapy/Occupational Therapy/Speech Therapy
- Mental Health and Substance Use Disorder Services
    - Applied Behavior Analysis
    - Electroconvulsive Therapy

    - Intensive Outpatient Treatment
    - Partial Hospitalization
    - Psychological Testing/Neuropsychological Testing
    - Repetitive Transcranial Magnetic Stimulation
- Specialty Pharmacy Medications that are covered by Medical Benefits
    - Infusion Site of Care
    - Medical Oncology & Supportive Care (through Carelon)
    - Provider Administered Drug Therapies

Carelon Medical Benefits Management will handle RCR for the following services:

- Advanced Imaging / Radiology
- Cardiology
- Molecular Genetic Lab Testing
- Musculoskeletal - Joint, Spine Surgery, Musculoskeletal - Pain
- Radiation Therapy / Radiation Oncology
- Sleep

Providers are encouraged to submit an RCR for services that previously required prior authorization to prevent post service medical necessity reviews. Refer to the RCR page for a list of applicable services.

Recommended Clinical Review Key Points

- RCR requests are optional medical necessity reviews conducted before services are provided. Submitting a request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity.
- Submitting a recommended clinical review evaluates the medical necessity of a service but does not guarantee the service will be covered under the participant's benefit plans. The terms of the participant's plan control the available benefits.
- Claims for services for which the RCR option is available will be subject to retrospective review if a provider elects not to submit a request for RCR.

For more information: Refer to the RCR page for information on RCR services and how to submit requests for services managed by BCBSTX or Carelon.

Learn more about our utilization management process, including prior authorization and recommended clinical review in the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

Utilization Management Update Including Change to Recommended Clinical Review Effective Sept. 1, 2024, for ERS Plans

What's changing: Blue Cross and Blue Shield of Texas will be making the following changes effective Sept. 1, 2024, for the Employee Retirement System of Texas (ERS) medical plans, including HealthSelect of Texas® and Consumer Directed HealthSelect℠:

- Moving all services previously requiring prior authorization, as well as other certain services needing medical necessity review, to **Recommended Clinical Review (RCR).**
    - RCR allows providers to submit requests for medical necessity review before the services are provided. RCR will replace post-service review for medical necessity when an RCR is completed. This includes concurrent reviews.
    - RCR is an optional medical necessity review conducted before services are provided. Submitting a request prior to rendering services informs you of situations where a service may not be covered based upon medical necessity or other plan rules.

- **Carelon Medical Benefits Management** will handle RCR for the following services:
    - Advanced Imaging (such as CT scan, nuclear stress test, MRI, PET scan with the exception of MRI of the breast)/cardiology imaging
    - Musculoskeletal (Joint/Spine), pain
    - Genetic/molecular testing

- Radiation (oncology) therapy for cancer
- Medical oncology specialty drugs and supportive care

Important: Medical necessity does not guarantee payment. Eligibility and other plan requirements must be met. You can access the HealthSelect of Texas and Consumer Directed HealthSelect documents at: healthselect.bcbstx.com/medical-benefits.

Coming soon: Refer to the updated ERS RCR Services List for the most current services applicable for an RCR and how to submit the requests.

Note: Providers may continue to request medical necessity review of additional services even when not included on the RCR Services List.

Effective Sept. 1, 2024, providers submitting RCR requests for services for ERS participants will have the option of submitting the request electronically via BlueApprovR℠ or the Availity® Authorization & Referrals tool.

More information: Be sure to check eligibility and benefits and confirm if a service is eligible for RCR through Availity® Essentials or your preferred vendor.

Learn more about ERS processes, including RCR on the Utilization Management section of our provider website. Follow our News and Updates page for future updates.

Contact Us

View our quick directory of contacts for BCBSTX.

Verify and Update Your Information

Verify your directory information every 90 days. Use the Provider Data Management feature on Availity® or our Demographic Change Form. You can also use this form to submit email addresses for you and your staff to receive the *Blue Review* each month.

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Material presented is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment. The fact that a service or treatment is described is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Primeto provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Change Healthcare is an independent third-party vendor that is solely responsible for the products orservices they offer.

HealthSmart RX is an independent company that has been contracted by BCBSTX on behalf of TRS to provide TRS patient support services for certain covered drugs. HealthSmart RX does not offer Blue Products or Services.

BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors

HEDIS is a registered trademark of NCQA.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificateof coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

Members should refer to their certificate of coverage for more details, including benefits, limitationsand exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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