Is Your Practice Secure?

Failure to comply with Confidentiality of Medical Records standards on an ongoing basis can pose serious risks to your practice. Your medical office compliance with the HIPAA security rule should be evaluated and reassessed on at least an annual basis.

Consider the following questions:

- **Who** will have access to confidential personal health information?
- **What** information is confidential?
  - Written?
  - Electronic?
- **Where** will confidential information be stored so that it is secure and accessible to authorized personnel only?
- **When** will periodic staff training occur to share your medical office confidentiality policies and procedures with office personnel?

Consider creating and posting a “Fact Sheet” as a quick reference for your staff. Make it a point to schedule practice “Training Scenarios” related to the use and disclosure of confidential information at staff meetings, especially when adding new staff or opening a new facility. Consider the impact of a new electronic medical record (EMR) system or an updated practice management system on the security of confidential personal health information. Security breaches can result in loss of patients, bad publicity and legal troubles. It is your practice - keep it safe.

Visit hhs.gov/ocr/hipaa for more information.
Low-Back Pain

Back pain is a common reason for emergency room visits in the United States and represents the fifth most common reason for all physician visits. Back pain is the second most common neurological ailment, affecting an estimated eight out of 10 people at some time in their lives.

Many options are available for diagnosis and management of low-back pain (LBP) and wide variations in clinical approach exist among clinicians. One of the first efforts to encourage consensus among providers was the development of a “Clinical Practice Guideline” by a panel of experts under the auspices of the U.S. Department of Health and Human Services. This guideline, released in 1994, concluded that uncomplicated acute LBP is a benign self-limiting condition for the vast majority of patients. In fact, 90 percent of patients presenting with uncomplicated low back pain, without radiculopathy, recover spontaneously in four weeks. The recommendation of the panel was that conservative treatment is appropriate in most cases of acute uncomplicated LBP.
A conservative approach is supported by more recent evidenced-based studies. In October 2007, The Annals of Internal Medicine published a joint clinical practice guideline developed by the American College of Physicians (ACP) and the American Pain Society (APS), which recommends that:

- Clinicians should conduct a focused history and physical exam to place patients in one of three categories: nonspecific LBP; back pain with radiculopathy; or, back pain associated with a specific spinal cause.

- Clinicians should not routinely obtain diagnostic imaging or testing in patients with nonspecific LBP.

- Clinicians should perform diagnostic imaging and testing for patients with severe LBP or when progressive neurologic deficits are present or serious underlying conditions are suspected.

The American College of Radiology (ACR) ‘Appropriateness Criteria’ mentions that uncomplicated acute LBP does NOT warrant the use of imaging studies.

The challenge confronting the clinician is identifying that small subset requiring a more detailed evaluation. The ACR identifies the following “red flag” findings that warrant further workup, which include:

- Recent trauma
- Unexplained weight loss or fever
- Immunosuppression
- History of cancer
- Intravenous drug use
- Prolonged use of steroids
- Osteoporosis
- Older than age 70
- Focal neurologic deficits with progressive or disabling symptoms
- Duration greater than six weeks

The focused history and physical exam, conducted by a knowledgeable clinician, remains the “gold standard” for evaluation of acute low back pain. Imaging studies are helpful tools to further assess the small percentage of “red flag” patients.

3 “Low Back Pain Fact Sheet,” NINDS. Publication Date July 2003.
6 Chou, Roger, MD
7 Bradley, WG Jr.
Magnetic resonance imaging (MRI)-guided high-intensity focused ultrasound ablation of uterine fibroids is a noninvasive procedure intended for the destruction of uterine fibroids. Using real-time magnetic resonance imaging, uterine fibroids are localized and ultrasonic beams are directed through soft tissues into the targeted fibroid, which raises the fibroid tissue temperature to 60 to 70 degrees Celsius, inducing thermal coagulation necrosis within the fibroid. The ExAblate® 2000 System (InSightec Ltd., Tirat-Carmel, Israel) has been approved by the U.S. Food and Drug Administration (FDA) for ablation of uterine fibroid tissue in symptomatic pre- or peri-menopausal women desiring a uterus sparing procedure.

The consensus of opinion among experts regarding magnetic resonance imaging-guided high-intensity focused ultrasound ablation of uterine fibroids is that to date, studies and/or clinical trials do not demonstrate this procedure to be equivalent or superior to currently accepted standard means of treatment.

Effective December 11, 2007, the Company has determined magnetic resonance imaging-guided high-intensity focused ultrasound ablation of uterine fibroids (CPT Category III Codes 0071T and 0072T) to be investigational and not eligible for reimbursement.

Please refer to the Corporate Medical Policy on our Web sites for the most current version of CMP 2007-E.

MedMutual.com
ConsumersLife.com
CarolinaCarePlan.com
**Corporate Medical Policies developed or reviewed and revised June 1 - October 31, 2007:**

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>94051</td>
<td>Pneumatic Compression Device</td>
</tr>
<tr>
<td>96018</td>
<td>Blepharoplasty, Brow Lift and Blepharoptosis Repair</td>
</tr>
<tr>
<td>200104</td>
<td>Bone Growth Stimulation: Electrical and Ultrasound</td>
</tr>
<tr>
<td>200135</td>
<td>Facial Muscle Surgery for Relief of Migraine Headache</td>
</tr>
<tr>
<td>200224</td>
<td>Sublingual Immunotherapy</td>
</tr>
<tr>
<td>200232</td>
<td>Gait Analysis</td>
</tr>
<tr>
<td>200301</td>
<td>Small Bowel, Small Bowel-Liver and Multivisceral Transplantation</td>
</tr>
<tr>
<td>2003-C</td>
<td>Electrical Stimulation for Treatment of Dysphagia</td>
</tr>
<tr>
<td>2004-B</td>
<td>Low-level Laser Therapy</td>
</tr>
<tr>
<td>2004-E</td>
<td>Fecal DNA Testing for Screening of Colorectal Cancer</td>
</tr>
<tr>
<td>200517</td>
<td>Infliximab (Remicade), Abatacept (Orencia) and Rituximab (Rituxan)</td>
</tr>
<tr>
<td>2005-B</td>
<td>Spinal Unloading Device for Low Back Pain</td>
</tr>
<tr>
<td>2005-D</td>
<td>Percutaneous Neuromodulation Therapy</td>
</tr>
<tr>
<td>2005-R</td>
<td>Transanal Radiofrequency Therapy for Fecal Incontinence</td>
</tr>
<tr>
<td>200604</td>
<td>Functional Electrical Stimulation for Rehabilitation of Paralyzed Lower Extremities</td>
</tr>
<tr>
<td>200610</td>
<td>Computed Tomography Colonography (Virtual Colonoscopy)</td>
</tr>
<tr>
<td>200611</td>
<td>Vagus Nerve Stimulation for Treatment of Depression</td>
</tr>
<tr>
<td>2006-E</td>
<td>Meniett Low-Pressure Pulse Generator for Treatment of Ménière's Disease</td>
</tr>
<tr>
<td>2006-G</td>
<td>Fluid-Ventilated Gas-Permeable Contact Lenses</td>
</tr>
<tr>
<td>200714*</td>
<td>Meniscal Allograft Transplantation</td>
</tr>
<tr>
<td>2007-E*</td>
<td>Magnetic Resonance Imaging-Guided High-Intensity Focused Ultrasound Ablation of Uterine Fibroids</td>
</tr>
</tbody>
</table>

*Indicates New Policy

**Corporate Medical Policies discontinued between November 1 - December 31, 2007:**

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-C</td>
<td>Meniscal Allograft Transplantation</td>
</tr>
</tbody>
</table>
Diabetes complications such as infection, nephropathy and coronary or peripheral vascular disease predispose diabetes patients to hospitalization. Often, inpatient management of hyperglycemia becomes of secondary importance relative to the condition responsible for the admission. However, studies have shown that there is an increased risk of morbidity and mortality if hyperglycemia is left untreated or under treated in any hospitalized patient.\(^1\) Hypoglycemia is an independent risk factor for death in the medical ICU population and merits caution when trying to achieve target blood sugar ranges in critically ill patients.

Hyperglycemia is reportedly related to immunosuppression, platelet aggregation, increased cytokine levels and inflammation, endothelial cell dysfunction and oxidative stress with increase risk of cell and tissue injury.\(^2\)

**Inpatient\(^1\)**
- Inpatient mortality rises in tandem with increasing plasma glucose levels in both newly hyperglycemic patients and those with diagnosed diabetes.
- Inpatient length of stay is longer in patients with diabetes or hyperglycemia.
- Blood glucose \(>220\) mg/dL on the first postoperative day is associated with significantly higher infection rates.

**Target Levels\(^3\)**
- The American Diabetes Association has established that blood glucose levels for patients in critical care units should be kept as close to 110 mg/dL as possible.
- In non-critically ill hospitalized patients, pre-meal blood glucose should be \(<126\) mg/dL and random blood glucose levels should be \(<180-200\) mg/dL.

**Improving Outcomes\(^3\)**
- Prominently display the diagnosis of diabetes in the medical record.
- Patients with fasting blood glucose higher than 126 mg/dL or a random blood sugar higher than 200 mg/dL should have bedside glucose monitoring and development of a treatment plan initiated.
During the perioperative period, as well as any critical care illness, a diabetic patient should have a continuous intravenous infusion of regular crystalline insulin instead of subcutaneous insulin.

- Involve appropriately trained specialists or specialty teams to manage inpatient diabetes and hyperglycemia to improve outcomes.
- Begin discharge planning at least 24 hours before expected discharge, including:
  - Establishing plans for follow-up testing and management, particularly in newly diagnosed diabetics.
  - Educate the patient and their family/caregivers regarding hypoglycemia, side effects of abnormal blood glucose levels, dietary management and drug administration.
  - Ensure adequate patient supplies.

1 Diabetes Care, Vol. 31, Supplement 1, American Diabetes Association: Clinical Practice Recommendations 2008, Standards of Medical Care in Diabetes, Pages 47-55.
3 Diabetes Care, Vol. 31, Supplement 3-4.

**Ohio’s Immunization Registry** A Link to Better Health:

In an effort to increase our immunization rates, the Company is promoting awareness of IMPACT SIIS (State Immunization Information System), a Web-based application developed by the Ohio Department of Health. This technology can link your Ohio practice to a statewide, centralized Immunization Registry that uses a confidential, computerized information system to provide one source of immunization records for patients and providers.

Using this tool, your healthcare practice will be able to:
- Track immunizations in a centralized location.
- Find patient information quickly and efficiently.
- Send immunization reminder/recall notices automatically.
- Manage vaccine inventory electronically to achieve operational efficiencies.
- Instantly produce online reports for HEDIS, schools and parents.
- Obtain automatic updates on new immunization protocols in a timely manner.

Learn more about Ohio’s Immunization Registry by visiting the impactsiis.org Web site or by calling IMPACT SIIS at 866/349-0002.
Medical Necessity Review and Prior Approval for Therapy Services

The Company has an agreement with Landmark Healthcare, Inc., a utilization review agency that assesses prior approval and medical necessity requests for physical, speech and occupational therapies, and chiropractic and osteopathic manipulation treatment for our Medical Mutual and Consumers Life members. Under this agreement, the Company retains responsibility and control of benefit coverage decisions and pays claims based on the terms of your Company provider agreement.

This process is in effect for covered persons with a benefit structure that provides an unlimited number of therapy visits with a medical necessity review requirement.

Remember, only the provider of service may seek prior approval for treatment.

Please contact Provider Inquiry using the telephone number on the back of the covered person's Medical Mutual or Consumers Life identification card to determine specific individual benefits and prior approval requirements.

Because not all benefit structures require medical necessity review, it is necessary to contact us regarding the covered person's benefits prior to requesting a review from Landmark. If the need for prior approval is confirmed, providers must submit a request form.

- For physical, occupational and speech therapies, fax authorization forms to 888/565-4225. For specific questions on the review process or a review outcome, contact Landmark Healthcare Inc. at 877/531-9139.

- For chiropractic and osteopathic manipulation treatment, fax authorization request forms to 800/599-8350. For specific questions on the review process or a review outcome, contact Landmark Healthcare Inc. at 800/638-4557.

Copies of the authorization request forms and instructions for their completion are available on the Medical Mutual and Consumers Life Web sites. Questions or requests for additional information regarding this process should be directed to your local Professional Contracting representative.
Tools Available to Reduce Inappropriate Antibiotic Use

Our Company has developed tools to help you educate your patients about appropriate antibiotic utilization.

Adult Antibiotic Brochure
Contains information about antibiotic resistance, appropriate antibiotic use and non-pharmaceutical options for treating colds and coughs in the adult population.

Pediatric Antibiotic Brochure
Contains information about antibiotic resistance, appropriate antibiotic use and non-pharmaceutical options for treating colds and coughs in the pediatric population.

Viral Infection Checklist
A tear-off checklist of treatments for your patient with a viral infection.

The increasing prevalence of antibiotic resistance in the United States is a major health concern. Recently, cases of community-associated MRSA in high school football players have been reported. These cases in individuals without established risk factors underscore the dangers of overutilization and inappropriate use of antibiotics in promoting antibiotic resistant bacteria.

To obtain copies: Visit our Web sites, call the Clinical Quality Improvement (CQI) department at 800/586-4523, or send your written request to us at:

Medical Mutual
MZ: 01-5B-7501
2060 East Ninth Street
Cleveland OH 44115-1355


Let the Right Hand Know What the Left Hand Is Doing

We annually measure how often medical information is shared between physicians when a Referring Physician requests an initial consultation from a Medical Consultant. Our goal is to have both treating physicians routinely provide the other with current and comprehensive patient information.

The rate at which Referring Physicians send the correct information to Consultants

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rate</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written information sent to Consultant prior to patient visit</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Quality of Information (if it was sent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written information included reason for referral</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Written information included a clinical summary</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The rate at which Consultants send information back to Referring Physicians

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rate</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written summary sent to Referring Physician</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Written summary sent within 30 days of consultation</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Since the slightest breakdown in communication increases the probability for medical errors, duplication of services and delays in treatment, there remains an opportunity for improvement:

- **Referring Physicians**: Send important medical information before the consultation appointment.
- **Consultants**: Send written summary to the Referring Physician as soon as possible after the consultation appointment.

Need a form for sending medical information?

Try our Physician Summary Communication Form (Z5417). You can obtain forms in one of three ways:

- **Internet**: Visit MedMutual.com. Select Providers, then Tools & Resources, Network Provider Forms and Clinical Supply Form.
- **Phone**: Call 800/586-4523.
- **Fax**: Send a request to 216/687-7787.
As a result of the Tax Relief and Health Care Act of 2006 (TRHCA), the Physician Quality Reporting Initiative (PQRI) was implemented on July 1, 2007. The PQRI was established to provide bonus payments to physicians for submitting data that includes additional details about the quality of care for covered professional services administered to Medicare beneficiaries. In December 2007, the President signed the Medicare, Medicaid and SCHIP Extension Act of 2007 (Extension Act), which included authorization to continue the PQRI in 2008.

Participating physicians can receive 1.5 percent of total allowed charges under the Medicare Fee Schedule by reporting the designated set of measures. The 2008 PQRI is based on 119 separate quality measures, including two structural measures: use of electronic health records and electronic prescribing.

Quality measures for the 2008 PQRI program are required to be endorsed or adopted by a consensus organization, such as the National Quality Forum (NQF), and are grouped into seven broad categories. Additionally, the selected measures must include those submitted by a physician specialty organization, and developed through a consensus-based process.

To participate, providers are not required to formally enroll in the PQRI. Participation occurs by reporting appropriate quality data codes on submitted claims. Bonus payments are administered if reporting thresholds are reached. Specifically, if three or less quality measures are applicable to services administered by an eligible provider, each measure must be reported in a minimum of 80 percent of instances when the service is reportable. For providers having four or greater applicable measures, the 80 percent threshold must be achieved on at least three of the measures being reported.

To learn more about the Physician Quality Reporting Initiative, including a complete list of the 2008 quality measures, reporting instructions and a provider toolkit, visit the Centers for Medicare and Medicaid Services Web site at cms.hhs.gov.

Reimbursement for Administration of Immunizations

Effective May 1, 2008, the administration of immunizations will be reimbursed as a distinct and separate service from the immunization itself.

Prior to this date, reimbursement for administration was included in the payment for the immunization. Payment for the administration of immunizations has always been made when the member’s benefit allowed, but will now be reflected as a separate line item.

Please contact your Professional Contracting representative with any questions.
Attention Deficit/Hyperactivity Disorder
Clinical Practice Guidelines

Attention Deficit Hyperactivity Disorder (ADHD) is a behavioral problem associated with inattention, impulsivity and hyperactivity. In 2006, the National Committee for Quality Assurance (NCQA) introduced a Healthcare Effectiveness Data and Information Set (HEDIS®) measure designed to help improve ADHD follow-up care. To evaluate adequacy of follow-up care, HEDIS asks health plans to measure the following annually:

- **Initiation Phase Treatment:** The percentage of our members ages 6 to 12 with a prescription for an ADHD medication who had at least one follow-up visit with a practitioner that has prescribing authority during the first 30 days of treatment.

- **Continuation and Maintenance Phase Treatment:** The percentage of our members ages 6 to 12 who remained on an ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, has at least two follow-up visits within nine months after the initiation phase has ended.

To assist our providers in the diagnosis and management of ADHD, the Company has made available the Pocketcard™ version of the American Academy of Child and Adolescent Psychiatry clinical practice guidelines. These nationally recognized guidelines provide practical information in a concise, easy-to-read format. Pocketcard versions were mailed to network providers who treat a significant volume of our members for ADHD based on analysis of 2006 and 2007 claims data. An electronic version of the guidelines is available in the provider section of our Web sites under Tools & Resources, Care Management/Clinical Quality Guidelines.

If you have any questions about any of the guidelines, please contact the Clinical Quality Improvement department at 800/586-4523.

**Formulary Update**

The following medications have been added to the Rx Selections formulary for our Medical Mutual and Consumers Life members:

<table>
<thead>
<tr>
<th>Generic</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ranibizumab</td>
<td>Lucentis™</td>
</tr>
<tr>
<td>Trastuzumab</td>
<td>Herceptin®</td>
</tr>
<tr>
<td>Lapatinib ditosylate</td>
<td>Tykerb®</td>
</tr>
<tr>
<td>Pegademase bovine</td>
<td>Adagen®</td>
</tr>
<tr>
<td>Mitoxantrone HCL</td>
<td>Novantrone®</td>
</tr>
<tr>
<td>Eculizumab</td>
<td>Soliris®</td>
</tr>
<tr>
<td>Maraviroc</td>
<td>Selzentry®</td>
</tr>
<tr>
<td>Temsirolimus</td>
<td>Torisel®</td>
</tr>
<tr>
<td>Factor VIIa, recombinant</td>
<td>Novoseven®</td>
</tr>
<tr>
<td>Desmopressin acetate</td>
<td>Stimate®</td>
</tr>
</tbody>
</table>

To download a PDF of the current Rx Selections formulary, visit medco.com/medco/corporate/home.jsp and click on Physicians, then Formulary.
Promoting preventive healthcare in men is a burden many physicians find difficult to manage, as men are less likely than women to be compliant with preventive care screenings and immunizations. Ignoring signs and symptoms may predispose men to be diagnosed with preventable diseases much later than their female counterparts, which partially accounts for the 5.2 year, shorter life expectancy of men. The average white male has a life expectancy at birth of 75.7 years and the average black male has a life expectancy of 69.8 years.¹

Women tend to be more accustomed to obtaining routine healthcare screenings because of the need for ongoing Pap tests and mammograms. Men have less regular screening needs, making it less opportune for providers to recommend preventive care screenings and immunizations to men between the ages 18 and 50.

Please reach out to your male patients between ages 18 and 50 and recommend preventive healthcare visits and screenings on a regular basis.

Recognizing Fibromyalgia

Fibromyalgia is an idiopathic, chronic, nonarticular pain syndrome defined by widespread musculoskeletal pain and multiple tender points. Other common symptoms include sleep disturbances, fatigue, headache, morning stiffness, paresthesias and anxiety. Initially called fibrositis, the name was changed to fibromyalgia when it became evident that systematic inflammation was not a critical element of this condition.

The American College of Rheumatology (ACR) 1990 criteria for the classification of fibromyalgia include presence of widespread pain for at least three months and all of the following:

- Pain on the right and left sides of the body
- Pain above and below the waist
- Pain in the axial skeleton
- Pain on palpation in at least 11 of 18 tender points (See chart at right)

Treatment options for mild cases include stress reducing lifestyle changes. For persistent and more severe symptoms, a combination of patient education, physical therapy, counseling and medications are usually recommended.

Patients may inquire about Lyrica® (pregabalin) because it is the first FDA approved agent for fibromyalgia. However, this does not always mean that it should be used first-line.

Treatment should start with low-impact exercise, cognitive-behavioral therapy and improving sleep. Treating possible depression, if present, may also help.1

Illustration of Tender Points

Other treatment options are as follows:

- Antidepressants such as amitriptyline, duloxetine and SSRIs are often used for sleep and depression.
- Gabapentin, Lyrica or analgesics can provide relief if muscle pain persists.
- Gabapentin can give modest benefits for fibromyalgia at doses of 1,200 to 2,400 mg/day.2

Lyrica might also help. Only about 28 percent of patients get a 50 percent reduction in pain with Lyrica. This efficacy may wane after weeks or months. The suggested starting dose of Lyrica is 75 mg twice daily which may be increased to 225 mg twice daily if tolerated.3 Higher doses cause more side effects without added benefit. If Lyrica is indicated for fibromyalgia, twice daily dosing is recommended.

References:
Online

For Your Information

We remain committed to supplying providers with the programs, information and support needed to ensure the health and well being of our members and the communities we serve. Access our Web sites and select the Providers tab for the following:

Tools and Resources:
- Care Management
- Credentialing
- Contact Us
- Forms
- Newsletters/Bulletins
- Manuals

Care Management:
- Clinical Quality
  - Mission
  - Quality Improvement Program Description
  - Quality Improvement Program Evaluation
  - Technology Assessment Program Description
  - Affirmation Statement
- Accessibility Standards
- Clinical Guidelines
- Discharge Planning
- Medical Necessity Criteria
- Patient Safety
- Corporate Medical Policies
- Rx Benefit Management

Credentialing:
- Clinical Credentialing:
  - Office Site and Medical Record Documentation Standards
  - Accessibility Standards
  - Sample Forms and Policies
- Network Nomination
- Credentialing Requirements
- One Stop Credentialing Application

Network Provider Forms:
- Therapy Prior Approval Forms
- Member Forms
- Cultural Competence Form
- Clinical Supply Form
  (Medical Mutual Web site only)

Newsletters/Bulletins:
- Eye on Quality Provider Newsletter
- Quality Connection Hospital Newsletter

Access this information on our Web sites, MedMutual.com, ConsumersLife.com and CarolinaCarePlan.com.
SuperWell® Disease and Maternity Management Program:

We offer the SuperWell Disease and Maternity Management Program, which provides education and support for members diagnosed with certain chronic conditions or who are currently pregnant. The program is offered at no out-of-pocket expense to eligible members. If you have members who are pregnant or diagnosed with one or more of the following conditions, please contact us to enroll your patients in the SuperWell Disease and Maternity Management Program:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes
- Coronary artery disease
- Asthma
- Chronic pain conditions
- Depression

For more information or to enroll your patient in the SuperWell Disease and Maternity Management Program, please call 800/861-4826.

These recommendations are for your information only. They are not intended to be, and should not serve as, an exclusive course of treatment or a substitute for professional medical advice, diagnosis or treatment. Decisions regarding care are subject to individual consideration and should be made by the patient in concert with treating medical personnel. The recommended services may not be covered by the member’s health insurance. Eligibility and coverage depend upon the specific terms and conditions of the applicable benefit plan.