



ROCKY MOUNTAIN

HEALTH PLANS®

Good health. That's the plan.

# GOOD HEALTH

## PROVIDER EDITION

WINTER 2004

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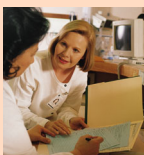
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## Welcome to your new newsletter....

Please enjoy your first issue of *Good Health, Provider Edition*. This new format combines the information you used to get in *Provider Insider*, *Quality Newslines*, and *The Capsule*. As you can see from the sidebar, information from our Professional Relations, Quality Improvement, and Pharmacy departments will be identified for easy reference. The administrative and clinical information is structured so that it can be separated to route to appropriate staff in your office.

*Good Health, Provider Edition*, will be published three times a year and promises to incorporate important clinical and administrative information for your office, facility, or business. Let us know how you like the new format by contacting your Professional Relations representative!

## The Capsule

### What to do with a COX-2

In the wake of the Vioxx withdrawal, practitioners are unclear about COX-2 inhibitors' place in therapy. It is unknown at this time whether other COX-2s share the prothrombotic potential of Vioxx. It is prudent to avoid these drugs in those at CV risk until we have sound clinical data supporting their safety.

### Who should NOT get a COX-2?

- **Patients with established CV disease.** (unopposed thromboxane could lead to thrombosis)
- **Patients with 2+ CV risk factors** (diabetes, smoking, obesity, high lipids, etc.)
- **Patients on cardioprotective ASA.** (It is well established that ASA negates COX-2 gastroprotective effect, the only reason for prescribing them.) *Since virtually all patients with CV risk factors should be on ASA, there is no place for COX-2 drugs in this population.*

### Who is an appropriate patient for a COX-2?

- **Not at CV risk, but at risk for GI bleed due to NSAID therapy.** Since COX-2s may produce fewer ulcers than nonselective NSAIDs, those at GI risk with a healthy heart may benefit.

The individual risk of having a CV event due to COX-2 therapy is small. However, the large number of patients on these drugs (20 million plus) puts many at risk (160,000 for Vioxx alone at 1.6% absolute risk).

COX-2 selectivity for some common NSAIDs: (*Ann Intern Med.* 2000;132:134-143.)

Ratio <1 indicates selectivity for COX-2.

Ketoprofen	8.16
Aspirin	3.12
Naproxen	1.79
Indomethacin	1.78
Ibuprofen	1.69
Etodolac	0.11
Celecoxib	0.11
Diclofenac	0.05
Rofecoxib	0.05

# ASTHMA GUIDELINES

## for Adults and Children Over Age Five

Revised: July 2004

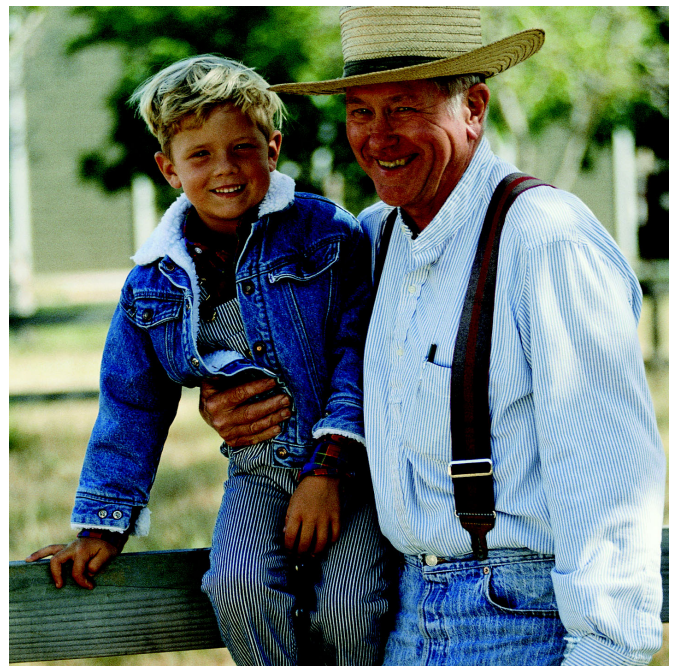
These clinical guidelines were developed by a committee comprised of physicians from the following areas: family practice, pediatrics, internal medicine, pulmonology and pediatric pulmonology, and representatives from Disease State Management, Nursing Case Management, and Pharmacy. They are based on the National Asthma Education and Preventive Program (NAEPP) Task Force guidelines published in 1997 and the NAEPP Expert Panel Report Update on Selected Topics 2002. The guidelines are provided as a general approach to the diagnosis and management of asthma in adults and children over age five, with the understanding that the care of each patient will be individualized by the physician. These guidelines are not a substitute for the physician's independent judgment.

### Measures of Assessment and Monitoring

- ▶ The diagnosis of asthma is based on the establishment of episodic airway obstruction and the reversibility of the obstruction as demonstrated by spirometry, FEV<sub>1</sub>, FVC, and FEV<sub>1</sub>/FVC before and after the administration of a short-acting bronchodilator in your office.
- ▶ Assess and classify the severity of your patient's asthma, using the table in Appendix A, at each office visit.
- ▶ As part of the initial evaluation, and at each office visit, perform a Peak Expiratory Flow measurement. Instruct the patient how to perform and monitor this measurement at home. Document this measurement on the Asthma Action Plan and in the medical record.

### Control of Factors Contributing to Asthma Severity

- ▶ It is useful for each patient with asthma to be aware of what triggers (smoke, pollutants, allergens, exercise, etc.) cause symptoms or exacerbations of asthma in his or her individual case.
- ▶ Consider an evaluation by an asthma specialist (allergist, pulmonologist, or pediatric pulmonologist) to assist in identifying such triggers, developing recommendations for avoidance of such triggers, and, when appropriate, immunotherapy.



- ▶ Provide appropriate treatment for medical conditions that cause asthma exacerbations, such as gastroesophageal reflux and sinusitis.
- ▶ Consider allergic factors in patients who concurrently have or have a past history of hay fever, perennial rhinitis, recurrent sinusitis or otitis media, eczema, or hives, and in children who experience asthmatic symptoms not associated with acute respiratory infection or exercise.

### Preferred Pharmacologic Therapy

Refer to the NIH Expert Panel Report Update on Selected Topics 2002 for complete recommendations regarding a stepwise approach for managing asthma (Appendix A-1) and usual dosages for medications (Appendix A-2).

#### Provide long-term control medication for: (Appendix B)

- ▶ Severe persistent asthma — high-dose inhaled corticosteroids **and** long-acting inhaled beta<sub>2</sub>-agonist.
- ▶ Moderate persistent asthma — low-to-medium dose inhaled corticosteroid and long-acting inhaled beta<sub>2</sub>-agonist or medium- dose inhaled corticosteroids.
- ▶ Mild persistent asthma — low-dose inhaled corticosteroid.

#### Provide a quick-relief medication for all patients.

- ▶ A short-acting inhaled beta<sub>2</sub>-agonist for the treatment of acute wheezing.

#### Leukotriene inhibitors

Leukotriene inhibitors may be used in:

- ▶ mild persistent asthma in the nonadherent patient,
- ▶ as additive therapy for moderate and severe persistent asthma, and
- ▶ aspirin induced asthma.

## Written Management Plan (Asthma Action Plan) for Patients with Moderate to Severe Asthma

- ▶ Provide a written management plan for each patient that includes instructions for daily management as well as instructions for the treatment of an acute exacerbation.
- ▶ In addition to medication directions, include instructions for when to add additional treatments, when to call the physician for advice, and when to seek emergency help.
- ▶ Patients with a history of life-threatening asthma attacks need clear instructions for obtaining emergency care.

## Education for a Partnership in Asthma Care

Base treatment on the concept of physician-guided self-management. Patients can be assisted in self-management by formal asthma education. Education may be provided by the primary care physician, the asthma specialist, or other organizations/sources.

The components of asthma education are:

- ▶ understanding the pathophysiology of asthma,
- ▶ understanding the role of triggers in causing an acute exacerbation of asthma and implementation of environmental control measures,
- ▶ measurement of peak expiratory flow,
- ▶ understanding peak expiratory flow values requiring further treatment or physician intervention,
- ▶ proper use of delivery devices (e.g., metered dose inhaler, spacers, nebulizers), and
- ▶ understanding how and when to use all medications in the treatment plan, and side effects of medications.

## Consider Consultation with an Asthma Specialist (Allergist, Pulmonologist, or Pediatric Pulmonologist) in the Following Situations:

- ▶ Patient with a life-threatening acute asthma exacerbation.
- ▶ Patient with atypical signs and symptoms or other problems in differential diagnosis.
- ▶ Patient in whom additional diagnostic testing is indicated.
- ▶ Patient not meeting treatment goals after three to six months of therapy.

- ▶ Patient with clinical entities complicating airway disease (e.g., sinusitis, polyps, vocal cord dysfunction, etc.).
- ▶ Patient needing additional resources or education.
- ▶ Patient with moderate to severe persistent asthma.
- ▶ Patient requiring continuous oral corticosteroids, or high-dose inhaled corticosteroids, or more than two bursts of oral corticosteroids per year.
- ▶ During and following hospitalization for asthma.
- ▶ Any patient who has experienced two emergency or urgent care visits for treatment of acute asthma within a 12-month period.

## Follow-Up

Re-evaluate patients with moderate to severe asthma every three to six months. Unstable patients (smoking, past history of hospitalization, history or potential of life-threatening exacerbation) may require more frequent re-evaluation irrespective of classification.

## Notes

- ▶ The most important determinant of appropriate dosing is the clinician's judgment of the patient's response to therapy. The clinician must monitor the patient's response on several clinical parameters and adjust the dose accordingly.
- ▶ The stepwise approach to therapy emphasizes that once control of asthma is achieved, the dose of medication should be carefully titrated to the minimum dose required to maintain control, thus reducing the potential for adverse effect.
- ▶ The reference point for the range in the doses for children is data on the safety of inhaled corticosteroids in children, which in general suggest that the dose ranges are equivalent to beclomethasone dipropionate 200-400 mcg/day (low dose), 400-800 mcg/day (medium dose), and >800 mcg/day (high dose).
- ▶ Some dosages may be outside package labeling.
- ▶ Metered-dose inhaler (MDI) dosages are expressed as the actuator dose (the amount of drug leaving the actuator and delivered to the patient), which is the labeling required in the United States. This is different from the dosage expressed as the valve dose (the amount of drug leaving the valve, all of which is not available to the patient), which is used in many European countries and in some of the scientific literature. Dry powder inhaler (DPI) doses (e.g., Turbuhaler) are expressed as the amount of drug in the inhaler following activation.

# Benefit Changes for the New Year



Each year, we review our existing plan designs and make changes based on feedback from our members, brokers, providers, and employees. These changes result in more comprehensive coverage for our members and, in some cases, help to keep premiums in check. The changes shown in the table do not apply to everyone — they apply to members covered through employer groups only, but do not apply to all members in all employer groups. Benefits for members should be verified by the members' plan documents or by calling RMHP Customer Service.

## These changes do not apply to Medicare, Medicaid, CHP+, PERA, or Basic and Standard Health Benefit Plans for Colorado members

Medicare members and PERA members have different changes which were mailed to the members. Please verify benefits for a member by calling RMHP Customer Service.

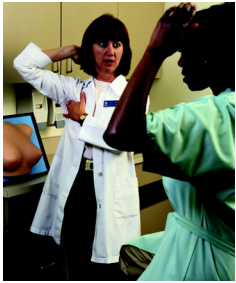
Benefit	Affected Plans	Current Benefit	2005 Benefit
Initial Prenatal Office Visit (subsequent office visits covered as a basic benefit)	C Plans	Basic Benefit	PCP office visit copay C-1, C-3, C1000, NC50 C-8, C5000 \$15 office visit copay \$20 office visit copay
Radiation Therapy	RM Direct Plans	Covered at 100% in-network, after deductible for plans with deductible	20% member coinsurance, after deductible, for plans with deductible No change out-of-network – covered as a basic benefit
Home Health	C Plans RM Direct Plans	Covered at 100% in-network, not subject to deductible for plans with deductible	C Plans – covered as a basic benefit with percentage copays RM Direct Plans – 20% member copay, after deductible, for plans with deductible No change out-of-network – covered as a basic benefit for PPO
Colorectal Cancer Screening	C Plans RM Direct Plans FITT Single Track Plans	Preventive colorectal cancer screenings covered at 100% Diagnostic colorectal cancer procedures covered with the outpatient surgery copay, after deductible for plans with deductible	All colorectal cancer screenings covered with a 20% copay, not subject to deductible for plans with deductible. Copay applies to out-of-pocket maximum. Associated services, such as anesthesia, are subject to the deductible
Cochlear Implants	C Plans RM Choice Plans (excluding Delta Chamber of Commerce) RM Direct Plans	Specifically excluded	Cochlear implants include surgery, medical equipment, and speech therapy, which will be covered as basic benefits with copays applicable to the type of service
Lab and X-ray	RM Direct Plans	In-network lab – covered in full, after deductible for plans with deductible In-network x-ray – \$50 copay, after deductible for plans with deductible	In-network lab – PCP level copay, not subject to deductible for plans with deductible. Copay does not apply to out-of-pocket maximum In-network x-ray – specialist level copay, not subject to deductible for plans with deductible. Copay does not apply to out-of-pocket maximum
Outpatient Surgery	RM Direct Plans	If member is admitted inpatient directly following an outpatient surgery, the member is responsible for both the outpatient surgery copay and the inpatient hospital copay	The in-network outpatient surgery copay is waived if member is directly admitted inpatient the same day
Mental Health	C Plans RM Direct Plans RM Choice Plans FITT Single Track Plans	Outpatient mental health office visits are covered with the specialist level copay	Non-biologically based outpatient mental health – covered with a 50% copay, not subject to deductible for plans with deductible and does not apply to out-of-pocket maximum Biologically based outpatient mental health – covered with the PCP level copay
Injectable Medication	C Plans RM Direct Plans FITT Single Track Plans	Injectables obtained at a physician's office or outpatient facility C Plans – covered as a basic benefit 20% copay after deductible for plans with deductible Copay applies to out-of-pocket maximum Injectables obtained at a retail pharmacy 20% copay up to a maximum copay of \$500 per fill Not subject to deductible for plans with deductible	Injectables obtained at a retail pharmacy and those identified on the Select Injectable List (drugs which are usually self-administered) 20% copay up to a maximum copay of \$500 per fill Not subject to deductible for plans with deductible. Copay does not apply to out-of-pocket maximum Other injectable and infusion drugs not received at a retail pharmacy C Plans – covered as a basic benefit 20% copay after deductible for plans with deductible. Copay applies to out-of-pocket maximum
Oxygen/Durable Medical Equipment	C Plans RM Direct Plans RM Choice Plans (excluding Delta Chamber of Commerce)	C Plans – maximum benefit level of \$1,500 per member per calendar year RM Direct Plans and RM Choice Plans – maximum benefit level of \$1,200 per member per calendar year	C Plans – maximum benefit level of \$2,000 per member per calendar year RM Direct Plans and RM Choice Plans – maximum benefit level of \$1,500 per member per calendar year
Out-of-network preauthorization penalty	RM Direct PPO Plans HCO Group Plans	50% coinsurance, not subject to deductible and not applying to out-of-pocket maximum for failure to obtain preauthorization for specified out-of-network services	50% coinsurance, subject to deductible and not applying to out-of-pocket maximum for failure to obtain preauthorization for specified out-of-network services
Interest	All Plans	18% annual interest rate charged on all overdue amounts owed to RMHP	24% annual interest rate charged on all overdue amounts owed to RMHP (this mainly affects HMO plan members who receive care from Western Slope providers)

# QI Study Results

The 2003 Rocky Mountain Health Plans clinical study results for childhood immunizations, cervical cancer screening, and mammography screening are summarized below. If you would like more information, please call Kathy Reimers, RN, QI Manager, at 970-248-5106 or e-mail kreimers@rmhp.org.

**(Data Source:** Retrospective claims and medical chart abstraction data)

## Mammography Screening



**Study Population Definition:** The HEDIS® sample of female RMHP members age 52 to 69 who were continuously enrolled through the measurement year (January 01 through December 31, 2003) and the year prior to the measurement year, allowing for no more than one break of up to 45 days during each year. Study includes members having at least one mammogram in either the measurement year or the previous year.

## Cervical Cancer Screening

**Study Population Definition:** The HEDIS® sample of female RMHP members age 18 to 64 who were continuously enrolled through the measurement year (January 01 through December 31, 2003) and the two years prior to the measurement year, allowing no more than one break of up to 45 days during each year. Study includes members having one or more Pap tests in either the measurement year or the two years prior to the measurement year.

## Childhood Immunizations

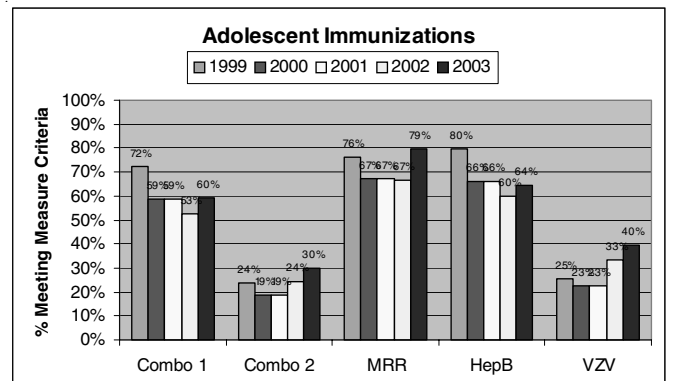
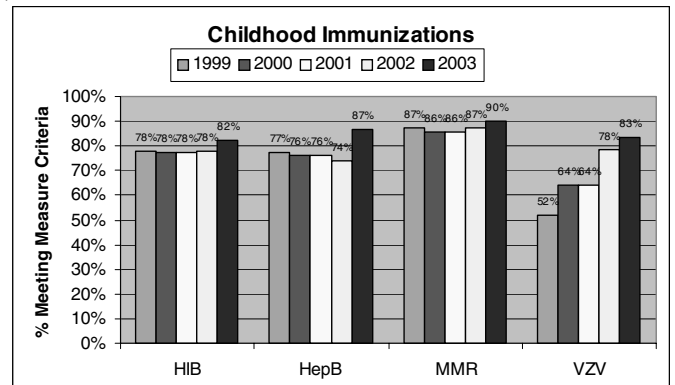
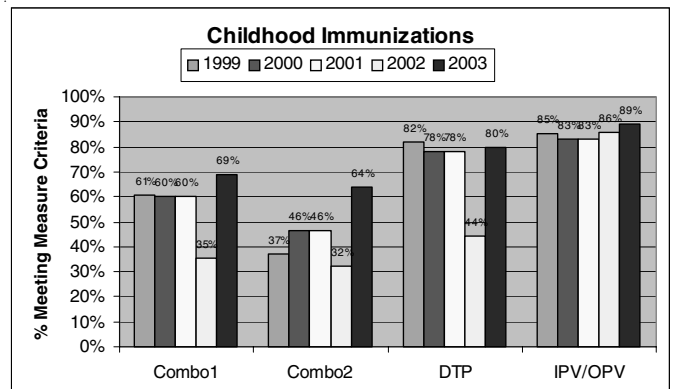
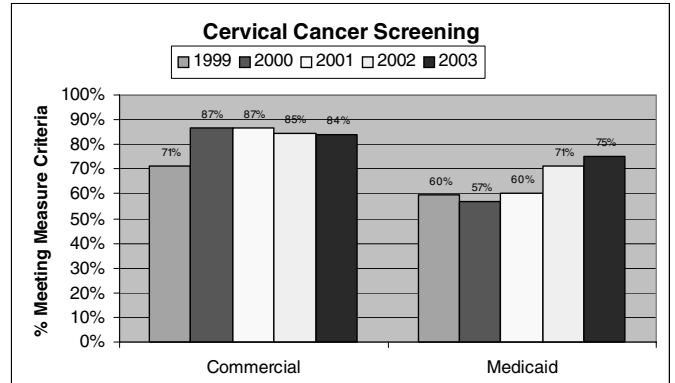
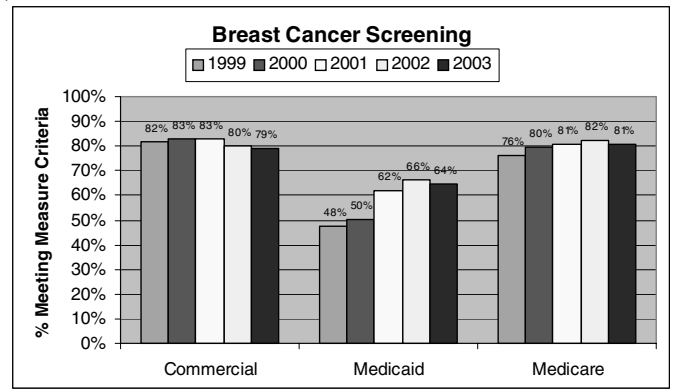
**Study Population Definition:** The HEDIS® sample of RMHP members who turned two years old during the measurement year (January 01 through December 31, 2003), who were continuously enrolled from 12 months immediately preceding their second birthday, and who have had no more than one break of up to 45 days during the 12 months immediately preceding their second birthday.

## Adolescent Immunizations

**Study Population Definition:** The HEDIS® sample of RMHP members who turned 13 years old during the measurement year (January 01 through December 31, 2003), who were continuously enrolled from 12 months immediately preceding their thirteenth birthday, and who have had no more than one break of up to 45 days during the 12 months immediately preceding their thirteenth birthday.

**Combo 1 =** 4 DTP/DTaP  
3 IPV/OPV  
1 MMR  
3 Hib  
3 Hep B

**Combo 2 =** 4 DTP/DTaP  
3 IPV/OPV  
1 MMR  
3 Hib  
3 Hep B  
1 VZV



# Network Changes in El Paso and Teller Counties

RMHP is excited and pleased to announce our expansion of products and services into Colorado Springs. We have formed an exclusive relationship with Memorial Hospital, one of the most respected health care providers in the Rocky Mountain region.

**After February 1, 2005, the Centura Health hospital facilities in Colorado Springs — Penrose St. Francis Hospital and Penrose Community Hospital — will no longer be participating providers with RMHP for members enrolled in our commercial plans (group and individual).**

The physician and ancillary components of our network have been expanded with the addition of the providers from the Memorial Hospital Medical Network. Ancillary providers and most physicians currently contracted with RMHP remain in the network.

Exceptions, as specified below:

- This change **does not affect** services at Centura hospital facilities before February 1, 2005.
- This change **does not affect** RMHP participating Centura Health hospital facilities in counties other than El Paso and Teller.
- This change **does not affect** RMHP Medicare members. Centura Health facilities in El Paso and Teller counties will continue to be participating providers for RMHP Medicare members.

Please call Customer Service at 970-248-5036 or 800-854-4558 with any questions you may have. Rocky Mountain Health Plans appreciates the opportunity to work with you in providing quality, affordable health care to Coloradans.



## Claim Action Request

Rocky Mountain Health Plans has worked in collaboration with the Colorado Medical Society, other payers, and government agencies to standardize the format and required information necessary to request a correction, reconsideration, or review of how a claim was processed.

The new Claim Action Request form on the next page may be photocopied for your immediate use. It replaces the RMHP Claims Inquiry Form. Please discard any Claims Inquiry Forms and begin use of this new standard form. In order for your request to be handled efficiently, please use one request form per member or issue. Do not attach a variety of issues on multiple members with a single request form.

1. Determine the reason the claim was not processed as you expected. The disallowed explanation codes on the Provider Remittances will aid in this process. Remember that plan policies and contractual limitations cannot be corrected.
2. Follow up with RMHP Customer Service for clarification if necessary. Sometimes a correction can be made based on your phone call alone. The telephone numbers for Customer Service are 800-854-4558 and 970-248-5036.
3. Mail the completed form to

Rocky Mountain Health Plans  
Research and Adjustment Team  
PO Box 10600  
Grand Junction, CO 81502-5600

**Please continue to use the Provider Dispute Resolution Form for submission of appeals. Use the “Attention: Claims Department” fax cover sheet to send information requested on your Claims in Process report, section one.**

For definitions of reconsiderations and appeals, please refer to the RMHP Provider Manual or call your Professional Relations representative.

Thanks to Dorien Rawlinson, Director of Front Range Provider Administration, for her participation in this project.

## Claim Action Request

-ACS (Medicaid)   
 -Aetna   
 -Anthem   
 -CIGNA   
 -Noridian (Medicare) – *I disagree with the claim determination*  
-PacifiCare   
 -Rocky Mountain Health Plans   
 -SloansLake (include payer): \_\_\_\_\_  
-UnitedHealthcare   
-Other: \_\_\_\_\_  
 Date (mm/dd/yyyy): \_\_\_\_\_

### Requestor Information

<b>Requestor Information</b>		
Provider Name:		
Provider # or TIN:		
Office or Practice Name:		
Contact Name:		Signature:
Telephone:		
Fax:		
Address:		
City:	State:	Zip:

### Claim Information

<b>Claim Information</b>	
Patient Name:	
Patient ID # or HIC*:	<i>(include prefix or suffix if applicable)</i>
Claim Number(s):	
Date(s) of Service:	
Billed Amount:	
Process Date:	

### Action Requested

**(Include a copy of the remittance notice and a corrected claim if necessary)**

<input type="checkbox"/> -Authorization/Referral #	<input type="checkbox"/> -Billed/Allowed Amount (attach copy of manufacturer's invoice)**	
<input type="checkbox"/> -COB	<input type="checkbox"/> -Date of Service	<input type="checkbox"/> -Denied as Duplicate
<input type="checkbox"/> -Diagnosis Code**	<input type="checkbox"/> -Number of Units	<input type="checkbox"/> -Patient Responsibility**/***
<input type="checkbox"/> -Place of Service	<input type="checkbox"/> -Procedure Code/Modifier**	<input type="checkbox"/> -Other**
Explain:		

\* HIC = Medicare use only

\*\* May require information that substantiates your request, i.e., statement from the physician, operative report, office notes, or supporting medical documentation, etc.

\*\*\* For Medicare, include copy of ABN

# Weiss Ratings, Inc. — America's Consumer Advocate for Financial Safety

Rocky Mountain Health Plans is pleased to report that we have received a B+ rating for our HMO line of business from Weiss Ratings, Inc. The B+ rating means that the company offers good financial security and has the resources necessary to deal with a variety of adverse conditions. The Weiss opinion also states that RMHP comfortably exceeds the minimum levels for all its rating criteria and is likely to remain healthy for the foreseeable future.

## Highlights:

- ▶ Capitalization: Excellent
- ▶ Investment Safety: Excellent
- ▶ Profitability: Excellent
- ▶ Liquidity: Good
- ▶ Stability: Good

The RMHP Utilization Management Preauthorization List effective January 1, 2005, has been distributed by mail. If you did not receive a copy, please contact the appropriate Professional Relations Department. Western Slope providers call 970-244-7798. Front Range providers call 303-689-7372.

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