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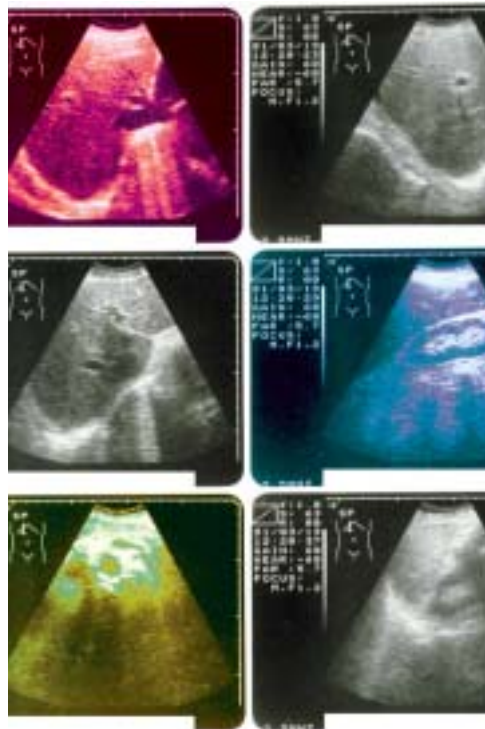
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*Inova Fairfax Hospital for Children's
NICU helps improve the quality of care
delivered to infants and their families.*

CLINICAL NEWS FOR PARTICIPATING PHYSICIANS AND PROVIDERS

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Best Practice

Inova Health System: Providing Quality Care

The following is presented in an effort to highlight hospital “best practice” around the region. CareFirst BlueCross BlueShield (CareFirst) wants to share with you the innovative ways in which Maryland, Virginia and Washington, D.C. hospitals are improving quality of care while controlling the rising cost of health care. Look for additional “best practice” features in future issues of InFocus.

Inova Health System, a not-for-profit health care organization based in Northern Virginia, consists of hospitals, emergency and urgent care centers, home care services, nursing homes, mental health services, blood donor services and wellness classes. Inova provides quality care and improves the health of surrounding communities. Inova offers a wide range of programs to meet the diverse needs of the patients that benefit from the system.

Inova hospitals are the backbone of the system because providers and other hospital staff facilitate medical, acute, surgical and critical care services in the hospitals. Although some programs are based out of a particular hospital, all Inova hospitals can use the services. Inova hospitals include:

Inova Fairfax Hospital for Children	Provides specialized care for children from birth to adolescence, including pediatric intensive care and a pediatric heart program
Inova Fairfax Hospital	Offers the full spectrum of organ transplantation (one of only six community hospitals in the nation)
Inova Alexandria Hospital	Has provided area residents with a full range of medical care and services for over 125 years
Inova Fair Oaks Hospital	Executes a full range of emergency, medical, surgical, critical, orthopedic, obstetric and pediatric care services
Inova Mount Vernon Hospital	Houses the Inova Rehabilitation Center

Inova Fairfax Hospital for Children

Neonatal Intensive Care Unit

As a member of the Vermont Oxford Network, Inova Fairfax Hospital for Children’s Neonatal Intensive Care Unit (NICU) strives to improve the quality and safety of medical care rendered to infants and their families.

The initiative, First Hour of Life Pathway, was recently recognized as a best practice by the Joint Commission on Accreditation of Health

Care Organizations. First Hour of Life Pathway helps improve the outcomes of babies born with a birth weight of less than 2 pounds, 12 ounces and defines the role of those involved in the predelivery, birth and up to one hour post delivery of underweight babies.

A plan is provided to the neonatologist, RN 1, RN 2, respiratory therapist and unit secretary involved, helping to ensure a smooth transition from the delivery room to the NICU and the procedures and tasks that must be accomplished in the first hour of life. Providers in the NICU administer surfactant to babies with Respiratory Distress Syndrome within the first 30 minutes of life, but the average time babies receive surfactant in the NICU is 25 minutes.

For more information about the NICU at Inova Fairfax Hospital for Children, call 703-204-6020.

Pediatric Neurosurgery

The Pediatric Neurosurgery Department offers services for the evaluation and treatment of cranial and spinal nerve disorders affecting infants, children and adolescents. Children with these types of birth defects have access to most of the care they need in the hospital.

For example, a child born with craniofacial abnormalities requires the services of a surgical team from different areas of the hospital, which can include doctors from the Craniofacial Program for surgery below the eyes and the Pediatric Neuroscience program for surgery above the eyes.

Children with cerebral palsy have access to doctors who, depending on the child’s need, perform surgery or implant an intrathecal Baclofen Infusion Pump to relax the child. “This procedure [of implanting the catheter] is so simple, yet so rewarding because it has such a dramatic impact on the patient’s life,” said Gary Magram, M.D., Chief of Pediatric Neurosurgery. The catheter is filled every three months.

For more information about the neuroscience capabilities of Inova Fairfax Hospital for Children, call 703-970-2600.

International Adoption Center

The living conditions and experiences in other countries can put children at risk for medical, infectious, developmental and emotional problems. Also, medical records can be unreliable or nonexistent. The International Adoption Center provides pre- and post-adoptive services to families adopting children from foreign countries.

Topics discussed at the pre-adoptive consultation include:

- Country of origin
- Growth and development
- Travel preparation
- Child's medical information, if available

Post-adoption services that are provided immediately after the adoption include:

- Developmental screenings
- Medical evaluations
- Screening for effects of institutionalization, infectious disease
- Immunizations
- Discussion of transition issues

Parenting classes that focus on the differences between adopted children born in foreign countries and those born in the United States are available for families. Yearly conferences are conducted for families and health care professionals. For more information on the center, classes and conferences, visit the International Adoption Center's Web site at www.adoptionclinic.org or call (703) 970-2651.

Inova Fairfax Hospital

Lung Transplant Program

The Inova Transplant Center established its Lung Transplant Program in 1991 and is responsible for the area's first single lung transplant (1991), first bilateral lung transplant (1996) and first heart-lung transplants (1997). The lung transplant program remains the only program in the Washington, D.C. area to offer lung transplantation and heart-lung transplantation.

"Lung transplantation is a last resort," said Medical Director Steven Nathan. "Patients are closely scrutinized before a decision is made whether they are a candidate for a transplant."

An initial consultation with the patient helps determine whether he is a candidate. The Pulmonary Hypertension and Interstitial Lung Disease Clinics are available as ancillary clinics to offer other therapies to patients who are not candidates for lung transplants. Once the decision is made to do the transplant, the patient views an educational slide show, has informative consultations with surgeons and physicians and

is put on a nationwide list for those awaiting lung transplants.

According to Dr. Nathan, nationally, 20-30 percent of patients waiting for lung transplants die in the 18-24 months they typically wait; the average wait time at Inova is only 5-6 months, enabling most listed patients to receive a transplant.

For more information, call 703-698-2748. To refer a patient, call 703-698-3281 or 800-358-8831 24 hours a day, 7 days a week.

Inova Mount Vernon Hospital

Inova Rehabilitation Center

Rehabilitation specialists at Inova's Rehabilitation Center help patients rebuild their lives by utilizing the diagnostic and treatment equipment and diverse medical specialties available in the acute care hospital. Medical and work-specific occupational rehabilitation programs are accredited by the Rehabilitation Accreditation Commission. The Center offers in- and outpatient services including:

- **General Rehabilitation Program** — inpatient program that offers individualized rehabilitation plans for people with skeletal and neuromuscular injuries, illnesses or conditions.
- **Brain Injury Program** — inpatient rehabilitation services for adolescents and adults with acquired brain injury.
- **Spinal Cord Injury Program** — inpatient rehabilitation services for adults with traumatic or non-traumatic spinal cord disorders, including contusions, fractures, tumors, myelitis and degenerative diseases like spinal stenosis.
- **Stroke Program** — inpatient rehabilitation services for adults who have experienced a stroke.
- **Bridge Program** — outpatient program for individuals recovering from acquired brain injury. Treatment provides a structured setting for renegotiating independence and community living skills following a life-changing neurological incident.
- **Outpatient Neurologic Rehab Program** — outpatient program that offers comprehensive therapeutic intervention for patients whose physical abilities have changed due to stroke, brain injury, spinal cord or neuromuscular disease.
- **Orthopedic Therapy Program** — specialty outpatient rehabilitation service for patients continuing their recovery from musculoskeletal diseases, surgery or injury.
- **Work Rehab** — specialized outpatient service for industrial and orthopedic rehabilitation of acutely injured workers, facilitating their return to work.

For more information about the programs offered at Inova's Rehabilitation Center, log on to www.inova.org or call 703-664-7597.

New and Emerging Technologies

CareFirst's Technology Assessment Committee, which includes CareFirst physicians, CareFirst nurses and consulting physicians outside of CareFirst, reviews new and developing technologies. The committee relies on current medical literature, local expert consultants and physicians to determine whether those technologies meet CareFirst's criteria for coverage. Coverage policies applicable to national Blue Cross Blue Shield accounts and Federal Employees benefits programs may differ from those at the local account level. The review criteria can be found in the *Providers & Physicians* section of www.carefirst.com by clicking on *Medical Policies*. The Technology Assessment Committee recently made the following determinations.

New Technology	Description	CareFirst Determination
<p>Laparoscopic adjustable silicone gastric banding</p>	<p>A surgery for morbid obesity that employs a restricting band around the upper portion of the stomach.</p>	<p>The procedure has a great deal of appeal to the patient because it is less invasive than the gastric bypass procedure and it can be easily removed. In clinical trials, the gastric banding allowed patients to lose excess body weight, but not as efficiently as the gastric bypass. Complications reported include gastric erosion, band slippage and port leakage. There has also been a high degree of patient dissatisfaction with the results. The data currently available would indicate that the technology does not meet criterion #4, as laparoscopic banding does not appear to be as effective for weight loss as the more widely accepted gastric bypass. The rate of complications (criterion #3) continues to be high for this type of procedure.</p> <p>CareFirst considers this surgery investigational.</p>
<p>Monochromatic infrared therapy (MIRE) for diabetic neuropathy</p>	<p>This cold laser treatment is advancing as a means of improving sensory loss in the diabetic foot. The device consists of an array of light-emitting diodes that can attach to an extremity, particularly the foot, to render 30 minute treatments. The wavelength of light used reportedly does not produce a warm sensation.</p>	<p>Evidence to support this treatment is extremely rare. Only one study involving a small, uncontrolled case series involving 49 patients with diabetic neuropathy appeared in peer-reviewed literature. The author reported that after twelve treatments the patient's sensory threshold increased as determined by the Semmes Weinstein filament test. It is not known whether the improvement was sustained after the follow-up period, or whether there was overall improvement in the management of the progression of the disease.</p> <p>There is insufficient evidence to form a conclusion on the effect this technology has on diabetes care, and therefore CareFirst considers it investigational.</p>

New Technology	Description	CareFirst Determination
<p>Cranial orthotic molding helmets, i.e. Dynamic Orthotic Cranioplasty®</p>	<p>A custom-molded helmet that reshapes the skull of infants with non-synostotic plagiocephaly.</p>	<p>Although infant skull plagiocephaly can have several causes, there is an increase in the number of infants presenting with occipital positional plagiocephaly in recent years. Pediatricians believe this to be a consequence of the “back to sleep” program, promoted by the American Academy of Pediatrics, which has seen a reduction in the number of SIDS cases. The evidence indicates that positional plagiocephaly can be prevented and, in many cases, corrected by repositioning the infant during sleep. Even if plagiocephaly does occur, pediatric neurosurgeons have indicated that there is no evidence that the infant’s neurological development is adversely affected. There is evidence that the use of fitted cranial molding helmets to correct positional plagiocephaly is safe and effective when used in accordance with labeling approved by the Food and Drug Administration.</p> <p>CareFirst has determined that the use of these devices in most cases constitutes a cosmetic intervention, and therefore is not eligible for coverage.</p>
<p>Duodenal switch procedure for morbid obesity</p>	<p>A modification of the older, biliopancreatic diversion procedure that causes a deficiency of nutrient uptake as well as restriction of food intake.</p>	<p>There is some controversy in the bariatric specialty over this procedure. The evidence indicates that it is effective for patients with very high BMI values who are unable to reduce excess body weight by other means. Like the gastric bypass procedure, patients who undergo the duodenal switch procedure lose a high percentage of excess body weight with improvement of associated co-morbidities. However, some bariatric surgeons consider this procedure more risky than gastric bypass with Roux-en Y due to the degree of malabsorption it creates with the associated fluid and electrolyte imbalances, and the possibility of malnutrition. Still, in carefully selected patients, particularly those who are extraordinarily, massively obese, there is documentation of long-term success and improvement of health, provided the patient has an understanding of the need for careful follow-up and a lifelong commitment to changes in lifestyle.</p> <p>CareFirst now considers duodenal switch to be a covered procedure for patients who meet criteria for surgery for morbid obesity, and whose health plan provides coverage for surgery for morbid obesity.</p>

Disease Management

Recent Literature on:

Asthma, Cardiovascular Disease, Congestive Heart Failure, Diabetes and Cancer

By T.A. Dadisman, M.D., Medical Director, Preventative Medicine and Health Promotion

This article is intended to call your attention to recent information you may have missed on issues concerning asthma, coronary artery disease, congestive heart failure, diabetes and cancer.

ASTHMA	Where to Find It:
<p>Physicians tend to underestimate the severity of a patient's asthma. Lower Physician Estimate of Asthma Severity Leads to Undertreatment states that treatment is often inconsistent with national guidelines and, as a result, the quality of asthma care and treatment outcomes is poor. Physicians should update their treatment based on their patients' symptoms and current guidelines.</p>	<p><i>Archives of Internal Medicine</i> 2003; 163 (No. 2, Jan 27): 231-236, http://archinte.ama-assn.org</p>
<p>The 'Crashing Asthmatic' is a good review of risk factors, recognition, assessment and treatment of episodes of severe asthma that are poorly responsive to initial therapy.</p>	<p><i>American Family Physician</i> 2003; 67 (No. 5, Mar 1): 997-1004, www.aafp.org</p>
CORONARY ARTERY DISEASE	Where to Find It:
<p>Secondary Prevention of Coronary Heart Disease in Women: A Call to Action is an editorial that comments on the "striking and alarming underuse of proven therapies for secondary prevention of coronary heart disease, which highlights a terrible discrepancy between what we know and how we treat our sisters and mothers." See also the accompanying study on pages 81-89.</p>	<p><i>Annals of Internal Medicine</i> 2003; 138: (No. 2, Jan 21) 150-151, www.annals.org</p>
<p>Multifactorial Intervention & Cardiovascular Disease in Patients with Type 2 Diabetes discusses the target-driven, long-term, intensified interventions aimed at multiple risk factors that reduced the risk of macrovascular and microvascular events by 50% in patients with type 2 diabetes and microalbuminuria. See also the accompanying editorial in the same issue, Reducing Cardiovascular Risk in Type 2 Diabetes. Both the article and editorial discuss the results of a long-term (e.g., mean of 7.8 years) study that assesses the impact of multiple risk factor interventions on type 2 diabetes patients. The study shows a reduction of 50% in the measured primary end-points (e.g., fatal and non-fatal MI, CABG, percutaneous coronary intervention, non-fatal stroke, amputation for ischemia or vascular surgery for PAD) in the intensive intervention group. Secondary end-points were diabetic nephropathy, retinopathy or neuropathy. The data suggest that ACE inhibitors be considered, barring contraindications, for all high-risk diabetic patients, even in the absence of hypertension and microalbuminuria.</p>	<p><i>New England Journal of Medicine</i> 2003; 348 (No. 3, Jan 30): 383-393, http://content.nejm.org</p>
<p>Aggressive Treatment of Atherosclerosis: The Time is Now is an excellent article that calls for the prompt treatment of patients with known symptomatic or asymptomatic cardiovascular disease with combination therapy of statins, aspirin, angiotensin converting enzyme inhibitors and beta-blockers, regardless of the presence or absence of hyperlipidemia or hypertension. Patients with diabetes also should be treated as if they have known pre-existing cardiovascular disease.</p>	<p><i>Cleveland Clinic Journal of Medicine</i> 2003; 70 (No. 5, May): 431-440, www.ccjm.org</p>
CONGESTIVE HEART FAILURE	Where to Find It:
<p>Awareness, Knowledge and Attitudes of Older Americans about High Blood Pressure discusses that limited awareness of the significance of systolic hypertension is a greater barrier to BP control than the cost of medicine for Americans 50 years and older. See also the editorial in the same issue that discusses this problem (634-636) and cites physician adherence to current treatment guidelines as another significant factor in poor BP control with increasing numbers of patients suffering stroke and CHF.</p>	<p><i>Archives of Internal Medicine</i> 2003; 163 (No. 6, Mar 24): 681-687, http://archinte.ama-assn.org</p>
<p>Effects of Initiating Carvedilol in Patients with Severe Chronic Heart Failure is a report of the results of <i>COPERNICUS</i> study. Survival curves show that as early as 14 to 21 days after initiation of treatment, differences began to appear between the carvedilol and placebo groups for all-cause mortality and the combined end points of death, hospitalization or withdrawal.</p>	<p><i>Journal of the American Medical Association</i> 2003; 289 (No. 6, Feb 12): 712-718, http://jama.ama-assn.org</p>
<p>The editorial, Continuing Progress in the Treatment of Severe Congestive Heart Failure, reviews the evidence of modern therapies proven effective for CHF and their unfortunately slow implementation in the community.</p>	<p><i>Journal of the American Medical Association</i> 2003; 289 (No. 6, Feb 12): 754-756, http://jama.ama-assn.org</p>

<p>DIABETES (See also the second and third citations under Coronary Artery Disease)</p> <p>What to Do About the Metabolic Syndrome? is an excellent editorial on the prevalence and diagnosis of and interventions for the metabolic syndrome. Another article in the same issue (163: No. 4, Feb 24) emphasizes the high prevalence of the syndrome in the U.S., and addresses variation with age, ethnicity, obesity and other concomitant risk factors. The metabolic syndrome affects up to 60% of obese adults and has major implications for the development of coronary artery disease.</p>	<p>Where to Find It: <i>Archives of Internal Medicine</i> 2003; 163: (No. 4, Feb 24): 395-397, http://archinte.ama-assn.org</p>
<p>See the excellent series of Editorial and Review Articles on Type 2 Diabetes on the following pages of this issue:</p> <ul style="list-style-type: none"> • Editorial: Treating Type 2 Diabetes: A Growing Epidemic 411-413 • Contributions of Insulin-Resistance and Insulin-Secretory Defects to the Pathogenesis of Type 2 Diabetes Mellitus 447-456 • Pharmacological Management of Type 2 Diabetes Mellitus: Rationale for Rational Use of Insulin 459-467 • Insulin Sensitizers 471-479 	<p><i>Mayo Clinic Proceedings</i> 2003; 78 (No. 4, April) www.mayo.edu/proceedings/</p>
<p>The Evidence Base for Tight Blood Pressure Control in the Management of Type 2 Diabetes Mellitus is a clear-cut, concise presentation of the evidence-based reasons for tight blood pressure control to prevent macrovascular complications and contribute to the prevention of renal and retinal microvascular complications.</p>	<p><i>Annals of Internal Medicine</i> 2003; 138 (No. 7, April 1): 587-592, www.annals.org</p>
<p>Treatment of Hypertension in Type 2 Diabetes Mellitus: Blood Pressure Goals, Choice of Agents and Setting Priorities in Diabetes Care discusses the treatment of hypertension in type 2 diabetes with a goal of 135/80 mmHg or less and reveals dramatic benefits. Aggressive blood pressure control may be the most important factor in preventing adverse outcomes in patients with type 2 diabetes.</p>	<p><i>Annals of Internal Medicine</i> 2003; 138 (No. 7, April 1): 593-602, www.annals.org</p>
<p>CANCER</p> <p>Colorectal Cancer Test Use Among Persons Aged \geq 50 Years - United States, 2001 recognizes colorectal cancer as the second leading cause of cancer-related death in the U.S. The lifetime risk for having colorectal cancer is 6%. Studies show that screening for colorectal cancer can save lives. Approximately half of U.S. adults \geq 50 years old have not received recommended annual screenings of fecal occult blood test (FOBT) and/or periodic screenings of lower endoscopy (varies from 5-10 years).</p>	<p>Where to Find It: <i>Morbidity and Mortality Weekly Report</i> 2003; 52 (No. 10, Mar 14): 193-196, www.cdc.gov/mmwr/</p>
<p>Prostate cancer screening is more common than colorectal cancer screening. Screening Men for Prostate and Colorectal Cancer in the United States reminds physicians to make sure that men screened for cancer are aware of the known mortality benefit of colorectal cancer screening and the uncertain benefits of prostate cancer screening.</p>	<p><i>Journal of the American Medical Association</i> 2003; 289 (No. 11, Mar 19): 1414-1420, http://jama.ama-assn.org</p>
<p>American Cancer Society Guidelines for the Early Detection of Cancer, 2003 is an excellent review of the ACS recommendations for cancer screening, including participation rates by age, gender and ethnicity in screening programs. See also CareFirst's Preventive Services Guidelines, 2003, available in the <i>Providers & Physicians</i> section of www.carefirst.com. Click on <i>Clinical Resources</i>.</p>	<p><i>CA Cancer Journal for Clinicians</i> 2003; 53 (No. 1, Jan/Feb):27-43, http://caonline.amcancersoc.org</p>
<p>OTHER TOPICS OF INTEREST</p> <p>The Agency for Healthcare Research & Quality (AHRQ) launched a web-based morbidity & mortality journal and forum dedicated to patient safety. Patient Safety is receiving increasing attention with related articles in the <i>New England Journal of Medicine</i>, the <i>Annals of Internal Medicine</i> and other publications. The AHRQ Web site has illustrative cases followed by informative discussions by experts in the field.</p>	<p>Where to Find It: www.webmm.ahrq.gov/</p>
<p>Testing Strategies in the Initial Management of Patients with Community-Acquired Pneumonia discusses diagnostic and prognostic testing in pneumonia.</p>	<p><i>Annals of Internal Medicine</i> 2003; 138 (No. 2, Jan 21) 109-118, www.annals.org</p>
<p>Rocky Mountain Spotted Fever: A Clinician's Dilemma is an excellent, timely article that reviews presentation, epidemiology and treatment of this tricky and deadly disease. The authors point out that "early diagnosis and treatment can save lives." Eight pitfalls in diagnosis and treatment are discussed. AAP and CDC both recommend doxycycline as the antibiotic of choice, even for children.</p>	<p><i>Archives of Internal Medicine</i> 2003; 163 (No. 7, Apr 14): 769-774, http://archinte.ama-assn.org</p>

Appropriate Use of Opioids

CareFirst promotes the appropriate use of opioids by reminding prescribers of proper indications, dosing regimens, titration phases, step-up or step-down therapy.

Reminder:

- OxyContin® is only approved for Q12h dosing and Avinza® for Q24h dosing. The drug release patterns were designed for such dosing.
- OxyContin® and Avinza® are indicated only for patients who require continuous pain management over an extended period of time.
- When additional dosage is required, do not use dosing intervals. Instead, use immediate release OxyContin® or Avinza® immediate release morphine, followed by increased OxyContin® or Avinza® dosage.

The controlled-release oral forms of oxycodone and morphine are indicated for the management of moderate-to-severe pain when a continuous analgesic is needed for an extended period of time. Neither OxyContin® nor Avinza® are intended for use as an as needed (prn) analgesic.²

Initiation of Opioids

When initiating OxyContin® in patients who have never used opioids and require continuous pain management for an extended period of time, 10-mg Q12h is recommended.³ When initiating Avinza® in these patients, it is recommended that the initial starting dose be 30 mg Q24h.⁴ For such patients, it is recommended that the dose of Avinza® be adjusted in increments not greater than 30 mg every 4 days.⁴ For patients who have used opioids, the initial dosage is based on conversion ratios from existing opioids to oxycodone or morphine.

The matrix drug delivery system of OxyContin® provides a biphasic dissolution and absorption pattern, which delivers controlled oxycodone over 12 hours. The initial dissolution occurs when tablets interact with GI fluids, providing an onset of analgesia within one hour in most patients. This phase accounts for 38 percent of the available dosage (half-life: 36 minutes). The slow absorption phase is mediated when oxycodone begins to diffuse through the matrix system upon contact with GI fluids. This phase accounts for 62 percent of the available dose (half-life: 6.9 hours).⁵

Dosing of Opioids

OxyContin® should not be dosed more frequently than Q12h because no clinical information exists about dosing intervals shorter than Q12h. Shortening the dosing interval of OxyContin® may result in elevations of steady state concentrations of OxyContin®. If dosing increases are necessary, frequency should not be increased.³

The daily dose of Avinza® must be limited to a maximum of 1600 mg/day. Avinza® doses of over 1600 mg/day contain a quantity of fumaric acid that is not demonstrated to be safe, and may result in serious renal toxicity.

The table below provides the current equianalgesic dosing for various opioids and is not intended to replace a prescriber's judgment. It is better to underestimate a patient's 24-hour opioid dose and make available rescue medication than to overestimate the 24-hour opioid dose and manage an adverse experience or overdose. Please consult respective package inserts for dosing instructions.

Oral Morphine	Oral Oxycodone	Oral Hydro-morphone	Oral Hydrocodone	Fentanyl Transdermal System
30 mg	20 mg	7.5 mg	20 mg	-
60 mg	40 mg	15 mg	40 mg	25 mcg/hr
90 mg	60 mg	22.5 mg	60 mg	25 or 50 mcg/hr
120 mg	80 mg	30 mg	80 mg	25 or 50 mcg/hr
150 mg	100 mg	37.5 mg	100 mg	50 or 75 mcg/hr
180 mg	120 mg	45 mg	120 mg	50 or 75 mcg/hr
210 mg	140 mg	52.5 mg	140 mg	50 or 75 mcg/hr
240 mg	160 mg	60 mg	160 mg	75 mcg/hr
270 mg	180 mg	67.5 mg	180 mg	75 mcg/hr
300 mg	200 mg	75 mg	200 mg	75 or 100 mcg/hr

References: American Pain Society, Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain, 4th edition, 1999, pages 14-15.; Derby S., Chin J., Portenoy, R. Systemic opioid therapy for chronic cancer pain: Practical guidelines for converting drugs and routes of administration. CNS Drugs 1998; 9(2):99-109.; Brant, J.M. Opioid equianalgesic conversion: The right dose. Clinical Journal of Oncology Nursing 2001; 5(4): 163-165. Duragesic® Package Insert.

Appropriate Use of Opioids (continued)

Unfortunately, OxyContin® is often abused by some patients and prescribed inappropriately by providers. Substance abuse is a major public health problem with societal financial estimates in excess of \$300 billion annually, including the costs of treatment, related health problems, absenteeism, lost productivity, drug-related crime and incarceration, and efforts in education and prevention. If you suspect substance abuse, immediately refer patients to a case manager and/or behavioral health practitioner for counseling and/or pain specialist or treatment center.¹

CareFirst Preferred Drug List

OxyContin® and Avinza® are the only branded- and MS Contin is the only generic- extended-release opioids on CareFirst's Preferred Drug List. For preferred opioids that are not extended-release, visit the *Providers & Physicians* section of www.carefirst.com and click on *Prescription Drugs* to access the *Prescription Drug Database*.

A free educational Web site for CME and additional information can be found at <http://npecweb.org>.

Resources:

1. American Psychiatric Association. Practice Guidelines for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opiates. http://www.psych.org/clin_res/pg_substance_2.cfm (accessed 2003 Apr 08).
2. AdvancePCS. AdvancePCS Prior Authorization Criteria.
3. OxyContin® Package Insert. Stamford, CT: Purdue Pharma L.P.; 2002 Jan.
4. Avinza® Package Insert. San Diego, CA; Ligand Pharmaceuticals Incorporated; 2002 March.
5. Kwarcinski M. Dosing Frequency of OxyContin Tablets. Letter.
6. Adapted from: Public Policy of the American Society of Addiction Medicine 2001. (Available at: www.ASAM.org/ppol/paindef.htm. Accessed on September 20, 2003.)

Management of Chronic Nonmalignant Pain

By Anthony G. Massey, M.D., Associate Medical Director, MidAtlantic Service Center of Magellan Behavioral Health

Since the discovery that opium suppresses the perception of painful stimuli, society has struggled with issues relating to the appropriate treatment of physical pain, an essential part of the human condition. The treatment of acute pain has probably had the most focus over the course of human history. However, management of chronic pain has gained prominence as new medications and technologies have given hope to those who suffer from various painful conditions.

Treatment varies depending on whether a patient's chronic pain is due to a malignant versus a nonmalignant condition. The use of opiate medications has only recently gained widespread acceptance for treatment of these conditions, but is only recommended within certain guidelines.

Risk of patients' misuse and abuse of highly addictive medications are valid concerns for clinicians, as this may lead to addiction and/or legal consequences. It is important to weigh the risk of misuse against that of under-treating a genuine and

painful medical condition, which may lead to significant suffering and morbidity. Inadequate treatment of chronic pain can occur by under-dosing pain medications and/or not using the full spectrum of pain treatment resources.

Treatment of chronic pain due to malignant pain is less controversial. Adequate pain management, defined as reducing pain severity to tolerable levels so that a patient's day-to-day activities and sense of well-being are maintained, is the standard of medical care relating to malignancies and terminal conditions. The use of opiates (even in very high doses) along with other treatment modalities should be considered for patients with these conditions.

In their efforts to continue to provide the best quality of service for members, CareFirst and Magellan will inform providers and members of current trends and technology in chronic nonmalignant pain management as information becomes available.

Prescription Drugs

Medbank and CareFirst Bring Medications to Your Patients in Need

Most medical practices have patients who cannot afford their medications. Many patients cannot comply with prescription regimes for financial reasons, which can be frustrating for health care professionals. Pharmaceutical samples can certainly help, but samples alone cannot resolve this issue. The Senior Prescription Drug Program and the Maryland Medbank Program both offer better solutions for you and your patients.

Senior Prescription Drug Program

CareFirst administers the Senior Prescription Drug Program, which is in its third year and has reached over 32,000 Medicare beneficiaries.

Enrollment in the program is limited to Medicare beneficiaries who are Maryland residents, do not receive prescription drug benefits through any other program or insurance plan and do not earn more than 300 percent of the Federal Poverty Level (e.g., \$26,940 for one person). For a \$10 monthly fee, payable quarterly, plus copays, participants can receive up to \$1,000 of prescription drug benefits in 12 months.

For more information about the Senior Prescription Drug Program, call 800-972-4612.



Maryland Medbank Program

The Maryland Medbank Program is in its fourth year and has reached over 21,500 patients. Medbank assists patients of **all** ages who cannot afford their medications by providing access to pharmaceutical industry patient assistance programs (PAPs), which offer brand name medications for free or at a low cost. To qualify, patients can earn no more than 300 percent of the FPL. Once a patient is qualified, medications from Pfizer, AstraZeneca and OrthoMcNeil are delivered within 3 days and medications from other pharmaceutical companies are delivered after several weeks.

Patients can self-refer to the Medbank Program by calling the toll-free number, 877-435-7755, from anywhere in Maryland.

If some of your patients take several medications, particularly branded medications, help them decide whether either of these programs meet their needs. The Senior Prescription Program is ideal for Medicare patients who take only a few medications and will not exceed the \$1,000 benefit in 12 months. Please note that if a patient enrolls in the Senior Prescription Drug Program, he will be ineligible for most PAPs in the Medbank Program.

Advise Patients Not to Use Vinarol

The FDA warned consumers not to purchase or consume a product known as Vinarol tablets, promoted for increasing sexual desire, confidence and performance.

This product, marketed as a dietary supplement and sold over the counter and on the Internet, contains the unlabeled prescription drug ingredient, sildenafil, which may pose possible serious health risks to some users. The interaction between nitrates and sildenafil can result in profound and life-threatening lowering of blood

pressure. The use of nitrates in any form is an absolute contraindication for sildenafil users.

The potential for this product to be taken by unknowing nitrate users is real, since erectile dysfunction is often a concurrent condition in patients with diabetes, hypertension, hyperlipidemia, smokers and patients with ischemic heart disease. Please advise patients, with these conditions in particular, of the dangers of taking Vinarol.

Communication with Behavioral Health Practitioners

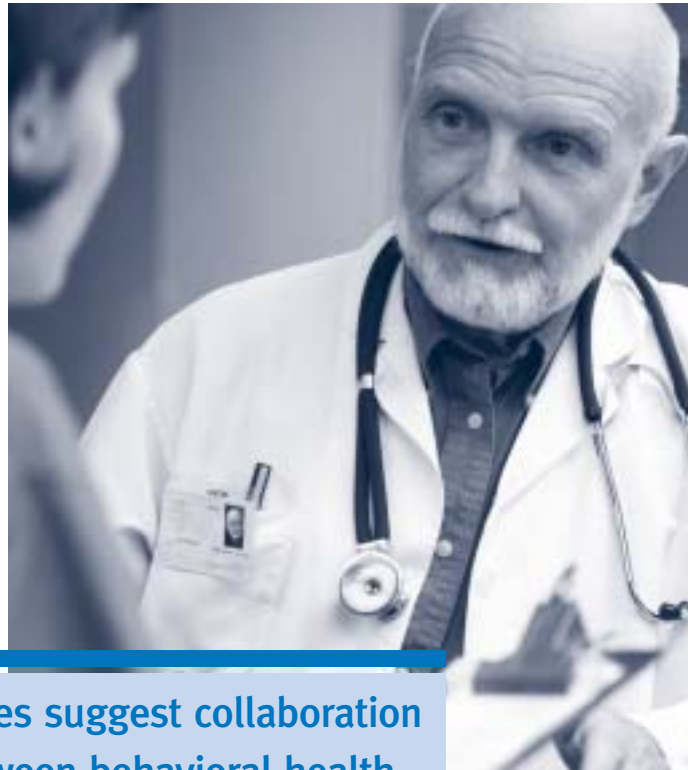
Upon reviewing the documentation in behavioral health practitioners' treatment records, Magellan Behavioral Health (Magellan), CareFirst's contracted mental health and substance abuse vendor, saw a decline in the level of collaboration between primary care physicians (PCP) and behavioral health practitioners.

Magellan and CareFirst constantly strive to improve continuity and coordination of patient care to encourage quality health care and value for our members. Studies suggest that collaboration between behavioral health practitioners and PCPs results in improved care and higher member satisfaction. The National

Committee for Quality Assurance (NCQA) also stresses the importance of monitoring and improving collaboration and coordination of care.

A comparison of 2001 and 2002 results of Magellan's assessment indicates a decline in coordination documentation from 44 to 38 percent. The desired goal is 80 percent. Magellan identified opportunities for improvement and will implement interventions, such as providing forums for high volume behavioral health practitioners and PCPs to promote the exchange of information.

Magellan and CareFirst's emphasis on the importance of communication between behavioral health practitioners and



Studies suggest collaboration between behavioral health practitioners and PCPs results in improved care and higher member satisfaction.

PCPs remains key in 2003 because many members are diagnosed with co-existing medical problems and mental health problems.

Behavioral health practitioners can help PCPs identify mental health issues and provide members with information on available treatment options. How can PCPs improve communication with Behavioral Health Practitioners?

- Recognize when it is clinically appropriate to communicate with behavioral health practitioners. Below are some examples of when care should be coordinated with the behavioral health practitioner:
 - After the behavioral health practitioner's initial evaluation
 - There is a significant change in the member's medical condition
 - Medications are initiated after a psychiatric evaluation
 - There are significant changes in medications used in the management of medical conditions

- Encourage members to sign an authorization form to release treatment specifics to the behavioral health practitioner. Inform the member that he or she can choose which information to release.
- Document the member's refusal to release information in the medical record.

Lastly, document in the medical record when the communication took place and what was communicated. Thank you for helping provide high quality care to members.

CareFirst's Commitment

CareFirst's Continuing Commitment to Provider Satisfaction

Recent Changes

This spring, the Maryland General Assembly passed legislation that will bring some organizational changes to CareFirst. The new law primarily deals with issues relating to corporate governance and does not interfere with CareFirst's day-to-day operations related to serving our members and providers. The legislation—

- Requires the appointment of new Maryland Directors to the CareFirst Board
- Requires Board approval of major changes in the premiums we charge or the provider reimbursements we pay
- Mandates quarterly reports to a Maryland legislative oversight committee
- Sets executive compensation comparable with similar non-profit insurers
- Bars any for-profit conversion for at least five years
- Clarifies the CareFirst mission

We are committed to fully complying with the legislation and are working with the insurance commissioners in Maryland, Delaware and the District of Columbia to that end.

CareFirst's Commitment to Provider Relationships— Now and in the Future

While these recent events may have caused concern, CareFirst is still committed to locally managing and delivering health care under the Blue Cross and Blue Shield logos by utilizing the quality health care professionals and institutions in our networks. We are also committed to investigating and implementing innovative ways to make doing business with us easier. We are retaining our provider focus by—

- Investing in state-of-the-art technology—
 - CareFirst recently launched an improved Web site with new

features, such as the capabilities to find your provider representative, register for provider seminars and download necessary forms.

- Last fall, CareFirst introduced iExchange®, a free Internet service that gives hospitals a single access point to exchange care management data and certification status with CareFirst, while reducing transaction turnaround time and administrative costs.
- In the future, all providers will have access to CareFirst Direct, also a free Internet service, which will provide on-line, real-time eligibility verification and claims status review. This service will be available via www.carefirst.com and rolled out in 2004.

- Providing better customer service— We have extended our provider service hours- giving you more flexibility when you need to contact us- and introduced advanced technology in our Provider Service Call Center, which allows our provider service representatives to more efficiently serve you.

- Helping your patients stay healthy— Eligible members with diabetes, heart disease, asthma or cancer can learn how to manage their conditions and avoid complications through our disease management programs. All programs are designed to reinforce the physician's plan of care.

For more than 65 years, CareFirst and our affiliates have been providing health care coverage to millions of customers in the Mid-Atlantic region. As we have in the past, CareFirst will continue to meet the needs of our members and partnered providers now and into the future.

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Eric Baugh, M.D.
Chief Medical Officer and Sr. Vice President of Medical Affairs

Erica Wasserman
Editor



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