CIGNA Behavioral Health

THE CBH PROVIDER CONNECTION

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EAP CORNER

Anniversary Debriefings

The anniversary of Sep. 11 is approaching. It is important that clinicians be prepared for symptoms that may appear in some of our clients. Anniversaries of traumatic events often trigger a re-experiencing of the emotions associated with the event. For some, anniversary reactions can include pervasive anxiety, sadness and depression; inability to concentrate, social withdrawal, irritability, insomnia and nightmares. In the workplace this can mean decreased productivity, and increased sick leave and accidents.

On an organizational level, the Employee Assistance Program will be offering our corporate customers On-Site Anniversary Debriefings. The Debriefing will be an hour long group meeting aimed at giving employees an opportunity to voice their thoughts, feelings and reactions on the occasion of the anniversary. It will also provide an opportunity to give and receive support and to normalize any symptoms associated with re-experiencing the traumatic events of that day. The managers' sessions will, in addition, focus on how to anticipate employees' reactions and be prepared for that week.

We will be calling on our network Critical Incident Debriefing specialists to provide these services. Providers will be coached on suggested formats and supplied with participant materials. If you have interest in providing these services, especially if you are from the New York or Washington areas, please email Dana Kiel at (Dana.Kiel@cignabehavioral.com) or fax her at 212-676-3132.

SAP Specialists Needed

The new federal mandate for employees who work for an FAA or DOT regulated position, requires that evaluation be completed by a Substance Abuse Professional (SAP) who has attended the required training. We are recruiting providers who meet SAP criteria (Licensed MSW or PHD, clinical knowledge in the diagnosis and treatment of Alcohol and Substance Abuse Disorders, knowledge of the SAP function as it relates to employer interests in safety-sensitive duties, knowledge of DOT regulations applicable to the employers/industries for whom he/she evaluates employees, and knowledge of the DOT/SAP guidelines and any changes in these materials) and completion of required training and continuing education.

If you are interested in providing SAP services for CIGNA Behavioral Health please contact Nance Moeller-Roy by email or fax (Nance.Moeller-Roy@cignabehavioral.com) fax to 952-996-2058

CLAIMS

Top eight reasons why claim payments may be delayed

What is the number one reason for claim payment delays? It's that unanswered question: Is another group benefit plan potentially responsible for a portion of the payment? To expedite claim payment, request that the patient complete a "Coordination of Benefits" form.

In an effort to help providers receive timely payment of submitted claims, CIGNA Behavioral Health Customer Support Services compiled a "helpful hints" checklist of the most common pitfalls of claims submission.

1. **Is the claim legible?** Typed claims submitted on HCFA-1500 or UB92 claim forms help to ensure that the claims are legible and uniform.

2. **Is patient-identifying information included?** This includes the member or subscriber social security number, patient name, date of birth, and address.

3. **Is this an EAP Clinical Services claim?** If services provided are EAP services, the newly added EAP billing code EAP09 (EAP Clinical Services per session) must be billed.

4. **Is there a diagnosis and CPT code (non-EAP Clinical Services claims)?** There were extensive changes to CPT codes in 1998. Please use current mental health/chemical dependency coding. For facility claims, please include the admitting diagnosis and an itemization of services.

5. **Is the date of service and the service charge included?** Even though this reminder seems redundant, we do occasionally receive claims that have omitted this essential information.

6. **Is the provider identifying information included?** Tax identification number and provider credentials must match the information submitted on the provider contract. Change of address or Tax Identification for contracted providers should be submitted in writing to the following address:

CIGNA Behavioral Health, Network Services
11095 Viking Drive, Suite 350
Eden Prarie, MN 55344

Please make sure to include a W-9 form. Claims submitted with a discrepancy will be returned.

7. **Has this claim been submitted before?** Once a claim is submitted electronically or by mail, there is no need to resubmit it. Our goal is to reimburse services on a timely basis. Duplicate billing within thirty (30) days adds administrative costs to the customer.

8. **Is another group benefit potentially responsible for a portion of the payment?** To expedite claim payment, request that the patient complete a "Coordination of Benefits" form. To better serve you, this form has recently been revised. As a result of your suggestions, either the plan participant or the provider may complete and sign the form. Additional copies may be obtained by calling Customer Service at 800.926.2273.

The goal of CIGNA Behavioral Health Customer Support Services is to assist in the delivery of affordable managed health care by providing timely, accurate and confidential claim service. When essential details are missing from claims, Customer Support Services must call to acquire the missing information or return the claim to the provider. This adds administrative costs to the customer and delays claim payment.

PROVIDER UPDATE INFORMATION

CIGNA Behavioral Health makes every effort to supply participating providers and members with the most accurate, up-to-date contact and referral information available. The Provider Info Update Form is available 24 hours a day, and makes it easy for providers to:

- Submit changes to their mailing addresses, telephone numbers or e-mail accounts.
- Update Live Voice Response* information for existing service locations.

This form is available on our website at **www.cignabehavioral.com**, click on " Providers" then click on "Customer Service" then click on Update Provider Info" Enter any changes and submit this electronically to us.

If you have any other changes which could not be submitted on the Provider Update Information Form, such as:

- Hours of availability
- Full practice
- Going on vacation
- Updated certifications
- Group practice information.

Please contact your local Professional Relations Department. This information is available on our website at **www.cignabehavioral.com**, click on " Providers" then click on "Customer Service" then click on "Contact Us" then click on "Professional Relations Field Office". Please submit your update to the field office assigned to the state of your practice location.

Please help us serve you and our participants efficiently by updating this form promptly each time your practice information changes.

Thank you

FROM OUR QUALITY MANAGEMENT DEPARTMENT

IMPROVING PATIENT SAFETY

The Institute of Medicine recently placed the safety of health care in the public spotlight by publication of their report, "*To Err is Human: Building a Safer Health System*." As a result, safety catapulted to a national health care issue. Every health care provider should be evaluating:

- What is my role in preventing potential errors or safety risks?
- What barriers exist to improving patient safety?
- What strategies can be implemented in my practice to reduce errors or improve safety?

While there are many steps needed to reduce error in America's complex health care system, a few steps providers can consider include:

- Evaluate and monitor a patient's potential risk to harm self or others.
- With approved consent, communicate and coordinate care with other behavioral health, primary care, or other health care providers who are involved in the participant's care.
- Gather information on all prescription, over-the-counter medications, and dietary supplements the participant is taking.
- Inquire about any known allergies or adverse medication reactions.
- Ensure prescriptions are written in a clear, easy-to-read fashion.
- Educate the participant on how and when to take medication and how to manage possible side effects.
- Evaluate how computerized records and other technology may contribute to improved safety.

Through the Quality and Utilization Management Program, CIGNA Behavioral Health evaluates data on various measures to identify opportunities for improving safety for our participants.

IMPROVING FOLLOW-UP AFTER HOSPITALIZATION

Participants being discharged from inpatient psychiatric care need timely access to outpatient care to maintain stability and continue treatment. In an effort to strengthen the bridge between inpatient and outpatient care, CIGNA Behavioral Health works with facilities and practitioners to achieve timely and appropriate discharge plans.

To gauge performance, we use measures that have become widely utilized and closely followed in the industry from the Health Plan Employer Data & Information Set (HEDIS®)*:

- The percentage of participants seen for outpatient mental health follow-up within 7 days after discharge from hospitalization for mental illness.
- The percentage of participants seen for outpatient mental health follow-up within 30 days after discharge from hospitalization for mental illness.

CIGNA Behavioral Health also monitors whether people with substance abuse disorders have successfully engaged in outpatient rehabilitation following discharge from inpatient detoxification. For the purposes of this measurement, treatment engagement is defined as attending at least three visits following inpatient discharge.

To drive improvements in follow-up, CIGNA Behavioral Health continues to use care management services to coordinate with facilities and outpatient providers in establishing discharge plans. We ask for your assistance in scheduling timely follow-up appointments for those participants being discharged from acute inpatient care. CIGNA Behavioral Health also places calls to providers to confirm the participant's attendance to scheduled follow-up appointments. We ask providers to place outreach calls to patients who do not attend appointments following hospitalization and encourage the patients to attend appropriate outpatient care.

**HEDIS® is a registered trademark of the National Committee for Quality Assurance.*

ENHANCING TREATMENT OUTCOME FOR PANIC DISORDERS:

The American Psychiatric Association Guidelines on Panic Disorder (1998) document the efficacy of Cognitive-Behavioral Therapy and antipanic medication in treating Panic Disorder with and without Agoraphobia.

The most successful Cognitive-Behavioral Therapy approaches for Panic Disorders emphasize several specific components, including:

- Psychoeducation – teaching the facts about Panic Disorder to address any misperceptions and provide a direct explanation for the symptoms.
- Continuous Panic Monitoring – instructing the patient to monitor the frequency, duration and antecedents of their panic attacks and anxious cognitions.
- Breathing Retraining – using abdominal breathing, progressive muscle relaxation and meditation daily to control physiologic reactivity.

- Cognitive Restructuring – examining and disputing maladaptive cognitions associated with anxiety sensations to alter the outcomes of bodily cues experienced.
- Exposure to Fear Cues (in vivo exposure) – using systematic and gradual exposure to a prescribed hierarchy of fear-evoking situations until the fear is lessened.

Numerous controlled studies employing these treatment methods have demonstrated a very significant number of patients receiving Cognitive-Behavioral Therapy to be panic free at follow-up.

Considerable evidence has documented the treatment effectiveness of medications in the treatment of Panic Disorders. While well-controlled studies exist demonstrating some efficacy for a number of medications, SSRIs are considered to be the first-line pharmacotherapy for Panic Disorders, due in part to the greater safety and tolerability of SSRIs relative to older agents (Otto, Tuby, Gould, Renee, & Pollack, 2001).

Patients are likely to show some improvement with either medication of Cognitive-Behavioral Therapy within 6-8 weeks. If Cognitive-Behavioral Therapy alone is not efficacious in decreasing the severity or intensity of panic attacks after 8-12 weeks, then according to the APA Guidelines, antipanic medication should be considered. To help evaluate the appropriateness of treatment for Panic Disorder, CIGNA Behavioral Health monitors the percentage of people with Panic Disorder that are in psychotherapy more than 12 weeks with no indication of a medication evaluation.

For more information, see the APA Practice Guidelines on Panic Disorder accessible through www.psych.org.

APA Guideline. (1998). Practice guideline for the treatment of patients with panic disorder. American Psychiatric Association. www.psych.org.

Otto, M.W., Tuby, K. S., Gould, R.A., Renee, Y.S. & Pollack, M.H. (2001). American Journal of Psychiatry, 158: 1989-1992.

IMPROVING ANTIDEPRESSANT MEDICATION MANAGEMENT

Dr. Michael Glasser, Associate Medical Director of CIGNA Behavioral Health's Glendale Operating Unit, regularly reviews and summarizes information from pertinent journal articles and shares this information with CIGNA Behavioral Health staff.

In a recent summary, Dr. Glasser reviewed topics directly related to the treatment of depression and the management of antidepressant medications. This information is particularly useful as we strive to improve HEDIS®* Effectiveness of Care measures associated with antidepressant medication management.

Important points from Dr. Glasser's recent literature review include:

New Standards of Depression Treatment: Remission and Full Recovery:

- Treat patients early and aggressively to maximize the chances for achieving full remission.
- In the initial stages of treatment it is essential to optimize medication dosage and educate the participant and family/significant others to the nature of depressive disorders, the goals of therapy and the importance of medication compliance.
- In choosing medications, the best choices are still made through a combination of history of what has been tired before, information about blood relatives and medications used, comorbid issues, side-effects that may or may not be desired, issues of compliance and the confidence and clinical experience of the prescribing clinician.
- The chances of achieving full remission are greatest during the first 6 months of antidepressant therapy.
- The longer a patient remains symptomatic, whether at a full level of diagnostic psychopathology or at a subsyndromal level, the lower the chance of complete recovery.
- Subsyndromal or residual symptoms are associated with significant psychosocial dysfunction.
- Residual symptoms have also been found to be associated with early relapse, an increased rate of recurrence and a significantly higher lifetime prevalence of suicide and psychosocial impairment than seen in patients who fully remit.

Goal of Treatment:

- The goal is to achieve full remission which is defined as a patient who is completely symptom free with a return to premorbid levels of psychosocial and occupational functioning. Achieving full remission provides the best opportunity for improving long term prognosis and preventing relapse/recurrence

Reaching the Goal of Full Remission:

- The successful treatment of major depressive disorder requires close adherence to treatment plans, in some cases for long or indefinite durations. Especially while symptomatic, it is important to keep in mind that patients with major depressive disorder may be:
  - Poorly motivated and unduly pessimistic over their chances of recovery with treatment
  - Suffering from deficits in memory and taking less care of themselves
  - Experiencing side effects or requirements of treatments that may lead to nonadherence
  - Particularly during the maintenance phase, euthymic patients may tend to undervalue the benefits of treatment and focus on the burdens of treatment.

- Encourage the patient to articulate any concerns regarding adherence, and emphasize the importance of adherence for successful treatment. Specific components of a message to patients that have been shown to improve adherence include emphasizing:
  - When and how often to take the medicine
  - The need for at least 2-4 weeks before beneficial effects may be noticed
  - The need to take medication even after feeling better

  - The need to consult with the doctor before discontinuing medication
  - What to do if problems or questions arise

- The successful treatment of patients with major depressive disorders, as referenced in the American Psychiatric Association Practice Guidelines for Major Depression in Adults, 2nd edition (2000), consists of:
  - An acute phase lasting a minimum of 6-8 weeks. during which remission is induced. Remission is defined as a return to the patient's baseline level of symptom severity and functioning. This baseline should not be confused with substantial but incomplete improvement.
  - After achieving remission, the patient enters the continuation phase, which usually lasts 16-20 weeks, during which time the remission is preserved and relapse is prevented. Relapse is generally defined as the reemergence of significant depressive symptoms or dysfunction following a remission.
  - Patients who successfully complete the continuation phase without relapse then enter the maintenance phase of treatment. The goal during the maintenance phase is to protect susceptible patients against recurrence of subsequent major depressive episodes. The duration of the maintenance phase will vary depending on the frequency and severity of prior major depressive episodes.

For more information, see the APA Practice Guidelines on Major Depression accessible through www.psych.org.

The HEDIS® measures are the most widely used metrics for assessing the treatment of depression. These scores assess whether treatment is in accordance with the AHCPR Guidelines on Depression in Primary Care (1993).

1. Optimal Practitioner Contact: The percentage of participants diagnosed with a new episode of depression and treated with antidepressant medication who receive at least 3 follow-up contacts with a practitioner in the first 12 weeks of medication. At least one of the visits must be with a prescribing practitioner.
2. Effective Acute Phase Treatment: The percentage of participants diagnosed with a new episode of depression and treated with antidepressant medication who remain on antidepressants for 12 weeks.
3. Effective Continuation Phase Treatment: The percentage of participants diagnosed with a new episode of depression and treated with antidepressant medication who remain on antidepressants for 6 months.

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AHCPR Guideline. (1993). Depression in primary care, volume 2. Treatment of major depression. Clinical Practice Guideline, Number 5. Agency for Health Care Policy and Research.

APA Guideline. (2000). Practice guideline for major depression in adults (2nd edition). American Psychiatric Association, www.psych.org.

Bakish, D. (2001). New standard of depression treatment: Remission and full recovery. Journal of Clinical Psychiatry; 62, (Suppl 26): 5-9.

Judd, L.L., Akisal, H.S., Maser, J.D., et al. (1998). A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. Archives of General Psychiatry; 49: 809-816.

Paykel, E.S., Ramana, R., Cooper Z., et al. (1995). Residual symptoms after partial remission: an important outcome in depression. Psychology Med.; 25: 1171-1180.

WE ENCOURAGE OPEN DIALOGUE

CIGNA Behavioral Health encourages you to communicate openly with your patients about appropriate treatment alternatives and does not penalize practitioners for discussing care that is felt by the practitioners to be necessary or appropriate.

COMPENSATION

CIGNA Behavioral Health compensates providers and staff in ways that are intended to promote quality care and appropriate use of services. We emphasize appropriate utilization, not under-utilization of services. The management decisions of our Medical Directors, Physician Advisors, and Care Management staff reflect this philosophy.

Staff compensation and incentives encourage the appropriate use of medically necessary care. CIGNA Behavioral Health considers the quality of care, quality of service and appropriate use of services prior to awarding any bonuses or incentives.

PRUDENT LAYPERSON STANDARD

We provide coverage for emergency services needed to screen and stabilize a participant without requiring pre-certification in any case where a prudent layperson acting reasonably, believes that an emergency medical condition exists. Coverage is also provided to eligible participants when CIGNA Behavioral Health staff or providers direct a participant to seek emergency care.

NOT TAKING NEW PATIENTS?

Practice full? Too busy? Taking a long sabbatical? Let CIGNA Behavioral Health know! CIGNA Behavioral Health can put a note in our electronic provider database indicating the dates you will not be available for referrals. So, when a participant calls seeking an appointment, your name will not be given out. This saves our participants the frustration of hearing, “Not taking new patients”, and saves you and your staff the time of answering those unnecessary calls. When you are unavailable or not taking new patients, please notify the CIGNA Behavioral Health office you work with most often. And don’t forget to let us know when you are available again!

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Primary Care:

Gateway to Behavioral Health Improvement

On a intuitive level it makes sense: Our emotional well-being affects our physical health. This is something that behavioral health providers have understood for some time, but within the sphere of employee benefits plans, there has traditionally been a separation between the two.

There is little debate over whether physical illnesses have significant behavioral health components, or vice versa. The debate is only one regarding the degree of connection between the behavioral and the physical.

Depression and Its Cost to Employers

It's widely known that behavioral health disorders affect up to 20% of any workforce, drive as much as 60% of all doctor office visits, and are a leading cause of disability and absenteeism. Behavioral health disorders also often constitute the top spends in pharmacy plans as the availability of medications used to treat behavioral disorders grows and their prescription becomes increasingly frequent.

The U.S. Surgeon General has identified depression as second only to heart disease in the burden it creates for society. Moreover, one recent study pegged the annual financial toll of depression at $70 billion to U.S. employers.

Integration: Crucial to Employer Programs

Those suffering from depression often struggle to carry out their work responsibilities while coping as best they can with a debilitating illness. Fortunately, medical science is making advances in understanding and treating behavioral health disorders, resulting in improved diagnoses and treatment.

It's important that health care professionals – doctors, pharmacists, and behavioral health care providers – work together across the continuum of care to maximize the chances of success in prevention, effective treatment and recovery for a company's employees.

Various forces have thrust the primary care physician into the leading role of integrating medical-behavioral care, especially in the treatment of clinical depression. The majority of antidepressant subscriptions are prescribed by primary care physicians. Two primary factors advancing the treatment of depression are a reduction in the stigma associated with seeking care for depression, and an increasing awareness at the primary care level of the symptoms of depression and it's treatment.

Generally speaking, patients don't view their behavioral health and physical health as separate. Therefore, within the management of an employee benefits plan, integration between a behavioral health plan and medical plan is becoming more of an imperative. Because we are concerned with facilitating the exchange of clinical information between behavioral and medical treating providers we have built into our processes and our technology prompts that help the behavioral provider identify co-morbid medical conditions, coordinate care with primary care physicians and play an active role in providing integrated care for their patients.

When a patient does receive treatment from someone other than their primary care physician, it's important that their primary care physician be aware of – and engaged in – that treatment. This collaborative approach helps both primary care physicians and behavioral health providers work together to treat the whole patient.

Linking Behavioral Care to Disease Management Programs

Because patients with certain physical conditions are at a greater risk for developing depression, an integrated approach to health care should also include appropriate behavioral health components housed within disease management programs. Early diagnosis and intervention helps employers save money through lower disability costs, decreased absenteeism and improved productivity, and improved clinical outcomes for the patient.

Two examples demonstrate the relationship between disease management and depression, and underscore the mind-body link. Screening for and treating depression in older people not only improves their quality of life, it may prevent coronary heart disease, according to one study in 2000 from the Cardiovascular Health Study Collaborative Research Group.[1] Diabetics are twice as likely as non-diabetics to suffer from depression.[2] While many believe depression is an effect of having a chronic illness, research suggests that depression often precedes – and may help trigger – the onset of diabetes.

As companies recognize the benefits of an integrated behavioral health and medical plan program in the prevention and resolution of problems that adversely affect their workplace, they will increasingly look to organizations that have the experience, clinical expertise, and technological capacity to deliver an integrated program.

[1]*American Family Physician, Nov. 15, 1999.*
[2]*Mental Health Weekly, July 2, 2001.*

CIGNA Behavioral Health

"CIGNA Behavioral Health" refers to CIGNA Behavioral Health, Inc., a behavioral benefits management company. CIGNA Behavioral Health, Inc. is a CIGNA HealthCare company. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by such subsidiaries, and not by CIGNA Corporation.