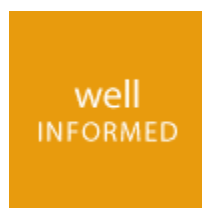




CIGNA Behavioral Health
A Business of Caring.

THE CBH PROVIDER CONNECTION

*Quarterly publication produced by CIGNA Behavioral Health's
Professional Relations Department to keep you . . .*



1st Quarter 2005
Volume XIII

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EAP CORNER

FAQs about SAPs

CBH is always in need of qualified SAPs (Substance Abuse Professionals) in our network. Below is a list of frequently asked questions we've received from providers about the SAP role, that might be helpful to our providers considering seeking this designation/certification.

Q: What do SAPs do?

A: SAPs evaluate employees who have (been accused of violating? found to have violated?) violated DOT drug and alcohol regulations, and make recommendations concerning education, treatment, follow-up testing, and aftercare. A SAP's input helps the employer decide whether an employee should return to a safety-sensitive position; for example, whether to place an employee behind the steering wheel of a school bus, in the cockpit of a plane, or at the helm of an oil tanker. Importantly, SAPs are not advocates for either the employer or the employee; their function is to protect the public safety by thoroughly and accurately evaluating the employee, recommending appropriate treatment and/or education, follow-up tests, and aftercare. SAPs do not provide the recommended treatment, however, in order to avoid any perceived conflict of interest.

Q: Who can become a SAP?

A: A SAP must have one of the following credentials:

- ## Licensed physician
- ## Licensed or certified social worker
- ## Licensed or certified psychologist
- ## Licensed or certified employee assistance professional
- ## Drug and alcohol counselor certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC); or by the International Certification Reciprocity Consortium (ICRC); or by the National Board for Certified Counselors (NBCC).

Q: If I have one of the above credentials, what else do I need to do to qualify as a SAP?

A: You also need to meet the following criteria:

- ## You must be knowledgeable and have clinical experience in the diagnosis and treatment of alcohol and substance use disorders.
- ## Be knowledgeable about the DOT regulations for the type of employer for which you are performing the evaluation, and about the SAP function in particular.
- ## You must complete qualification training covering specific subjects related to DOT regulations (go to http://www.dot.gov/ost/dapc/NEW_DOCS/part40.html for specifics).
- ## Following completion of the above training, you must pass an examination administered by a nationally-recognized professional or training organization.
- ## During each three-year period from the date you pass the exam, you must complete at least 12 hours of continuing education relevant to performing SAP functions.

Q: Where can I get the training and take the exam? Can they be done online?

A: Both can be done either online or in a classroom setting. Following are some resources (CIGNA Behavioral Health does not endorse, nor are we affiliated with, any of these organizations):

- ## Employee Assistance Professionals Association (EAPA). (703) 387-1000. www.eapassn.org. Classroom training and online examination.
- ## NAADAC. (800) 548-0497. www.naadac.org. Offers classroom training and examination, plus a home study course and examination.
- ## ICRC. (703) 294-5827. www.icrcaoda.org. Examination only.
- ## Professional Training Center / Tom Foley and Associates. (888) 876-7770. www.professionaltrainingcenter.com or www.tomfoleyassociates.com. Classroom training.
- ## Substance Abuse Program Administrators Association. (301) 540-2783. www.sapaa.com. Classroom training and home study course.
- ## Substance Abuse Program Administrators Certification Commission. (866) 538-4788. www.sapacc.org. Examination.

- # Program Services. (305) 223-9612. www.programservices.org. Home study course and examination.
- # The Institute for the Advancement of Human Behavior and Buckley Productions, Inc. (650) 851-8411. www.iahb.org. Home study course and examination.
- # American Substance Abuse Professionals. (888) 792-2727. www.go2asap.com. Home study course.
- # Blair Consulting Group. (612) 827-4147. www.blairconsultants.com. Classroom training.

Q: How does CBH reimburse SAPs?

A: CBH-credentialed providers are reimbursed for all SAP services at their 99404 rate. All time spent on the case, including administrative time, is reimbursed at the full rate.

If you have any further questions, please contact the Regional EAP Manager for your region (see *Regional Recruitment* section of this newsletter).

Regional Recruitment

New England region (CT, MA, ME, NH, RI, VT): needs SAPs, critical incident responders, and trainers (trainers deliver wellness seminars and management training) across the region. Inquire by email to Dan Fallon at Daniel.Fallon@cignabehavioral.com.

Northeast region (NY, NJ, PA): needs SAPs throughout the region, and needs critical incident responders and trainers (for wellness seminars and management training) in the following counties of New York State: Jefferson, St. Lawrence, Franklin, and Lewis. Inquire by email to Dana Kiel at Dana.Kiel@cignabehavioral.com.

Mid-Atlantic region (AR, DE, KY, MD, NC, SC, VA, WV): needs critical incident responders in Delaware, Maryland, North Carolina, and

Virginia. Inquire by email to Carlton Weinstein at Carlton.Weinstein@cignabehavioral.com.

Southeast region (AL, FL, GA, LA, MS, TN, PR, USVI): needs SAPs across the region. Inquire by email to Marsha Shewanown at Marsha.Shewanown@cignabehavioral.com.

Midwest region (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI): needs SAPs across the region. Inquire by email to Robbie Hamill at Robbie.Hamill@cignabehavioral.com.

Western region (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY): needs SAPs and critical incident responders across the region. Inquire by email to Bruce Steele at Bruce.Steele@cignabehavioral.com.

Reminder to Providers

The 17th Annual EASNA (Employee Assistance Professionals Society of North America) Institute, May 5-7, 2005, in Chicago, offers you as professionals a tremendous learning and networking opportunity. The theme this year is "Expanding the Vision: New Leverage Points for Health and Performance," and draws upon an extraordinary lineup of speakers that promises to make for an exciting and well-attended conference.

Consider the benefits of learning more about EAP today, and review the EASNA Institute's advanced program that is available on-line www.easna.org

Any references in this material to other organizations or companies, including their Internet Websites, is not an endorsement or warranty of services, information or products provided by those organizations or companies.



PROFESSIONAL RELATIONS CORNER

CIGNA Behavioral Health 2005 Provider Conferences

CIGNA Behavioral Health is proud of its provider community and wants to take the opportunity to once again show its appreciation. This year, CBH will be hosting several one-day seminars at locations throughout the United States. We are in the process of scheduling these conferences and will send out information when specific dates and locations have been determined. The seminars are open to all contracted CIGNA Behavioral Health providers. As with previous CBH conferences, Continuing Education Units (CEUs) will be provided to our contracted attendees.

Please contact your local Professional Relations department if you have questions or would like additional information.



CLINICAL CORNER

Care Advocacy Program (CAP) Update

Welcome to year two of the Care Advocacy Program! As the Care Advocacy Program develops, we continue to make adjustments to enhance the quality of the services CIGNA Behavioral Health offers to participants and providers. CBH is now moving into a new phase of Care Advocacy.

In CBH's literature review process, we have noted the reports and research from the American Medical Association and other organizations within the last few years that identify 'health literacy' as a pervasive barrier to quality healthcare and positive treatment outcomes. Additionally, CBH continually reviews the trends in the industry as to what types of services are requested by customers, participants and providers. As a result, we have chosen to extend our outreach to CBH participants – to particularly address the importance of understanding their illness and the factors that can have a strong impact on treatment outcomes. We will not be attempting to contact every participant who accesses services, but will begin with those participants who access services and are diagnosed with Major Depression.

CBH is very aware of the great work that you, participating providers, are doing and we also know the challenges that you face as the direct provider of treatment. We know that it is not unusual for patients to fail to follow prescription directions exactly - such as taking medications at structured times - and that there is an increased chance that participants will discontinue medications prematurely once they are feeling better.

CBH hopes to support providers and participants by offering participants educational information about their illness, treatment options and the impact of medications. We wanted you to know that we may be calling some of your patients to offer these services and we welcome any feedback that you may receive from patients who have requested this information. We will also be encouraging participants to make sure that they discuss any questions they may have with you – their provider.

From the positive feedback that CBH has received from participants and providers, we continue to build the educational/informational resources that are available - either online at the CBH website or via verbal requests to receive through the mail.

We look forward to assisting participants and providers in the provision of the highest quality management of benefits.

QUALITY MANAGEMENT CORNER

Providing Convenient Services

Participants need geographically convenient access to behavioral health practitioners and facilities, if they are to attend treatment appointments. Annually, CIGNA Behavioral Health measures the distance from participant residence addresses to the location of our contracted network practitioners and providers. The availability of physicians, non-physician therapists, and facilities is evaluated; as are ratios of available physicians, non-physicians, and facility providers per participant. CIGNA Behavioral Health identified nine standards for access availability and desired performance goals were set against each of these measures. Geographical access is determined, and then judged against the following standards for urban/suburban and rural practitioner and facility availability:

Practitioners	Standard	Goal
- Ratio		
	1 non-physician per 800 covered lives	1 non-physician per 800 covered lives
	1 physician per 1500 covered lives	1 physician per 1500 covered lives
- Geographic distribution		
Urban/Suburban	1 Non-MD in 15 Miles	98%
	1 MD in 15 miles	95%
Rural	1 MD in 25 Miles	85%
	1 Non-MD in 25 Miles	90%
Providers	Standard	Goal
- Ratio		
	1 facility or program per 10,000 covered lives	1 facility or program per 10,000 covered lives
- Geographic distribution		
Urban/Suburban	1 Facility in 20 Miles	80%
Rural	1 Facility in 30 Miles	80%

In 2004, CIGNA Behavioral Health measured access for each of its five operating units. The Dallas, Chesapeake, Tampa, California Operating Units and the National Care Center met all goals for geographical convenience as measured in miles from participants to practitioners and providers, with the exception of rural physician and rural facility availability at the National Care Center. The distribution of populations covered by the National Care Center nationwide is more highly biased to rural, remote geographies where the availability of physicians and facilities is limited. In these areas, non-contracted or ad hoc practitioners and providers may be called upon to assure the delivery of timely services when contracted practitioners are unavailable. Further, the National Care Center's performance may be understated, since that Operating Unit also uses "purchased" networks, available through underlying customer contracts. Performance within those networks is not included in CIGNA Behavioral Health's annual access measurement. All CIGNA Behavioral Health sites met targets for minimum ratios of participants to practitioners and providers.

Additionally, CIGNA Behavioral Health sets standards and measures performance as needed for state specific regulatory requirements. For example, the Chesapeake Operating Unit measured geographic convenience by drive time for the State of Vermont. The time standards include: 1 practitioner within 30 minutes, 1 outpatient facility within 30 minutes and 1 inpatient facility within 60 minutes. The Chesapeake Operating Unit met all time standards for the State of Vermont.

QUALITY MANAGEMENT CORNER (cont.)

Going on Record

A well-documented treatment record facilitates communication, coordination, and continuity of care. It promotes efficient and effective treatment. For each participant treated, CIGNA Behavioral Health's contracted providers agree to maintain records that are current, detailed, organized, and conducive to effective, confidential participant care and quality review.

Who was Audited?

To assess compliance in 2004, the medical record-keeping practices of selected high-volume practitioners were audited quarterly against CIGNA Behavioral Health's record-keeping standards. When selected practitioners are due for re-credentialing, five clinical records and two Employee Assistance Program records of participants they have seen in the prior 12 months are identified for review. To ensure a distribution of medical record reviews that accurately represents the distribution of practitioner type in the network, a high-volume provider is defined as:

- Ⓢ Any physician who has seen 90 or more CIGNA Behavioral Health participants in the previous 12 months
- Ⓢ Any PhD psychologist who has seen 35 or more CIGNA Behavioral Health participants in the previous 12 months
- Ⓢ Any masters-level therapist who has seen 30 or more CIGNA Behavioral Health participants in the previous 12 months

The Audit Tool

CIGNA Behavioral Health's standardized audit tool contains 32 questions, which you can view in the Practitioner Medical Record Review Tool in appendix F of your CIGNA Behavioral Health *Provider Guide*. You can also view it online on the News and Resources page in the provider section of CIGNA Behavioral Health's Web site at www.cignabehavioral.com.

Audit Results

For 2004, a total of 209 contracted providers submitted 1033 blinded clinical records for review. Our goal is at least 80% compliance with standards. Of the 209 providers whose records were reviewed, only three providers scored below 80%. The average score was 95%.

Summary of Compliance Trends

Compliance trends, based on 2004 audits, demonstrate that records are generally well documented. Highlights of the findings are as follows:

⚡ Participant identifying-information, administrative information, presenting problem, diagnosis, treatment planning, progress notes, and screening activities for safety of self and others (100%); a medical-psychiatric history (97%); a record of prescribed medications (98%); co-morbid medical conditions (98%); and the use and abuse of substances (94%); were all well documented. (Isn't the "well documented" description meant to apply to documentation of all these items?).

⚡ However, evidence for continuity and coordination of care (79%), the presence (87%) or absence (89%) of allergies, a developmental history (87%), and documentation of informed consent for medication (84%) scored lower, and each represents an opportunity for improvement in 2005.

CIGNA Behavioral Health encourages you to take advantage of the information and tools in the CIGNA Behavioral Health *Provider Guide* regarding primary care physician communication, and to generally assess your own medical record-keeping practices. We hope that you will "go on record" as an advocate for improved documentation of care, through better record-keeping.

QUALITY MANAGEMENT CORNER (cont.)

Achieving Balance

To find a commensurate balance between the availability of network diversity and participant diversity needs, CIGNA Behavioral Health annually compares the contracted practitioner and provider network with known population demographics for ethnicity, gender, age, and language. Although there is no requirement that participants or practitioners report cultural/linguistic status, many do so and CIGNA Behavioral Health encourages it, appreciating a potential relevance to the treatment experience. We make every effort to link participants with practitioners based upon clinical appropriateness, while respecting any expressed linguistic and cultural preferences. Based on the findings of the cultural/linguistic assessment for 2004, CIGNA Behavioral Health's Professional Relations department will attempt to recruit additional Hispanic and Spanish practitioners as appropriate in selected states. However, overall the network appears adequate to meet the cultural/linguistic needs of participants.

CIGNA Behavioral Health handled behavioral health benefits for more than 6 million individuals nationwide in 2004. In a typical month, more than 62,000 persons received outpatient services, and nearly 2,000 persons received inpatient care, through a network of greater than 40,000 practitioners and providers. Those using behavioral health services are annually surveyed to assess trends in satisfaction across socio-economic and demographic groups. The 2004 findings suggest a potential to improve satisfaction by increasing sensitivity and accommodation to specific population-based needs for minority, elderly, and less well-educated participants through staff training in 2005.

Key 2004 Cultural and Linguistic Findings:

Ethnicity: The District of Columbia has the highest percent of African American participants and practitioners. In states with at least 50 practitioners, the highest percent of practitioners (8.7%) and of the general population (36.3%) who are African American, is in Mississippi. For states with at least 50 practitioners, the highest ethnic concentrations are in: Florida for Hispanic practitioners (11.9%), Oklahoma for Native American practitioners (5.2%), Nevada for Pacific Island decent (1.9%), and New Jersey for Asian practitioners (6.0%).

Language: In states with at least 50 practitioners, 62.8% (27/43) of practitioners speak Spanish, a greater percentage than do the general population, aged 5 years and over. In all states, English is the most commonly spoken language. Spanish is the second most commonly spoken language in forty-four (44) of fifty-one (51) states or territories. Where Spanish is not the second most commonly spoken language, the second most common language is: French (Louisiana, Maine, New Hampshire, Vermont); German (North Dakota, South Dakota); and Tagalog (Hawaii).

Age: Of states with at least 50 practitioners, 25% or more of practitioners treat all age groups, except in Louisiana and New York, where treatment for the 1-5 year old age group is slightly less well represented. The highest percentage treatment by practitioners nationally is for the 18-59 years age group, and the smallest is for the 1-5 year age group.

Gender: In most states, there are slightly more females than males. States with greater than 50% male populations include Colorado, Idaho, Nevada, Utah and Wyoming, Alaska and Hawaii. Most networks have a higher percentage of female practitioners, except Utah where females represent 48.3% of practitioners and 49.9% of the general population.

Requests To change Practitioner or Facility: Gender is the most common cultural reason for requesting a change of practitioner.

QUALITY MANAGEMENT CORNER (cont.)

Telephone and Appointment Access

CIGNA Behavioral Health monitors performance and reports on compliance with established telephone access standards, quarterly and annually. Further, based on assessment of the clinical urgency of a participant's situation when accessing care, CIGNA Behavioral Health has established standards for timely access to appointments, which now include office wait times, and compliance is reported annually. The following table offers a summary of CIGNA Behavioral Health's access standards:

Standard Name	Standard Measure	Goal
Appointment Access		
Non-Life Threatening Emergency	Within 6 hours	100%
Urgent	Within 48 hours	90%
Routine	Within 10 working days	85%*
Office Wait Times	15 minutes or less	80%*
Telephonic Access		
Average Speed of Answer	< 30 seconds	< 30 seconds
Abandonment Rate	< 5%	< 5%

* Derived from the percent of ECHO Participant Satisfaction responses of Always and Usually.

2004 Telephonic Access Performance:

Annual measurement reveals that, with the exception of California and Chesapeake Operating Units, average telephonic speed of answer met threshold in all locations and for all of CIGNA Behavioral Health's various books of business and operations, including After Hours coverage, the Employee Assistance Program, and Disability products. Annual measurement for abandonment rates met established thresholds in all locations, for all books of business, and for all products. Improvement plans are in place in Chesapeake and California where performance had been impacted by staff attrition, new hiring and training issues.

2004 Appointment Access Performance:

Annual performance for appointment access was measured in all appointment categories and for all CIGNA Behavioral Health Operating Units and After Hours coverage. All of CIGNA Behavioral Health's Operating Units performed marginally under goal for routine appointments but the office wait time goal was met in all sites, as indicated by participant responses on the ECHO Satisfaction survey, a standardized survey administered annually, as recommended by the National Committee on Quality Assurance, that assesses satisfaction of individuals who received services. Emergent timeframes were generally close to threshold, but did not meet the performance goal in any location nationwide, while urgent timeframes were met in all locations except the Dallas Operating Unit and the National Care Center. CIGNA Behavioral Health has identified appointment access as an area of opportunity for 2005. Actions taken in 2004 to improve access include expansion of the crisis stabilization network and increased practitioner availability through growth in overall network size. Interventions planned for 2005 include the creation of a new Intermediate Care network that will intervene to provide precautionary and preventive care to participants who could escalate to higher levels of care without timely and effective response.

QUALITY MANAGEMENT CORNER (cont.)

Identifying and Overcoming Health Care Disparities

Some populations experience access to health care very differently from others, and the reasons are both complex and challenging. However, disparities in access should not be allowed to contribute to disparities in the health outcomes of any population.

Through thoughtful partnership with our practitioner and provider network, we know that improvements in health care access and outcomes can be achieved. CIGNA Behavioral Health encourages you to consider issues and solutions over which you have control within your practice, particularly for minority, elderly, and less-well-educated participants, who may need increased sensitivity and responsiveness in order to enter and sustain care.

CIGNA Behavioral Health addresses some of the potential problems in the following ways:

Possible Cause:	Possible Solutions:
Geography or lack of transportation may limit availability of or access to care providers	<ul style="list-style-type: none"> ## Assess geographic availability ## Measure appointment access
Consistent longitudinal relationship with health care provider may be lacking, leading to failure of screening and early detection	<ul style="list-style-type: none"> ## Provide tools to primary care physicians to identify and manage behavioral disorders ## Collaborate with medical providers
Language barriers	<ul style="list-style-type: none"> ## Use telephonic translation services ## Make materials available in languages other than English
Attitudes toward health care may limit willingness to seek or sustain care	<ul style="list-style-type: none"> ## Outreach following inpatient discharge ## Mail Care Advocacy Program educational materials upon receipt of the first claim for service ## Provide Internet-based educational materials
Language barrier or lack of formal education may disrupt relationships with care providers	<ul style="list-style-type: none"> ## Evaluate written communications for reading level ## Use telephonic translation services ## Make materials available in languages other than English
Systemic barriers and complexity, with no advocate to assist in navigating the health care system	<ul style="list-style-type: none"> ## Initiate collaboration to provide single points of entry for co-morbid conditions ## Provide assistance through Personal Care Advocates ## Provide online provider directories ## Create open-access model for routine care
Failure to take advantage of preventive health opportunities	<ul style="list-style-type: none"> Publicize availability of preventive health programs ## Encourage use of programs and services through outreach

QUALITY MANAGEMENT CORNER (cont.)

ParentsMedGuide.org: A Pediatric Depression Resource, Now Available

On February 1, 2005, the American Psychiatric Association (APA) launched a new resource center for parents of children and adolescents with depression, as well as for physicians who treat them. The new Web site, www.ParentsMedGuide.org, is the product of a large coalition of medical, family and patient-advocacy organizations.

In addition to advice for families, the Web site contains a fully footnoted *Physicians Medication Guide* written for frontline physicians who have joined with parents to seek more accurate information about pediatric depression, treatment alternatives, and the latest science and research findings. The guides and the site will be updated on an ongoing basis with the latest scientific and medical research. *

The Parent Guide can be found on the Web at:

<http://www.parentsmedguide.org/parentsmedguide.htm>

The Physician Guide is at:

<http://www.parentsmedguide.org/physiciansmedguide.htm>

The Physician Guide includes a summary of the Food and Drug Administration's decision to place a black box warning on all antidepressant medications used to treat depression and other disorders in children and adolescents. The guide also includes information on recognizing, diagnosing, and treating childhood and adolescent depression, and risk factors for suicide.

* Any references to other organizations or companies, including their Web sites, is not an endorsement or warranty of services.

National Care Center Accreditation

CIGNA Behavioral Health's National Care Center (NCC) in Eden Prairie, Minnesota, has earned a three-year, full accreditation for Managed Behavioral Health Organizations from the National Committee for Quality Assurance (NCQA). The accreditation is effective from November 2004 through 2007, and applies to 2.3 million participants who are enrolled nationwide in commercial, managed behavioral health products administered through that site.

The exceptional results of the National Care Center survey match those of CIGNA Behavioral Health's Chesapeake Care Center in Lutherville, Maryland, which also earned three-year, full accreditation status from NCQA in January 2003. The Chesapeake care center serves nearly 1.3 million members from several health plans located in ten eastern states, as well as the District of Columbia.

Taken together, the survey results for the National Care Center and the Chesapeake Care Center demonstrate that CIGNA Behavioral Health's commitment to excellence in quality of care and service is displayed consistently throughout our care management system.

NCQA grants full accreditation for a period of three years to only those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards. NCQA accreditation standards are intended to help organizations achieve the highest level of performance possible, reduce patient risk for untoward outcomes, and create an environment of continuous improvement.

The National Care Center received the highest possible outcome in the NCQA accreditation survey. NCQA highlighted several areas of excellence, including thoughtful and meaningful quality improvement activities. Most notable were improvements in appointment access times for members, reduced hospital readmissions for those with mental illness, and improved practitioner satisfaction.

QUALITY MANAGEMENT CORNER (cont.)

Bridging the Care From Inpatient to Outpatient

The period immediately following discharge from hospitalization can be a difficult time for patients. Failure to engage them in outpatient services during this time greatly increases the probability of relapse and readmission. As a result, CBH has been striving to improve the percentage of its participants being seen within seven days of discharge from the hospital.

Literature has demonstrated that facilitating the linkage from inpatient to outpatient care increases the likelihood of the participant attending scheduled follow-up. This linkage consists of:

- £ Starting aftercare with the outpatient practitioner while the participant is still in the inpatient setting
- £ Communication between inpatient staff and outpatient clinicians about the patient's discharge plans
- £ Involving family/loved ones during the hospital stay and in discharge planning

In order to support the linkages, CBH has taken the following steps:

- £ Arranging inpatient pre-discharge consultations (aka *meet-and-greet* visits) between the patient and the outpatient practitioner
- £ Reimbursing practitioners at a higher rate for the meet-and-greet service

What is a “Meet-and-Greet”?

Inpatient pre-discharge consultations, or meet-and-greets, are visits conducted by contracted non-MD practitioners for the purposes of establishing clinical rapport with the participant and scheduling an ambulatory follow-up appointment within two to seven days after discharge. These visits are initiated by CBH and require prior benefit authorization from a CBH care manager or care coordinator.

Frequently Asked Questions About Meet-and-Greets

£ **Does a practitioner have to be credentialed by or affiliated with the facility?**

Practitioners enter the facility as visitors; therefore they do not have to be credentialed by or affiliated with the facility. Please note that meet-and-greets are usually performed during visiting hours, but scheduling may vary by facility.

£ **Does the participant have a co-pay for this service?**

Participants do not have a co-pay for this service as long as the network practitioner has obtained a benefit authorization from a CBH care manager or care coordinator.

£ **Which CPT code should practitioners submit with their claim form?**

Practitioners should submit their claim with CPT code 99499 – *unlisted evaluation/management services*. Claims will be processed only if practitioners include a written description of the service provided; i.e., “pre-discharge consultation, or meet-and-greet.” Without a written description by the practitioner, the claim will not be processed, for lack of information. Unfortunately, claims for this service cannot be filed online because comments cannot be entered on the online CMS-1500/HCFA form.

£ **How much is a practitioner reimbursed for this service?**

Reimbursement for a 99499 varies by licensure and state. Please refer to your fee schedule for your specific reimbursement rate, or contact your local CBH Professional Relations department.

£ **How does a practitioner become listed as available for this service?**

If you are interested in having this specialty listed in your profile, please e-mail your Professional Relations department at: ProviderEducation@cignabehavioral.com.

QUALITY MANAGEMENT CORNER (cont.)

Enhancements to Primary Care Physician Web Pages

In our continuing commitment to the continuity and coordination of medical and behavioral care, CIGNA Behavioral Health has enhanced its Web site pages for primary care physicians. These pages contain useful information and tools to assist primary care physicians to identify and manage behavioral disorders and co-morbid behavioral conditions that appear frequently in the primary care setting.

CIGNA HealthCare's primary care physician network is informed about this resource through the CIGNA HealthCare physician newsletter and provider relations department. Additionally, many of the materials are cross-posted on CIGNA HealthCare's Web site pages for physician access and reference. All the materials are free for primary care physicians to use and download.

CIGNA Behavioral Health's *Tools for Primary Care Physicians* can be found in the provider section of CIGNA Behavioral Health's Web site at www.cignabehavioral.com. Follow the link for "News and Resources," and then for "Tools for Primary Care Physicians," in the left sidebar. The destination page, entitled "Treating Behavioral Conditions," contains links to the many available documents. For depression, attention-deficit/hyperactivity disorder, alcohol, and behavioral conditions in pregnancy, condition management resources include:

- ☞ Interactive Practice Guidelines
- ☞ Printable Practice Guidelines
- ☞ Participant Tool Kits
- ☞ Practitioner Tool Kits
- ☞ Articles of interest

All materials and guidelines available on CIGNA Behavioral Health's primary care physician pages were designed and approved specifically for use by primary care physicians. We encourage you to explore them and mention them in your collaborative communications with primary care physicians as a regular part of your practice.



CLAIMS/CUSTOMER SERVICE CORNER

CIGNA Behavioral Health Claims Operations recognizes that administrative service delivery impacts the provider's experience. We would like to share some administrative improvements completed during 2004 using Six Sigma project methodology:

- § Requesting additional information prior to finalizing a claim
- § CBH correspondence for additional information.

These changes have resulted in more efficient claims processing and improved communications with our provider community.

2004 Improvements

§ On 7/13/04, CBH simplified the processing of incomplete claims (i.e. incomplete, missing or termed procedure or diagnosis codes). Prior to this date, CBH would pend the claim and send letters at 30-day intervals requesting the information needed to finalize the claim. Currently, CBH will deny these charges with a comment requesting a corrected bill, thus reducing the volume of letters sent to the provider.

§ All claims letters and requests for information were rewritten and became effective 12/16/04. Approximately 90% of all letters are now printed in a 1 or 2-page format.

§ Letters are now directed to a provider or a member based upon who can supply the needed information. A “delay letter” then informs the other party when a claim requires additional information prior to resolution. For example, a request for provider credentials would be sent to the provider; the member would receive a “delay letter.”

Claim Reminder:

When submitting services for medication management use CPT Code 90862; M0064 is not a recognized CPT code on a contracted provider’s fee schedule, nor is it compatible with CBH’s Care Advocacy Program (CAP). Submission of a claim with Code M0064 will result in a claim denial and will require a new submission with the corrected code for processing.

We want to hear from you. Do you have any feedback about “The CBH Provider Connection” newsletter? Do you have suggestions for article topics? Please email us at <mailto:ProviderServiceDel@CIGNABehavioral.com>.

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