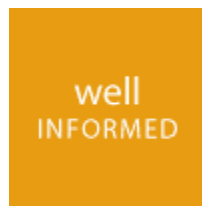




THE CBH PROVIDER CONNECTION

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



1st Quarter 2006 Volume XVII

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EAP CORNER

TIPS FOR EAP PROVIDERS

The year 2006 is off to a running start and the demand for EAP services is expected to increase in the coming months. To help you have a successful experience providing EAP services to CIGNA Behavioral participants, we have compiled this short list of reminders:

- Be sure to use the 99404 CPT code when billing CIGNA Behavioral for EAP services you provide. This will ensure that your filed claims are paid in an efficient and timely manner.
- Participants are given an authorization number and are told to give you this number when they call for an appointment or come to your office.
- Clinical audits by purchasers of EAPs are becoming more frequent. It is important that your files reflect comprehensive EAP assessments, and that you document post-EAP referrals.
- If you are one of our critical incident response providers, we would like to thank you for your hard work addressing our customers' difficult workplace losses in the past year. Please keep in mind, especially when providing these services to banks and other financial institutions, that any questions or issues pertaining to workplace security should be immediately referred to the customer's corporate security division.

Finally, the CBH website at www.cignabehavioral.com has many resources that employees may find helpful. Please refer them to our website and advise them to get their *employer ID* and *pin* from their employer.

REGIONAL RECRUITMENT

New England (CT, MA, ME, NH, RI, VT): needs EAP counselors, SAPs, and critical incident responders* across the region, and experienced trainers** throughout Connecticut, Massachusetts, New Hampshire and Maine. Inquire by email to Dan Fallon at Daniel.Fallon@cignabehavioral.com.

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

Mid-Atlantic (AR, DE, KY, MD, NC, SC, VA, WV): needs critical incident responders* in Delaware, Maryland, North Carolina, Virginia, and Washington, D.C., and trainers** in the Baltimore/Washington area. Inquire by email to Carlton Weinstein at Carlton.Weinstein@cignabehavioral.com.

Southeast (AL, FL, GA, LA, MS, TN, PR, USVI): needs SAPs and trained critical incident responders across the region.*



Inquire by email to Jeff Van Pelt at jeffrey.vanpelt@cignabehavioral.com.

Midwest (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI): needs SAPs across the region, especially in northern Michigan and Minnesota. We also need critical incident responders in the Houston area. Inquire by email to Robbie Hamill at Robbie.Hamill@cignabehavioral.com.

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

*Critical incident responders must have training in critical incident debriefing protocols.

**Trainers deliver wellness seminars and management training.

PROFESSIONAL RELATIONS CORNER

EIGHT WAYS TO INCREASE YOUR CBH REFERRALS

1. **Update Demographic Information:** Keeping up to date such information as your current service address, telephone, fax, and tax ID number is essential for receiving referrals and timely payments from CBH. This information can be updated online at:
<http://apps.cignabehavioral.com/web/basicsite/provider/toolsAndSupport/onlineTools.jsp>

2. **Update Your Specialties and Populations Served:** Updating your specialties, the populations you serve, and your “diversity information” ensures that you are getting the appropriate types of referrals. Some privileged specialties have special requirements. Please contact your *Provider Education Specialist* (PES) if you would like to review or update your list of specialties, or if you have questions (see below for contact information).
3. **SAP/DOT:** Please let us know if you have obtained a Substance Abuse Professional (SAP) certification as defined by the Department of Transportation (DOT). You will need to submit copies of your certificates to your local CBH Professional Relations department. Contact your PES for any questions or concerns regarding this process.
4. **Crisis Stabilization:** Join the CBH *Crisis Stabilization network*—a nationwide initiative to ensure that participants who are experiencing a mental health emergency can see a provider within six hours of the initial phone call. You can obtain more information or join the network by contacting your PES.
5. **Intermediate Care:** Join the *Intermediate Care network*—a level of intervention that provides precautionary and preventive care to participants who present with a level of acuity that, if not addressed



within 48 hours, could escalate to needing a higher level of care. If you have questions regarding this service, or want to join the Intermediate Care network, contact your PES.

6. **Critical Incident Response:** If you have received training or have experience performing *critical incident stress debriefings*, we invite you to join our Critical Incident Response Team. Please contact your PES if you have any questions.
7. **Inpatient Pre-Discharge Consult:** Also known as a “meet and greet,” its purpose is for the provider to meet the participant while he or she is still hospitalized, so the participant will feel more comfortable with the discharge plan. A meet and greet service does not encompass a therapeutic intervention. The goal is to help the participant establish a connection and some initial rapport with their therapist prior to being discharged from the hospital. This service is coordinated with the facility and usually scheduled during visiting hours.
8. **Provider Profile Information:** As of January 2005, CIGNA Behavioral Health has the ability to help providers market and identify opportunities to expand and enhance their practice. Providers are now able to post their photo and a practice outline on the CBH website at www.cignabehavioral.com. If you need assistance with your

online profile, you can contact our Web support line at 800.334.8925.

You can contact your Provider Education Specialist by sending an email to ProviderEducation@Cignabehavioral.com.

QUALITY MANAGEMENT CORNER

DALLAS REGIONAL CARE CENTER RECEIVES FULL ACCREDITATION BY NCQA

CIGNA Behavioral Health’s Regional Care Center located in Dallas, Texas, has received *full accreditation* by the National Committee for Quality Assurance (NCQA). The accreditation was effective December 2005 and extends for a three-year period.

The accreditation was awarded following the NCQA’s extensive review of the Care Center’s customer service and clinical quality performance, as compared with the requirements of the NCQA’s Managed Behavioral Health Organization (MBHO) standards for Quality Management and Improvement, Utilization Management, Credentialing and Recredentialing, Enrollees’ Rights and Responsibilities, and Preventive Health. A rigorous on-site evaluation was part of the process, and criteria included member satisfaction, quality of care, access, and service. The Dallas Regional Care Center demonstrated strong member satisfaction and clinical quality scores.



NCQA is a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. Its mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, and to make more informed health care purchasing decisions. The NCQA's governing Board of Directors includes employers, consumer and labor representatives, health plans, quality experts, policy makers, and representatives from organized medicine.

CIGNA Behavioral Health is committed to excellence in quality and service. In addition to our Dallas Regional Care Center, two other Regional Care Centers, located in Maryland and Minnesota, have been awarded full accreditation status from the NCQA. "We are committed to ensuring that our members get the personal support and help they need to manage their behavioral health concerns," said Keith Dixon, president and chief executive officer of CIGNA Behavioral Health. "We are pleased that the NCQA has recognized our excellence in these areas."

YOU ARE NOT ALONE

In the complex play between emotions and physical illness, coordination between behavioral care and primary care is essential for optimal outcomes. However, health plans are moving away from the requirement that PCPs act as gatekeepers for participant care, and CIGNA Behavioral Health's Care Advocacy Program offers participants

access to routine outpatient care without contacting us for pre-authorization. These changes pose new challenges to coordination between behavioral and primary care. Below are some of the ways these challenges are being met.

We Do

To encourage appropriate, collaborative communication between behavioral providers and PCPs, CIGNA Behavioral Health's provider contracts explicitly state the expectation that this will occur. Our *Provider Guide* offers communication guidelines and tools for this purpose. Our protocols for follow-up and monitoring of inpatient care address medical-behavioral communication, as do our protocols for high-risk cases. Further, an innovative and collaborative care management project provides participants with the full range of medical and behavioral resources when care access involves comorbid conditions. Additional steps being considered include target materials for our participant education library, and the placement of prompts, along with a downloadable consent form, near the online *Provider Directory* that is used by participants to select practitioners on our website.

You Do

CIGNA Behavioral Health's network practitioners and facility providers are expected to obtain primary and medical care providers' contact information from participants, discuss the case-specific importance of



communication, and obtain a signed consent form, as required by law for the exchange of information. If the participant refuses to grant this permission, the provider should document the participant's refusal and reasons. Communications may be written, faxed, or telephoned, but must be conveyed in a confidential manner.

Say: "How Do You Do"

With proper consent, facilities may contact primary care physicians upon admission and discharge. Outpatient practitioners are expected to exchange appropriate clinical information directly with PCPs in an effective and timely manner throughout treatment. In CIGNA Behavioral Health's *Provider Guide*, which is available on our website for reference and download, the minimum expectations for exchange of information between PCPs and behavioral health practitioners are as follows:

- After the initial assessment, to include diagnosis, medication, initial treatment plan, and diagnostic tests recommended or ordered
- When a participant is not compliant with treatment recommendations
- When a participant's condition is unstable
- When there are clinically significant changes in a participant's condition and/or level of care, including but not limited to inpatient treatment, partial hospitalization, intensive outpatient treatment, comorbid medical and behavioral conditions,

new or substantial medication changes

- At the completion of behavioral treatment

Appendix L of the *Provider Guide* includes a sample consent form, letter, and a new *Behavioral Health Practitioner/Facility to Primary Care Physician Communication Form*, added for 2006, that helps to standardize communication in a convenient and easy-to-use format. You are welcome to use these tools to support your communication with PCPs.

MEETING DIVERSITY NEEDS

A diverse provider network is essential to meeting the needs of a diverse healthcare membership. Earlier articles in our newsletter reminded practitioners that diversity may impact access to care for some individuals, and outlined suggestions to assure that disparities do not occur.

In 2005, CIGNA Behavioral Health implemented two related initiatives. Staff was trained to be more sensitive to diversity, and practitioners were encouraged to provide their specialty and diversity information for our provider directory. The latter may help to increase your referrals, and it helps us to assess the network's ability to respond to participant linguistic and cultural preferences.

To assess the adequacy of our network 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 or linguistic status, many do so because they recognize the potential relevance to treatment.

Key 2005 Cultural and Linguistic Findings

Ethnicity: In states where CIGNA Behavioral Health's network included at least 50 practitioners, and where the ethnic population constituted 25% or more of the state's population, the ethnicity of the population and the network were compared.

The following opportunities for network recruitment were found where population distributions were larger than network distributions for a given minority. In the states of California, Arizona, Nevada, New York, Colorado, Texas, and New Mexico, the percentage of Hispanic individuals in the general population exceeded by at least 10% the percentage of the practitioners in the CIGNA Behavioral Health network who identified themselves as Hispanic. In the states of New York, Mississippi, Louisiana, South Carolina, Maryland, Georgia, Alabama, Virginia, North Carolina, Arkansas, Tennessee, Florida, and Illinois, the percentage of black individuals in the general population exceeded by at least 10% the percentage of the practitioners in the CIGNA Behavioral Health network who identified themselves as black. There were significant clusters of Hispanic individuals in the states of Arizona, Florida, New Mexico, and Texas; of blacks in the states of Alabama,

Georgia, Maryland, Michigan, Mississippi, and North Carolina; of Native Americans in Oklahoma; and of Asians in the states of Hawaii, Virginia, Oklahoma, and Wyoming. However, except as noted, network resource distribution was adequate to population distribution.

Language: In all states, English is the most commonly spoken language. Spanish is the most common non-English language spoken at home. At home, Spanish is spoken by greater than 25% of the population in California, New Mexico, and Texas. Opportunities for recruitment appear in Texas, where 27% of the population speaks Spanish at home, but only 10.3% of the practitioners speak Spanish; and in California, where 25.8% of the population and 15.2% of the practitioners speak Spanish. Where Spanish is not the second most commonly spoken language, the second most common language is as follows: French (Louisiana, Maine, New Hampshire, Vermont); German (North Dakota, South Dakota); and Tagalog (Hawaii).

Age: The highest percentage of CIGNA Behavioral Health network practitioners (ranging from 88.6% to 99.4% by state) treat the 18- to 59-year-old group. The age group with the smallest percentage of CIGNA Behavioral Health network practitioners (5.4% to 34.2% by state) is the one- to five-year-old group. No noteworthy opportunities for improvement were revealed by the age analysis.

Gender: In most states, there are slightly more females than males



among the general population, as well as among CBH participants and practitioners. States with greater than 50% males include Colorado, Idaho, Nevada, Utah, Wyoming, Alaska, and Hawaii. Most states in CBH networks have a higher percentage of female practitioners; the only exception is Utah, where females and males each represent 50% of the network. No noteworthy opportunities for improvement were revealed by the gender analysis.

ANNOUNCING A NEW DEPRESSION MANAGEMENT PREVENTIVE HEALTH PROGRAM

According to the National Institutes of Health, depression is one of the most common mental illnesses, affecting more than 20 million Americans each year. The CIGNA *Well Aware for Better Health*® program for depression, available January 1, 2006, integrates the company's expertise in behavioral health, pharmacy, and medical management to more readily identify members with depression and get them appropriate care. Participants are identified through claims for depression treatment and medications used to treat depression. Identified members receive a letter inviting them to participate in the program.

Features of the new depression-disease-management preventive health program include:

- Personalized coaching and intervention from CIGNA Behavioral Health professionals to help participants manage their

depression and the impact it has on their lives.

- Identification and intervention to avoid drug interactions and ensure appropriate pharmacy management of antidepressants.
- Ongoing education and support from behavioral health specialists to help participants follow the treatment plan recommended by their primary care physician. Specialists also help to coordinate referrals for more specialized care, as needed.
- Information and tools to help participants and family members better understand and manage depression and potential medication side effects.
- Education about depression and depression management for primary care physicians and OB/GYNs, as well as customized feedback about their patients' progress to help ensure seamless and coordinated care.

CIGNA *Well Aware for Better Health*® consists of eight condition-specific disease management programs. Each program provides initial depression screening and response, but the new depression disease management program offers a highly integrated approach for participants whose depression has already been identified. Because it provides information, tools, and resources, this program is considered a tertiary preventive health initiative. Goals include providing information about depression and the importance of treatment compliance; monitoring, managing, and reducing the impact and severity of depression;



and providing practitioners with resources to improve the safety and outcomes of care.

With more than 600,000 participants, CIGNA *Well Aware for Better Health*® is the nation's largest population-based disease management program, consistently delivering outstanding results for improving health and reducing costs. *Well Aware for Better Health*® earned national recognition, including the Disease Management Association of America's 2005 Health Plan Disease Management Leadership Award.

TELEPHONE AND APPOINTMENT ACCESS

Ease of access to care is a strong predictor of overall participant satisfaction and is a critical component of health-care service and quality. CIGNA Behavioral Health measures access to care regularly, and standards are defined for both telephonic responsiveness and appointment access:

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%*

Standard Name	Standard Measure	Goal
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.

2005 Telephonic Access Performance

In addition to the *Intake* line, CIGNA Behavioral Health offers callers a *Crisis Line* to facilitate response that is consistent with clinical presentation. Automated reporting systems continuously monitor responsiveness to participant telephonic calls and assess whether participants receive timely information and assistance in obtaining services. Both the *Intake* and the *Crisis* phone lines are monitored.

Annual measurement for the *Intake* line reveals that, with the exception of the Employee Assistance Program and the California and Chesapeake Operating Units, average telephonic speed of answer and abandonment rates met threshold in all locations and for all of CIGNA Behavioral Health's various books of business and operations, including for After Hours coverage and the CIGNA Preferred Provider Organization. Those locations not meeting standards did so by year-end, as misdirected calls and staffing issues were resolved. Additionally, on the 2005 Participant Satisfaction Survey, participants expressed a strong desire



to be better-educated and informed about treatment options and local resources. In response, CIGNA Behavioral Health enhanced its Care Advocacy Program (CAP) to provide additional information and resources to callers. This higher level of service increased call duration, contributing to increased latency of response to incoming calls on the Intake line.

Annual measurement for the Crisis Line reveals that all locations met threshold for average telephonic speed of answer and abandonment rate. There are opportunities for improvement in 2006 on average speed of answer and abandonment rates on the Intake line.

2005 Appointment Access Performance

Stringent service expectations led CIGNA Behavioral Health to establish high goals for appointment access, such that only one in five Operating Units met goal for each of the measured access categories in 2005. However, all Operating Units noted year-over-year improvement for routine and urgent access. Non-life-threatening emergent access improved for four of five Operating Units. Statistically significant improvement was achieved by one Operating Unit for routine access, by three Operating Units for urgent access, and by two Operating Units for non-life-threatening emergent access.

Timely access to care was supported by placing a note near the Online Provider Directory about our access standards, and a reminder to call CIGNA Behavioral Health for assistance if

difficulty is experienced in securing appointments within stated time frames. Critical to access improvements for urgent care needs was the development of the intermediate care network that provides additional care options and reduces the risk for higher levels of care. Finally, the continued growth and refinement of the Crisis Network to offer 24-hour and business-day emergency appointments opened the way for additional practitioners to serve participants with emergent needs, and this was a key to improved non-life-threatening appointment access.

WEBSITE UPDATE: CLINICAL PRACTICE GUIDELINES

Last quarter we reported that CIGNA Behavioral Health has, wherever possible, adopted source documents from professional societies (e.g., American Psychiatric Association, American Academy of Pediatrics) for our *Clinical Practice Guidelines* that guide clinical decision-making.

We encourage you to visit and explore a new page on the CIGNA Behavioral Health website that was created for our behavioral health practitioners. It is dedicated to the *Clinical Practice Guidelines* that are currently in use by CIGNA Behavioral Health, and it provides links to the sources, as well as to tools for practitioners and participants.

The link for the new *Clinical Practice Guidelines* page can be found in the Provider section of our website, on the "Provider Resources" page, under the "Clinical" list. The direct link is:



<http://apps.cignabehavioral.com/web/basic/site/provider/newsAndLearning/practiceGuidelinesForBehavioralHealthPractitioners.jsp>

PROVIDING CONVENIENT SERVICES

Participants need access to geographically convenient behavioral health practitioners and facilities, if they are to attend treatment appointments. Annually, CIGNA Behavioral measures the distance from participants' homes to our contracted network practitioners' and providers' offices. The availability of physicians, non-physician therapists, and facilities is evaluated, as are ratios of available physicians, non-physicians, and facility providers *per participant*. 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 physician per 1500 covered lives	1 physician per 1500 covered lives
	1 non-physician per 800 covered lives	1 non-physician per 800 covered lives

Practitioners	Standard	Goal
- Geographic distribution		
Urban/ Suburban	1 MD in 15 miles	95%
	1 Non-MD in 15 Miles	98%
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 2005, CIGNA Behavioral Health measured access for each of its five operating units. The Dallas, Chesapeake, Tampa, and 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 for the Preferred Provider Organization. The distribution of populations covered by the Preferred Provider Organization is skewed toward 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 Preferred Provider Organization's performance may be understated, since that product also uses "purchased" networks, available through underlying customer contracts. Performance within these 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, where necessary, CIGNA Behavioral Health sets standards and measures performance as needed for state-specific regulatory requirements. Performance consistently meets these state-specific requirements.

2005 MEDICAL RECORD REVIEW FINDINGS

CIGNA Behavioral Health establishes treatment record standards to facilitate communication, coordination, and continuity of care, and to promote efficient, confidential, and effective treatment. Medical records should reflect all diagnostic, therapeutic, and ancillary services that practitioners provide, or for which they refer elsewhere. Contracted practitioners and providers agree to maintain records that comply with CIGNA Behavioral Health's requirements for record content, organization, confidentiality, and ease of retrieval.

Medical Record Review Process

To assess compliance with its medical record standards in 2005, the medical-record-keeping practices of selected high-volume practitioners were audited quarterly. In 2005 CIGNA Behavioral Health used a standardized audit tool that can be reviewed in Appendix F of the CIGNA Behavioral Health *Provider Guide*. To improve impartiality and reliability of scoring, our record reviewers were trained and two separate inter-reviewer reliability tests were administered.

As high-volume practitioners near time for recredentialing, participants seen by them in the prior 12 months are identified. A letter is sent to selected practitioners soliciting blinded copies of five clinical records and two EAP records that were chosen by CIGNA Behavioral Health for review. Should a practitioner's records fail to meet the goal established for compliance, the practitioner is notified and deficiencies must be resolved within 90 days. The percentage, by discipline, of medical records reviewed accurately represents the distribution of each 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 Ph.D. psychologist who has seen 35 or more CIGNA Behavioral Health participants in the previous 12 months
- Any master's level therapist who has seen 30 or more CIGNA



Behavioral Health participants in the previous 12 months

Medical Record Review Findings

For 2005, a total of 249 contracted network practitioners submitted 1,221 medical records for review. The goal is 80% overall compliance with standards. Of the 241 practitioners whose records were reviewed, 24 practitioners, or 9.6% scored below the 80% compliance goal.

Compliance trends, based on 2005 audits and changes from 2004, indicate that records are generally well-kept, but that opportunities for improvement do exist. The 2005 average overall compliance score declined to 91.1% from 95% in 2004. Four items did not meet the 80% threshold in 2005: documentation of allergies (78.9%), time frames for treatment goals (79.1%), dates of follow-up appointments (70.3%), and a record of prescribed medications (77.8%). Further, the general trend was for declining scores and in 2005 the only improvements were for: documentation for continuity and coordination of care (82.9%), developmental history (93.6%), and informed consent for medication (92.9%).

Record documentation strengths in 2005 included the presence of: participant identifying information and administrative information, presenting problem, diagnosis, treatment plan, legible progress notes, and medical/psychiatric history—all scored 95% or better.

The following declines were notable and each represents an opportunity for improvement: Dates of follow up appointments (declined by 24.9%), time frames for achievement of treatment goals (declined by 11.8%), participants noted to be homicidal or suicidal were referred to the appropriate level of care (a 6.4% decline from 100% in 2004), and “allergies or lack of allergies” continues to be missing around 20% of the time.

Next Steps

For 2006, tabulation of results in the Medical Record Review tool was automated to reduce errors in scoring, and several questions have undergone revision. The question concerning continuity and coordination of care has been divided into two questions: one that addresses coordination of behavioral care with the PCP, and another that addresses coordination of behavioral care with other behavioral care practitioners, institutions, and ancillary providers. Two 2005 questions about allergies and adverse reactions are now combined into one, which also asks whether the medication and nature of the reaction were documented. Finally, a non-scored question was added to ascertain whether practitioners are using standardized diagnostic and severity instruments, such as the PHQ-9 and the AUDIT.

CIGNA Behavioral Health encourages you to take advantage of the information and tools regarding PCP communication that are located in our *Provider Guide* (see link at end of article), and to assess your own medical record-



keeping practices. We hope that you will help us to improve the documentation of care, through better record keeping.

Link to CBH *Provider Guide*:

<http://apps.cignabehavioral.com/web/basic/site/provider/newsAndLearning/providerguide.jsp>

CLAIMS/CUSTOMER SERVICE CORNER

CHANGES TO CPT CODES FOR PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING

We have received many inquiries from psychologists about CPT code changes. CBH is aware of the recent changes and we have revised our claims system to accommodate the new codes. In 2006 you must bill using the updated CPT codes in order to be reimbursed for services provided.

CLINICAL CORNER

BUPRENORPHINE AND THE SUBLINGUAL PREPARATIONS: SOME INFORMATION ABOUT A NEW TREATMENT FOR OPIOID DEPENDENCE

So What is the Big Deal About Buprenorphine?

Several changes in the last six years have had an impact on the treatment

of opioid abuse, including the passage of the Drug Addiction Treatment Act of 2000, and the FDA approval of two sublingual forms of buprenorphine for detoxification and maintenance treatment. Therefore, it is now possible for all qualified physicians, even in outpatient settings, to provide opioid detoxification and maintenance treatment. This is a significant change from traditional maintenance programs (mostly methadone-based) where there are stricter regulations and the need for daily program attendance. With the advent of more flexible requirements for the treatment of opioid dependence using the sublingual forms of buprenorphine, we can now open the doors for more participants and offer another, more reasonable, treatment option for both detoxification and maintenance.

How it Works

Buprenorphine has its principal effects on the mu receptors. Buprenorphine is actually a partial agonist at the mu receptor, with a high affinity and slow dissociation from this receptor. It is at the mu receptors that buprenorphine has its major actions and subsequent effects. Because it is a partial agonist at higher doses, there is a ceiling on its effects, unlike the purer agonists, such as morphine and methadone, which continue to have increased receptor activity as the dose is increased. Being a partial agonist, at lower doses buprenorphine acts as a weak agonist, but at higher doses it has more antagonistic effects to other opioids that are agonists, such as morphine. Due to the higher affinity of this partial



agonist, it can displace the purer agonists such as morphine. This displacement with its weaker agonistic effects leads to less euphoria, less intense withdrawals, decreased probability of intoxication, and less risk of overdose than found with other opioids. At the same time, it allows the participant to have a more comfortable detoxification.

Buprenorphine has FDA Approval for Some Uses

These include opioid detoxification and opioid maintenance. However, only the sublingual forms, including a buprenorphine/naloxone combination, have been approved for the treatment of opioid maintenance.

Why do we Have Different Buprenorphine Preparations?

It is important to remember that although buprenorphine is a generic form, there are several different preparations, including a parenteral form of buprenorphine that is not approved for opioid maintenance, and that has a higher potential for abuse than the sublingual forms. The sublingual combination of buprenorphine and naloxone is the more commonly used form for both detoxification and maintenance. In the sublingual combination of buprenorphine/naloxone the mixture of buprenorphine and naloxone is in a ratio of 4 to 1, respectively. In this sublingual form, the buprenorphine has a bioavailability

of at least 30-40 percent that of the parenteral form, where the naloxone component has poor bioavailability after sublingual absorption. But when dissolved and used parenterally, naloxone has a high bioavailability. So naloxone has minimal effects through sublingual absorption and is primarily used in the sublingual preparation as a way to prevent abuse by participants attempting to dissolve the sublingual preparation, leaving a mixture of buprenorphine and naloxone. When this dissolved mixture is taken parenterally, the dissolved naloxone, with its increased bioavailability, then exerts an antagonistic effect, hence blocking the euphoria. In addition, naloxone can precipitate a rapid withdrawal for those already on other opioids. In the case of the sublingual preparation of just buprenorphine, there is no naloxone, and therefore when it is dissolved and used parenterally it has a higher likelihood of diversion and abuse. Due to this higher risk, the sublingual preparation with just buprenorphine is used more in situations where there is a high risk of complications due to withdrawal, such as in pregnant women (pregnant women should not have naloxone in the sublingual form.)

Detoxification and Maintenance

There are suggested dosing strategies for outpatient and inpatient detoxification and maintenance treatment for opioid dependence using the sublingual preparations of buprenorphine. For



further information, go to www.suboxone.com.

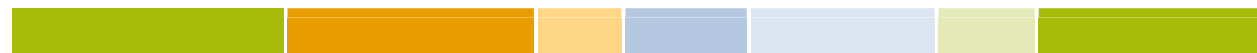
Who is a Candidate for Buprenorphine Use?

Remember, not everyone is a good candidate for outpatient detoxification, or even maintenance treatment, with the sublingual buprenorphine preparations. Participant selection should take into account many factors, including psychosocial issues (living arrangements, sober living environment, stability of home environment, etc.), medical and psychiatric stability, drug-drug interactions, work environment, special populations (e.g., participants who are pregnant), as well as Resistance to treatment and past failures at detoxification. In addition, family

support, NA or AA, and other forms of psychosocial rehabilitation should be implemented simultaneously when induction is started, and should be ongoing.

The clinical guidelines and information featured in this article are intended only as a tool to assist you in the evaluation and treatment of your patients. These guidelines are not intended to replace your best clinical judgment or establish a protocol for all patients, but do represent a thorough review of the current literature on this topic.

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