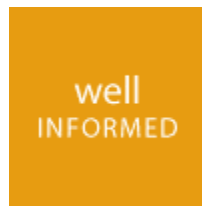


THE CBH PROVIDER CONNECTION

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



2nd Quarter 2004 Volume X

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EAP CORNER

REMINDER TO USE CPT CODE 99404

As a follow up to a letter you received earlier this year, we would like to remind you that CIGNA Behavioral Health (CBH) has begun authorizing EAP services using the CPT code 99404. The change was effective March 18, 2004. Please ensure that your staff is aware of this change and submits EAP services billing under this new CPT code. Billing under previous codes will be denied. There is also a new billing address. Please send claims to:

EAP Claims
CIGNA Behavioral Health
PO Box 46790
Eden Prairie, MN 55344

SUBSTANCE ABUSE PROFESSIONAL (SAP) AND CRITICAL INCIDENT RESPONSE (CIR) TRAINING

If you are a regular reader of this newsletter, you have likely read the requirements for our SAP and our CIR network. In speaking with providers, we have discovered that many of you would be interested in providing SAP and CIR services and see it as an opportunity to expand and diversify your practice. Also, many of you are unsure where to go for the qualifying training. Below are some resources for training that, while not affiliated with or officially endorsed by CBH, will provide you with the knowledge CBH considers

necessary to be a SAP or CIR provider. Once you have completed your training, please contact your Regional EAP Manager to be added to the network.

Substance Abuse Professional Training Resources

- Lee Mauk; Senior Consultant, Blair Consulting Group; 3243 East Calhoun Parkway; Minneapolis, MN 55408; 612.827.4147; 612.827.1886 fax; <mailto:LMauk@blairconsultants.com> <http://www.blairconsultants.com/>
- Employee Assistance Professionals Association; 703.387.1000 www.eap-association.org
- Buckley Productions; 877.508.3979 www.buckleyproductions.com
- American Substance Abuse Professionals, Inc.; 888.792.2727. www.go2asap.com. SAP Online™, a web-based, self-paced, self-study training course for Substance Abuse Professionals working towards meeting the new DOT eligibility requirements, is available from ASAP Inc. Cost is \$225 (\$199 for [ASAP affiliates](#)). Register for SAP Online by completing and submitting the [Registration Form](#).

Critical Incident Response Training Resources

- International Critical Incident Stress Foundations; 410.750.9600 www.icisf.org
- Crisis Management International; 800.274.7470 www.cmiaatl.com



- American Red Cross
www.redcross.org

REGIONAL RECRUITMENT

If you are interested in providing EAP presentations, Critical Incident Stress Debriefings, or SAP services, please contact the Regional EAP Manager for your area (email addresses below).

We have a special need for Spanish speaking EAP counselors and trainers in the Los Angeles, California, area. In addition, we are looking for all types of EAP trainers and counselors in the Tucson, Arizona, area.

In Connecticut, Rhode Island, Maine, Massachusetts, New Hampshire, and Vermont, there is a need for all of the afore-mentioned specialties. Additionally, there is a need for providers with management referral experience.

New England Region (CT, MA, ME, NH, RI, VT): Dan Fallon—send email to Daniel.Fallon@cignabehavioral.com

Mid-Atlantic Region (AR, DE, KY MD, VA, WV, NC, SC): Carlton Weinstein—send email to Carlton.Weinstein@cignabehavioral.com

Southeast Region (AL, FL, GA, LA, MS, TN, PR, USVI),: Marsha Shewanown—send email to Marsha.Shewanown@cignabehavioral.com

Midwest Region (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI): Robbie Hamill—send email to Robbie.Hamill@cignabehavioral.com

Western Region (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY): Bruce Steele - send email to Bruce.Steele@cignabehavioral.com

Northeast Region (NY, NJ, PA): Dana Kiel - send email to Dana.Kiel@cignabehavioral.com

KNOW YOUR REGIONAL EAP MANAGER (REM)

In order to enhance the REM relationship with the provider community, we have profiled a REM from each region in past newsletters. The series had a brief hiatus but it is back. The role of the Regional EAP Manager is to work with EAP customers, making their programs the best they can be, and to work with CBH EAP providers. Initiatives with providers include: recruiting, training, and certifying for EAP specialties such as Critical Incident Response, SAP services, Employee Education and Supervisor Trainings.

Our REM for this quarter is from the Northeast Region, Dana Kiel.

Dana, can you please describe your educational background and EAP experience?

I am a Certified Social Worker (New York State) and a Licensed Clinical Social Worker (New Jersey). I am also a Certified Employee Assistance Professional. I received my masters' degree in Social Work from New York University and my bachelors' degree in Applied Clinical Psychology from Alfred University. I have a background in chemical dependency treatment as well as psychiatry. As far as EAP experience, I have worked as an Onsite



EAP Counselor for a major corporation (50,000 employees) as well as managed their program nationally as their dedicated EAP Manager. In my current role, I provide clinical oversight to all EAP programs in my region with special focus on implementation, sales, EAP promotion, and planning of onsite services such as wellness seminars. As mentioned above, I also have a role in credentialing providers for the EAP specialties.

How long have you been with CBH?
I have been with CBH for almost 11 years. I have been in the Mental Health and Substance Abuse field for about 19 years.

Where is your office located and what states are included in your region?
My office is located on Wall Street in Manhattan. My region includes New York, New Jersey and Pennsylvania.

What is your philosophy about the value of EAP to our customers?
EAP is a valuable addition to an employee's benefit portfolio. Its value conveys prevention and kindness to employees but also makes financial sense for employers. As far as prevention, EAP provides support to individuals through difficult times as well as resources for day-to-day issues like child care and legal consultation. However, for employers, it is a tool to keep employees motivated and productive, which of course has financial implications.

Is there anything special you would like the providers to know about your customers?

My region has a diverse group of customers. From financial institutions and law firms, to union workers and nurses' aides. It is important that CBH providers can be perceptive about the pressure of all these different type of work environments, remembering that not only is the participant a customer but so is the employer.

Our standard for providers is to offer all EAP referrals an appointment within 48 hours. It doesn't have to be a prime evening appointment—it could be a morning appointment. If the employee cannot make a morning appointment, that will be their choice. For urgent and crisis situations, that time frame speeds up. Also, if you are a Critical Incident Provider, you need to be willing to supply a cell or pager number and be willing to clear your schedule if a situation arises.

Do you have any particular need for providers in your area?
I am looking for SAP providers throughout my entire region. I have need for trainers and Critical Incident providers in Pennsylvania, particularly the Harrisburg and Altoona areas and northern Pennsylvania.

What do you think about the strength of CBH's provider community and their value as a "face to the customer"?
CBH participating providers are fabulous, and we would be nowhere without them! My general experience is that CBH providers do wonderful services for our customers, and we are



lucky to have individuals with such a wide array of skills and talents providing EAP services to our customers. Their work is what helps us retain business and gain new business.

Thank you, Dana, for your time! If you are a provider in the Northeast Region (states listed above) and would like to contact Dana about providing additional services for the EAP, please send email to:

Dana.Kiel@cignabehavioral.com

Look for the REM from your area in the upcoming newsletters!

PROFESSIONAL RELATIONS CORNER

INTRODUCING THE PROVIDER EDUCATION SPECIALISTS

The Professional Relations department would like to announce the creation of a new position designed to keep network providers informed of CBH policies and procedures. Provider Education Specialists are responsible for, but are not limited to:

- Facilitating New Provider Orientations
- Updating provider specialties
- Verifying DOT Substance Abuse Professional qualifications
- Writing and distributing eBriefs and regional newsletters
- Organizing updates for the Provider Guide
- General Care Advocacy Program (CAP) clarification/education

- General education on CBH policies and procedures

At CBH, we value the quality of our relationship with each provider. To ensure a strong foundation for that relationship, 30-45 minute telephonic New Provider Orientations are offered to newly contracted providers. In addition to providing a review of CBH policies and procedures, network practitioners are given the opportunity to ask questions during these sessions. Although these orientations were designed for newly contracted providers, they have also proven useful for seasoned providers and their office staff, and in training new office staff. Some topics discussed in these orientations are:

- Who to contact at CBH
- Information on CAP and Online Resources
- Claim Diagnostic Coding Update
- Crisis Stabilization Network

As a CBH provider, you are welcome to join any of these teleconference orientations. For future orientation dates and times, please email the Provider Education Specialist at provideredspecs@cignabehavioral.com. Or, to find the Provider Education Specialist assigned to your state, go to <http://apps.cignabehavioral.com/web/basic/site/provider/customerService/contactProfessionalRelations.jsp>.

QUALITY MANAGEMENT CORNER



THE PATH MOST TRAVELED

Daily, CBH works closely with practitioners and providers to arrange access to care. We share the common commitment to utilize available behavioral health benefits in a manner that is objective and evidence-based and that fairly considers individual circumstance and local service delivery systems. In doing so, we rely on a common pathway to known and proven treatments. CBH's *Level of Care Guidelines* assist us in decision-making. They are evidence-based and they are periodically revised to reflect changing research, literature, and feedback from practicing clinicians.

As you encounter CBH's *Level of Care Guidelines* through care management and in your own practice, we hope that you will share any recommendations for improvement that come to mind. You can provide feedback, by contacting the Professional Relations Representative on our website at [CIGNABehavioral.com](http://www.cignabehavioral.com) - [Customer Service: Contact Professional Relations](#).

ANNOUNCING A NEW PREVENTIVE HEALTH PROGRAM FOR DEPRESSION IN ADULTS

On June 15, 2004, all CBH participants will have access to depression preventive health program materials on our website <http://www.cignabehavioral.com/>. In addition, participants whose benefits are managed through the National Care Center, and who are hospitalized for major depression, will receive educational information and tools to support aftercare and relapse prevention. Two

mailings containing information specific to the diagnosis will be sent at 30-day intervals. The first contains educational information and tools that support medication compliance and attendance of treatment appointments. The second contains information that supports continuation of care and depression relapse prevention. Participants will also be directed to additional materials on our website <http://www.cignabehavioral.com/>.

The goals of the program are to improve treatment compliance, limit functional and emotional deterioration, and reduce the likelihood of depression relapse. A tertiary prevention focus consists of outreach education and prompts to comply with treatment. However, a secondary prevention focus encourages early identification through information and a screening tool made available on CBH's website. We encourage you to review these materials and hope they will be useful to you in your practice.

If you have any questions or would like more information on the new Preventive Health Program for Depression in Adults, contact CBH's National Care Center and a Personal Care Advocate will assist you.

UNITY WITHIN DIVERSITY

Threads

Diversity is the one thing we all have in common. Like unique threads of a magnificent tapestry, we are woven together in patterns of profound richness that are not otherwise possible. One expression of respect for diversity



is a practitioner network that has sufficient numbers and types of behavioral health care practitioners to meet the needs and preferences of participants. Our uniqueness sometimes requires support, in the context of community.

CBH *does not require* but does encourage practitioners to identify their cultural/racial/ethnic status. Participants consider their preferences when choosing, or when asking for, a referral to a therapist. When practitioners elect not to report their racial/ethnic status, it is CBH's policy to respect this stance. To ensure the appropriate availability of practitioners, therefore, CBH annually assesses the cultural, ethnic, racial, and linguistic needs of participants, and adjusts the practitioner network, as necessary.

Seeking Symmetry

State-by-state information concerning participant characteristics is obtained from the U.S. Census Bureau. Characteristic information that practitioners have agreed to share is obtained from CBH's practitioner database. Our database can search for fluency in 51 languages, for gender, ethnicity, and for multiple cultural and practice specialties.

In 2003, similarly located participant populations and practitioners were compared. Satisfaction survey findings were examined and participant requests to change practitioner for culture-related reasons were reviewed. Symmetrical presentation between participant population and practitioner

network were generally found for specialty, ethnicity, gender, language, and age and age-related expertise. The following exceptions have been selected for improvement in 2004:

- Recruitment of additional Hispanic and Spanish speaking practitioners in California, Colorado, and Texas; and
- Recruitment of additional African American practitioners in Florida.

Many Streams, One River

Improvement opportunities were shared with CBH's Professional Relations department for inclusion in the 2004 network development plan. Progress is monitored quarterly. With each new addition, our network is strengthened and better able to meet the clinical and service needs of participants. President George Bush said, "We are a nation of communities." CBH is committed to a national practitioner network that celebrates and supports diversity.

A QUALITY COMMITMENT

CBH's Quality Management Program is designed to monitor, identify and address opportunities for improvement in clinical care and service. A defined committee structure meets at least quarterly to review results related to quality of care, coordination of care, clinical outcomes, participant and practitioner satisfaction, appointment and telephone access, claims turn-around time and other key measures. At least annually, each Operating Unit evaluates the program's success in improving care and service.



Results for 2003

- Appointment Access: Nationwide, CBH is largely meeting goals measured for routine, urgent, non-life threatening emergent, and life-threatening emergent appointments. For sites not at goal, improvement actions are planned in 2004.
- Telephone Access: Nationally, CBH achieved a 19-second average speed of answer and an abandonment rate of only 3.63%, against goals of 30 seconds and less than 5% respectively.
- Follow-up After Hospitalization for Mental Illness: Measures for attendance of outpatient appointments within 30 days of discharge are over 70% nationally but have varied. These are a target for improvement in all sites in 2004.
- Complaints: Only about 1 ½% of those using services report dissatisfaction with some aspect of the service received from CBH or its practitioner and provider network. Nearly all complaints are resolved within 30 days and most are resolved within one day of receipt. Complaint data is trended and improvement opportunities are acted on as they present.
- Compliance with Guidelines for Panic Disorder: 96% of individuals with the diagnosis who are in treatment for greater than 12 weeks have received an evaluation for the appropriateness of medication as a part of the treatment.
- Antidepressant Medication Management: Rates for practitioner contact and for acute and continuation treatment vary nationwide and are a target for improvement in 2004.
- Engagement After Substance Abuse Detoxification: About 75% of individuals who experience inpatient detoxification for substances attended at least three outpatient appointments in the 30 days following hospital discharge. This is also an area targeted for improvement in 2004.
- Improving Substance Abuse Treatment through the Use of Intensive Outpatient Programs and Group Treatment: Rates for those who attend group-based treatment have varied and are a target for continued improvement in 2004.
- Participant and Practitioner Satisfaction: CBH uses the ECHO survey recommended by NCQA to measure participant satisfaction. Practitioner and Participant Satisfaction are surveyed annually. In July 2003, based on satisfaction results and practitioner feedback, CBH implemented the CAP that eliminated the need to preauthorize coverage for routine outpatient care, reduced administrative requirements, and provided educational and other supports to care.
- Network Appropriateness and Adequacy: Studies done for geographical distribution, the match of the network composition with cultural and linguistic characteristics of those served, and the degree to which timely appointments are available, show that CBH's practitioner and provider network is generally able to meet the needs of those it serves.



Targeted recruitment continues in 2004 for specific areas of need.

For more information on the Quality Management Program, quality results, and specific information about our operating units, contact the Quality Service Manager at the CBH office that you work with most often.

PREVENTIVE HEALTH PROGRAM UPDATE

Periodically, CBH assesses use of our Preventive Health Programs to determine whether we are meeting our objectives and to identify any actions for improvement.

We recently reviewed our Preventive Health Program for children aged 12 years and younger who are diagnosed with Attention-Deficit/Hyperactivity Disorder. This program seeks to make a broad range of information available to parents to better observe, report, and coordinate care. Materials are also provided on our website to provide practitioners with resources that improve safety and outcomes. We also hope that educating parents may increase sensitivity to ADHD signs and symptoms in siblings.

Our data suggest we are effectively capturing eligible cases and doing a good job of distributing educational information and tools. Survey data from those who used the program indicates that 84% agree that the materials were both helpful and complete. Ninety-one percent (91%) said they would recommend our program to other parents of ADHD-diagnosed children.

Key improvement recommendations, based on our assessment include:

- Assessing whether participants are using the program tools and materials, and sharing them with treatment practitioners.
- Encouraging greater medical and behavioral communication between Primary Care Physicians and Behavioral Health Practitioners in ADHD cases.
- Over time, considering the addition of materials that target related disorders or are designed for those who have carried the diagnosis for a longer time.

If you have suggestions or input pertaining to our ADHD Preventive Health Program, please let us know.

CLAIMS/CUSTOMER SERVICE CORNER

The Mental Health Parity Act of 1996 was implemented January 1, 1998. This act is aimed at companies employing more than 50 workers, and applies only to mental health diagnosis, and does not include substance abuse. Mental health benefits cannot be subject to annual/lifetime dollar limits lower than or less favorable than any other illness, but co-pays, deductibles, day and/or visit limits may differ. Prior to the Mental Health Parity Act of 1996 only five states had parity laws. The federal law allowed for legislation at the state level creating stricter standards for insured or HMO plans, and today there are 48 states with Mental Health Parity laws.



State parity laws vary in a number of ways, and there is no single model law that all states have adopted. Several states mandate mental health and/or substance abuse lifetime coverage and annual spending limits which are no more restrictive than those for physical health coverage, however, they allow co-payments and limits on treatment visits. For some states, laws specify that parity and its extended benefits will be available only for specifically “biologically-based” or “serious mental illness” (e.g., schizophrenia, major depression, paranoia, and autism, while other states extend coverage to all conditions included in the DSM (Diagnostic and Statistical Manual of Mental Disorders) except for substance abuse. As indicated above, state laws do not apply to self-insured companies—companies that underwrite their own employees’ health care claims, determine the scope of benefits and pay another carrier or company to administer claim payment for these employees—since the Employee Retirement Income Security Act of 1974 (ERISA) restricts states from regulating self-insured companies.

How is the State Mandate Applied?

Typically the mandate that applies is based on the state in which the policy or contract is written. However, some states have written into the law “extraterritorial” provisions, which allow a state to extend its jurisdiction past its own territory. This means the mandate for the state in which the member resides applies, even if the policy or HMO contract is written in another state.

What Does this Mean for Providers?

Because the state parity mental health laws vary widely from state to state in coverage and other key elements, it can be a challenge to understand which mandate applies. Understanding the mental health laws in your state is fundamentally important, because “biologically-based” or “serious mental illness” definitions fluctuate between states. For instance, Nebraska’s mandate defines a “serious mental illness” as “any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that subsequently limits the life activities of the person with the illness.” Included in this definition but not limited to it are schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder. Kentucky’s mandate defines a mental health condition as “any condition that involves mental illness or alcohol or drug abuse that fall under a DSM diagnostic code.” Contact your state’s Division of Insurance for information on state mandated mental health laws.

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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