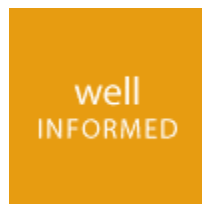




# THE CBH PROVIDER CONNECTION

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



## 3rd Quarter 2004 Volume XI

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## EAP CORNER

### CRITICAL INCIDENT RESPONSE SERVICES

- **National Recruitment Effort**  
Considerable growth in our banking and financial services customer base will require rapid expansion of our Critical Incident Response network resources. Providers with prior Critical Incident Response experience in the workplace, ability to provide these services upon short notice, and desire to be selected for these high profile services with premium reimbursement should contact their Regional EAP Manager. Contact information is described below in the regional recruitment section.
- **Note to Our Existing CIR Providers**  
As noted above, CBH is in expansion mode with our CIR provider network. However, it is important that we have a quality network. CIR providers must recognize that flexibility and availability are important aspects of this work. If for some reason you are no longer interested in being a CIR provider or will have a period of time when you will be unavailable please let us know. This will by no means negatively impact any other work you do for us or make you appear like a less valuable provider. In fact, this type of open communication will help us provide better service to our customers—particularly to those in crisis.

### CHANGES IN EMPLOYER SERVICE COORDINATORS FOR NORTHEAST, WEST & MIDWEST

Providers who do any wellness seminars, management training or health/benefits fairs for CBH, please note that we have two new Employer Service Coordinators:

#### Northeast and Canada

Ann Bohnert (replaces Lindsay Kohn)  
800.241.4057 extension 2646, option 4

#### West and Midwest

Emily Johnson (replaces Melody Sandell)  
800.241.4057 extension 2646, option 6

The third remaining Employer Service Coordinator has not changed:

#### Southeast, including Texas, Puerto Rico and US Virgin Islands

Marlin Hohbein  
800.241.4057 extension 2646, option 5

You can email all three ESCs at [esh.comments@cignabehavioral.com](mailto:esh.comments@cignabehavioral.com)

### REGIONAL RECRUITMENT

**New England Region (CT, MA, ME, NH, RI, VT):** *There is a need for Critical Incident Providers, SAPs and Trainers throughout New England.* Dan Fallon—send email to [Daniel.Fallon@cignabehavioral.com](mailto:Daniel.Fallon@cignabehavioral.com)

**Mid-Atlantic Region (AR, DE, KY MD, VA, WV, NC, SC):** *There is a need for Critical Incident Providers in Maryland, Virginia, Delaware and North Carolina.*



Carlton Weinstein—send email to [Carlton.Weinstein@cignabehavioral.com](mailto:Carlton.Weinstein@cignabehavioral.com)

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

**Midwest Region (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI):** *There is a need for SAPs and Critical Incident Providers throughout the Midwest.* Robbie Hamill—send email to [Robbie.Hamill@cignabehavioral.com](mailto:Robbie.Hamill@cignabehavioral.com)

**Western Region (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY):** *There is a specific need for trainers in the Bay Area and the Silicon Valley Area.* Bruce Steele—send email to [Bruce.Steele@cignabehavioral.com](mailto:Bruce.Steele@cignabehavioral.com)

**Northeast Region (NY, NJ, PA):** *Trainers needed in Pittsburgh and Danville, PA, also SAPs are needed throughout the region.* Dana Kiel—send email to [Dana.Kiel@cignabehavioral.com](mailto: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. This is the last entry in our series. The role of the Regional EAP Manager is to work with EAP customers, making their programs the best they can be. REMs also work with network EAP providers. Initiatives with providers include: recruiting, training, and certifying for the EAP specialties

(Critical Incident Response, SAP services, Employee Education and Supervisor Training).

**Our REM for this quarter is from the Western Region, Bruce Steele.**

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

I've been in the EAP field for about 20 years now. I graduated with a degree in psychology from Iowa State University and a Master of Counseling degree from Arizona State University. I worked in community mental health, with the sex offender treatment program at the Arizona State Prison, and in inpatient and outpatient chemical dependency treatment before getting into EAPs. Before joining CBH, I worked for another regional EAP provider where I did, at various times, assessments, training, account management, staff supervision and regional management. I've been the Western Regional EAP Manager for CBH since coming on board.

**How long have you been with CIGNA Behavioral Health?**

All told, 10 years. I joined CBH (then MCC) in 1994. I took an extended "vacation" in 2001 and spent a couple of years as a consultant, trainer and coach. I was never far from CBH, though, as they were my biggest customer as a trainer. CBH recruited me back in May of last year, and so here I am again!



### **Where is your office located?**

In my den! Actually, I love working from home--it's a great perk. But to answer your question, I'm located in Brea, California. People often confuse Brea with La Brea, of the Tar Pits fame, but I'm actually in Orange County, about 12 miles north of Disneyland.

### **What is your philosophy about the value of EAP to our customers?**

EAPs, when properly used, provide a multitude of benefits. Since I personally enjoy consulting, I am particularly fond of assisting our customers in achieving strategic goals. Beyond this, EAPs provide valuable services to managers and human resource staff in dealing with troubled employees. Promoting these services assists our customers in maximizing their return on the EAP.

### **Bruce, you are the Regional EAP Manager for the Western Region. What states does this include?**

Everything west of the line from New Mexico to Montana. Of course, we don't have a lot of accounts in Montana. Now if we can just sell some more business in Hawaii . . .

### **Is there anything special you would like the providers to know about your customers or CBH?**

During my 2 years as a freelance trainer, I had opportunities to work with many EAP vendors, and I have to say that my decision to accept CBH's

offer to return as the Regional EAP Manager speaks to the quality of our program and our people. No group is perfect, of course, but I am excited by our commitment to providing quality EAP services to our customers. And network providers play a critical role in the delivery of these services; they quite literally are CBH to the participant.

### **Do you have any particular need for providers in your area?**

In general, I would like providers to be knowledgeable about the range of benefits offered by the EAP. When a participant is in a provider's office, the provider may be able to offer resources via the EAP that will augment a treatment plan or provider tools to assist a participant's family. The EAP offers so much more than "just" the face-to-face sessions. It might be helpful for network providers to check out the member portion of our website. Also, I've had some issues recently in my region with provider availability for EAP appointments. So, I'd encourage any provider who is interested in adding EAP assessments to his/her profile to contact me or Professional Relations. And finally, I am always interested in providers who are trained in critical incident response, SAPs, and/or who enjoy doing stand-up training.

### **What do you think about the strength of CBH's provider community and their value as a "face to the customer"?**

I believe that network EAP providers are particularly strong. I have a lot of



confidence in the quality of the clinical services they provide. Happy participants usually translate into happy customers, and happy customers keep us all working!

*A thanks to Bruce for his time! If you are a provider in the Western Region (states listed above) and would like to contact Bruce about providing additional services for the EAP, please him at:*  
[Bruce.Steele@cignabehavioral.com](mailto:Bruce.Steele@cignabehavioral.com)

## PROFESSIONAL RELATIONS CORNER

### SAVE THE DATE! CIGNA BEHAVIORAL HEALTH 2004 PROVIDER CONFERENCES

One-day Seminars Presented FREE for  
CIGNA Behavioral Health Providers

Join us if you would like to:

- Learn more about "Psychopharmacology for the Clinical Practitioner"
- Earn 6.0 Continuing Education Units Free
- Network with other providers and facilities
- Work with CIGNA Behavioral Health staff

This program is recommended for Physicians, Nurse Practitioners, Psychologists, Social Workers, Marriage & Family Therapists, & Mental Health Counselors.

CIGNA Behavioral Health is proud of its provider community and wants to take the opportunity to show its appreciation. This year, CBH is hosting eight one-day seminars at locations throughout the United States. These seminars are open to all contracted CIGNA Behavioral Health providers.

Thomas Smith, FASCP, LMHC, will be presenting "Psychopharmacology for the Clinical Practitioner" at the following conferences, with the exception of Charlotte, NC.

- September 30 - Danville, PA
- October 8 - Tampa, FL
- October 15 - Chicago, IL
- October 22 - Parsippany, NJ
- October 29 - Glendale, CA
- November 5 - Phoenix, AZ
- November 12 - Dallas, TX
- November 12 - Charlotte, NC\*

\*Hardeep Singh, MD, and Barbara Ziv, MD, will be presenting at the Charlotte seminar. Dr. Hardeep will present "Clinical Psychopharmacology: Current and Future Applications" while Dr. Ziv will share her expertise on "Dialectic Behavioral Therapy (DBT) in the Treatment of Borderline Personality Disorders."

All seminars promise to be informative and practical for all behavioral health disciplines and are recommended for all levels of licensure and clinical practice.

The overall goal of this series of one-day seminars is to provide each attendee with additional sources of knowledge and skills that can be used



to contribute to the care provided to CIGNA Behavioral Health participants. By attending the seminar presented by Thomas Smith, you will have a more thorough understanding of:

- “Back-pocket” skills on appropriate and available therapeutic alternatives
- Recognizing the risks and benefits of therapeutic choices
- Assessing side effects of drugs
- Educating your patients on psychopharmacology and therapeutic options

By attending the seminar presented by Dr. Singh and Dr. Ziv, you will have a more thorough understanding of:

- The impact of current psychotropic interventions on the practice of psychiatry
- Identifying skills for incorporating a discussion around psychotropic care into a treatment plan
- Explaining the clinical and ethical considerations when choosing a medication
- Increasing your understanding of Dialectic Behavioral Therapy (DBT) and incorporating it into your practice

Registration is required for the events above. You are welcome to attend any conference. Seating is limited.

Invitations will be sent to contracted providers by email or fax within the next few weeks. Please contact your Professional Relations department if you have any questions.

## QUALITY MANAGEMENT CORNER

### DEPRESSION TOOLS AND RESOURCES

Successful depression treatment often requires an adequate course of treatment with antidepressant medication. Yet internal review of pharmacy data suggests that adequate dosing and duration of antidepressant medication does not always occur.

To support practitioners in improving the treatment of depression, CIGNA Behavioral Health has been working closely with CIGNA HealthCare to provide information, tools, and resources to medical and behavioral practitioners. Quarterly, high volume prescribers of antidepressant medication receive a report that includes metrics on practice pattern pertaining to antidepressant medication, along with helpful information on the CIGNA participants they treat. Prescribers also receive guideline summaries, tracking tools, training resources, and consumer-focused materials on depression.

If you are not a prescriber or have not received the quarterly mailing, we encourage you to access and use the tools and resources in your clinical practice. Often the non-physician therapist plays a key role in communicating with the physician and reinforcing the recommended medication regime. Materials are available through several avenues:



- <http://apps.cignabehavioral.com/web/basicsite/provider/newsAndLearning/providerguide.jsp>, then click "Appendix C: Depression Resource Material."
- <http://apps.cignabehavioral.com/web/basicsite/consumer/educationAndResourceCenter/knowningWhatToExpectAboutDepression.jsp>
- Or go to [www.CIGNABehavioral.com](http://www.CIGNABehavioral.com) and log in through the provider area to access the full library of articles and resource materials for providers.

If you do not have Internet access, you can request a hard copy by calling 888-259-6279.

## CARE FOR CHRONIC CONDITIONS

Chronic medical conditions can make it difficult to manage commitments and responsibilities. Self-care, functioning, treatment adherence, and even outcome can be negatively affected if depression occurs. For that reason, CIGNA Behavioral Health and CIGNA HealthCare collaborate around the continuity and coordination of behavioral and medical care for five separate medical conditions, using disease management protocols that include routine screening for depression. Included are:

- Asthma
- Diabetes
- Heart disease
- Low back pain
- Chronic obstructive pulmonary disease

In the CIGNA Well Aware for Better Health<sup>SM</sup> programs, participants have access to a registered nurse for consultation; self-care information and condition-specific educational materials; reminders of important tests or exams; and informational newsletters that help to anticipate and manage symptoms. Initially and annually, those with a target diagnosis also receive structured telephone screening to help identify comorbid depression. If depression is suspected, interventions are triggered simultaneously at the participant, practitioner, and care management levels, and they will continue until the depression remits. Participants may be referred to their Primary Care Physician or to a CIGNA Behavioral Health network practitioner for depression treatment and are monitored to reduce the risk of depression recurrence.

Since 2000, disease management protocols and depression screening have been applied sequentially across increasing numbers of conditions. The number of participants who receive depression screening, the number who score positive for depression, and the number who are referred to their primary care physician for follow-up, are assessed annually. Characteristic and consistent trends include:

- A dramatic year-to-year increase in the number of individuals screened for depression
- An incidence for depressive illness that is relatively stable in Asthma, Diabetes and Cardiac populations (5%-6%) but that is higher with Chronic Pain (11%).



- A lower rate of consent for follow-up notification to Primary Care Physicians since privacy regulations have increased sensitivity to confidentiality and privacy issues

Analysis of 2003 results produced several program enhancements for 2004. Widely accepted and validated components of the PRIME-MD are now being used as initial depression screening tools. Screening and intervention has been expanded to include stress and anxiety, and screening tools have been made available to Primary Care Physicians that validly assess depression severity—an important consideration in treatment planning.

Depression may accompany chronic medical conditions. However, following a treatment plan under a physician's care can greatly reduce complications and risk. Proper treatment, information, and support can help participants manage their condition and maximize their potential. If you would like more information about the CIGNA Well Aware for Better Health<sup>SM</sup> programs, please contact the Quality Service Manager at the CIGNA Behavioral Health office that you work with most often.

### HEDIS® 2004 EXPANDS TO INCLUDE ALCOHOL AND OTHER DRUG (AOD) SERVICES MEASUREMENT

According to the National Committee for Quality Assurance (NCQA\*\*), an estimated 5 million people who need treatment for an alcohol or other drug dependence disorder (AOD) are not

receiving it, despite the availability of treatment resources. Therefore, the NCQA has added measures for the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* to the 2004 Health Plan Employer Data and Information Set (HEDIS®). Beginning in 2004, organizations will measure and report data on the following measures to NCQA:

- Treatment Initiation: The percentage of people who receive addiction-related services within 14 days of diagnosis—the timeframe when patient motivation may be especially strong.
- Treatment Engagement: The percentage of people who actually begin the process of treatment and go on to receive at least two additional addiction-related services within the next 30 days.

CIGNA Behavioral Health is committed to improving the care participants receive and is asking practitioners and programs to do what they can to ensure participants initiate and engage in treatment.

Research has shown that participation in structured group counseling significantly lowers the probability of relapse, especially when followed by ongoing 12-step group participation after treatment (Fiorentine and Anglin, 1996)<sup>1</sup>. In addition, data collected by CIGNA Behavioral Health revealed that approximately 72% of our participants first seen for AOD disorders in the structured group therapy setting in 2003 engaged in treatment. By



comparison, of those first seen for AOD disorders in family or individual therapy, only 33% engaged in treatment.

Tips to consider for improving treatment initiation and treatment engagement include<sup>2</sup>:

- Consider the first phone call as an opportunity to support treatment engagement. Offer timely appointments for assessment and intervention.
- Create a contract between the patient and program/provider that defines responsibilities on both sides and introduces the patient to the treatment process.
- Have a written process to inform the patient and family about the course and expectations of treatment.
- Use motivational interviewing or Motivational Enhancement Therapy techniques (see “Encouraging Readiness to Change” below).
- Minimize the number of different staff involved in a patient's intake and assessment.
- Minimize the time from the assessment appointment to the first treatment visit.

If you have any questions, or would like further information about the new HEDIS measures or effective treatment modalities for alcohol and other drug diagnoses, please contact the Quality Service Manager at the CIGNA Behavioral Health office that you work with most often.

\*\*NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS®, the performance measurement tool used by more than 90 percent of the nation's health plans.

<sup>1</sup>Fiorentine, R. & Anglin, M.D. (1996). More is better: Counseling participation and the effectiveness of outpatient drug treatment. Journal of Substance Abuse Treatment, July-August, 13(4): 341-8.

<sup>2</sup>The Network for the Improvement of Addiction Treatment. ([www.niatx.net](http://www.niatx.net))

## ENCOURAGING READINESS TO CHANGE

Have you experienced difficulties in treating clients who are abusing substances or wondered if there is a more effective approach to those who appear to resist change?

Though not a new theory of intervention, Motivational Enhancement Therapy has gained the support of the American Psychiatric Association as a particularly effective approach to less motivated clients who are dealing with substance abuse or dependence. By understanding motivation and the process of change, it may be possible to transform resistance into a readiness to change.

## Therapeutic Alternatives

In contrast to techniques that guide individuals to recovery using step-by-step training, Motivational Enhancement Therapy (MET) is an intervention approach based on principles of motivational psychology



and is designed to evoke rapid, internally motivated change in problem drinkers. Motivational counseling first builds, and then strengthens the commitment and motivation for change. (Miller & Rollnick, 1991)<sup>1</sup>

## The Cycle of Change

With or without formal treatment, individuals often move through a series of stages to change. As envisioned by Prochaska & DiClemente, (1984, 1986)<sup>1</sup>, individuals do not consider changing their behavior, and are merely PRE-CONTEMPLATIVE, until a problem is recognized and they have weighed the feasibility and costs of change through a CONTEMPLATIVE process. If this consideration results in a DECISION to take ACTION, individuals may apply strategies to produce change, after which work shifts to the MAINTENANCE of achieved gains. Any failure to sustain change may result in a RELAPSE, which requires that individual's return to some earlier stage before going forward again. Several revolutions through this cycle may be needed to sustain change.

## Necessary and Sufficient Conditions

For Motivational Enhancement Therapy, the basic issues and tasks of the contemplation and determination stages are most critical, whether during initial treatment or treatment for relapse. The therapeutic assignment at any given moment is to encourage tasks and processes that match a client's stage and readiness for change. Only the client can decide how much of a

problem drug use poses. While coming to understand the positive and negative affects of drug use, the balance of pros and cons must tip toward change, if contemplation is to morph into the firm resolve needed for effective action. Miller and Sanchez (1994) identified six active ingredients of change that illustrate typical therapeutic approaches to the various phases of the change cycle:

- Develop FEEDBACK about personal risk or impairment
- Emphasize personal RESPONSIBILITY for change
- Offer clear ADVICE to change
- Develop a MENU of alternative change options
- Extend therapeutic EMPATHY
- Facilitate client SELF-EFFICACY or optimism<sup>1</sup>

## When Change Becomes Personal

Individuals embracing responsibility must make a personal choice. Ambivalence toward change is normal. Instead of struggling to overcome resistance, in Motivational Enhancement Therapy, energy is channeled into building motivation. From this view, change occurs when people view a compelling discrepancy between where they are and where they want to be (Miller & Rollnick, 1991)<sup>1</sup>. Therefore, Motivational Enhancement Therapy uses such techniques as feedback, questioning and summarizing to evoke and reinforce personal descriptions of discrepancy and the need for change, while the therapist simultaneously supports the client's sense of self-efficacy to achieve change.



## Who Can Benefit

Treatment outcome research strongly supports these strategies as effective in producing change in problem drinkers, whether used as an independent intervention or as a prelude to continuing therapeutic encounter for individuals who are insufficiently motivated.<sup>1</sup> In both cases, Motivational Enhancement Therapy techniques can help to clarify the goals that might be achieved through treatment, or determine what type of treatment services are most likely to be effective in meeting these goals.

## To Learn More

If you are interested and would like to learn more about Motivational Enhancement Therapy, you may view and download the Motivational Enhancement Therapy Manual (NIH Pub. No. 94-3723. 1994) located at:

<http://www.niaaa.nih.gov/publications/match.htm>

The Motivational Enhancement Therapy Manual is included in the Project Match Series of publications offered by the National Institute on Alcohol Abuse and Alcoholism.

<sup>1</sup>Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

<sup>2</sup>Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones/Irwin.

Prochaska, J. O., & DiClemente, C. C. (1986). *Toward a comprehensive model of change*. In W.R. Miller & N. Heather (Eds.), *Treating addictive*

*behaviors: Processes of change* (p. 3-27). New York: Plenum Press.

<sup>3</sup>Miller, W. R., & Sanchez, V. C. (1994). *Motivating young adults for treatment and lifestyle change*. In G. Howard (Ed.), *Issues in alcohol use and misuse by young adults*. Notre Dame, IN: University of Notre Dame Press.

## DIAGNOSING PANIC DISORDER

The history of Panic Disorders can be traced back as far as 1621 when an English clergyman, Robert Burton, described the symptoms in his book, *Anatomy of Melancholy*. However, it was not until the late 1800s that Panic Disorder was included in the medical literature when symptoms were documented in the treatment of Civil War soldiers. Panic Disorder became a subject in clinical research in the middle part of the 20<sup>th</sup> century and in 1980 panic disorder was introduced into the *Diagnostic and Statistical Manual of Mental Disorders (DSM III)*.

## Prevalence Rates<sup>i</sup>

- Current literature indicates that about 1.7% of the adult population in the United States has a panic disorder in a given year, (i.e., 2.4 million Americans; ages 18 -54).
- Women are twice as likely as men to develop panic disorder.
- Panic disorder typically strikes in young adulthood, developing before the age of 24.

<sup>i</sup>National Institute of Mental Health (NIMH); *Facts about Panic Disorder*, Publication No. OM-99 4155.



## CIGNA Behavioral Health Prevalence Rates

The data from 2003 indicate that approximately 0.16% of the population covered by CIGNA Behavioral Health (CBH) were diagnosed with panic disorder. This is comparable to the same rate reported for 2002. Given that the prevalence rates for panic disorder is trending well below the figures outlined in the literature, it is clear that it would be beneficial to focus on this trend and the barriers associated with the diagnosis of this diagnostic category.

## Coexisting Conditions

As the research indicates that panic disorders can coexist with other disorders, it is important that the assessment and diagnostic process of each individual take into consideration the complexity of conditions that a person brings to treatment.

According to the guidelines published by the American Psychiatric Association, the disorders that most often coexist with panic disorder are depressive disorders and substance abuse disorders.<sup>2</sup> Depression and comorbid anxiety disorders are associated with increased disease severity and relapse. Specific to panic disorder coexisting with substance abuse disorders, about 30% of those with a panic disorder abuse alcohol and about 17% abuse drugs. The individual's substance abuse is usually an unsuccessful attempt to alleviate the distress caused by the symptoms of their panic disorder.

CIGNA Behavioral Health's most recent diagnostic data support depression and substance abuse disorders as having the highest presentation rates for participants for both inpatient and outpatient services. In order to ensure that these individuals are successful in treatment, it is important that they are assessed for a coexisting panic disorder, and when present, this diagnosis and treatment be added to their ongoing treatment plan. In addition, if participants diagnosed with depression and substance abuse do not show adequate improvement, a reassessment for a coexisting condition such as panic disorder should be considered.

## Etiology of Panic Disorder

Heredity, other biological factors, stressful life events, and thinking in a way that exaggerates relatively normal bodily reactions, are all believed to play a role in the onset of panic disorder. The exact nature of the cause or causes of panic disorder is unknown and is the subject of scientific investigation.

## Diagnostic Evaluation

According to guidelines published by the American Psychiatric Association, evaluation for panic disorder should include a history of the present illness and current symptoms.<sup>ii</sup> This should include past psychiatric history, general medical history and the participant's history of substance use and treatment. "Value added" information would be their personal history (e.g., psychological development, response to life transitions, social, occupational



functioning, and family history). A review of the patient's medications, review of systems, mental status examination, physical examination, and diagnostic tests are recommendations for a total assessment.

## Screening Tool

In order to identify panic disorder as a coexisting disorder, this quick screening tool could be useful to facilitate your assessment of your patient.

### Does this Sound Like You?<sup>i</sup>

Do you have sudden bursts of fear for no reason?

Please put a check in the box next to any problems you have during these sudden bursts of fear.

- I have chest pains or a racing heart.
- I have a hard time breathing or a choking feeling.
- I feel dizzy or I sweat a lot.
- I have stomach problems or feel like I need to throw up.
- I shake, tremble, or tingle.
- I feel out of control.
- I feel unreal.
- I am afraid of dying or going crazy.

For additional information on Panic Disorder, remember the CIGNA Behavioral Health Provider website

contains a link to the APA Guidelines for the Treatment of Panic Disorder.

<sup>i</sup>National Institute of Mental Health (NIMH); Facts about Panic Disorder, Publication No. OM-99 4155.

<sup>ii</sup>American Psychiatric Association; Clinical Practice Guidelines for the Treatment of Panic Disorder; May 1998.

<sup>iii</sup>National Institute of Health (NIH); A Real Illness: Panic Disorder, Publication No. 00-4679.

## Planning for Safety

As network practitioners and providers, you have received periodic newsletter updates on many activities conducted by CIGNA Behavioral Health that impact participant safety. Currently, information that is regularly collected and analyzed includes:

- Visits to high volume behavioral health care practitioner office sites,
- Consistency of treatment with clinical practice guidelines,
- Continuity and coordination of care activities, including exchange of medical and behavioral information and information concerning transitions in levels of behavioral care,
- Complaint and appeals,
- Telephone and appointment access,
- Follow-up after hospitalization, and
- Readmissions within 30 days following discharge.

Beginning in January 2005, CIGNA Behavioral Health will enhance the analysis of participant safety with information from a national survey of contracted inpatient facilities. The survey is designed to gather information on the safety initiatives and practices of contracted facilities.



Quantitative and qualitative analysis of strengths and opportunities for improvement will be presented for review in an aggregate report that better recognizes the partnership between participants, practitioners, and CIGNA Behavioral Health to ensure safe practice.

Practitioners and facility providers will receive patient safety and other performance data results through practitioner newsletters and the CIGNA Behavioral Health Provider Guide. Participants will receive patient safety and other performance results through postings to the CIGNA Behavioral Health's website.

If you have any questions or would like further information about the 2005 Patient Safety Plan, please contact the Quality Service Manager at the CIGNA Behavioral Health office that you work with most often.

### LEARNING ABOUT CIGNA PHARMACY COVERAGE

Many participants with coverage through CIGNA Behavioral Health have pharmacy benefits offered through CIGNA HealthCare. The easiest way to tell which pharmacy plan a participant has is to check the CIGNA HealthCare ID card. If one or two pharmacy copayments are shown, the participant has a Two-Tier Prescription Drug Program. If three pharmacy copayment amounts are shown, the participant has a Three-Tier Program. The following information applies for participants with CIGNA Pharmacy coverage:

1. How do I find out what medications are covered on the CIGNA prescription drug list?

The full CIGNA HealthCare Drug Formulary is available online at [https://secure.cigna.com/health/fo rm/drug\\_list.html](https://secure.cigna.com/health/fo rm/drug_list.html). In addition, to **download** the CIGNA prescription drug list to your hand-held device, health care providers may access the CIGNA HealthCare formulary through ePocrates.

2. How are formulary decisions made?

CIGNA has a Pharmacy and Therapeutics Committee that determines CIGNA HealthCare formulary policy. This committee reviews evidence-based drug reviews to clinically evaluate the safety and efficacy of medications. The committee uses the information to determine if the drug has an advantage over therapeutic alternatives.

The Pharmacy and Therapeutics Committee is comprised of 20 members and meets quarterly. All voting members are physicians or pharmacists. External practitioners (those not employed by CIGNA HealthCare) who are in active practice make up 75% of the committee. The committee membership includes psychiatric representation.

CIGNA values the input of providers into the development and management of CIGNA HealthCare Drug Formulary. You may request that the Pharmacy and Therapeutics Committee consider a drug by sending your suggestion to the Medical



Director of the CIGNA Behavioral Health Operating Unit you work with most often. When you make a request, please include supporting literature evidence as well.

3. What if an exception may be needed?

If as a physician you feel that for medically necessary reasons a patient needs a certain medication that is not on the CIGNA HealthCare Drug Formulary, then you may request an exception by contacting the CIGNA HealthCare Pharmacy Services department. You can also find clinical coverage position at <http://www.cigna.com/health/provider/>

If an exception is approved, CIGNA HealthCare will cover the drug under the patient's prescription benefit plan.

The Coverage Request Form available online at: [http://www.cigna.com/health/cons/sumer/service/pharmacy\\_priorauth.html](http://www.cigna.com/health/cons/sumer/service/pharmacy_priorauth.html). Please fax the completed form to CIGNA HealthCare Pharmacy Service department at 1.800.390.9745.

4. Does CIGNA have a mail order pharmacy service?

Yes, CIGNA Tel-Drug is an effective way for your patients who are CIGNA HealthCare participants to save time when filling their maintenance medication prescriptions. CIGNA Tel-Drug customers promptly receive their medications at home and may realize lower out-of-pocket

expenses for their medications. Patients can contact CIGNA Tel-Drug by calling 1.800.285.4812 or visiting <http://www.teldrug.com/>.

To make it convenient for your patients to fill prescriptions for maintenance medications through CIGNA Tel-Drug, remember to write their prescriptions for a 90-day supply, where medically appropriate. You may need to write two prescriptions: one to be filled immediately at retail and the other to be mailed to CIGNA Tel-Drug for home delivery.

### HIPAA PROVIDER POINTS

For a provider to call into CIGNA Behavioral Health to obtain participant information, the provider must supply the following:

#### For Participant's Benefit, Eligibility and Clinical Information

- Provider's Tax ID or Provider's CIGNA Behavioral Health ID
- Participant's name
- Subscriber's (Employee's) Member Number

#### For Claim Information

- Provider's Tax ID or Provider's CIGNA Behavioral Health ID
- Participant's name
- Subscriber's (Employee's) Member Number
- Date of Service\*\*\*
- Amount\*\*\*
- Provider to be paid\*\*\*

\*\*\*Provider/office staff must know two of the three answers.



As an utilization review agent, CIGNA Behavioral Health will often contact facilities, clinics, and providers for various reasons:

- To complete pre-certification of coverage for a higher level of care,
- To review a case,
- To find an appointment for a participant, and/or
- To follow up with the facility, clinic or provider to find out if a participant kept his/her first appointment.

The HIPAA regulations allow for communication between treating providers and benefit plan administrators, like CIGNA Behavioral Health, for such purposes, which are considered treatment, payment and health plan operations functions.

If calling to determine whether a participant kept an appointment, or to arrange for an appointment on the participant's behalf, CIGNA Behavioral Health staff may give the participant's name and ID number, the date of the scheduled appointment, the provider name, and our tax ID number.

For more information on HIPAA, visit our website at <http://www.cignabehavioral.com/>.

## CLAIMS/CUSTOMER SERVICE CORNER

### 8 WAYS TO AVOID CLAIM ISSUES

#### 1. CHECK ELIGIBILITY AND BENEFITS:

Call the number on the member's card or go to our website at <http://www.cignabehavioral.com/>.

#### 2. PROMPT SUBMISSION OF CLAIMS:

It is best to file a claim as soon as possible.

#### 3. MAIL TO CORRECT ADDRESS:

There are many different claim addresses as well as claim numbers. It is best to call the number on the participant's card to check the claim's address. Remember that the address printed on the participant's card is most likely for medical claims, so please do not assume you can send your claims to that address.

#### 4. COORDINATION OF BENEFITS:

Requesting COB information at the time of the patient's visit could eliminate unnecessary delay. COB forms are available via your Provider Resource packets and/or through our Customer Service department at 800.926.2273. *GHP members: call 888.210.0208.*

#### 5. DIAGNOSIS CODE:

While the DSM-IV is a great clinical tool and closely follows the ICD-9-CM, it does have codes that have different meanings and some codes that are considered termed and/or invalid. Most insurers now use ICD-9-CM coding for claim reimbursement. Due to the new federal HIPAA regulations, CIGNA



Behavioral Health is no longer able to accept claims with outdated or invalid diagnosis codes. Please be sure you are using the current version of the ICD-9. Claims submitted using outdated codes will be denied, with instruction to submit a corrected bill with current diagnosis codes. Below are examples of diagnosis codes where the modifiers have changed:

<u>Outdated</u>	<u>Current</u>
296.0	296.00
296.1	296.10
296.2	296.20
291.0	291.0
311.0	311
311.00	311
799.90	799.9
300	300.00
300.0	300.00

**6. PROCEDURE CODES:**

Using outdated and/or invalid codes will result in your claim being denied, with instructions to submit a corrected bill with current procedure codes. Please see CPT Code Refresher page included in the Provider Resource packet or contact Zoë Webb, Provider Education Specialist at 800.274.7603 x5806 or <mailto:Zoe.Webb@CIGNABehavioral.com>.

**7. COMPLETE "CLEAN" CLAIM FORM:**

Making sure all of this information is on the billing will help ensure clean and proper payment.

The following are mandatory fields for the claim to be considered "clean":

- Employee Name
- Policy Holder's Social Security Number or Member ID
- Patient Name
- Patient's Date of Birth
- Current and Valid Procedure Code
- Current and Valid Diagnosis Code (ICD-9-CM)
- Date of Service
- Dollar Amount of Service
- Provider's Name and Credentials
- Provider's Address
- Provider's Tax ID Number

**8. WEB CLAIMS:**

<http://www.cignabehavioral.com/> CBH offers an enhanced website where claims can be submitted, status checked and the information is pre-populated for subsequent claims. The system is set up to automatically notify you if the claim is missing pertinent information. The usual turnaround time for payment is 10-15 business days.



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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