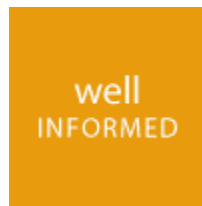




CIGNA Behavioral Health

THE CBH PROVIDER CONNECTION

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



2nd Quarter 2005
Volume XIV

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CLAIMS/CUSTOMER SERVICE CORNER

Code changes for IOP

As of September 1st 2005, CPT Codes 99199 and 90899 will no longer be accepted for billing Substance Abuse and Mental Health IOP services, respectively. If claims are received with these codes, the claims will be pended for correction. Codes 905 (MH IOP) and 906 (SA IOP) should be used for both authorization and billing of IOP services.

Claims Recovery Process

When CIGNA Behavioral Health issues claim payment to the incorrect party we recommend that you return this check to CBH with an explanation, rather than endorsing it to the correct party. We will then expedite the “correction process” and reissue payment to the correct party.

There are two reasons for this process. First, practitioner payments are reported as income to the IRS, and endorsing an incorrect payment means it counts as income for you. Second, our recovery unit will need to research the issue and may be unable to determine the reason for return. The end result could include the check being reissued to you in error.

If you have any further questions about the claims recovery process, please contact CBH’s Customer Service team at 800.926.2273.

EAP CORNER

Availability of EAP Services

You are probably aware that many of your patients have benefits through an employer-sponsored Employee Assistance Program (EAP), but you may not be aware of the extensive array of services that many employers make available to employees and their families through EAPs. These services can be an important supplement to your clinical plan of treatment, or may provide guidance and support for non-clinical issues that exacerbate stress and reduce coping abilities.

You can refer your patients to their EAP with a high level of confidence, as EAPs are easy to access by phone, in person, or online. (Anyone who does not know how to access their EAP should contact their human resources or benefits manager.)

EAP services are confidential and usually free to employees. User satisfaction ratings are high—in a recent CIGNA Behavioral Health survey, over 90 percent reported that EAP services had resolved their presenting issues.

Clinical Services

At CBH, EAP clinical services are delivered by qualified EAP professionals who are part of our provider network. EAP professionals may provide short-term counseling and support, or use their knowledge of community and insurance resources to assist with appropriate referrals. Clinical services include education and counseling concerning the challenges of daily living, family issues, care giving, health matters, and much more.



Work/Life Services

Employers who offer an EAP usually offer non-clinical, or “work/life services,” as well as clinical services. Work/life issues include stressful or challenging situations involving child care, elder care, work relationships, financial problems, legal concerns, and so forth. A broad range of services is offered, including legal consultation, financial information, educational materials, child care and elder care referrals, and ongoing support for all of these types of concerns.

If you believe these services might be helpful as a component of your patient’s treatment plan, be sure to inquire about their EAP benefits. With an EAP in place, there are many options available.

FAQs about SAPs

Since we are always in need of qualified SAPs (Substance Abuse Professionals), and we get lots of questions from providers about the SAP role, we thought a list of frequently asked questions might be helpful to our providers.

Q: What do SAPs do?

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

Q: Who can become a SAP?

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

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

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

A: You also need to meet the following criteria:

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

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

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



- # Employee Assistance Professionals Association (EAPA). (703) 387-1000. www.eapassn.org. Classroom training and online examination.
- # NAADAC. (800) 548-0497. www.naadac.org. Offers classroom training and examination, plus a home study course and examination.
- # ICRC. (703) 294-5827. www.icrcaoda.org. Examination only.
- # Professional Training Center / Tom Foley and Associates. (888) 876-7770. www.professionaltrainingcenter.com or www.tomfoleyassociates.com. Classroom training.
- # Substance Abuse Program Administrators Association. (301) 540-2783. www.sapaa.com. Classroom training and home study course.
- # Substance Abuse Program Administrators Certification Commission. (866) 538-4788. www.sapacc.org. Examination.
- # Program Services. (305) 223-9612. www.programservices.org. Home study course and examination.
- # The Institute for the Advancement of Human Behavior and Buckley Productions, Inc. (650) 851-8411. www.iahb.org. Home study course and examination.
- # American Substance Abuse Professionals. (888) 792-2727. www.go2asap.com. Home study course.
- # Blair Consulting Group. (612) 827-4147. www.blairconsultants.com. Classroom training.

Q: How does CBH reimburse SAPs?

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

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

CIGNA Behavioral Health Employee Assistance Program Referrals

The CIGNA Behavioral Health Employee Assistance Program (EAP) is a workplace-based program designed to help employees and their household members identify and resolve problems regarding work, personal, and family issues. The ultimate goals of an EAP are both to aid employees in resolving personal and workplace concerns, and to prevent or resolve productivity problems that can arise when employees are distracted by these concerns.

As an EAP provider, you play a critical, twofold role in the delivery of these services. Not only do you help employees and their family members solve their problems, but you assist employers by promoting employee health, productivity, and job satisfaction. In essence, you have two customers: the employee and the employer.

This article will describe the four different types of EAP referrals you may receive from us, and will clarify your role with each.

Self-Referrals

When participants self-refer, they contact the EAP directly and voluntarily. No information is shared with the employer regarding the participant's contact. Your role in providing clinical services will vary from assessment and referral to short term counseling, depending on the number of face-to-face sessions contracted for by the employer (usually 1-3, 1-5, 1-6, or 1-8).

Informal Management Referrals

These are appropriate when a manager learns of an employee's personal problem, or suspects it based upon observed behavior such as crying, social withdrawal, or changes in personal appearance. The manager, who may or may not have observed early signs of a decline in performance, simply reminds the employee that EAP services are available, and are free and confidential. The employee's decision to use the EAP is voluntary and is handled by you and by us just like a self-referral. The manager has no further involvement.



Formal Management Referrals

These result when an employee is exhibiting a decline in job performance, and a manager or human resource representative would like to offer EAP as a voluntary way for the employee to address any personal issues that may be impacting his or her job performance. The EAP is recommended as a resource, as part of a job corrective action plan. The employee is asked (but not required) to accept the referral and to sign an Authorization for Use and Disclosure of Private Health Information (Privacy Authorization) form, authorizing CIGNA Behavioral Health to disclose limited information to the referring manager. The Privacy Authorization allows the party named to be informed of EAP appointment compliance, the treatment recommendations of the provider, and the employee's compliance with the recommendations. The release does not allow for any other clinical or diagnostic information to be disclosed to the employer.

Continuation-of-Employment Referrals

Continuation-of-employment referrals are a type of formal management referral where the manager decides that the employee's continued employment is contingent on his or her keeping EAP appointments and complying with EAP recommendations. These referrals usually result from a serious violation of company policy, such as a positive drug or alcohol screen. Continuation-of-employment referrals differ from other management referrals in that they are mandatory, and a potential consequence for noncompliance is job termination. The employee is asked to sign the Privacy Authorization noted above, and the same reporting guidelines are followed as for other formal referrals.

What you need to know about CIGNA Behavioral Health Management Referrals

All *formal management referrals* and *continuation-of-employment referrals* are managed by a CIGNA Behavioral Health *Employee Assistance Consultant* (EAC). When you receive a management referral, you will be notified by an EAC prior to the employee's first appointment, and will be given background information about the referral. You report to the EAC on your assessment, and he or she manages all contact with the employer while the employee is under their EAP benefit—you should not be in contact the employer. The EAC is your best resource for support and information when you receive a management referral.

Regional Recruitment

New England region (CT, MA, ME, NH, RI, VT): needs EAP Practitioners, SAPs, critical incident responders*, and trainers** across the region, and throughout the northern, eastern and western reaches of Maine. Inquire by email to Dan Fallon at Daniel.Fallon@cignabehavioral.com.

Northeast region (NY, NJ, PA): needs SAPs throughout the region, and needs critical incident responders* and trainers** 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 region (AR, DE, KY, MD, NC, SC, VA, WV): needs critical incident responders* in Delaware, Maryland, North Carolina, Virginia, and Washington, D.C., and especially trainers** in the Baltimore/Washington area. Inquire by email to Carlton Weinstein at Carlton.Weinstein@cignabehavioral.com.

Southeast region (AL, FL, GA, LA, MS, TN, PR, USVI): needs SAPs across the region. Needs critical incident responders* and trainers** in Puerto Rico and the U.S. Virgin Islands. Inquire by email to Marsha Shewanown at Marsha.Shewanown@cignabehavioral.com.



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

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

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

**Trainers deliver wellness seminars and management training.

QUALITY MANAGEMENT CORNER

A Commitment to Quality

Over 13.5 million individuals count on CIGNA Behavioral Health (CBH) to manage their benefits and provide services through a variety of health plans, preferred provider organizations, employer products, Medicare, EAPs, and disability programs. Our Quality Management Program monitors these services and identifies and addresses opportunities for improvement to ensure that each individual receives high quality clinical care and service. We continuously assess the quality and coordination of care, clinical outcomes, participant and practitioner satisfaction, appointment and telephone access, claims turnaround times, and other key measures.

Results for 2004:

1. Appointment Access: Appointment access is stratified by urgency of need. Measurement for *routine* and *urgent* appointments is based on participant report. Goals mirror the national performance averages reported by National Committee for Quality Assurance (NCQA) of 80% and 50%, respectively. In addition, CBH measures urgent and emergent access during the care management process through timeframes recorded in CBH's Information System. These goals are 90% and 100%, respectively. CBH operating units' performance on appointment access was as follows: three of five met goal for routine appointments; two of five met goal for urgent, and none met the goal of 100% for emergent appointments. To improve appointment access in 2005, CBH will post a reminder on our Web site for participants to call CBH if they experience delays in getting appointments through our online directory. We will also conduct an analysis of network performance, and develop an *intermediate care* network for urgent need.
2. Telephone Access: CBH's telephone access goals for both our intake and crisis lines are 30 seconds or less average speed of answer, and less than a 5% abandonment rate. Nationally, CBH met goal for intake line speed of answer 83% of the time, and for crisis line 100% of the time. We met goal for intake line abandonment rate 83% of the time, and for crisis line 67% of the time. CBH's After Hours service met all thresholds for the year. To improve telephone access in 2005, CBH has hired and trained additional staff, improved the efficiency of automated call-routing prompts, and improved monitoring of staff performance.
3. Ambulatory Follow-up after Inpatient Discharge for Mental Illness: The rate for outpatient appointments within 7 days of discharge has improved, and the rate for appointments within 30 days is stable. However, the goals of 65% and 87%, respectively, were not achieved nationally. The improvements are attributed to better discharge planning, more active management of the transition across settings of care, and partnership meetings with facilities.
4. Complaints: CBH welcomes feedback from participants and providers as it helps us identify opportunities for improvement. In 2004, 1.4% of those using services expressed some



dissatisfaction. CBH tracks and trends complaints, and examines each for opportunities to improve care and service. As an example, we implemented our Care Advocacy Program in response to complaints that pre-authorization requirements for routine outpatient care were burdensome and unnecessary.

5. Compliance With Guidelines for Panic Disorder: Practitioner and participant education initiatives were expanded in 2004, and resulted in an improved compliance rate. 96% of the individuals who were in treatment for more than 12 weeks received an assessment for the appropriateness of medication as a part of the treatment. Because CBH presentation rates for panic disorder are below national averages, we encourage practitioners to screen patients for panic disorder as a secondary diagnosis, especially in the presence of depression.
6. Compliance With Guidelines for Depression: 2004 HEDIS rates for practitioner contact, and for acute and continuation treatment improved nationally and at every CBH operating unit. These improvements resulted from practitioner feedback on individual prescription patterns and providing depression management educational tools to 68,000 medical practitioners and 5,000 Psychiatrists/Nurse prescribers. Additionally, CIGNA pharmacy made 126 outreach calls to primary care physicians nationwide to discuss prescription patterns and CBH made available participant education materials about depression through its Web site and Care Advocacy Program. In 2005, these efforts will continue and will be supplemented by a joint CIGNA Healthcare/CIGNA Behavioral Health care management initiative for depression screening and a formal depression disease management program.
7. Engagement After Substance Abuse Detoxification: It is our goal for 70% of individuals who receive inpatient detoxification for substances to attend at least three outpatient appointments in the 30 days following hospital discharge. This goal was met for 2004. CBH continues to strengthen discharge planning and the transition to outpatient care. We seek to improve partnerships with our contracted Intensive Outpatient Programs, and to contract with additional programs in 2005.
8. Improving Substance Abuse Treatment through the Use of Intensive Outpatient Programs and Other Group Treatment: Although use of group-based treatments was higher for alcohol and other substance *dependence* diagnoses than for *abuse* diagnoses, neither population met the goal of 80% in 2004. In 2005, CBH implemented a study of initiation and engagement rates for alcohol and other drug dependence treatment, aimed at finding ways to supplement treatment and improve motivation, discharge planning, and outreach.
9. Participant and Practitioner Satisfaction: The ECHO survey recommended by NCQA is used to measure participant satisfaction. In 2004, scores for access to treatment exceeded NCQA national averages and demonstrated year-to-year improvement at every operating unit. Other scores were mixed. Improved satisfaction with access appears to have resulted from CBH's implementation of the Care Advocacy Program.
10. Network Appropriateness and Adequacy: CBH's analyses of provider geographic distribution, the match between network composition and cultural and linguistic characteristics of those served, and the degree to which timely appointments are available, show that our practitioner and provider network is able to meet the needs of those it serves. Targeted recruitment for specific areas of need continues in 2005.

For more information on the Quality Management Program, or for the performance of specific operating units, contact the Quality Service Manager at the CBH office that you work with most.



Depression Screening in Disease Management – An Update

Since 2000, proactive depression screening and intervention have been routine for CIGNA HealthCare participants diagnosed with low back pain, diabetes, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). Innovations for 2004 include stress and anxiety screening for individuals with COPD and asthma, and the use of well-accepted components of Pfizer Corporation's PRIME – MD Depression Screening Inventory as screening tools.

Those who screen positive for depression receive intensive care management plus educational and other resource materials. Where consent is given, care guides, tip sheets, and other resource materials are provided to their primary care physicians to help them treat depression in addition to medical problems. Those who screen positive for anxiety receive intensive care management plus educational resources and anxiety management tools, and they may be referred to their primary care physician or a behavioral health practitioner where appropriate.

2004 Findings:

Longitudinal trends across all included populations were similar, regardless of the specific disease management program in which they were enrolled:

- The number of individuals who completed screening has risen sharply.
- The number who screened positive for depression has declined.
- There was a greater incidence of depression found in low back pain, asthma, and COPD than in diabetes and cardiac conditions.
- The number of individuals providing consent for primary care physician notification has fallen. Higher consent rates were provided by individuals enrolled in the diabetes and cardiac programs than by individuals in the low back pain, asthma, and COPD programs.

Next Steps:

Year-over-year changes in the case finding rates and consent rates are being reviewed. Pharmacy claims are being examined to determine whether those who screen positive for depression are subsequently receiving prescriptions for antidepressant medications. Recommendations for 2005 program enhancements will be forthcoming.

Panic Disorder

According to the National Institute of Mental Health, about 1.7% of the U.S. population age 18 to 54 has panic disorder in a given year.¹ Lifetime prevalence is estimated at 1.6% to 2.2%.² In psychiatric practice, panic disorder is the primary diagnosis for 5% to 10% of patients.³ Individuals with panic disorder are more likely to be hospitalized for physical problems and have higher medical utilization (Klerman, et al., 1991).⁴ Yet, with appropriate diagnosis and treatment, 70% to 90% of these individuals show improvement (NIMH, 1999).

For CIGNA Behavioral Health (CBH), anxiety disorders were the third most common diagnostic category for outpatient care in 2003 and 2004. Anxiety disorders are also common diagnoses for inpatient care. However, we have found that panic disorder, a type of anxiety disorder, is diagnosed in our population at a lower rate than the above prevalence data would predict.

¹ NIMH Publication. (1999). Facts about panic disorder. Publication No. OM-99 4155 (Revised). www.nimh.nih.gov.

² APA Guideline. (1998). Practice guideline for the treatment of patients with panic disorder. American Psychiatric Association. www.psych.org.

³ Rouillon, F. (1996). Epidemiology of panic disorder. *Encephale*, 22 (Spec No 5): 24-34.

⁴ Klerman, G., Weissman, M.M., Ouellette, R., Johnson, J., & Greenwald, S. (1991). Panic attacks in the community: Social morbidity and health care utilization. *JAMA*, 265: 742-746.



CBH adopted the evidence-based treatment guidelines of the American Psychiatric Association in January 2000. The APA guidelines on panic disorder indicate that only two methods of treatment, cognitive-behavioral therapy (CBT) and anti-panic medication, have been extensively studied and proven effective for treatment of panic disorder. Patients are likely to show improvement with either medication or CBT within 6-8 weeks. If CBT alone does not decrease the severity and frequency of panic attacks after 8-12 weeks, then anti-panic medication should be considered (APA Guideline, 1998). Therefore, CBH decided to:

1. Evaluate how well panic disorder is being identified, by measuring its rates of screening and diagnosis
2. Evaluate the appropriateness of treatment by measuring whether those in therapy more than 12 weeks have been referred for medication services

Looking at the latter measure first, the year 2000 was used as a baseline rate. That year 90.93% of panic disorder patients who remained in therapy longer than 12 weeks received referrals for medication services. The rate improved for the period 2001 to 2004, ranging from 92.84% to 95.59%.

But while improvement was seen in treatment-to-guideline for medication services, identification rates during the same period have remained lower than in the literature, ranging between 0.16% and 0.17%. CBH encourages screening, identification, and treatment of panic disorder according to APA guidelines.

We continue to provide:

- Fact sheets and educational materials to participants through our Care Advocacy Program
- Web services that include educational information and online coaching for participants
- Resources for behavioral health practitioners and primary care physicians

As part of a total assessment, always consider panic disorder when you encounter a history of sudden episodes of fear without cause, especially when accompanied by physical discomfort, feelings of loss of control, unreality, or fears of dying or going crazy. Additional information on panic disorder and its treatment may be found on the APA Web site at

http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

Reminders

Level of Care Guidelines:

CIGNA Behavioral Health (CBH) uses objective guidelines for medical necessity decisions, and seeks input from practitioners and providers in developing and reviewing these guidelines. They are based on clinical evidence, individual need, and the availability of services in a given delivery system.

The *CIGNA Behavioral Health Level of Care Guidelines (2004 edition)* is available free of charge at <http://www.cignabehavioral.com>: select "Are You a Provider?" then "News & Resources," "Review Treatment and Practice Guidelines," and "CIGNA Behavioral Health's Level of Care Guidelines." If you are unable to access the Internet, you can contact us at 888.259.6279 to request a copy.

CIGNA Behavioral Health Staff Availability:

Licensed behavioral health and substance abuse professionals, backed by physicians, are available at CBH 24 hours a day, 365 days a year to respond to emergencies and perform utilization management. You can call us at the toll free number for the operating unit with which you ordinarily work, or at one of the numbers listed below, for assistance with referrals, benefit or claims information, to speak with a customer services or professional relations representative, or to obtain information or materials from our Care Advocacy Program. We can also be reached through our Web site at <http://www.cignabehavioral.com>. Whatever your need, we are here when you need us.



National Care Center
11095 Viking Drive, Suite 500
Eden Prairie, MN 55344
800-338-1992

Chesapeake Regional Care Center
1447 York Road, Suite 700
Lutherville, MD 21093
800-274-7603

Dallas Regional Care Center
6600 E. Campus Circle Drive, Suite 110
Irving, Texas 75063
888-800-8849

Glendale Regional Care Center
450 North Brand Boulevard, Suite 500
Glendale, CA 91203
800-866-6534

Tampa Regional Operating Unit
3101 W. Martin Luther King Blvd, Suite 201
Tampa, FL 33607
800-274-4573

Measuring Quality: Where Do You Fit In?

The health care industry has mobilized around the need to improve quality and efficiency of health care and to align treatment with evidence-based recommendations. Behavioral health is no different—nearly every behavioral health organization and many state legislative bodies have now adopted some framework for assessing and improving clinical care and service.

Each quarter CIGNA Behavioral Health (CBH) reports on the results of our ongoing quality improvement initiatives. As a network practitioner or provider for CBH, your story touches our story in the telling. Through CBH's care management and your care delivery, we weave stories about availability of care, access to care, compliance with practice guidelines, patient satisfaction, and other key metrics that reflect whether we are meeting the needs of participants.

Around 1920, Shewart (in Berwick, Gofrey, and Roesssner, *Curing Health Care*, Jossey-Bass Publishers, 1990) applied "continuous quality improvement" concepts to American manufacturing and gave us tools to define and prioritize opportunities for improvement, to evaluate root causes of problems, and to formulate hypotheses and interventions leading to re-measurement and the continuous cycle of self-examination and improvement. CBH uses these principles in our quality management program. Network practitioners and providers assist these efforts in the following ways:

- § Billable services generate administrative data about appointment timeframes, level and intensity of care, occurrence and lapses in treatment. Transitions and continuity of care across care levels can be seen by reviewing the cross-section of multiple providers for any given participant in treatment.
- § Pharmacy data helps to provide an understanding of medication prescription patterns and compliance with medication treatment plans.
- § Care management records and medical record reviews provide information about presentation rates, coordination of care among multiple providers, and care outcomes.
- § Feedback about quality of service, and about clinical consensus between CBH and providers, is available through complaint, appeal, and denial records, and also through participant self-report surveys and rating scales that are administered annually by CBH.



Where do you fit in? We encourage network providers to develop similar quality improvement programs in their own practices to whatever degree feasible. You can routinely collect participant self-report information at admission and discharge, and periodically throughout treatment (for example, session and outcome rating scales). You can track your own performance by using standardized tools for assessing and monitoring clinical progress, by adherence to evidence-based practice guidelines, and through good record-keeping practices. All of these activities shape a culture of ongoing self-evaluation and improvement. It is our story; it is your story. We invite you to be a thoughtful and active author.

PROFESSIONAL RELATIONS CORNER

SAVE THE DATE!

2005 CIGNA Behavioral Health Provider Conferences

One-day seminars presented FREE for contracted CIGNA Behavioral Health Providers

Join us if you would like to:

- €# Learn more about evidence-based management of high risk cases for the treatment of dual-diagnosis, substance abuse, and bipolar disorder
- €# Complete your professional ethics requirement for the year
- €# Earn 6.0 Continuing Education Units
- €# Network with other contracted providers and facilities
- €# Meet CIGNA Behavioral Health staff

This program is recommended for physicians, nurse practitioners, psychologists, social workers, marriage and family therapists, and 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 nine one-day seminars at locations throughout the United States. These seminars are open to all contracted CIGNA Behavioral Health providers. A schedule follows:

- | | |
|---------------------------------|--------------------------------|
| €# September 9 – Phoenix, AZ | €# October 7 – Los Angeles, CA |
| €# September 16 – Boston, MA | €# October 21 – Denver, CO |
| €# September 23 – Dallas, TX | €# October 28 – Tampa, FL |
| €# September 30 – Knoxville, TN | €# November 4 – Chicago, IL |

These 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 these seminars is to provide attendees with knowledge and skills that can be used in the care of CIGNA Behavioral Health participants. By attending, you will gain a more thorough understanding of:

- €# “Back-pocket” skills—expanding your therapeutic options and alternatives
- €# The risks and benefits of various therapeutic choices
- €# Areas of professional vulnerability
- €# Most frequent ethical and malpractice complaints
- €# Involvement in the court system
- €# Steps to take when a complaint is received

Registration is required as 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.



CLINICAL CORNER

Documentation and the SOAP Note (Part 1)

In clinical practice, good documentation is essential to good treatment. You cannot provide consistently good clinical care if you don't adequately document your findings, plans, and interventions. Here are just a few of the reasons we need good documentation:

- 1) To improve communication among all those caring for the patient
- 2) To display the assessment, problems, and plans in an organized format, in order to facilitate the care of the patient, and for use in record review and quality control
- 3) To maintain a business record that will serve as the first line of defense in a malpractice case
- 4) To maintain your credibility: what is written is what happened, and what is not written didn't happen (at least in a court of law)
- 5) To satisfy various auditors. Insurance carriers, including Medicare and Medicaid, have specific requirements for documentation. Failure to follow these guidelines can lead to problems for the clinician, including but not limited to recovery of fees paid. Clinicians usually run into documentation problems as a result of an audit.
- 6) To help cut down on requests for reviews by insurance carriers

There are many different notation systems for documenting visits with patients. The "SOAP note" is one system commonly used by both outpatient and inpatient clinicians.

SOAP stands for:

- S** - Subjective
- O** - Objective
- A** - Assessment
- P** - Plan

Although the SOAP note is more commonly used for follow-up visits, consultations, and therapy sessions, it can also be used for initial evaluations—with more details, of course, especially historical information. Here is some of the information included in a SOAP note:

Subjective: This is what patients tell you. It is their description of their symptoms, problems, issues, and concerns. For an initial evaluation you should inquire about and record their chief complaints, onset of symptoms, medical, psychiatric, and substance abuse histories, past and current medications, allergies, family history, developmental history, etc. Notes for follow-up visits should include how patients are feeling at the time of that visit and have felt since the last visit, including any improvement or worsening of their condition. Patients should be asked to report on response to medications, including side effects, and on anything that has helped or worsened their condition.

Objective: This comprises what the clinician sees or observes. It can include testing (including mental status exam and vital signs), lab reports, and consultation reports. It should also include such observations as whether patients are agitated, sedated, angry, flat, tearful, grandiose, excited, or have pressured speech or poverty of speech. Discussions with other providers, family members, friends, and significant others can be documented here.

Assessment: This is your working diagnosis and a statement about how you arrived at that assessment with the information gathered. For a follow-up visit you might include any relevant new information, especially when you are changing the diagnosis. Your note can include how the patient has or has not improved, barriers to improvement, and anything else relevant to the patient's condition and treatment.



Plan: This is your treatment plan. It may include requesting consultations, ordering lab work, and recommending psychiatric testing. The plan includes any medications you are prescribing, as well as the reasons, dosages, frequencies, and quantities given. It includes any referrals for special programming, changes in level of care, new therapies you will be using or recommending (for example, CBT, family, marital), estimated frequency of visits, documentation of consent for medications and other treatments, and the date and time of the next visit.

CIGNA Behavioral Health has its own requirements for documentation. Here is the link to these requirements on our Web site:

<http://apps.cignabehavioral.com/web/basic/site/provider/pdf/provGuideSect5.pdf>

Member Rights and Responsibilities

As a practitioner, it is important for you to talk with your patients about their rights and responsibilities. The following is a statement of member rights and responsibilities given to CIGNA Behavioral Health participants periodically. Please refer to Appendix D of your *CIGNA Behavioral Health Provider Guide* for the complete rights and responsibilities statement.

As a CIGNA Behavioral Health participant, you have the right to understand your behavioral healthcare benefits and services, and to obtain information about CIGNA Behavioral Health as an organization, about the CIGNA Behavioral Health practitioner network, and about the clinical guidelines that direct your care. In addition you have the right to:

- ⚡ Be treated with respect, with recognition of your dignity and right to privacy
- ⚡ Receive services in a prompt, courteous manner that respects your cultural and ethnic identity, religion, disabilities, gender, age, marital status, and sexual orientation
- ⚡ Partner with your practitioner in decision making regarding your treatment plan
- ⚡ Discuss appropriate or medically necessary treatment options, regardless of cost or benefit coverage
- ⚡ Voice complaints and file appeals about CIGNA Behavioral Health or the care you received from a practitioner
- ⚡ Make recommendations regarding CIGNA Behavioral Health's member rights policy

As a CIGNA Behavioral Health participant, you have the responsibility to:

- ⚡ Provide the information necessary for CIGNA Behavioral Health practitioners and providers to assist in your treatment goals
- ⚡ Participate in your treatment, establishing treatment goals and objectives with your practitioner
- ⚡ Follow through with the instructions necessary to carry out your mutually agreed-upon treatment plan
- ⚡ Call CIGNA Behavioral Health at (800) 244-6224 for any behavioral care issue for which you need assistance—we are available 24 hours a day, 365 days per year



When Intimacy Hurts

As professionals, we know that domestic violence is not a private matter, and that early intervention is crucial. Experience shows that levels of violence in these relationships can escalate, and even when emotional abuse is not accompanied by physical or sexual assault, there is risk for lasting damage. As silence and myths have been dispelled, we have learned that emotional and physical abuse can occur in all kinds of couples—married, dating, living together, lesbian, and gay. Elders and children are also abused by family members.

It is estimated that during their adult lives 20%-30% of American women suffer abuse by intimate partners.⁵ Annually, more than 5.3 million American women over 18 are victimized by their partners.⁶ Violence results in an estimated 2 million injuries and 1,300 deaths annually.⁷ Further findings from a national survey by the National Institute of Justice and Centers for Disease Control and Prevention estimated that more than one-half million women are treated annually for abuse injuries, and that 26% of injuries are serious enough to warrant hospital treatment.⁸ Sadly, sometimes health care providers treat injured women without ever inquiring about or recognizing the underlying reason for their injuries.⁹ The *Journal of the American Medical Association* found that less than 10% of primary care physicians routinely screen for domestic violence during regular office visits.¹⁰

Domestic violence against women is a significant risk factor for depression, post-traumatic stress disorder, anxiety, and substance abuse.¹¹ Asking about domestic violence and sexual assault is one way to increase disclosure and create early intervention opportunities that protect health and safety. To increase rates of early identification and intervention, and to reduce morbidity, many national health care organizations, including the American Medical Association and the American Psychological Association, recommend screening for domestic violence by health care professionals. CIGNA Behavioral Health encourages providers and practitioners who are not already doing so to begin screening patients for domestic violence and sexual assault when logical opportunities arise. Health assessment questionnaires and interviews should include specific screening questions. Direct, confidential, and non-judgmental inquiries should be made upon admission, at discharge, and periodically throughout treatment when appropriate (for example, when changes in relationships are reported or when suspicious injuries are observed).

Resources are available from the Centers for Disease Control and Prevention Web site at: <http://www.cdc.gov/ncipc/>.^{*} Given the prevalence of domestic violence and sexual assault, and the potential severity of injury, screening is clearly warranted. It is an important way for practitioners and providers to employ a preventive health approach rather than waiting to treat the aftermath.

*Reference to Web sites, materials, or resources does not constitute CIGNA Behavioral Health's endorsement of specific products or services.

⁵ National Institute of Justice and Centers for Disease Control and Prevention. Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention; 1998.

⁶ Ibid

⁷ Ibid

⁸ Ibid

⁹ National Institute of Justice and Centers for Disease Control and Prevention. Above. Rodriguez MA, Bauer HM, McLoughlin E, Grumbach, K. Screening and Intervention for Intimate Partner Abuse. *JAMA* 1999; 282: 468-474.

¹⁰ Rodriguez MA, Bauer HM, McLoughlin E, Grumbach, K. Screening and Intervention for Intimate Partner Abuse. *JAMA* 1999; 282: 468-474.

¹¹ American Psychological Association. Report of the American Psychological Association Presidential Task Force on Violence and the Family. Washington, DC: American Psychological Association; 1996.



Clinical Review Guidelines

As a practitioner or facility working with managed care patients, you are frequently asked to support the clinical approach and treatment plan you are taking with your patients. To help you through this process more efficiently, CIGNA Behavioral Health is providing you a copy of our *Clinical Review Guidelines*.

You can help expedite the review process with our care managers by using the applicable guidelines to decide what information will be needed. You will find the following guidelines under the subtopic of “Clinical”, under “Provider Resources” on our website after July 11th, 2005:

Outpatient Treatment

Mental Health Intensive Outpatient

Substance Abuse Intensive Outpatient

Inpatient Initial Review

Inpatient Concurrent Review

Inpatient Discharge Review

Feel free to review the guidelines online and/or print them out for continued reference.



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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