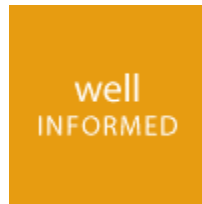




# THE CBH PROVIDER CONNECTION

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



## 3rd Quarter 2005 Volume XV

**In This Edition:**

<u><i>Critical Incident Response in the Aftermath of Hurricane Katrina</i></u> .....	1
EAP Corner .....	1-3
<u><i>The Differences Between EAP and Behavioral Health Referrals</i></u> .....	1-2
<u><i>Guidance Around Employment Law Excluded from EAP</i></u> .....	2-3
<u><i>Regional Recruitment</i></u> .....	3-4
Professional Relations Corner .....	4-5
<u><i>2005 CIGNA Behavioral Health Provider Conferences</i></u> .....	4
<u><i>Intermediate Care: Definition and Objectives</i></u> .....	5
<u><i>Intermediate Care Network: Frequently Asked Questions</i></u> .....	5-6
Quality Management Corner .....	6-8
<u><i>Participant Safety</i></u> .....	6
<u><i>2005 Facility Safety</i></u> .....	6
<u><i>What We Learned</i></u> .....	7
<u><i>Future Directions</i></u> .....	7-8
Clinical Corner .....	8-9
<u><i>Documentation Part II: Documentation Tips</i></u> .....	8-9
Claims Corner .....	9-10
<u><i>Correct Claim Coding Streamlines Processing</i></u> .....	9
<u><i>EAP Services</i></u> .....	9-10
Editorial Board .....	10



## CRITICAL INCIDENT RESPONSE IN THE AFTERMATH OF HURRICANE KATRINA

The work of recovery and rebuilding continues in the wake of Hurricane Katrina. CIGNA Behavioral Health has been very busy servicing the needs of our customers and others in the disaster area, as well as many organizations and individuals outside the area that were affected indirectly. We have provided over 600 hours of onsite critical incident response services to businesses that were affected by the hurricane and its aftermath. This includes disaster management consultation with managers and HR, debriefing groups for employees, and face-to-face sessions with at-risk individuals to screen, stabilize, and/or refer them for further services.

And we could not have done this without you, our very capable and hard-working network of providers. We want to take this opportunity to thank each of you who have provided services for CBH to those affected by the hurricane. Your responses during this tragedy have been tremendously helpful, and the feedback from our customers has been overwhelmingly favorable.

There is one more thing: when your onsite disaster work is finished, don't forget to get debriefed yourself. The disaster-response literature is emphatic that disaster responders need to take this final step before their work is

complete. After such stressful work we tend to want to get home and get back to our lives. We often fail to recognize the impact that our experiences working with disaster victims have on our lives. But the evidence is that disasters affect the helpers in many of the same ways they do the victims.

“Debriefing the debriefers” generally only takes 15 minutes to a half hour, though it can be longer for prolonged exposure to stressful situations. If you were working with a team, you can debrief with them before going your separate ways. Otherwise you can do it with another clinician who is familiar with the debriefing model. The process parallels the debriefing process you use with victims: discuss what happened, how you feel about it, any symptoms you are experiencing, and how you plan to take care of yourself.

So, please debrief and take care of yourself—we need you back again!

## EAP CORNER

### THE DIFFERENCES BETWEEN EAP AND BEHAVIORAL HEALTH REFERRALS

An EAP (Employee Assistance Program) is one of many benefits that an employer can provide for its employees. It can be offered alone or in conjunction with a behavioral health plan. Because EAP is a separate and distinct benefit, there are some procedures that differ from behavioral health referrals. Listed



below are the most important EAP differentiators that providers need to be aware of:

- **No copays:** EAP services are prepaid by the employer, so there are no out-of-pocket costs for participants.
- **EAP referrals *do* require an authorization.** EAP services are available to employees and their household members. With few exceptions, we do not verify eligibility for EAP accounts. For this reason, all EAP participants must obtain authorizations for EAP counseling sessions. Participants can get authorizations by calling their EAP access number or by going to the CIGNA Behavioral Health website and logging in using their Employer ID and PIN. Participants are responsible for bringing their authorization number with them to their first appointment. If a client does not have an EAP authorization, providers may call CBH and obtain the authorization for them. You will need the client's demographic information and the name of their employer.
- **Use CPT code 99404** for all EAP claims. EAP claims can be submitted by mail to P.O. Box 46790, Eden Prairie, MN 55344, or can be filed electronically on our website at [www.CIGNABehavioral.com](http://www.CIGNABehavioral.com).
- ***Statement of Understanding* form:** EAP clients should review and sign this form at their first appointment, and it should be filed in their chart. The form can be found by visiting [www.CIGNABehavioral.com](http://www.CIGNABehavioral.com) and choosing the following options: *Are*

*You a Provider / Provider Resources / EAP Statement of Understanding.*

- **Closing EAP cases:** In order to help us track EAP utilization and treatment outcomes, providers should call CBH to close EAP cases when they are completed. When you close a case, you will be asked to provide the following information: diagnosis, risk assessment, medication status, any chemical dependency issues, confirmation that the *Statement of Understanding* was signed, and recommendations for any further treatment, if needed. You may self-refer for continued treatment beyond the EAP if clinically appropriate.

### GUIDANCE AROUND EMPLOYMENT LAW EXCLUDED FROM EAP

There has been confusion recently about counselors providing guidance to EAP clients in the area of employment law. Cited below are exclusions pertaining to EAP services, a complete list of which can be found in Section 6, p. 14, of the *Provider Guide* on the CIGNA Behavioral Health website at: <http://apps.cignabehavioral.com/web/basic/site/provider/pdf/provGuideSect6.pdf>.

#### Exclusions

The CIGNA Behavioral Health EAP benefit excludes coverage for:

#### Employment Law

Coverage for employment law is excluded due to the dual nature of the EAP client—the individual employee or family member, and the employer who



sponsors the program. Any legal information or advice given by a provider to an individual client concerning employment law can have potentially detrimental consequences for the employer. To avoid this conflict of interest, employment law services are excluded from the program. In the course of providing EAP services, providers shall refrain from discussing legal recourse as a potential action in resolving workplace concerns or disputes. Employees with concerns about workplace practices should be referred to their Human Resources department for further assistance. Examples of excluded employment law questions or concerns are:

- Workplace safety, accidents, injuries, or illnesses;
- Coworker liability (including workplace assaults or threats);
- Employee benefits issues/disputes or disputes concerning the agents of company-sponsored benefits or services;
- Pension rights, employment termination, retirement questions or disputes;
- Employer-based civil rights violations (including workplace sexual harassment allegations); and
- All other alleged employer liability issues.

## REGIONAL RECRUITMENT

**New England** (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](mailto:Daniel.Fallon@cignabehavioral.com).

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

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

**Southeast** (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](mailto:Marsha.Shewanown@cignabehavioral.com).

**Midwest** (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI): needs SAPs across the region, especially northern Michigan and Minnesota. Inquire by email to Robbie Hamill at  
[Robbie.Hamill@cignabehavioral.com](mailto:Robbie.Hamill@cignabehavioral.com).

**West** (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](mailto:Bruce.Steele@cignabehavioral.com).

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

\*\*Trainers deliver wellness seminars and management training.

## PROFESSIONAL RELATIONS CORNER

### 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 treatment of high risk cases, including dual-diagnosis, substance abuse, and bipolar disorder
- Complete your professional ethics requirement for this year
- Earn 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 several one-day seminars at locations

throughout the United States. These seminars are open to all contracted CIGNA Behavioral Health providers and will be held:

- October 7 - Los Angeles, CA
- October 21 - Denver, CO
- October 28 - Tampa, FL
- November 4 - Chicago, IL

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 attendees with additional knowledge and skills that can contribute to the care provided to CIGNA Behavioral Health participants. By attending, you will have a more thorough understanding of:

- "Back-pocket" skills on appropriate therapeutic alternatives
- Recognizing the risks and benefits of therapeutic choices
- Areas of professional vulnerability
- Typical ethical and malpractice complaints
- Involvement in the court system
- Steps to take when a complaint is received

Registration is required for the events above. Seating is limited. Please contact your Professional Relations department at [ProviderEducation@cignabehavioral.com](mailto:ProviderEducation@cignabehavioral.com) if you would like to sign up or if you have any questions.



## INTERMEDIATE CARE: DEFINITION AND OBJECTIVES

At CIGNA Behavioral Health *intermediate care* refers to a level of intervention that provides pre-cautionary and preventive care to a participant who presents with a specific and complex diagnosis and with a level of acuteness that if not addressed within 48 hours could escalate and require a higher level of care. The goal of our intermediate care network is to link complex cases with providers who have the clinical expertise to treat challenging diagnoses and problems. It is expected that interventions be conducted by licensed mental health professionals, the key objectives being to assess and stabilize patients and to identify the most appropriate level of care at that time. The intervention should include the following components:

- A comprehensive psychiatric and medical history
- A description of the participant's impairments and any risks (for example, suicidal or homicidal ideation)
- Comprehensive evaluation for substance abuse
- A psychosocial evaluation, including the patient's family and support network
- Any barriers to a successful treatment plan
- Documentation of any current treatment providers, the services provided, and medications if any (including dosages and frequencies)

**PLEASE NOTE:** Intermediate care services must be initiated and authorized by CBH clinical staff, and use CPT code 90808.

Following is a list of key objectives for intermediate care services:

- Providers will be able to intensify treatment plans as clinically indicated for their participants in order to prevent unnecessary hospitalization.
- Providers will develop short-term, evidence-based treatment plans incorporating a systems approach.
- Providers will include in their treatment planning effective collaboration between CBH, psychiatrists, PCPs, and other community resources prior to requesting any higher level of care.
- Providers will have a clear understanding of managed care philosophy, as well as an understanding of CBH policies and procedures regarding claims and utilization review processes, especially those resources available online.

## Intermediate Care Network: Frequently Asked Questions

- **What are the advantages of joining the intermediate care network?**
  - Increase in number of referrals
  - Receive appropriate referrals that match provider's clinical expertise
  - Database capability to search for this access level and specialty



- **Does this service require pre-authorization?**  
Yes; the Care Advocacy Program (CAP) does not apply to this service.
- **Does the participant have a co-pay for this service?**  
Yes; the standard outpatient visit co-pay applies. Refer to the customer service number on member's card.
- **Am I able to request additional 90808 sessions?**  
Please contact a care manager to review the ongoing clinical needs of the participant.
- **If I participate in the crisis stabilization network, can I also participate in the intermediate care network?**  
Yes.
- **How do I sign up for this service?**  
A provider interested in signing up for the intermediate care network should contact their local Provider Education Specialist or send an e-mail to [ProviderEducation@cignabehavioral.com](mailto:ProviderEducation@cignabehavioral.com).

## QUALITY MANAGEMENT CORNER

### PARTICIPANT SAFETY

CIGNA Behavioral Health is committed to network-wide safe clinical practices that reduce the risk of harm to participants. Such practices include

continuity and coordination of care, treatment that is consistent with evidence-based clinical practice guidelines, and timely access to appropriate care with qualified practitioners who take actions to improve patient safety. Updates and analyses on activities that impact participant safety are regularly provided to practitioners through CIGNA Behavioral Health's practitioner newsletter and *Provider Guide*. Participants receive participant safety results and other CBH performance metrics through postings on the CBH Web site.

### 2005 Facility Survey

In order to assess safety practices and to analyze network-wide opportunities, CIGNA Behavioral Health surveyed 874 contracted facilities that provide acute or residential services to participants. The survey consisted of sixteen questions selected following a review of typical safety concerns, and issues identified by a CIGNA Behavioral Health national staff workgroup.

Facilities answered questions with "yes," "no," or "not applicable." Five questions were aligned with 2004 National Safety Goals of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for acute care facilities. These involved accuracy of patient identification, effectiveness of communication among caregivers, medication safety, clinical alarm systems, infection risk, and use of internal patient satisfaction surveys. The remaining eleven questions identified potential problems in the use and tracking of suicide



precautions, seclusion and restraint, adverse medication response, advance directives and discharge planning, as well as providing an overview of organizational commitment to safety practices.

The national response rate to the survey was 50.1%, with 314 acute care and 124 residential facilities responding. Regional response rates ranged from 46.9% in the West to 51.8% in the Mid-Atlantic region.

### What We Learned

The incidence of “yes” answers from acute care facilities ranged from 95.7% to 100%. The question that had the lowest “yes” response rate (95.7%) was, “Do you have a process to ensure the behavioral health practitioner will receive a copy of their patient’s discharge summary?” Acute care facilities generally had higher scores than residential facilities, particularly on the first five questions related to JCAHO safety goals. Most residential facilities follow the guidelines of the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, residential care facilities had a greater number of “N/A” responses than did acute care facilities. However, on questions not derived from JCAHO, overall affirmative scores for residential facilities responding with other than “N/A” ranged from 76.2% to 100%.

Acute and residential care facilities’ score differences were generally related to the nature or functioning of these facilities, rather than to

potential safety concerns. For example, less use of clinical alarm systems and seclusion and restraint was reported in residential facilities compared to acute care facilities. Although 92.4% of residential facilities have a seclusion and restraint policy and procedure, only 81.3% of these facilities reported tracking seclusion and restraint data. Similarly, facilities serving youth were less likely to report verification of advanced directives proxy for each admission. One hundred percent of residential facility respondents reported a process to ensure that patients receive a copy of discharge instructions.

### Future Directions

Overall scores in the 2005 survey indicate that network facilities have well defined processes for addressing patient safety issues, and strong organizational commitments to patient safety. Based on the 2005 findings, separate surveys for acute and residential facilities are being considered for the future. CIGNA Behavioral Health will partner with acute care facilities to improve the rate at which discharge summary information is communicated to outpatient therapists, and a focused annual survey of all contracted inpatient facilities will identify actions taken to improve patient safety. In 2005 and 2006 CIGNA Behavioral Health plans to develop and validate performance metrics appropriate for use at the individual practitioner level; in 2007 practitioner level quality and safety data will be available to



participants and practitioners on the CIGNA Behavioral Health Web site.

## CLINICAL CORNER

### DOCUMENTATION PART II: DOCUMENTATION TIPS

This is the second of two articles on proper documentation of mental health treatment. The first article presented the SOAP format. This one presents some broader considerations.

Starting with the basics, it is important to always record the patient's name, the date and time seen, amount of time spent with the patient, and to sign off with your own name and credentials (MD, PhD, etc.). Also *print* your name if your signature is not legible.

When discussing symptoms or presenting problems it is helpful to describe and quantify how patients have been affected in their ability to function at work or school, their ability to care for themselves, their relationships, cognitive changes, and how their illness has affected their insight, judgment, and danger to self or others. When asking about suicidal ideation, document how often the patient thinks about it, any intent, plans, means, and a plan for safety.

It is not enough to write that the patient "is improving and will continue treatment." A more useful progress note might say something like the following:

Patient is being seen for a recurrent major depressive disorder and has been on an antidepressant (name and dosage) for two months ... depression seems to be improving as evidenced by going to work every day, having only occasional fleeting suicidal ideation about once a week with no intent or plans. Patient is sleeping seven hours straight and eating about 2000 calories a day. Has started to go bowling again once a week. Patient is now attending therapy only once a month and working on strategies to improve communication with his sons. However, patient has a history of relapsing into depression when not in treatment; therefore it is recommended that he continue therapy sessions once a month and stay on antidepressant. I will decrease frequency of medication management visits to once a month. Discussed risks and benefits of his medication and treatment, as well as alternative treatments.

Professionalism is critical in your documentation. Always remember that others, including lawyers, auditors, and even the patient, may read your notes. What you write may affect others, for example, if records are subpoenaed by a court. It is not usually a good idea to criticize other providers, especially if you do not have all the facts. Avoid giving your opinions and using subjective terms such as *manipulative* or



*sociopathic*. Instead, describe what you observe—what you see and hear.

When using medications you should periodically, especially when making changes, report that you have discussed with the patient the potential risks, side effects, benefits, and alternative treatments. Such discussions are especially important when the diagnosis does not support the use of a medication or when using a medication for an off-label use. When possible, discuss medication use and other treatments with family members and document that they are aware of and agree with the choices. Document other medications the patient is taking, including herbal preparations.

It is a good idea for even non-prescribing clinicians to ask about medication compliance and side effects and, if there are any concerns, consult with the prescribing clinician (with the patient's permission). Document any coordination of care with other providers, as well as any testing or lab results you sought or used.

Discuss goals of treatment, and progress or lack thereof toward these goals. Metrics you can use for setting treatment goals and measuring progress include how often patients are missing work, how much sleep they are getting, how often and how much they are eating, and any weight loss or gain and the time frame. Describe how treatment is helping or not helping, and when there is a setback or exacerbation of symptoms, discuss possible reasons for the change. Then discuss your plan of action for addressing the problem(s).

On a final note, remember that your documentation needs to be legible. It's not enough that you can read it. An auditor or court of law can take you to task for inadequate documentation if it cannot be read by someone else. When you make an error in your writing, cross it out using a single line, put your initials and the date beside the cross-out, and then write what you intended. Never erase, discard, or completely cross out the error. It may be taken as tampering with evidence.

## CLAIMS CORNER

### CORRECT CLAIM CODING STREAMLINES PROCESSING

This is a reminder to providers that effective 5/19/05, CBH is now able to use Universal Billing Codes, or Revenue Codes 905 and 906, to process Intensive Outpatient Programs when using the UB92 claim format. CBH has had a coding transition period from 5/19/05 through 8/31/05 where codes 99199 and 90899 were converted to Revenue Codes 905 and 906.

As of 9/1/05 codes 99199 and 90899 will no longer be accepted for IOP claim submissions. Claims will be rejected with a request to submit a corrected claim using current procedure codes.

### EAP Services

Claim coding is key to correct claim outcome. When a member presents for EAP services and the provider bills



without knowing it is an EAP case, the claim is processed against current behavioral benefits, typically requiring a participant co-payment. When CBH receives the correct information, many times we need to handle the previously processed claim as an over-payment due to the correction from behavioral benefits to EAP. Providers question why this process requires so many steps to correct. An overpayment is recorded for the original payment because EAP and behavioral benefits may be paid from different banking arrangements. A seemingly simple correction turns into recovery and

reprocessing of the original claim. Please clarify with all patients when they initially present for care whether the services are EAP or behavioral. If EAP, use code 99404 to avoid the extra steps above.

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>.

## Editorial Board

### Editorial Board Leader

Sherry Estrada, Professional Relations Manager

### Article Contributors

Josue Arguello, Provider Education Specialist, Glendale Regional Care Center

Sheila Cain, Professional Relations Manager, Dallas Regional Care Center

Robert Cirelli, Associate Medical Director, Chesapeake Regional Care Center

Dale Demarest-Bryan, Manager, EAP Services

Dana Kiel, Regional EAP Manager

Jan Miller, Senior Account Manager

Ken Richard, Quality Manager

Jeffrey Van Pelt, EAP Manager

Caroline Woitas, Claim Supervisor

### Design & Editing Contributors

Anita Ivarson, Project Manager

Elizabeth Jordan, Legal Resource Consultant

Jeffrey Van Pelt, EAP Manager