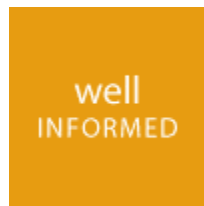




# THE CBH PROVIDER CONNECTION

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



## 2nd Quarter 2006 Volume XVIII

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## EAP CORNER

### HURRICANE READINESS

The hurricane season is upon us once again, and it is an optimum time to reflect upon how prepared we were last year when the devastating storms swept across our nation, and what we can do to be even more effective this season and in the future.

**Access** to services can be impacted significantly by hurricane activity, based upon the conditions at the affected site and your availability to provide any needed services.

**Communication** is key in coordinating this access.

- If you find yourself impacted by natural disasters such as the hurricanes of 2005, and you are still able to serve in the capacity as a CBH provider, please contact the CBH Service Center at 800.952.6684. Your name will be added to a bank of available, easily accessible providers able to provide critical services as needed.
- If you are a provider in near proximity to an affected area and would like to be added to the bank, please also call us at 800.952.6684.
- CBH will also make proactive outreach calls to those providers in near proximity to affected areas, but who have not been impacted themselves, to add to the bank of available providers.

These steps, in partnership with those you take, will help assure that we will be able to find the right help and effective service for the affected population. We'd like to hear from you, too, regarding how we in EAP can further support you with information and resources during these crucial times.

Thank you for your service to CBH in the past and the services you will provide in the future.

## PROVIDER RELATIONS CORNER

### SPECIALTY PRIVILEGING

In an effort to better service our participants with complex conditions, CIGNA Behavioral Health has implemented a specialty privileging program. The purpose of this program is to collect documentation about a CBH practitioner's clinical education and training history in order to more successfully refer a participant with a specific problem or diagnosis for treatment. Please review the following list of requirements for the privileged specialties of Dialectic Behavioral Therapy (DBT), Hypnotherapy, and Eye Movement Desensitisation and Reprocessing (EMDR).

Dialectic Behavioral Therapy (DBT):  
Completion of Level 1 & 2 Training in DBT -OR- Completion of 10-Day Intensive Training Course in DBT.



Hypnotherapy: Certification in the practice of Hypnotherapy

EMDR: Successful completion of Level 1 & 2 Training in EMDR.

Any CBH provider interested in adding these specialties to his/her profile will need to submit copies of training certificates along with a Specialty Network Worksheet to his/her local Provider Education Specialist. If you have any questions regarding this process, you can contact a Provider Education Specialist by email at [ProviderEducation@cignabehavioral.com](mailto:ProviderEducation@cignabehavioral.com).

## QUALITY MANAGEMENT CORNER

### A COMMITMENT TO QUALITY

Currently, 17.9 million individuals count on CIGNA Behavioral Health for benefit management and to provide services through a variety of health plans, preferred provider organizations, employer products, Medicare, Employee Assistance Programs, and disability programs. Our Quality Management program monitors, identifies, and addresses opportunities for improvement, to assure that each individual receives quality clinical care and service.

We continuously assess quality of care, coordination of care, clinical outcomes, participant and practitioner satisfaction, appointment and telephone access, claims turnaround time and other key measures in defined

committees that meet at least quarterly. At least annually, CIGNA Behavioral Health's California, Texas, Minnesota, Maryland, and Florida operating units evaluate our success and the challenges to improve care and service for participants.

### Results for 2005

1. Appointment Access: Appointment access is stratified by urgency of need. Measurement for Routine appointments is based on participant self report in the annual ECHO participant satisfaction survey. The goal is set to the National Committee for Quality Assurance (NCQA) national performance averages of 80%. During care management activity, urgent and emergent appointment access is measured through timeframes recorded in CIGNA Behavioral Health's information system, where goals have been established for 90% and 100%, respectively. All five CIGNA Behavioral Health operating units met goals for routine access. All performed under the 100% goal for emergent appointments. Performance on urgent access ranged from 80.5% to 98.3%, with only one operating unit exceeding the 90% goal. To drive improved appointment access in 2006, CIGNA Behavioral Health will continue the website reminder for participants to call CIGNA Behavioral Health if they experience delays in getting appointments through our online directory. We will also conduct an analysis of network performance and continue the implementation of



the intermediate care network for urgent need.

2. Telephone Access: Nationally, CIGNA Behavioral Health established goals of 30 seconds for average speed of answer and less than 5% for abandonment rate. The goals are measured monthly and are identical for our separate intake and crisis lines. Nationally, the CIGNA Behavioral Health average speed of answer exceeded the 30-second threshold one month in the year on the intake line and no months in the year on the crisis line. The average abandonment rate exceeded the less than 5% threshold two months in the year on both the intake and crisis lines. To drive improvements in 2006, CIGNA Behavioral Health has hired and trained additional staff, improved the efficiency of automated call-routing prompts, and regularly monitors staff performance.
3. Ambulatory Follow-up After Inpatient Discharge for Mental Illness: Although goals of 68% and 85% were not achieved nationally, performance shows improvement for attendance at appointments both 7 and 30 days after discharge from an inpatient facility for a mental health admission. Improved discharge planning, more active management of the transition across settings of care, and facility partnership meetings and teleconferences drove the results.
4. Complaints: Feedback is welcomed and helps to identify areas of

improvement opportunity.

Nationally in 2005, 1.32% of those using services expressed some dissatisfaction. The most common category of complaint in 2005 was accessibility of services (0.28%) followed by attitude of provider or their staff (0.15%). CIGNA Behavioral Health tracks and trends complaints, seriously examining each for opportunities to improve care and service.

5. Compliance With Guidelines for Depression: 2005 rates for practitioner contact and acute and continuation treatment improved nationally, driven by mailing individual performance scores and depression management tools to 55,890 medical and 5,439 psychiatric high-volume prescribers of antidepressants. In a fax-back survey to these practitioners, 79% of medical and 74% of psychiatric prescribers agreed that this was an effective program to improve quality of care. In addition, CIGNA Behavioral Health made participant education materials available through its website and Care Advocacy Program. In 2005, these efforts were supplemented by a joint care management initiative for depression screening and response in CIGNA Healthcare medical populations, and by the development of a formal Depression Disease Management program.
6. Engagement After Substance Abuse Detoxification: The 70% goal was met in 2005 for individuals who experienced inpatient detoxification



and attended at least three out-patient appointments in the 30 days following hospital discharge. CIGNA Behavioral Health continues to strengthen discharge planning and the transition to outpatient care, to increase compliance partnership with existing Intensive Outpatient programs, and to pursue contracting of additional programs in 2006.

7. Participant and Practitioner Satisfaction: The ECHO survey recommended by NCQA is used to measure participant satisfaction annually. In 2005, scores for access to treatment exceeded NCQA national averages and demonstrated year-to-year improvement at four of five operating units. Among the other scores that showed improvement and exceeded the NCQA national average were "rating of counseling and treatment" and "how well clinicians communicate."
8. Network Appropriateness and Adequacy: Annual studies of geographical distribution, the match of the network composition with cultural and linguistic characteristics of those served, and the degree to which timely appointments are available, show that CIGNA Behavioral Health's practitioner and provider network is able to meet the needs of those it serves. Target recruitment continues in 2006 for specific areas of need.

For more information on the Quality Management program, results, and specific information about the

operating unit with which you work, contact the Quality Manager at the CIGNA Behavioral Health office that you work with most often.

## REMINDERS

### Level of Care Guidelines

CIGNA Behavioral Health uses objective guidelines for medical necessity decisions and seeks and documents input from practitioners and providers in reviewing or developing these guidelines. They are based on sound clinical evidence and are applied based on individual need and an assessment of the availability of services in the delivery system.

The CIGNA Behavioral Health Level of Care Guidelines (2004 edition) are available, free of charge, at <http://www.cignabehavioral.com>. From our home page, select "Are you a Provider?" then select "Provider Resources." From there, select "Level of Care Guidelines." Clicking on the link there will open CIGNA Behavioral Health's Level of Care Guidelines as a PDF document, which you can freely review or download. 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 CIGNA Behavioral Health 24 hours daily, 365 days a year to respond to emergencies, or to answer questions about and to



perform utilization management. When you contact us, you will be connected to the most appropriate staff to discuss your needs and answer your questions, whether non-clinical or clinical. We can also be reached by fax, email, or through our website at <http://www.cignabehavioral.com>. Reach us using the toll-free telephone number for the operating unit with which you ordinarily work, or by calling one of the numbers listed below for assistance with referrals, benefit or claims information, to speak with a customer services or Provider Relations representative, or to obtain information and materials from our Care Advocacy Program. 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 East Campus Circle Drive, Ste 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 Care Center  
3101 West Martin Luther King Blvd, Ste 201  
Tampa, FL 33607  
800.274.4573

## Provider Guide

Please be sure to check for new and revised information in CIGNA Behavioral Health's Provider Guide, which is updated quarterly. It is available on our website at:

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

## SCREENING TOOLS FOR PSYCHIATRIC DISORDERS

In recent years, as medical care has become more complex and specialized, screening tools have been developed and increasingly utilized to diagnose mental health and/or substance abuse disorders. In a busy primary care clinic, clients may be asked to fill out a questionnaire about depressive symptoms if they have a history of headaches, back pain, and fatigue. Such screenings help the clinician quantify possible depressive symptoms and help the clinician discuss and possibly diagnose a depressive disorder. Similarly, a client with complaints of gastrointestinal problems, anger outbursts, and marital discord may be screened for an alcohol problem.

Health plans, employer groups, and epidemiologists are increasingly recommending the use of screening instruments to identify individuals with an undiagnosed disorder that is not treated so that appropriate services are available for intervention before conditions become more severe.

CIGNA HealthCare has recommended that primary care physicians use the



PRIME-MD Patient Health Questionnaire (PHQ-9) to screen for depression and the Alcohol Use Disorders Identification Test (AUDIT) to screen for alcohol abuse. As behavioral health professionals, you should be aware of these instruments and their use. Primary care physicians may refer clients to you for screening positive on these instruments and request that you perform further assessment and treatment.

The PHQ-9 is a screening instrument based on the depressive criteria from DSM-IV. PHQ-9 assesses both the criteria and severity of depression and was developed by researchers at Indiana University and Columbia University. The instrument is easy for clients to complete and quick for professionals to score. For psychiatrists, psychologists, and master's level behavioral professionals, the PHQ-9 provides an ongoing assessment of the severity of depression as treatment progresses by repeated administration of the instrument. The PHQ-9, along with the Mood Disorder Questionnaire (MDQ) (a screening tool for bipolar disorder), are available for use on CIGNA Behavioral Health's website. (<http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/practitionerToolkitDepression.jsp>).

The AUDIT is a 10-item questionnaire that takes clients less than 5 minutes to complete. The AUDIT was developed by the World Health Organization to assist in the identification of under-diagnosed, alcohol-related disorders. The questionnaire is available for download at the CIGNA Behavioral

Health website and is included in the publication entitled "Helping Patients Who Drink Too Much," printed by the U.S. Department of Health & Human Services.

(<http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/PractitionersGuideAlcohol.pdf>).

## CLAIMS/CUSTOMER SERVICE CORNER

What's important to us is what is important to you. From CBH claims administration, it is important for us to streamline the administration of claims to assist you in your practice. Below are some simple tips and updates.

**Tip:** At the start of each visit, ask the participant if his/her coverage on record is current. This simple question can avoid issues with plan changes, eligibility updates, or mailing addresses.

**Updates:** CBH claim and customer service systems were enhanced to provide better service related to a participant's Coordination of Benefits.

1. CBH updates Coordination of Benefits (COB) information on a rolling annual basis. To facilitate the update process, a subscriber can contact our toll-free customer service number and be connected to the Interactive Voice Recognition (IVR) system 24 hours a day to acknowledge no other coverage exists. The information is downloaded to the claims system. Claims



that were previously pended for this information will begin the adjudication process. The subscriber must initiate the IVR process by calling 800.472.1680.

2. CBH updated our claim system's logic to automatically adjudicate claims when another insurance plan is primary. Using the data from both the claim and primary carrier's explanations of benefits, the claim system can administer multiple types of COB plan structures. This results in faster claim finalization.

## CLINICAL CORNER

### PSYCHOSOCIAL ADJUNCTIVE TREATMENTS IN BIPOLAR DISORDERS

#### Why They are Important

Although pharmacotherapies are the cornerstone in the treatment of bipolar disorders, psychosocial treatments are also important as adjunctive treatments. They can be helpful by improving patient adherence to medications, decreasing stress, reducing the stigma of the illness, helping to identify early warning signs and symptoms, improving supports, educating the participant and family as well as other factors that can contribute to an exacerbation of bipolar symptoms. It is also important to remember that a good therapeutic alliance with the patient and, when possible, family members is significant. One of the more frequent reasons for relapse in participants with bipolar

disorder is non-adherence to medications. There is a higher rate of relapse and risk of hospitalization associated with non-adherence to medications, as well as longer inpatient stays and increased costs.

There are many different psychosocial strategies, including these more common ones:

1. **CBT (cognitive behavioral therapy):** There are many forms/types of CBT to help fit the disorders being treated. CBT for depression can be used in the depressive phases of a bipolar disorder, while a modified version of CBT may be used specifically for bipolar disorder, with a focus on medication compliance/adherence to treatment, education and treatment of bipolar disorder, stress relief, lifestyle management, acceptance of the condition, early detection, and intervention.
2. **Family, marital, and Family Focused Therapy (FFT):** FFT is a family-based therapy that focuses on psycho-education and skills training in communication and problem-solving in order to minimize stress when dealing with others. Family and marital therapy can also be helpful to promote healthier communication and improve relationships, in turn decreasing stress levels. This is especially important in that by improving relationships, there is a greater chance that the patient will allow family or significant others to be involved in the treatment plan,



thereby potentially helping them to monitor early warning signs and symptoms. Things like giving one's credit cards and car keys to family members when prodromal symptoms like euphoria are emerging can decrease chances of patients making impulsive decisions.

3. **Brief individual psycho-educational therapy:** This type of therapy focuses on teaching patients about bipolar disorder, managing the illness (learning about early warning signs, relapse prevention, medication compliance, stigmas, symptom relief, etc.). Usually it involves a brief course of treatment of about 6-10 sessions.
3. **IP-SRT:** Interpersonal and social rhythm therapy (IP-SRT) is a form of interpersonal therapy developed specifically for bipolar disorder, which combines behavioral techniques and interpersonal principals. In part, the goal of IP-SRT is to help those with bipolar disorder to maintain more regular daily routines which, when disrupted, may exacerbate a bipolar condition. One can use daily activity charts to monitor sleep, appetite, stress levels, etc.
5. Motivational techniques are therapeutic interactions that can be used even during medication management visits. The goal is to help engage the participant to create a set of conditions that will enhance his/her own motivation in making changes and a commitment to change, and to help the participant come to his/her own

interpretations or conclusions as to why it is important to be compliant with treatment. Rather than telling the participant, "if you stop your medications you will not do well," the goal is to help the participant identify in his/her own words how stopping medications or having increased stress and subsequent mania or depression has affected their life. This can be done, for example, by discussing the events preceding a recent manic episode. Remember to establish a rapport, be empathetic and avoid confrontation and argumentation.

## Conclusion

Bipolar disorder is by far one of the more challenging mental health disorders to treat. It has a high risk of suicide and is very costly, both personally and financially. Despite the increasing number of psychopharmacological treatments available, the relapse rate for bipolar disorder continues to be significant, although in large part preventable. Treatment of bipolar disorder, like most mental health conditions, requires a well-balanced treatment plan that includes a good therapeutic alliance, pharmacotherapy and psychosocial treatments to which the participant can agree. Participants must be educated about the course of the condition, expectations, relapse prevention, and the importance of adherence to medications.



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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