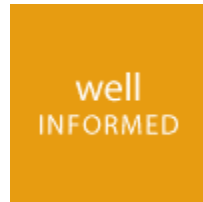




THE CBH PROVIDER CONNECTION

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



3rd Quarter 2006 Volume XIX

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EAP CORNER

CIGNA BEHAVIORAL NETWORK PROVIDERS: SERVING AS AN EAP PROVIDER

As one of CBH's network providers, you may be asked, "What's the difference between seeing an EAP affiliate and seeing a counselor through my Behavioral Health benefit?" We want to provide you with information to respond to this question and other EAP-related questions.

- CBH's EAP services are a resource to assist employees and their household members in managing the challenges of work and home life. For the majority of our customers, these services include: 24/7 crisis intervention availability, Telephonic EAP counseling, Work/Life referrals, and access to web-based information at www.cignabehavioral.com.
- The full spectrum of CBH EAP services is available to assist employees/household members in addressing their concerns. You can suggest they contact us for help in areas such as childcare, elder care, financial, legal, and other concerns.
- EAP sessions provide the opportunity to engage the participant in a collaborative process of clarifying concerns and engaging the participant in managing or resolving the issue. During the assessment, it is important to arrive at a shared understanding of the tasks to be

undertaken in the EAP sessions and any homework assignments you may suggest. When the assessment results in the need for additional Behavioral Health services, the EAP sessions can be used as a bridge to continue care with a provider covered under the participant's Behavioral Health benefits. Types of referrals:

- Informal Referrals occur when an employee's manager suggests an employee consider talking with an EAP provider, but the workplace does not receive any confirmation as to whether this contact occurred. Generally speaking, there are no performance concerns on the part of the employer.
- In the case of Formal Management Referrals, an employee is referred to an EAP Provider to address documented concerns about the employee's attendance, performance, or behavior. The expectation is that your EAP sessions with the employee will be used to address whatever factors are interfering with the employee's ability to perform at full capacity in the workplace. The employee will have signed a release of information form allowing a CBH Employee Assistance Consultant (EAC) to work with you and the employer,



keeping the company apprised of EAP attendance and compliance.

You will be working only with a CBH EAC on these cases. You will not be asked to report any information directly to the employer. The CBH EAC serves as your liaison to convey information to the referring employer.

- The CBH Statement of Understanding, signed at the outset of the EAP sessions, also outlines the basic parameters of the services.
- Payment for services: EAP sessions require no co-payment or co-insurance to be paid by the employee. The employer has contracted with CBH for these services to be provided as part of a comprehensive EAP program they have purchased for their employee population.
- After providing EAP sessions, as a CBH affiliate, use the CBH's EAP CPT Code 99404 for all EAP sessions.

NOTE: A DSM-IV diagnosis isn't a necessary outcome of the sessions.

Accessing EAP may be a person's first effort to engage professional assistance in changing their lives for the better. Thank you for all the service you provide to CIGNA Behavioral Health and our customers.

EAP SPECIALTY PROVIDER RECRUITMENT

Critical Incident Responders

Critical incident responders must have training in critical incident debriefing protocols. Responders are needed in MI, HI, MN, NV, AL, LA, MS, Puerto Rico, Washington D.C., and MD.

EAP Trainers

Trainers deliver wellness seminars and management training to EAP customers. Trainers are needed in Puerto Rico, U.S. Virgin Islands, Washington D.C., MD, ME, MS and Northern VA.

Management Referral Specialist

Management Referral Specialists possess an advanced knowledge of workplace issues, management referral processes and the skills to perform an initial substance abuse evaluation. These specialists are needed in WI, Washington D.C., RI, VT, Puerto Rico, NM, NV, MS, LA, IA, AL, CA, SC, TX, FL, NC, PA, NY, IL, IN, GA and AZ.

If you have an interest in any of these EAP specialties, inquire by email to Carlton Weinstein at carlton.weinstein@cignabehavioral.com

Critical Incident Response Training Resources

International Critical Incident Stress Foundation

410.750.9600

www.icisf.org <http://www.icisf.org>



American Red Cross

www.redcross.org <http://www.redcross.org>

Crisis Care Network

888.736.0911

www.crisiscare.com

COMPASS Gerald Lewis, Ph.D. & Associates, P.C.

800.649.6228

www.geraldlewis.com

PROVIDER RELATIONS CORNER

2006 CIGNA BEHAVIORAL HEALTH PROVIDER CONFERENCES

One-day seminars presented FREE for contracted CIGNA Behavioral Health providers.

Join us if you would like to:

- 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:

- September 15 - Los Angeles, CA
- September 15 - Dallas, TX
- October 20 - Phoenix, AZ
- November 10 - Tampa, FL
- November 10 - Newark, NJ

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.

Registration is required for the events above. Seating is limited.

Please contact your Professional Relations department at ProviderEducation@cignabehavioral.com if you would like to sign up or if you have any questions.

CONSUMERISM & PROVIDER SELF-INTRODUCTIONS

As the health care industry has gone through the indemnity model, which focused on reimbursing providers, and in recent years, the managed care model, we are now on the frontier of a new generation - Consumerism. At the heart of consumerism is the promotion of the consumer's interests. CBH has a



long tradition of focusing on participants and advocating on their behalf.

Consumer Directed Health Plans (CDHPs) such as HRAs and HSAs are the most common health plans that reflect this evolution. Consumers are shouldering greater responsibility for making their health care decisions. Increasingly, the decisions they make will impact the amount of money they spend. As consumers, we often “shop around” for products and services based on quality, cost and convenience. More and more, consumers are approaching health care decisions in a similar manner. To that end, our participants are looking to us to help them understand the choice, quality and cost factors at work for their particular situations.

To that end, one of CBH’s initiatives to help participants make well-informed choices is the provider self-introduction. Over 5,000 providers have already written an introduction about themselves and their practice style to be posted on the CBH website. Along with their picture, CBH incorporates the self-introduction information we receive from providers into our participant provider search function on the web. As with so many things, consumers are accustomed to looking on the web to obtain information. Participants find the posted self-introduction information very useful, as it helps them in selecting a provider they feel they can “fit with.” For you, the provider, it is a way to showcase your practice and increase referrals, knowing the participant is coming to

you having already made that choice based upon information about you, provided by you.

If you have not already done so, we encourage you to complete a self-introduction. You can do this by going to our website at www.cignabehavioral.com or by calling 800.241.4057 x3069.

A NEW AND BETTER WAY TO SUBMIT YOUR CREDENTIALING DATA

CIGNA Behavioral Health and the Council for Affordable Quality Healthcare® (CAQH) have simplified the credentialing data collection process—with Universal Credentialing DataSource.

One application—for everything! Now you can use a single application to satisfy the credentialing requirements of multiple participating organizations. You can complete the application online at a secure Internet site. Best of all, there’s no cost to use the system and no special credentialing software or services required.

How it works:

- You submit just one standard application to a single database to meet the credentialing data needs of all participating healthcare organizations.
- If you have a larger practice, your office manager can use the Practice Administrator Module to create a



template for information common to multiple providers.

- You can update your information online or by fax, at any time.
- Each quarter, CAQH will send a re-attestation notice to you to confirm the completeness and accuracy of data on file.
- When you update information, the system automatically notifies all your healthcare organizations.
- Only the participating organizations you authorize have access to your provider data.

What is CIGNA Behavioral Health doing?

- Providers who participate in the CBH network are recredentialed every three years, and we initiate the recredentiaing process six months in advance.
- If you are currently registered with CAQH and your credentialing application information is complete and current, the CBH recredentiaing process will be more streamlined.
- You must authorize CBH to access your provider data if you have not already done so.
- If you are not currently registered with CAQH, you will receive a registration kit from CAQH. It contains your CAQH Provider ID number and information on registering and using the UCD system.

- If you have questions about the CAQH Universal Credentialing DataSource, you should call the CAQH Help Desk at 888.599.1771.
- Once recredentiaing begins CBH or our credentials verification organization, Aperture, will reach out to you if there are any additional requirements.

What can you do?

- Familiarize yourself with CAQH by going to www.caqh.org.
- If you are not currently registered with CAQH, you may do so at any time.
- Once you are registered, you will be able to use your CAQH provider ID to proceed to the next step of obtaining a username and password.
- You are then ready to complete the application.
- Contact the CAQH Help Desk at 888.599.1771 for assistance.

We look forward to having all CBH participating providers using the CAQH Universal Credentialing DataSource. CIGNA Behavioral Health believes that you will save time and paperwork by using this application. CBH and CAQH staff can provide the support you need to walk through the process.



AMBULATORY FOLLOW-UP RESOURCE SHEET

Together, we share a common goal of achieving superior clinical outcomes for patients/participants. One critical indicator of our participants' quality of care and quality of life is the HEDIS Ambulatory Follow-Up measure.

The National Committee on Quality Assurance (NCQA) states, "Appropriate follow-up care helps reduce the risk of repeat hospitalization for some people, and identifies those in need of further hospitalization before they reach a crisis point." This is supported by the literature and exemplified in the study done by Nelson, Maruish and Axler, (n = 3,113 patients), where a participant's risk for rehospitalization was doubled without at least one outpatient appointment following the index hospital discharge.¹

NCQA uses the HEDIS 7-day and 30-day Ambulatory Follow-Up rates to measure this clinical initiative. The HEDIS 2005 90th percentile target rates for 7-day and 30-day follow-up are 70.2% and 86.2% respectively.

We are committed to working with you to help our participants achieve these levels of follow-up, post-hospitalization. Please read below for helpful hints and ways CIGNA Behavioral Health can assist to this end.

¹ Nelson Ed.D., Maruish Ph.D., and Axler M.D. *Effects of Discharge planning and Compliance With Outpatient Appointments on Readmissions Rates*. Psychiatric Services July 2000: Vol 51 No. 7

Helpful Hints:

- Starting discharge planning on the day of the admission
- Educating participant and/or family on the importance of discharge planning
- Involving the family and participant in scheduling appointments
- Can your MDs do med check groups?
- Using CBH contracted providers to schedule appointments shortly after discharge
- Giving the participant a specific date and time for his/her follow-up appointment
- If the participant met with an out-patient therapist prior to admission, see if that provider can schedule an appointment for his/her patient within 7 days of discharge
- Do you have on-site therapists who can hold a group session post-discharge?

How CIGNA Behavioral Health Can Assist:

- Offering lists of contracted providers to you and/or the participant
- Offering providers who can do "Meet and Greets" (For someone who has not worked with an out-patient provider prior to hospitalization, it may be helpful



for the participant to meet and talk with his/her new outpatient therapist while s/he is still at your facility).

- Assistance with finding therapy and medication management appointments
- Offering educational materials and having CBH staff speak with participant and/or family to stress the importance of discharge planning and to determine any possible barriers to follow-through.

Please do not hesitate to contact us if we can help you in any way with this process. We share a common goal and look forward to working with you to provide quality care for our collective patients/participants.

FAQ ABOUT THE “MEET & GREET” SERVICE

Did you know . . . “Meet & Greets”—otherwise known as Inpatient Pre-Discharge Consults—are visits to patients in hospitals/facilities conducted by our non-MD providers for the purpose of coordinating ambulatory follow-up appointments? These visits are initiated by CBH and do require benefit authorization by a CBH Care Manager.

Why do we do “Meet & Greets”? Sometimes participants have questions or concerns about going to therapy and this gives them the opportunity to get those questions answered and ease those concerns. The patient may not have previously established a

relationship with an outpatient provider and may be wary of going to that first outpatient appointment. “Meet & Greets” also give the patient an opportunity to schedule an appointment that is convenient for them. All we ask of our providers is that the appointment be within 7 days of the patient’s discharge from the hospital. We believe that having a face-to-face encounter with their new provider will make our participants feel more comfortable and will increase the chances that they will follow through with their aftercare planning. And, participants who follow through with their aftercare plans are less likely to readmit.

Does a Practitioner Need to be Affiliated With the Facility to Perform This Service?

No, the practitioner will enter the facility as a visitor; therefore, there is no need to be credentialed or affiliated with the facility. Usually, these appointments will take place during visiting hours.

Does the Participant Have a Co-Pay for This Service?

No, there is no charge or co-pay to the participant for this service, as long as the benefit is authorized by a CBH care manager!

Which CPT Code Should a Practitioner Submit With the Claim?

For claim submission for this service, please use the CPT code 99499--



“Unlisted Evaluation/Management Services.” It is very important to include a brief written description of the service provided; i.e., Pre-discharge Consultation or Meet & Greet. Without a brief written description, the claim will not be processed for reimbursement due to a lack of information. Unfortunately, claims for this service cannot be processed online due to the inability to enter comments into the online HCFA form.

How Much Does This Service Reimburse a Practitioner?

Reimbursement for a 99499 will vary by licensure and state. Please refer to your fee schedule, contact your local Provider Relations department, or email ProviderEducation@cignabehavioral.com for any inquiries or concerns.

How Can a Practitioner Become Listed as Available for This Service?

If you are interested in providing this service to our participants, please email your local Provider Education Specialist at ProviderEducation@cignabehavioral.com. We will be happy to add this specialty to your profile!

QUALITY MANAGEMENT CORNER

ANTIDEPRESSANT OUTCOME IMPROVEMENT PROGRAM

In an attempt to improve the treatment of depression toward clinical practice guidelines, CIGNA HealthCare and CIGNA Behavioral Health collaborate in the distribution of profile reports to high-volume medical and psychiatric prescribers of antidepressant medication. These reports provide feedback on antidepressant prescription patterns. Using nine months of pharmacy claims data, reports are created that include practitioner-specific metrics with comparison to the network averages, as well as member-specific measures for either gaps in the prescription history, one-time fills, or a history showing a drug therapy of less than the recommended guideline of six months.

Starting in the first quarter of 2004, and continuing quarterly through 2005, targeted educational mailings of these profile reports, along with physician and patient educational tools, were sent to high-volume prescribers across the country. During that time, 651,975 antidepressant compliance scores were shared. During that same time, 55,890 educational mailings were sent to medical and 5,439 mailings were sent to psychiatric prescribers.

The percentage of participants who were prescribed antidepressant medications and who completed a six-month period of compliance as



measured by pharmacy claims, showed an improvement from 46% in Q1, 2005 to 57% in Q4, 2005. In a follow-up survey, 79% of medical and 74% of psychiatric prescribers agreed this is an effective program to improve the quality of care for participants who are prescribed antidepressant medication.

2006 Plans

In 2006, CIGNA Behavioral Health and CIGNA HealthCare is continuing to provide quarterly mailing to high-volume medical and behavioral prescribers. Educational materials are being considered for possible update and enhancement. Based on this initiative, and as announced in our Q1, 2006 newsletter, a Depression Disease Management program has been developed and implemented with a goal of increasing medication adherence and improving clinical outcomes. Options to allow outcomes analysis and to measure changes in prescriber prescription patterns over time will also be explored.

JOIN CIGNA BEHAVIORAL HEALTH IN A COMMITMENT TO CULTURAL COMPETENCY

Cultural identity is not limited to a common ethnic heritage. Any group membership can influence and define us as we interact. Patterns of language, common sense, symbols, definitions of normal and abnormal, health, illness, and deviance may be shaped by cultural group influences. Our dominant values and beliefs, even our coping processes and resources may

derive from socio-cultural group identifications.

Cultural group norms may strongly affect a person's view of themselves, should they become ill. Language, verbal and non-verbal communication patterns, gender styles and roles may influence what symptoms are experienced, what gets reported, and how symptoms and signs of illness are described. Group beliefs may dictate or influence which healing methods are used or restricted, who makes decisions about health care, when help is sought, and from whom. There are differing explanatory models for what causes health and illness and, in many cultures, native folklore medicines respond to these explanations through involvement in a hierarchy of alternative remedies and healers, either in addition to or before seeking relief through Western medicine. Traditional models of illness and health care may come into conflict with Western ideas and practice, so that Western medicine may not be sought, or will be practiced in combination with traditional folk medicine. Or there may be specific folk illnesses as learned syndromes, indigenous to a specific cultural identity, which require folk medicine remedies or the services of a folk healer, exclusively.

And yet, a culturally competent practice should not simply make us better at stereotyping. Sensitivity to culture happens at the point of contact between you and another individual. Wide individual differences can exist even in persons who share the same cultural group or ethnic identity. Our



challenge as practitioners is to respect individuals and their cultural viewpoints, while at the same time providing assessment and treatment that is both scientifically valid and culturally meaningful.

Cultural competency implies the ability to work effectively with diverse populations. Whenever we respond and interact, assess and treat, it must be with an understanding that we always treat people in a context. There is a need to identify and understand the role of predisposing, enabling, and reinforcing factors that can contribute to health problems and to assess and enlist culture-specific health beliefs and practices, or unique strengths and resources that support and promote change. Ultimately, we need to be able to see beyond our own biases, to ask the right questions, and to really hear and understand another person's own description and explanation of what is happening to them, and why, and what might be done about it. Otherwise, misunderstanding, offensiveness, misdiagnosis, inappropriate care, poor compliance or care refusal, and poor outcomes may result.

To become culturally competent, we need to know how our own cultural biases create a tendency to think and feel and act in certain ways. We need to understand research related to diverse cultures and behavioral health, and to develop skills sufficient to create and implement culturally appropriate interventions in our practice. Training may increase sensitivity to differences between our own and alternative cultures, and it may help us

to adapt our skills and enlarge our repertoire of responses. You may also wish to highlight your own skills with specific diversity populations in the Provider Self-Introduction section of CIGNA Behavioral Health's online practitioner directory.

CIGNA Behavioral Health's staff hiring and network recruitment strategies are sensitive to the need for adequate cultural representation. Our current policies and medical management models incorporate a culturally competent philosophy. We offer language translation services, and participant materials are evaluated for appropriate grade and reading skill level. CIGNA Behavioral Health is currently developing a nationwide training in cultural competency to better prepare staff to provide culturally competent services to diverse cultural and ethnic groups. We hope that you will join and support us, by making a personal and important commitment to cultural competency in your own practice.

Suggested Readings for Additional Information:

- Hayes, Pamela, *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors*, American Psychological Association, 2001.
- Israel, Cuellar and Paniagua, Freddy (editors), *Handbook of Multicultural Mental Health*, Academic Press, 2000.
- Mezzich, Juan E, Kleinman, Arthur, Fabrega, Horacio, Parron, Delores (editors), *Culture and Psychiatric Diagnosis: A DSM-IV Perspective*, American Psychiatric Press, 1996.



PATIENT SAFETY

In a commitment to network wide safety practices, CIGNA Behavioral Health regularly provides updates and analysis on many activities that reduce the risk of harm to participants. These include continuity and coordination of care, evidence-based clinical practice guidelines, and timely access to appropriate care with qualified practitioners. Practitioners receive these updates through CIGNA Behavioral Health's practitioner and provider newsletter and in the Provider Guide, and similar postings are provided to participants on CIGNA Behavioral Health's website.

2005 Facility Survey

In an April 2006 effort to assess safety practices and to analyze network-wide opportunities, CIGNA Behavioral Health mailed 998 safety surveys to acute and residential facilities. The national response rate was 27.9% and regional response rates ranged from 25.4% in the Northeast to 29.9% in the Southwest. Respondents included 142 acute care facilities, 104 reported being residential facilities, and 32 facilities reported offering both acute and residential services. Each facility responded to three questions:

- How do you identify safety issues in your facility?
- Have you identified safety issue trends in the past year?
- Please describe your actions in the past year to improve patient safety.

Survey Findings

Source of Information Used to Identify Safety Issues

According to the respondents, 99.3% indicate that safety issues are most commonly identified through the use of incident reports. Eight-six percent of respondents state that patient and/or family complaints are used as an additional information source to identify patient safety issues. Additional means used to identify patient safety issues include safety rounds, staff reports, family or vendor surveys, and performance improvement activities (56.5%).

Safety Trends and Actions Taken to Improve Safety

With little variation by type of care provided, facilities can reduce their incidence of safety issues, such as falls, medication errors, elopements, use of seclusion/restraint, and suicide attempts, through improved safety strategies. The most common strategies for improving patient safety are: staff education, policy and procedure revision, and equipment repair or replacement. Other responses varied by facility and issue, but included improved patient assessment, and new or revised training or program development. Reducing medication errors was consistently identified as a target of priority for improvement action.



REVISIONS AND UPDATES TO THE PROVIDER GUIDE

Remember that CIGNA Behavioral Health updates the Practitioner and Provider (Medical Management Program) Guide quarterly in an effort to provide you with the most relevant, up-to-date information on working together. Recent revisions included new information regarding clinical practice guidelines, an updated description of CIGNA Behavioral Health's Care Advocacy Program, new Primary Care Physician communication materials, medical records-keeping practices and the Participant Rights and Responsibilities statement.

In addition to being a resource for working together successfully, it is also a legal and binding document, referenced in all of our Provider, Clinic, and Facility Agreements. If you have not reviewed the Provider Guide recently, we encourage you to do so. It is in Adobe PDF format, and can be found at:

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

DEPRESSION SCREENING IN MEDICAL DISEASE MANAGEMENT

Since 2000, Medical Disease Management programs within CIGNA Well Aware for Better HealthSM have been augmented by routine screening for depression. Additional screening for stress and anxiety is routinely included for those with Chronic Pulmonary Obstructive Disorder and Asthma. Depression screening is accomplished, initially and

annually, using components of Pfizer Corporation's highly validated PRIME-MD Depression Screening Inventory (the PHQ-2 and PHQ-9). Performance for depression screening and intervention is measured annually.

2006 populations receiving the depression screening include three program categories:

1. Selected chronic medical conditions included Diabetes, Cardiac Disease, Asthma, Low Back Pain, and Chronic Obstructive Pulmonary Disorder (COPD),
2. Selected Targeted Medical Conditions, new in 2005, included Inflammatory Bowel Disease, Acid Related Stomach Disorders, Pressure Ulcers, Atrial Fibrillation, Hepatitis C, Fibromyalgia, Osteoporosis, Irritable Bowel Syndrome, Osteoarthritis, and Urinary Incontinence; and the
3. Comprehensive Obesity Solution program, which included the Bariatric Surgery Program, Weight Complications, and Weight Loss Wellness Program.

Those who screen positive for depression or anxiety receive intensive care management plus educational, condition management, and other resource materials. Where consent is given, depression care guides, tip sheets, and other resource materials are sent to Primary Care Physicians to assist to treat depression in addition to the medical condition. Alternately, referrals to behavioral health practitioners are



available for depression or anxiety treatment. Interventions are sustained until the behavioral condition remits and participants are monitored over time to reduce the likelihood of recurrence.

2005 Annual Findings

- 9% fewer participants completed the screening for depression in 2005 than in 2004, related to changes in population size.
- Depression identification rates were 5% in 2005, up 3% from 2004, perhaps related to the 2004 adoption of the PRIME-MD as the screening tool.
- In 2005, 66% of those who screened positive consented to notify Primary Care Physicians of the findings, as compared to 33% in 2004. A staff training initiative is believed to be responsible for improved rates across all programs in 2005.
- For HMO/Flexcare products, year over year rates for completion of screening increased in the Diabetes, Cardiac, and COPD programs, while decreases were seen in completion rates for the Low Back Pain and Asthma programs.
- In 2005, the target medical conditions program was added, and findings were encouraging, but there are no comparative rates for 2004 for that program. More than 2,000 persons were screened and a 17% depression identification rate was achieved with 74% of those who screened positive consenting to physician notification.

- For the Preferred Provider Organization, comparative annual rates for completion of screening increased only for the COPD population. However, all rates for positive screening and for consent to notify physicians increased.
- Across all products in 2005, the highest rates for depression were found in the Low Back Pain and Asthma populations, and these populations were also the most likely to indicate clear relief-seeking through provision of consent for physician notification.

Future Directions

The volume utilization and rates for depression identification in the new Targeted Medical Conditions program is encouraging. We look forward to continued growth and success in 2006 with this program and also with depression screening as a part of the new Comprehensive Obesity program. CIGNA Behavioral Health also is pleased with the success of the 2005 staff training initiative that resulted in the achievement of significant increases in provision of consent for physician notification of results for those who screened positive, and we will continue to develop additional supports to the treatment of depression in the Primary Care setting in 2006.

CLAIMS/CUSTOMER SERVICE CORNER

Many providers submit claims listing a single diagnosis to benefit plans for reimbursement. While the submission



of at least one diagnosis is a billing requirement, a single diagnosis frequently does not fully reflect the patient's treatment concerns. By simply adding secondary or other subsequent diagnosis codes to submitted claims, providers can help CIGNA Behavioral Health appropriately outreach to our plan participants. Additionally, by providing subsequent diagnoses, providers assist in CIGNA Behavioral Health's data analysis process to improve treatment plans, create effective and more comprehensive outreach materials, and improve our partnership. So, next time you're completing a claim form, add that additional diagnosis, or two or three! Your help is greatly appreciated.

CLINICAL CORNER

TREATMENT GUIDELINES FOR BIPOLAR DISORDERS

How do They Help?

Despite some flaws, treatment guidelines can help guide us in making choices on what, when and how to apply various treatments available, especially with the growing complexity of new medications and large amounts of data now available. They enable us to test our clinical decision-making as to whether we are in line with experts in our field and best practices. Evidence-based practices are important to treatment and to treatment guidelines. Despite the many evidence-based practices, there are still a lot of

missed treatment opportunities and patients being treated with unproven or a lack of evidence-based studies.

What are Some of the Guidelines?

The more common guidelines include: 1) the APA's Practice Guidelines For The Treatment of Patients With Bipolar Disorder, 2) The Texas Implementation of Medication Algorithms for Bipolar Disorder (TIMABD), 3) The Expert Consensus Guidelines for Bipolar Disorders, and 4) The British Association for Psychopharmacology (BAP) for Bipolar Disorders Guidelines. Although there are other guidelines and algorithms, these are some of the more widely used and recognized guidelines.

How are They Similar or Different?

Each guideline has its advantages and disadvantages as well as some differences in the choices and combinations of medications, but for the most part they are somewhat similar. One example of slight differences in the first line treatment for acute and short-term treatment of mania is seen in the BAP guidelines as compared with the APA guidelines. For example, for patients not already on long-term treatment for bipolar disorder with severe mania or mixed states, the BAP guidelines recommend initiating monotherapy with an antipsychotic or valproate because of their rapid antimanic-effect. They state that an atypical antipsychotic should be considered as a choice for antipsychotic medication.



For less ill manic patients, lithium or carbamazepine may also be considered. The BAP guidelines further recommend additional augmentation/combination strategies to the first line medication if the patient is still in a manic phase and still not improving. As for the APA guidelines, the first line pharmacological treatment for more severe manic or mixed episodes is the initiation of either lithium plus an antipsychotic or valproate plus an antipsychotic. For less ill patients, they recommend monotherapy with lithium, valproate, or an antipsychotic such as olanzapine. The APA and BAP guidelines both recommend atypical antipsychotics over other types of antipsychotic medications. Although APA and BAP guidelines are similar, for acute mania the APA recommends combination medications as an initial strategy of both a mood stabilizer and an antipsychotic for more severe mania of mixed states, and the APA recommends lithium as a first line treatment if combined with an antipsychotic medication. All the guidelines make some references to psychosocial treatments as well, but not in great depth. The British Association guidelines tend to give more details about time frames of treatment options for depression when using antidepressants. The TIMABD includes an easy-to-use flow sheet/algorithm with stages. It is worthwhile to review the different guidelines and to understand some of the important differences among them, especially when faced with a difficult or treatment-resistant bipolar disorder.

Is it Enough to Just Know the Different Treatment Guidelines?

No. We must remember that guidelines were created to help us, but we still need to consider many other factors when considering the best overall choices for each individual patient. There is often room for personal preferences from classes or groups of medications that are evidence-based treatments. Such choices should be based on things such as the patient's age, race, sex, lifestyle, body type, medical history, other medications taken, compliance with medications/labs, responsibility, ability to monitor the patient, supports, pregnancy, child-bearing age and relationships. Therefore, even with good consensus guidelines, we still need to avoid a "cookie cutter"-like approach for all patients, as there will be other clinically relevant factors to consider. We need to think about those who might be more likely to have adverse side effects, such as sedation, weight gain, sexual dysfunction, drug-drug interactions, and medical complications, when deciding on the most appropriate treatment.

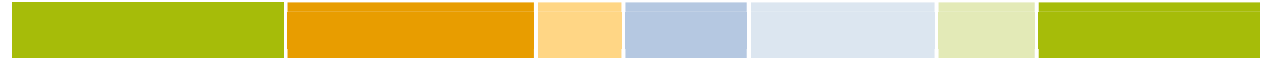
Below are web links for the guidelines referenced:

- 1) for the TIMABD:
<http://www.dshs.state.tx.us/mh/programs/TIMA.shtm>
- 2) APA guidelines :
http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
- 3) BAP for Bipolar:
<http://www.bap.org.uk/consensus/FinalBipolarGuidelines.pdf>



Expert consensus (2005 still not available on line but some information is available at this site):

<http://www.psychguides.com/ecgs15.php>



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