

Attention-Deficit/Hyperactivity Disorder (ADHD) Preventive Health Program Results



Through its Preventive Health program for ADHD, CIGNA Behavioral Health (CBH) is educating and empowering caregivers to reduce the impact of problems commonly associated with ADHD and encourage early detection of ADHD in siblings. Additionally, the program encourages coordination among a child's and family's medical and behavioral care, educational, and social systems. Children aged 12 years and under who are newly diagnosed with ADHD are identified by automated claims rules in our Care Advocacy Program (CAP). Once identified, educational information and tools are mailed to the child's parent(s) and/or guardian(s) to help them understand and manage their child's condition. The program has identified 19,470 new ADHD cases since inception in October 2003. In 2006:

- 6,215 information packets were mailed to the parents or guardians of newly diagnosed children.
- 2,695 additional information packets were distributed by our Personal Care Advocates in response to independent telephone requests, and
- 7,383 web page visits were recorded when members, behavioral health practitioners and primary care physicians accessed ADHD Preventive Health program information through CBH's Web site. Over the life of the program, nearly 25,000 page visits have been recorded to the ADHD Web page.

Approximately 30 days after an ADHD informational mailing, program members are surveyed. The 2006 survey response rate was 7.38% nationwide. 38% of the surveys were distributed from the National Care Center, 14% from Dallas, 22% from Tampa, 20% from Chesapeake, and 6% from Glendale. Survey respondents are typically mothers (80%), 35-44 years of age (54%), whose educational experience includes college (84%), and whose child diagnosed with ADHD is between the ages of 6-12 (94%), residing in a household that contains 1-3 children (89%). A rise in guardian and grandparent responders is seen in 2006 (9% vs. 2% in 2005). Although scores for helpfulness, use, and completeness continue to be high, program materials and tools were used and scored more lightly in 2006 than in 2005. Submitted comments suggest that condition-specific educational information from a variety of sources is being used. Nevertheless, 90% of respondents would recommend the program materials and tools to others. There was a modest increase in perception of practitioner skill, and improved satisfaction with treatment progress in 2006. Use of program tools in the treatment process remains limited.

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The 2006 program emphasized medication use and compliance. A new question-set added to the 2006 survey reveals that approximately 85% of treatments now include medication. Survey report for outcome effectiveness suggests that treatment regimens combining medication and behavioral therapy, or medication alone, are experienced as more effective than behavioral therapy alone. Year over year improvement in the following areas was noted by those surveyed:

- 89% felt satisfied with treatment progress, compared with 83% in 2005.
- 95% felt their practitioner was skilled or very skilled, compared with 93% in 2005.
- 82% found CBH's Web site helpful, compared with 79% in 2005.



The following observations from a June 2006 program review by CBH's National Practitioner and Provider Advisory Board will be considered in the design of the 2007 program: (1) Parents of ADHD children may also have the condition. Therefore, online coaching, including management coaching and reminders, short 'sound-bites' of 'just-in-time' information might benefit parents of children with ADHD, (2) Strengthening the link between behavioral practitioners and pediatricians is critical, including protocols on when to refer members for behavioral treatment, and (3) Standardized protocols for behavioral therapy, to supplement program materials and medication guidelines, might be considered along with education on the effectiveness of combined medication and behavioral treatment regimens for ADHD.

The ADHD Preventive Health Program materials and additional information about ADHD can be found in the 'Provider Resources' section of our Web site, under 'ADHD Awareness', at www.cignabehavioral.com, or can be obtained by contacting the CBH operating unit with which you are customarily associated. Practitioner feedback and input is welcome.

Telephone and Appointment Access Standards

CBH has adopted the National Committee for Quality Assurance's (NCQA's) access standards, and our appointment access standards now include office wait times.

Practitioners are asked to make every effort to ensure compliance by seeing members within these access standard time frames. Practitioners who are unable to schedule a member visit within the access standard time frames should immediately refer the member to the online provider directory, or contact CBH through the mental health and substance abuse telephone number on the member's identification card for alternative referral. When seeing members for treatment, practitioners should include appropriate discussion of available treatment options and/or support groups, since the 2006 CBH Member Satisfaction Survey indicates member perception that this is not frequently done.

Network practitioners must have the capability of 24-hour access for members in crisis. Answering machine greetings should contain clear instructions for accessing care in the event of a crisis. General referrals to emergency room settings for all access standards other than non-life-threatening and life-threatening emergencies are not considered to be evidence of appropriate crisis coverage. Intermediate Care (Urgent) and Crisis (Non-Life-Threatening) referrals require CBH care management preauthorization.

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CBH monitors and reports quarterly and annual compliance with established telephone and appointment access standards. Annual performance measurement includes all of CBH's locations, books of business, and operations. Appointment access standards reporting for compliance includes assessment of the clinical urgency of a member's situation and office wait times. The following table provides a summary of CBH's access standards:

Standard Name	Standard Measure	Goal
Appointment Access		
Non-Life Threatening Emergency	Within 6 hours	100%
Urgent	Within 48 hours	90%
Routine	Within 10 working days	85%*
Office Wait Times	15 minutes or less	80%*
Telephone Access		
Average Speed of Answer	< 30 seconds	< 30 seconds
Abandonment Rate	<5%	<5%

* Derived from the percent of ECHO Participant (Member) Satisfaction responses of Always and Usually.

2006 Telephonic Access Performance:

For 2006, the National Care Center, After Hours coverage, and Employee Assistance/Disability products did not meet threshold for average telephonic speed of answer. Only Employee Assistance/Disability products did not meet threshold for annual measurement of abandonment rates. Improvement plans are in place where established standards were not met.

2006 performance was negatively impacted by several organizational changes in structure and workflow made in the last half of the year. Call-answering teams were reorganized in October 2006 with the goal of improving call handling by eliminating the need to transfer calls to other departments for service. While members and practitioners will ultimately benefit from this initiative, initial implementation put near-term pressure on speed of answer due to the need to increase and train staff. Additionally, call durations expanded during Quarter 4, 2006, as changes to CBH's member portal for online care access, the closure of the Tampa Operating Unit, and the loss of several bilingual agents resulted in increased call volume for existing resources. In September 2006, CBH added a new metric with the goal that 80% of all callers will reach a CBH agent in 30 seconds or less, and which will be analyzed in conjunction with average seconds to call-answer.

2006 Appointment Access Performance:

Annual appointment access performance was measured in all appointment categories and for all CBH Operating Units and After Hours coverage. The 15-minute goal for office wait time was met in all sites except Tampa, as indicated by member report on the ECHO Participant (Member) Satisfaction Survey. None of CBH's Operating Units met the 85% goal for Routine Appointments in 2006, however, the lowest performance score was 79%, at the National Care Center. All sites exceeded the 90% goal for Urgent Appointments, and all sites except Tampa achieved statistically significant improvement when 2006 was compared with 2005. While only three sites met the 100% goal for Non-Life-Threatening Emergent response in 2006, all sites except Dallas achieved statistically significant improvement in year over year compliance scores.

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CBH has identified improving appointment access as an area of opportunity for 2007. Actions taken to improve access include expansion of the crisis stabilization network and increased practitioner availability through growth in overall network size, as well as the 2006 creation of an Intermediate Care network to provide precautionary and preventive care to members who could require higher levels of care without timely and effective intervention. Open access within the Care Advocacy Program, and Web-site access standards notation including a reminder to call CBH for assistance in scheduling appointments, complemented staff's ability to assist members by using practitioner specialty searches and to provide relevant educational materials.

Primary Care Physician Communication

CBH promotes communication between behavioral healthcare practitioners and Primary Care Physicians (PCPs) to effectively coordinate behavioral and medical care. This communication serves as a foundation for collaborative professional relationships and offers members a holistic approach to care focused on improving overall physical and emotional health. At least annually, CBH monitors the frequency of this communication to identify and address opportunities for improvement and partnership.



CBH requires and facilitates the exchange of clinical information between participating behavioral practitioners and PCPs. CBH educates members about the value of coordinated medical and behavioral care and asks them to support this by consenting to the communication with their PCP. As appropriate during care management activity, CBH monitors and promotes the exchange of information between behavioral and medical practitioners.

CBH's network practitioners are contractually obligated to coordinate care with PCPs and are informed of specific procedural expectations in the practitioner newsletters and the *Provider Guide*. It is the responsibility of the practitioner to obtain member signatures on all necessary written consent forms, to initiate and maintain direct communication with PCPs, and to maintain documentation in the member's medical record of all related communication.

Sample forms for communication with primary care physicians can be located in Appendix L of the *Provider Guide* on the CBH website at www.cignabehavioral.com. Please feel free to contact your Professional Relations Representative if you have any questions.

Meeting Diversity Needs

Adequate practitioner diversity is essential in network development and service availability. Provider diversity can drive access to care for some individuals and, if inadequately addressed, can reduce care effectiveness.

Historically, CBH has improved staff sensitivity to member diversity through ongoing training. Practitioners have been encouraged to use personal profiles within the Online Practitioner and Provider Directory and in CBH's Provider Management and Referral System to make specialty and diversity information available to members accessing care. CBH annually compares the participating practitioner and provider network with known population demographics for ethnicity, gender, age, and language.

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Although there is no requirement that members or practitioners report cultural/linguistic status to CBH, many do so voluntarily because they recognize it is important to link members with practitioners who can meet their linguistic and cultural needs and preferences.

2006 Cultural and Linguistic Findings

Ethnicity: States where CBH's network included at least 50 practitioners and where the ethnic population constituted 15% or more of the state's population include: Hawaii, the District of Columbia, California, Mississippi, Louisiana, Maryland, Georgia, New Mexico, South Carolina, and New York.

States where the ethnic composition of CBH Practitioner Network is at least 10% less* than that of the Population: Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Illinois, Louisiana, Maryland, Mississippi, Nevada, New Mexico, New York, North Carolina, South Carolina, Tennessee, Texas, and Virginia.

Gender: States with more than 50 practitioners and which have more than 65% female practitioners include Rhode Island, Vermont, New Mexico, Maine, Idaho, West Virginia, and Colorado. The percentage of females in the general population in each of these states ranges from 49.6% (Colorado) to 52.0% (Rhode Island).

Language: The network in two states was identified as potentially needing improvement in serving those populations who speak a language other than English at home. In California 25.8% of the member population speaks Spanish at home, while only 14.9% of the practitioner network in California speaks Spanish. In Texas, 27% of the member population speaks Spanish at home, while only 12.1% of the practitioner network in Texas speaks Spanish.

Age: The 18-59 age group has the highest percentage of practitioners treating that age group. Between 92.9% and 99.2% of CBH network practitioners in each state treat members in this age group. The age group with the smallest percentage of practitioners treating members is the 1-5 age group, with 7.3% to 35.9% of CBH network practitioners in each state treating that age group. Since the U.S. Census Bureau data does not provide a further break down of the 1-18 year old age group, it is not known what the percentage of each state's population is between 1 and 5 years old. No noteworthy opportunities for improvement were revealed pertaining to the age analysis.

2007 Priorities

CBH continuously responds to identified network specialty and diversity needs. Based upon the analysis outlined above, the following high leverage opportunities were identified for 2007: recruitment of additional Hispanic practitioners in California and Texas; recruitment of additional Spanish speaking practitioners in California and Texas; encouraging practitioners to use the Provider Profile on the web site to assist members in selecting a practitioner who best meets their needs, including cultural needs.

Additional opportunities for network recruitment were identified in those states where clear differences exist between the percentage prevalence of ethnic minorities within the population versus the network. As such, states where Hispanic practitioner recruitment is desirable include: New Mexico, California, Texas, and Arizona. States where recruitment of black practitioners is desirable include: Mississippi, Louisiana, South Carolina, Georgia, Maryland, and Alabama. Except as noted, network resources are viewed as adequate to population distribution for other minority populations in other states.

Providing Convenient Services

Members are more likely to attend treatment that is geographically convenient. Annually, CBH measures the distance from member residence addresses to the location of participating network practitioners and providers. Geographical access is then determined to physicians, psychologists/nurse practitioners, masters-level clinicians, and facilities/programs, using the following geographical availability standards for both urban/suburban and rural practitioner and facility locations, and for ratios of participants to practitioners and facilities:

Practitioners	Standard	Goal
-Ratio		
	1 Masters level clinician per 800 covered lives (excluding Nurse Practitioners with prescription privilege)	1 Masters level clinician per 800 covered lives (excluding Nurse Practitioners with prescription privilege)
	1 Psychologist/Nurse Practitioner with prescription privilege per 1500 covered lives	1 Psychologist/Nurse Practitioner with prescription privilege per 1500 covered lives
	1 Physician per 1500 covered lives	1 Physician per 1500 covered lives
- Geographic distribution		
Urban/ Suburban	1 Masters level clinician in 15 miles (excluding Nurse Practitioners with prescription privilege)	98%
	1 Psychologist/Nurse Practitioner with prescription privilege in 15 miles	95%
	1 Physician in 15 miles	95%
Rural	1 Masters level clinician in 25 miles (excluding Nurse Practitioners with prescription privilege)	90%
	1 Psychologist/Nurse Practitioner with prescription privilege in 25 miles	85%
	1 Physician in 25 Miles	85%
Facilities	Standard	Goal
- Ratio		
	1 facility or program per 10, 000 covered lives	1 facility or program per 10, 000 covered lives

In 2006, geographical access was measured for each of CBH's five operating units and for the Preferred Provider Organization product. All goals were met for geographical convenience measured both in miles from participants to practitioners and providers and by minimum ratios of participants to practitioners and providers. Additionally, CBH met standards and measures for performance as needed to satisfy state-specific regulatory requirements.

Appeals of Coverage Denials

For clinical cases under review resulting in an adverse determination (coverage denial) following the peer-to-peer review, a review of the decision is available with a practitioner not previously involved in the case. This first level appeal review is with a CBH board certified psychiatrist, and may be done on either a standard or an expedited basis. A second level appeal review is available to a member, the member's delegate, or provider/practitioner on behalf of the member, in those instances when the denial is upheld at first level appeal. For CIGNA Healthcare (CHC) members, the appeal, whether expedited or standard, is filed through the health plan's Appeals Committee. For non-CHC members, the appeal is filed through CBH's Central Appeals Unit. It is important to note that Appeals Committees are for the purpose of resolving member issues. Payment disputes where the member is held harmless are not eligible for review by the Appeals Committee, unless the provider/practitioner, with a member's written authorization, requests an appeal on behalf of a member.

A member, the member's delegate, or provider/practitioner on behalf of a member, who is dissatisfied with the outcome of the Appeals Committee determination, may file an appeal by following the health plan, or in some instances, the state's external appeals process. Many states offer an expedited process if the member feels the situation requires quick response. The CBH Care Manager assigned to the case can provide information regarding available appeals.

All levels of appeal are reviewed and determinations made by board certified psychiatrists. If an adverse determination is overturned upon appeal review, CBH will implement the appeal decision and/or process the authorization or claim for the applicable benefit payment. All adverse determination decisions are communicated in writing and contain the following information:

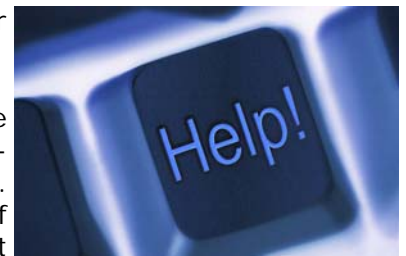
- The specific guideline on which the determination is based, as well as the page number reference within CBH's Level of Care Guidelines.
- The case detail considered, and
- The clinical basis for the determination.

If you have any questions regarding the appeal process, please contact your local Provider Relations Department.

Online Coaching Services

Online coaching is a service offered through CBH, designed to provide eligible Employee Assistance Program (EAP) members with a convenient, engaging, interactive environment where they can obtain information and learn new skills in order to overcome problems and improve the quality of their lives.

Coached programs offer members the opportunity to explore topics in depth, providing up to nine cognitive-behaviorally-based online sessions, complete with homework assignments. Homework assignments are designed to promote practice of skills or check the member's understanding of an important part of the session.



Online coaching is not therapy and is not a substitute for therapy, but may be a helpful adjunct to therapy. Practitioners who see EAP members can direct their clients to this service if they feel it is appropriate.

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The topics for which online coaching modules have been created include:

- Building a Stronger Intimate Relationship
- Coping With Chronic Pain
- Depression
- A Leader's Guide to Effective Writing and Speaking
- Stress: Managing Your Anxiety, Stress, and Worry
- Substance Abuse

How to Access Online Coaching

1. From www.cignabehavioral.com, click on the well BALANCED box
2. Enter the employer ID and Pin, and hit the 'Login' button
3. Click on 'Go to Online Coaching & Health Management' on the left
4. Create your personalized account by filling in the required fields and hitting 'Submit'
5. Follow the prompt after your new account has been created to the Emotional Well-Being page

Taking A Coached Series

To begin an online coaching series, a member completes a short questionnaire, submits it and receives an automated welcome letter that is individualized to the member's responses. The welcome letter contains information on how to use the series and emphasizes the benefits of practicing the skills taught in each session. These sessions are followed by optional homework assignments.

Members are given the option of sending their completed homework assignments to a coach for feedback on how well they understood and completed the assignment, suggestions for improvement, and encouragement regarding their progress through the program.

In cases where clinical concerns requiring immediate attention are identified, appropriate recommendations are made to the member. The member is encouraged to resume or seek professional help in addition to using the coaching program.

When Not To Use Online Coaching

Where risk or other urgent clinical issues are identified, coaches encourage members not in therapy to seek consultation in addition to using the coached program.

For members who have indicated they are currently in therapy, coach responses are not intended to override or replace a members' work with his or her practitioner or health care provider. Where discrepancies become apparent, members are encouraged to discuss these issues openly with their practitioner or healthcare providers.

Online Coaches

Our Coached Series programs, while not therapy or counseling, are based on proven cognitive-behavioral change principles and techniques. Coaches are licensed mental health professionals, thoroughly trained in the use of our coaching system. Our programs are not meant to take the place of face-to-face counseling, and coaches will not enter into a counseling relationship with members. Any message that is submitted to a coach for feedback will be assigned to the next available coach so that a response will be provided to the program member within 3 business days. To ensure continuity, each coach reviews previously completed homework and the feedback received. Members are identified only by their user name so that anonymity and confidentiality are assured.

National Provider Identifier (NPI) Frequently Asked Questions

CBH utilizes CIGNA's Electronic Data Interface (EDI) systems for Claim and Explanation of Benefit/Payment transactions. Below are answers to some NPI-related 'Frequently Asked Questions' to assist you.

1. What is the NPI?

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions, issued to health care providers and covered entities who perform certain electronic transactions (i.e. electronic claims submission and eligibility verification) through the National Provider System (NPS). As of May 2005, the National Provider System, an entity established by the federal government, began issuing NPI's to providers who apply and qualify for them.

This identifier, which implements a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by health plans and health care clearinghouses in HIPAA standard electronic transactions by May 23, 2007.

NPIs **will replace** other provider identifiers previously used by health care providers (and assigned by payers).

NPIs **will not replace** the tax identification number (TIN) on HIPAA electronic transactions when used for tax reporting.

For general information about the NPI and NPI application process, visit <http://www.cms.hhs.gov/apps/npi/npiviewlet.asp>, a CMS Web page. If you'd like to apply online for an NPI, visit the CMS link, <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

2. How will CIGNA test NPI submissions with health care providers?

CIGNA will test NPI-related changes to HIPAA transactions with EDI vendors, clearinghouses and direct submitters of these transactions. We will not test NPI submissions directly with health care providers. Providers should contact their clearinghouse vendors for more information about including the NPI on their transactions to ensure accurate submissions and reporting.

3. When will CIGNA begin accepting the NPI?

By May 23, 2007, CIGNA will be able to accept the NPI on all HIPAA standard electronic transactions.

At this time, CIGNA can receive the NPI in the following transactions:

- 837 Electronic Claim (other than pharmacy claims)
- 270 Eligibility Inquiry

For electronic claims submissions, the provider's taxpayer identification number (TIN) will still be required to complete the transaction. The provider's adoption of an NPI will *not* change any reporting requirements for other data elements, such as TIN, billing name, or billing address.

4. When will CIGNA begin returning the NPI on electronic transactions?

We anticipate that in the first quarter of 2007 we will begin reporting the NPI on electronic transaction responses when the NPI is submitted on the inbound transaction or exists in our database.

5. What will CIGNA do with standard electronic transactions that are submitted without an NPI?

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For an undetermined period after the NPI effective date, CIGNA will not reject transactions due to the absence of an NPI in HIPAA transactions.

6. How and when should I report my NPI to CIGNA?

CIGNA will begin to collect and store provider NPIs in the fourth quarter of 2006. To reduce your administrative burden, we plan to collect the NPIs from various sources and we will not ask you to report your NPI to us for our data collection.

7. How should I include NPI in my electronic transactions with CIGNA?

Your EDI clearinghouse can give you detailed information about how to submit the NPI in your HIPAA transactions.

2006 Medical Record Review Findings

Participating practitioners and providers agree to maintain records that comply with CBH's requirements for record content, organization, confidentiality, and ease of retrieval. These requirements intend that medical records are current, and that they facilitate communication, coordination and continuity of care, reflect all diagnostic, therapeutic, and ancillary services, and promote efficient and effective treatment.

Medical Record Review Process

To determine compliance, selected records of high volume practitioners are audited quarterly and assessed against CBH's medical record-keeping standards. To improve impartiality and reliability of scoring, CBH uses a standardized audit tool that can be reviewed in the CBH Provider Guide, and staff reviewers have been administered training and Inter-Reviewer Reliability tests. Should a practitioner's records fail to meet the goal established for compliance, the practitioner is notified and deficiencies must be resolved within 90 days.

As high volume practitioners near re-credentialing, members seen by them in the prior 12 months are identified. A letter is sent to selected practitioners, soliciting blinded copies of 5 clinical records and 2 Employee Assistance Program (EAP) records chosen by CBH for review. To ensure that the distribution of medical record reviews accurately represents the distribution of practitioner type in the network, a high volume practitioner is defined as:

- Any physician who has seen 90 or more CBH members in the previous 12 months.
- Any Ph.D. psychologist who has seen 35 or more CBH members in the previous 12 months.
- Any master's level therapist who has seen 30 or more CBH members in the previous 12 months.

2006 Medical Record Review Findings

For 2005, a total of 231 participating network practitioners submitted 1,001 medical records for review. The goal is 80% overall compliance with standards. Of the 231 practitioners whose records were reviewed, 40 practitioners, or 17.3%, scored below the 80% compliance goal. Overall compliance trends indicate that records generally exceed thresholds for all disciplines:

2006 Compliance Scores By Professional Discipline				
MD's	PhD's	NP's	MA's	Total
90.0%	87.3%	90.6%	86.2%	87.9%

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The two lowest scores, by professional discipline, were as follows:

- Physicians: coordinating behavioral care with other behavioral practitioners (65.2%), and coordinating behavioral care with the PCP (72.2%).
- Psychologists: coordinating behavioral care with other behavioral health practitioners and coordinating behavioral care with the PCP (both at 62.1%)
- Nurse Practitioners: documentation of a developmental history for child/adolescent at 45.5%, coordination of behavioral care with other behavioral health providers (57.5%) and coordination of behavioral care with the PCP (62.2%)
- Masters level practitioners: medications prescribed (64.3%) and documentation of allergies – (65.8%)

Nationally, the 80% goal was not met in seven categories: initial goals including time-frames for attainment (79.5%), informed medication consent (78.2%), allergies or reactions to medications or other substances (77.7%), documentation of preventive services as appropriate (77.5%), developmental history (75.2%), and attempts to coordinate with the primary care physician (67.1%), and with other behavioral care providers (64.5%).

Record documentation strength in 2006 included the presence of: Presenting problem (98.6%), diagnosis (96%), and a focus of initial treatment interventions with the initial treatment plan with the presence of a treatment plan (96.5%).

Next Steps

In 2007, CBH will undertake a review of its record review criteria against current industry practices and accreditation standards and will modify the audit tool as appropriate. Medicare-specific questions are being considered for elimination, since scores on other audit items provide sufficient data for assessment of record-keeping practices. Coordination of care continues to be an opportunity for improvement. CBH encourages you to take advantage of the information and tools in the CBH Provider Guide regarding Primary Care Physician communication, and to generally assess your own medical record-keeping practices. We hope that you will help us to improve the documentation of care through better record-keeping.



Pharmacotherapy in the Treatment of Alcohol Dependence

More than 8 million people in the US alone are alcohol dependent. Most would agree that this condition, with its high relapse potential, has been a challenge to treat. Traditionally alcohol dependence has been treated primarily by psychosocial interventions, yet relapse is still common. There are, however, a growing number of adjunctive pharmacotherapies that have been FDA approved and supported in the APA practice guidelines. Despite such support only a very small percentage of those with alcohol dependence are on any form of pharmacotherapy specifically for alcohol dependence, either alone or in combination with psychosocial interventions. There are presently three FDA-approved treatments for alcohol dependence: naltrexone, acamprosate and disulfiram.

Naltrexone is an opiate receptor antagonist. It is believed that the mode of action occurs by decreasing or by modulating the reward/pleasure/reinforcing feedback system that occurs when an alcohol-dependent person is drinking. Hence, it helps to decrease feelings of intoxication and may, therefore, decrease the amount of alcohol one chooses to consume. The usual prescribed dosage of

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naltrexone is 50 mg daily, orally. Additionally, in 2006, the FDA approved a long-acting monthly injectable form of naltrexone. In prescribing naltrexone, one must be alert to the fact that, as an opioid antagonist, naltrexone can precipitate withdrawals. The member for whom naltrexone is being prescribed should be opioid free for 5-10 days (dependent on the type of opiate used). Although a rare side effect, hepatotoxicity can occur. Increased risk factors include doses above 100 mg/day, and member obesity. In general, naltrexone is well tolerated and easy to use, with generally mild and/or transient side effects. It is recommended that those taking naltrexone carry an ID card with information regarding their use of naltrexone and the drug's interactions.

Acamprosate was FDA approved in the US in 2004, although it has been used in Europe for some time. Its mechanism of action is still unknown, but one theory is that it may work through its effects on the glutamate and GABA system. Chronic use of alcohol disrupts this system and the disruption can last for months after cessation of alcohol consumption, which may contribute to early and subsequent abstinence. Acamprosate may help to normalize this aberrant or disrupted system. Acamprosate is generally well tolerated. The recommended dosage is 666 mg (two 333-mg pills) three times a day. The side effects are usually mild and transient. Since acamprosate is not metabolized by the liver and is excreted by the kidneys, one must be cautious about use in those with renal impairment. Although the goal in prescribing acamprosate is to help the patient remain sober, acamprosate has minimal (if any) interactions with alcohol if one relapses.

Disulfiram is used as an aversion treatment to drinking. It causes a very significant adverse reaction when mixed with alcohol, due to an inhibition of the enzyme aldehyde dehydrogenase and a subsequent accumulation of acetaldehyde. This then causes various unpleasant symptoms, such as nausea, vomiting, headaches, flushing, anxiety and hypotension, and, in rare cases, more serious reactions such as significant chest pain, liver dysfunction, respiratory distress, cardiac arrhythmias, myocardial infarction and even death. Due to the potentially dangerous and, in some cases, even fatal, side effects this medication may produce when combined with alcohol, it is imperative that the prescribing clinician knows and understands how to use this medication. The member to whom it is prescribed should be well-informed of the potential adverse reactions.

There are multiple studies and practice guidelines that support the use of the above FDA approved medication treatments, in combination with psychosocial interventions, for alcohol dependence. Below is a link to the APA's web site. To learn more about treatment recommendations for alcohol dependence via the APA web site, (<http://www.psych.org/>) access 'Psychiatric Practice', then 'Practice Guidelines', then 'Substance Use Disorders'.

A Testimony To Excellence

Two separate Operating Units of CBH were recently awarded full three-year accreditation for Managed Behavioral Health Organizations from the National Committee for Quality Assurance (NCQA). The accreditations cover commercial managed behavioral health products managed at the Tampa, Florida and Chesapeake, Maryland Operating Units. Initial accreditation for Tampa was effective 11/13/06 and re-accreditation for Chesapeake was effective 12/22/06.

Full Accreditation is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous accreditation standards. NCQA Accreditation standards are intended to help organizations achieve the highest level of performance possible, reduce patient (member) risk for untoward outcomes, and create an environment of continuous improvement.

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CBH focuses on improving behavioral health by coordinating care, ensuring access, and providing good customer support for members. Our mission is to provide compassionate and innovative service as well as unparalleled clinical expertise to our customers, members and business associates. To improve operational efficiency and to better meet our service commitments, CBH reduced its number of Operating Units from five to four. In mid-January 2007, as a result, participants managed out of the Tampa Operating Unit were transitioned to our Dallas, Texas and Chesapeake, Maryland Operating Units, both of which are fully NCOA accredited. Increased staff levels at these Operating Units will enable business growth while ensuring continued high levels of service and care excellence for existing behavioral health customers.

As a private, non-profit organization, NCOA is dedicated to improving health care quality. NCOA accredits and certifies a wide range of health care organizations, recognizes physicians and physician groups in key clinical areas and manages the evolution of HEDIS, the tool the nation's health plans use to measure and report on their performance. NCOA is committed to providing health care quality information through the Web, media and data licensing agreements in order to help consumers, employers and others make more informed health care choices. For more information, visit www.NCOA.org.

Announcing the 2006 Revision of CIGNA Behavioral Health's Level of Care Guidelines

The 2006 revision of CBH's *Level of Care Guidelines* has been completed and can now be reviewed or downloaded free of charge, on CBH's Web site at: <http://apps.cignabehavioral.com/web/basicsite/provider/newsAndLearning/guidelines.jsp>

A hard copy of the 2006 *Level of Care Guidelines* can be requested, telephonically or in writing, by contacting the CBH Operating Unit nearest you and asking to speak with a Professional Relations representative.

CBH's *Level of Care Guidelines* are a guide to clinical decision-making. They are evidence-based and consistent with industry best practice for condition-specific illness management. CBH applies its *Level of Care Guidelines* on case-by-case basis, taking into account each individual's unique situation and the availability of services in the local delivery system. Annually, an Inter-Rater Reliability assessment is conducted to determine whether our care managers and physician reviewers apply the *Level of Care Guidelines* consistently, and training or other improvement actions are conducted as needed. Practitioners and facilities are notified annually in writing that the guidelines are available.

Practitioners have always played an important role in the creation and growth of CBH's *Level of Care Guidelines*. A multidisciplinary clinical workgroup developed an initial draft, based on research, literature, and practice, and practitioners and providers have played an important role in each subsequent revision. In June 2006, CBH's National Practitioner and Provider Advisory Board reviewed and made recommendations to the 2006 draft guidelines. Additional solicitation of practitioner and facility feedback was made by mail and by use of an on-line hyperlink near the guidelines when, from October through December 2006, the proposed guidelines were made available on CIGNA Behavioral Health's Website for review and commentary.

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The online hyperlink remains and continues to provide a convenient means to comment or provide input and feedback on the current guidelines.

The 2006 revision reflects recent changes in the research and literature on treatment, and improves consistency with the American Psychiatric Association and other Practice Guidelines adopted for use by CBH. New guidelines were added on Safety of Transfer, Methadone Maintenance, and to better differentiate the need for crisis stabilization versus use of a 24 hour stabilization bed. Subsequent work is underway to train staff in the use of the new Guidelines and to contract with participating providers to expand the availability of methadone service options.

As you experience CBH's *Level of Care Guidelines* through care management and in your own practice, we hope that you will share any recommendations for improvement that come to mind.



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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: www.ProviderEducation@cignabehavioral.com

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