ASAM NEWS

American Society of Addiction Medicine

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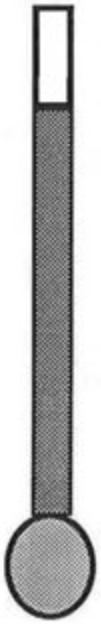

Ruth Fox Memorial Endowment Fund

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as of 12/5/91

Inside

ASAM Certification
Where Are We Now?

by **Anne Geller**, MD

ASAM is very actively pursuing our primary goal, which is to gain formal recognition within the structure of organized medicine for our specialty of addiction medicine. Many ASAM members have been involved in discussions with specialty societies and specialty boards, as well as with The American Board of Medical Specialties (ABMS).

At the last ASAM board meeting in October, several board members told me that members in their areas were uncertain about where we are going. Some were concerned about the effect of the recent Certificate of Added Qualifications (CAQ) in Psychiatry. This article is an attempt to answer some of your questions. It will probably generate further questions, to which I hope to respond in a future newsletter.

Certification Glossary

Some definitions will be helpful.

1. **American Board of Medical Specialties (ABMS)**: member board. There are currently 24 boards which are ABMS members. Examples: American Board of Internal Medicine (ABIM), American Board of Family Practice (ABFP).

2. **Certificate of Added Qualifications (CAQ)**: For physicians already certified and current in a specialty, who meet the training criteria and pass an examination set by the parent board. CAQs can be given conjointly by two or more boards.

3. **Certificate of Special Qualifications (CSQ)**: Training criteria and examination set by a specialty board. Theoretically, a CSQ could become the path to a subspecialty not requiring parent board certification to take the examination.

4. **Conjoint Board**: Established and functions under joint sponsorship of not less than two primary boards. Applicants must complete a training program acceptable to at least one of the sponsoring boards and to the Conjoint Board. Only example: Allergy and Immunology (Internal Medicine, Pediatrics).

5. **Conjoint Board (Modified)**: Established under sponsorship of not fewer than five ABMS-member boards. National specialty societies may be included as sponsor. Applicants must complete a training

(continued on p. 2)

ASAM is a specialty society of 3,500 physicians who are concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

ASAM Certification

(continued from p. 1)

program acceptable to the Conjoint Board (Modified) which sets its own requirements.

6. **Self-Designated Boards**: Not affiliated with ABMS. Usually set up by specialty societies and administered by an independent agency. Criteria for training and examination very variable. Examples: Bariatric Medicine, Forensic Psychiatry.

7. **Specialty Societies**: Example: American College of Physicians (ACP), American Psychiatric Association (APA), American Academy of Family Physicians (AAFP).

Questions from Members

• *Why do we not just call ourselves a board, or set up an independent board and make the ASAM certification a board certification?*

We could. It would take a few months. We could set up an organization separate from ASAM to prepare, administer and grade the examination, and to issue certificates. The advantage would be that we could *call* ourselves "Board Certified in Addiction Medicine." However, being unrecognized by ABMS would not provide us with any more qualification than does the ASAM certification now. And it would carry significant disadvantages: it would create an antagonistic position for us outside the medical mainstream, and would effectively marginalize us. The scope of addiction medicine is huge. For our patients to be properly treated, we need to be a part of the teaching of medicine -- in medical schools, in residencies, and in fellowships. We cannot do this from the sidelines. Setting up an independent board, although it seems attractive, assertive, and useful for ASAM members who are not associated with a primary medical specialty, would not give us a qualification which would carry the weight of an ABMS member board. It would present significant disadvantages for our specialty, our patients, and ultimately ourselves.

• *Are we really focused on becoming an ABMS-member board, or are we settling for CAQs in several specialties?*

Our ultimate goal is for addiction medicine to be a full specialty, meeting the requirements for a conjoint board or conjoint board (modified). However, although diseases of addiction are extremely prevalent and our patients are found in all specialties, we need to build a stronger training base. In order to do this, we have to ally ourselves with existing specialties. It is encouraging that several specialty societies and boards are interested in addiction medicine, and are concerned, as are we, that our patients be taken care of by physicians who are adequately trained. It seems quite possible that a number of boards might agree to collaborate and establish a joint CAQ in addiction medicine. If so, this would provide an incentive for training programs that would give us the foundation we need for a full specialty at some later date. A joint CAQ would mean that several boards would certify through the same examination, would have the same standards, and would jointly recognize the training requirements. There is the outside chance that the boards would agree to establish a conjoint board (modified).

• *Is ASAM abandoning those members who are not board eligible or certified, or who are certified in a specialty such as surgery, pathology, or anesthesiology, which are unlikely to develop CAQs or CSQs?*

Emphatically not. The ASAM certification is widely

respected. Although it does not have the status of a board (only an ABMS member board can have that), the entire examination process, the standards we have set for the exam's administration and content, have received approval -- indeed admiration -- within organized medicine. It is really advisable for anyone under the age of, say, 45, who wants to come into the field now, to first get board certified in medicine, family medicine, pediatrics, or psychiatry. For we as yet have no training programs in addiction medicine, and until we do, we owe it to ourselves and to our patients to get the best medical foundation we can within the specialities which are most relevant for our field.

• *Now that psychiatry has a CAQ, does this mean that addictions will soon be treated only by psychiatrists? And that ASAM has, in fact, lost the battle for addiction medicine to become a broadly based field?*

No, to both. The psychiatrists interested in addiction, both within and outside of ASAM, have taken the initiative in developing a CAQ. This has had the very positive effect of generating interest among other specialities in developing their own credentials, and to talk with ASAM about ways in which we can cooperate. The members of APA whom I have contacted do not believe that addiction is exclusively within the province of psychiatry. The fact of a CAQ in psychiatry, however, may lead on an administrative level to channeling patients and programs to psychiatry in some locations. If we wish to avoid that outcome, it is important for ASAM members from all specialties, including psychiatry, to continue educating others about the broad-based nature of our field and the need for experts from many specialties. It is also important for ASAM members from internal medicine, family practice, pediatrics, emergency medicine, and public health to promote the cause of addiction medicine within their own specialities.

• *What is ASAM doing now?*

The following ASAM members have been involved in both informal and formal meetings with specialty societies and boards over the last three months: **David C. Lewis**, MD, **John R. Durburg**, MD, **Stanley E. Gitlow**, MD, **Michael Fleming**, MD, **Larry H. Patton**, MD, **Anthony B. Radcliffe**, MD, and former executive director E. M. Steindler. Jim Callahan, ASAM's executive vice president, has been present at all of these meetings.

The contacts have been with the following organizations: The American Board of Psychiatry and Neurology, The American Board of Internal Medicine, The American Academy of Family Physicians, The American Board of Emergency Medicine, The American Board of Pediatrics, The American Board of Preventive Medicine, The American Board of Medical Specialties.

Our purpose in these discussions is to try to involve the boards and specialty societies in the push to get full recognition for addiction medicine in the ABMS world.

These activities will continue, along with many others designed to bring our field to maturity. We have gained the respect and support of our peers in medicine by our commitment to achieving excellence in patient care, and by our sense and moderation in pursuing our goals. We need to continue these efforts.

I welcome any questions, comments, suggestions, complaints, or offers of service.

Dr. Geller is Chief , Smithers Center, St. Luke's/Roosevelt Hospital, New York City. She is president-elect of ASAM, and was chair of the Ad Hoc Committee on Specialty Status. Dr. Geller is author of "Restore Your Life," published by Bantam Books last March.

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*Names in **boldface** are first mentions of ASAM members.*

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National Consensus Symposium on Children of Alcoholics and Co-Dependence

CONFERENCE DIGEST

by **Nady el-Guebaly,** MD

This first-ever symposium gathered 127 invited physicians, psychologists, social workers, counselors, researchers, administrators, policy makers, and teachers to Warrenton, Virginia, for discussion in depth about CoAs and co-dependence.

Ably organized by psychiatrist **Steven J. Wolin,** MD, of Washington, DC, chair of ASAM's Family and Generational Issues Committee; cosponsored by ASAM, and by ADAMHA's OSAP (Office of Substance Abuse Prevention) and OTI (Office of Treatment Improvement), the conference was held from Oct. 17-20 at the Airlie Center. The conference center is a retreat set amidst 3,000 acres of rolling hills and fiery fall colors in beautiful rural Virginia. It was designed for intense on-premises communication (i.e. no telephones or TV's in the rooms).

Participants were sent 15 detailed review papers to read in advance. Presenters highlighted the salient points of these papers in plenary sessions, but most of the time was used for feedback from audience, as a whole group discussing each presentation, and in small (25 each) assigned groups. Each panel answered questions that were presented either in writing or verbally.

The first panel dealt with assessing CoAs, both child and adult. Jeanette L. Johnson, PhD, from the University of Maryland, presented a cognitive developmental perspective. She included a comprehensive review of the 35 or so United States studies, which include a total of only 2,000 CoAs . Seventy percent of the instruments utilized were investigated only once. A standardized assessment package beyond "descriptors" for CoAs that would assess the process of change was recommended. Tarpley M. Long, LCSW, a Maryland practitioner, identified ten important clinical questions to include in an interview with an ACoA (adult child of an alcoholic). Ralph E. Tarter, PhD, from the University of Pittsburgh, presented a thorough perspective on the neurobehavioral risk factors of alcoholism. The ensuing discussion by the whole conference on these papers helped to refine their factual content, and included a call for qualitative research.

The second panel, moderated by David Berenson, MD, was on theories of co-dependence. There were historical reviews by Stanford's Margo Horn, PhD, who warned against over-applying the disease concept to an increasing range of behaviors, and by Chicago's Steven B. Jacobson, PhD, who analyzed the recovery movement in the context of a psychologically sophisticated generation of "baby boomers." On the clinical side, San Francisco's **Timmen L. Cermak,** MD, proposed his diagnostic criteria for co-dependence as a personality disorder. He also reviewed and elaborated upon the complementary myths of Narcissus and Echo. Stephanie D. Brown, PhD, another San Franciscan, was worried about the current trend of over-generalizing and over-simplifying the term "co-dependence" to include "any undesirable aspect of a relationship." She recommended limiting the term to the interactional systems dynamics of alcoholism and chemical dependence, and suggested that clinical assessment be along environmental, systems, and individual development perspectives. The presentations in this panel generated, as one would assume, a great deal of passionate conversation, which was pursued in the discussion groups (both small groups and the conference in general) for the rest of the day.

On Saturday, Karol L. Kumpfer, PhD, from the University of Utah, presented a scholarly review of the interplay between risk and protective factors . She highlighted the marked gender difference between genetic and environmental causative factors of alcoholism, and offered a creative review of the community, family, school, and peer risk factors.

Possibly the first, scientific data on the positive effect of an ingredient of spirituality, i.e. "life purpose" (by one of Dr. Kumpfer's students, B. Neiger) are now available.

Dr. Wolin elaborated on observed resiliency factors , and reminded participants that only a minority of the children of alcoholics grow to develop the disease of substance abuse. He introduced a "challenge model" which included seven individual resilient mechanisms and five areas of family functioning that are critical to resilience. This work will capture the imagination of those of us interested in preventing an intergenerational transmission.

Moderated by Peter Steinglass, MD, the second Saturday panel focused on child and family treatment and prevention.

Ann Lawson, PhD, and Gary Lawson, PhD, who are from San Diego, reviewed the literature on alcoholic family systems and approach to therapy. There was discussion about the need for initial individual work with the child and the recovering parent prior to involvement in therapy as a group. Ellen R. Morehouse, ACSW, from New York, reviewed the services provided to children, and shared her concern that while the pilot programs for CoAs are no longer experimental, the remedial resources available to these children at risk are growing at a slow pace. Parenting, the most complex of life's tasks, remains the one for which the least amount of organized training is available.

The last panel, expertly moderated by Claudia Black, PhD, included a survey of conference participants by Harvard's Marsha Vannicelli, PhD, which was done prior to the conference. She noted agreement regarding the validity of a group experience, but also a fifty/fifty split among the participants around the uniqueness of ACoA issues and the need for treatment of all ACoAs. Half believe that ACoA issues are not unique and that *not all* ACoAs need treatment! When an ACoA *does* require treatment, Dr. Vannicelli said that there was 85% agreement that the focus should be on the impact of growing up in an alcoholic home. Baltimore's **Charles L. Whitfield**, MD, was satisfied with the presence of some 23 definitions of co-dependence. He emphasized the centrality of spirituality in the processes of wounding and subsequent recovery. Elizabeth Hanson Hoffman, PhD, from Harrisburg, PA, described a multimodular outpatient service for ACoAs that lasts nine months or longer. Inpatient facilities for co-dependency were also described, such as the Caron Foundation, Onsite, and the Claudia Black Treatment Program. Once more, the emotional moments of the ensuing discussion focused around the need for widely accepted treatment standards.

Compliments to Dr. Wolin's bold initiative. The conference forced a dialogue for the first time among representatives of many constituencies who have appeared so far to avoid one another. Half the agenda covered a "safe" factual update of the ever-expanding array of risk and protective factors that are relevant to the development of substance abuse, particularly alcoholism. Despite limited resources, the achievements are impressive. We are well on the way in this area!

By contrast, the other half of the agenda was naturally more controversial. This was co-dependency with its many dimensions: developmental, adaptive, trait or syndrome, state of vulnerability, spiritual and/or sociopolitical. Can we serve our patients better by having one single definition of co-dependency, or many? Should we do away with the term altogether? Should it be restricted to children of alcoholics, or apply to all children of troubled families? Can some ACoAs escape co-dependency? Are there standards for different levels of care?

Any consensus was premature. At times, participants who are experienced with the academic culture, and those schooled in the experiential culture, had difficulties communicating with one another. But the questions to be addressed were clearly formulated.

The conference ended with a mesmerizing native healing circle led by Ann A. Latimer. Dr. Timmen Cermak is the new chair of ASAM's Family and Generational Committee, replacing Dr. Wolin. Dr. Cermak was unanimously supported in his proposal to design a core curriculum around ACoA issues for training and certification purposes. A research agenda owned by both clinicians and researchers is being designed. A number of coalitions were formed. ASAM was well represented by our executive vice president James F. Callahan, DPA, three board members (**Max A. Schneider**, MD, **Sandra Jo Counts**, MD, and me), and of course the many other members of our organization who are playing a major role in advancing the field. The largest gathering of authors I had seen in a while were able to meet. A common greeting was, "I've read all your work ... so pleased to meet you at last!" We should have another symposium in two years. Meanwhile, the book of proceedings is due to be published by summer 1992.

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Dr. el-Guebaly is Region IX representative to the ASAM Board. He is Director of the Department of Psychiatry at Foothills Hospital in Calgary, Alberta, Canada, is a professor at the University of Calgary's Department of Psychiatry, and has published a dozen papers in this field.

*Names in **boldface** are first mentions of ASAM members.*

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Revised AIDS Booklet

The 34-page *Guidelines for Facilities Treating Chemically Dependent Patients at Risk for AIDS or Infected by HIV*, revised by ASAM's AIDS and Chemical Dependency Committee, is available now at ASAM headquarters. Price: $3.75 ASAM members, $4.50 non-members, postpaid, prepaid.

LETTERS TO THE EDITOR

Dear Editor:

The office and most of the records of the *Forensic Drug Abuse Advisor*, a monthly newsletter, were destroyed in November's California brush fire. We believe we had around 100 ASAM subscribers, some enrolled in our CME program (in association with University Medical Center in Las Vegas). We plan to reconstitute the mailing list and publish our November/December newsletter in December.

If any subscriber who was taking CME contacts me, we will send new materials and any missed back issues.

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Family & Generational Issues Names New Chair, New Curriculum Project

The FGI Committee met during ASAM's National Consensus Symposium on Children of Alcoholics and Codependence in October. **Timmen L. Cermak**, MD, of San Francisco, succeeded **Steven J. Wolin**, MD, as committee chair. After discussion, the committee endorsed the following project:

"We will operate as a study group to outline the major topics which fall within the purview of 'family and generational issues' related to substance dependency. Once a comprehensive set of topics is agreed upon, we will survey the literature pertinent to each topic, to determine both the research data and the substantive clinical theories with which all physicians who are experts in addiction should be familiar. The final product is to be a curriculum guide, with the following potential uses:

1) to serve as the backbone for an ASAM syllabus, workshops, courses and conferences,

2) to provide questions for ASAM's certification exam.

"The rationale behind the FGI committee's syllabus project: efforts to raise awareness of the existence of family and generational issues have been successful, but now require an additional step. It is therefore time to place these issues on as firm an academic and research footing as is currently possible."

"The committee hopes to broaden its input base as widely as is feasible. Any ASAM member who would like to serve on the committee, and/or to contribute to the syllabus project, is encouraged to write: Dr. Timmen Cermak, c/o Genesis Psychotherapy Center, 1325 Columbus Avenue, San Francisco, CA 94133. Dr. Cermak assures all potential members that the committee's work will be conducted almost exclusively by mail and by phone."

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Joint National/State Membership

The board last month voted by mail to change the society bylaws approving conjoint membership in ASAM and its existing state chapters *[see ASAM NEWS Sept.-Oct., p. 1)*. Vote was 19 in favor, one opposed, and one abstention. Effective date: Jan. 1, 1994. There are currently 17 state chapters. Committee chair is **P. Joseph Frawley**, MD.

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ABOUT ASAM

Members-in-Training

Attention: ASAM Members

"Your future ASAM colleagues are *now* working their way through medical school, residency and fellowship programs," wrote **Daniel Glatt** to *ASAM NEWS*. "As current ASAM members, with the opportunity to interact on a professional and personal basis with those in training, the Members-in-Training Committee offers medical students and residents an affordable opportunity to participate in ASAM. Please take the time to invite those future colleagues who express an interest in becoming involved in addiction medicine to join our committee." For more information, contact either Mr. Glatt at (415) 692-3986 or the committee co-chair **David Gastfriend**, MD, at (617) 726-2712.

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Mailing from 'A Place For Us' Not Endorsed by ASAM

Several ASAM members have expressed concern about a recent mailing they received from Janet Greeson's 'A Place For Us.' We want to advise you that this mailing was *not* sanctioned by ASAM, nor did ASAM rent this organization the ASAM mailing list. The organization and its activities are *not* endorsed by ASAM, nor is ASAM in any way affiliated with 'A Place For Us.' Members are hereby advised of these facts. We would further advise you *not* to complete the questionnaire enclosed with the 'A Place For Us' mailing ... [JFC]

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CONFERENCE DIGEST

ASAM State-of-the-Art Course

by **Ann Birch**, MD, MPH

At age 71, I have no intention of taking the ASAM certification exam. I've worked for ten years in "the field" in a rural area, where CME courses and workshops are rare and distant. However, I do attend ASAM's annual medical-scientific conferences, among others, read widely, and telephone experts freely for advice. To me, some of the most interesting aspects of our field are matters of opinion, philosophy, policy, politics or conjecture. I like a conference that includes these, along with interesting updates taught by people well-known for their breadth of knowledge and experience.

In general, this promise was well met by ASAM's "State-of-the-Art in Addiction Medicine" Course Oct. 24-26 in Orlando, Florida, directed by **Andrea Barthwell**, MD, and **Terry A. Rustin**, MD. Although the course contained much review of basics, this was well done, and so integrated with new material as to be enjoyable and informative.

Course attendees ranged widely from people with long experience to newcomers (mostly psychiatrists) to the CD field. Some had never been to an ASAM conference, or even attended a 12 Step meeting, but said that they hope to take an ASAM certification exam.

I heard some talk among those planning future "State of the Art" courses that perhaps *more* basics should be included to accommodate such physicians. In my admittedly biased view, this would be a pity. Instead, I believe that these physicians could attend the ASAM Review Course, which is given the year of the exam, and study the 630-page ASAM *Review Course Syllabus*. (Copies of the 1990 text are still available at ASAM headquarters, $50 ASAM members, $90 nonmembers, postpaid, prepaid).

Since I've never been able to recall for long those beautiful colored diagrams of multiple neurotransmitters and receptors, I enjoyed **Milton E. Burglass,** MD, of Harvard saying that neurotransmitters are primarily heuristic constructs, which help us to understand addiction in a theoretical way, even though nothing of substance has been proven or disproven about a neurochemical explanation for addiction.

As a longtime aficionado of **Vincent P. Dole, Jr.**, MD and the late Marie Nyswander, MD, I was pleased to see data emerging to support their neuro-hormonal hypotheses. Another welcome ambiance was to find methadone maintenance experts of long standing integrated and accepted by ASAM 12-Step oriented addiction treatment "mainstreamers." I wish this attitude would reach more counselors and people in the "recovering" groups. Our progress is surely due in part to the annual April ASAM meetings, and to ASAM's five annual AIDS and Chemical Dependency forums.

The ethics/legal case presentation and perspectives was so good, I wished it could go on all day! Only one case could be discussed but it covered almost everything imaginable. The interplay and switching back and forth between the treatment (Dr. Burglass), legal (J. Ray Hayes, PhD, JD) and ethical (Jonathan D. Moreno, PhD) perspective spokespeople was highly stimulating, even at 8:00 AM.

Special mention should be accorded **Larry Siegel**, MD, for cheerfully packing ten years of alcohol, drugs and AIDS into one hour. Having followed this closely for personal reasons, though not yet much affected professionally in our rural area, I was impressed by how well he managed to do it.

A great deal of very useful and up-to-date didactic material was included in the 250-page, two-and-a-quarter pound, spiral-bound *State of the Art Syllabus*. (This is not the same book as ASAM's *Review Course Syllabus*.) Copies are available at ASAM headquarters: $25 ASAM members, $35 nonmembers, postpaid, prepaid.

In the introductory "Scope of Addiction Medicine" session, **Martin C. Doot**, MD, pinch-hit for Drs. **Anne Geller** and **John P. Morgan**, whose plane from New York City was delayed. He talked about how AA has had a reputation in the psychiatric community of objecting to any member taking a drug such as lithium, and how this stems from case incidents where an individual member has said to another: "Don't take that drug!" This, in turn, can lead a newcomer to feel that AA has rejected him or her.

As most ASAM physicians know, although the fellowship of AA has no opinion on consumption of other drugs by members, individuals can and do. "Thankfully, addiction medicine has seen this change in many ways," said Dr. Doot. "AA members have become more educated about recovering alcoholics with mental illness. In Illinois, we've encouraged alcoholics with dual diagnoses to establish their own 12-Step fellowship groups, originally called MIRA (Mentally Ill Recovering Alcoholics), now called DDA (Dual Diagnosis Anonymous)."

The bottom line on this is in AA's official Preamble: "The only requirement for membership is a desire to stop drinking." AA as an organization takes no position on what drugs a prospective or current member is or is not taking, even mood-altering ones. Although individual AA members -- and even whole groups -- may sound off about anything, which could be interpreted as "rejection by AA," a knowledgeable physician will advise the patient to try another group. Most areas, even my rural one, have a wide menu from which to choose.

Dr. Birch of Seneca Falls, NY, has "retired" from medical practice: she "only" holds seven part-time jobs!

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Update on Managed Care

ASAM Incident Report Form Survey

At ASAM's State-of-the-Art in Addiction Medicine Course in Orlando, Florida, Oct. 24-26, **Michael M. Miller,** MD, presented on "Managed Care in Addiction Medicine" with Jonathan D. Moreno, PhD.

Dr. Miller is chair of the Reimbursement Committee of ASAM's Standards & Economics of Care Section. He has supervised the "Access to Care Denial Incident Report Form," which was published in *ASAM NEWS* July-August 1990 and March-April 1991, with requests to readers to fill out and return them to ASAM. The purpose of the form was not to initiate intervention by ASAM in individual reimbursement cases, but to compile a data base. To date, 196 survey forms have been returned to ASAM. according to Dr. Miller, who gave the following highlights in Orlando of the data that are relevant to managed care.

Nearly three-quarters requested extension of service in the current level of care. The rest asked for admission to a given ADM service.

Requests that were denied were *not* predominantly for hospital-based care: only one-third were for hospital-based rehab. The remainder included requests for residential rehab (52%), hospital-based detox (7%), and for ADM IOP (intensive outpatient) rehab (3%).

Denials by Managed Care

Denials by managed care companies: 49% subcontracted by indemnity insurer; 7% subcontracted by HMO; 5% subcontracted by employer/union; 2% HMO prior authorization agent.

Denials by others: 24% commercial insurance, prior authorization agent; 4% Medicare/medical assistance, prior authorization agent (gatekeeper).

Stated reasons for denial by managed care:

32% insufficient biomedical comorbidity; 29% no reason given at all; 9% doesn't meet criteria; 7% benefit has been exhausted; 4% not covered benefit; 3% the patient hasn't been tried in OP yet.

When "managed care" denies access to a given level of ADM care, what level of care do they recommend for your patient in its place?

40% ADM intensive outpatient rehab; 23% ADM ongoing OP care (not IOP Rx); 18% no recommendation made for further care; 6% no further care in ADM; 2% each: halfway house, some other level of ADM care, discharge the patient.

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Strategies for Dealing with Managed Care

by **Michael M. Miller**, MD

1. Be courteous. Be aware that no matter how frustrated you are, case management in addiction medicine is a reality for the present and the future. Case management is here to stay, and nothing you say to the person on the phone will make managed care go away. You will be less likely to get the outcome you want from the managed care reviewer if you are antagonistic and go out of your way to make it an unpleasant experience for him or her. Remember, they are just doing their job!

2. Clearly identify yourself, your professional discipline, and your role in the management or monitoring of the patient's care in your facility.

3. Try to ensure that you are being reviewed by a peer. Go beyond the R.N. review level if you're having difficulties. For instance, you might ask very politely, "Do you have a physician reviewer on your staff who is a certified addictionist?"

4. Have a clear idea about what level of care your patient needs, and why.

5. Use the specific admission and continuing stay criteria for your treatment center when you discuss the case with the managed care reviewer. Use the ASAM/NAATP criteria if you choose, as this may provide a common vocabulary with the reviewer. (*Patient Placement Criteria* , published by ASAM in June 1991, is available from ASAM headquarters, $65 members, $80 nonmembers, postpaid, prepaid.)

6. If your reasons for recommending the patient's admission or continuing stay are clearly supported by the clinical material, if you've documented them in the clinical record, but your request for reimbursement is still denied, inform the reviewer that the patient cannot be clinically discharged within standards of acceptable medical practice. Explain that documentation is going into the patient's chart that the patient does not meet criteria for discharge at that time.

7. Remember: you saw the patient, the external reviewer didn't. You know the clinical severity of illness data, and the history. If criteria support your treatment plan, **file an appeal** of the external reviewer's adverse decision. **If you don't appeal**, and there is a negative clinical outcome, you could be considered to have capitulated to the managed care firm and to be in concurrence with its decision. Based on your clinical decision to discharge the patient, a court could hold you liable for the clinical outcome.

8. Keep a permanent file within your facility, separate from the patients' charts, in which telephone and written communications with managed care reviewers are documented. This permanent file can be used in the future in the process of appeals. Also, maintaining a separate (though permanent) file prevents the patient's clinical record from becoming the repository of the volleying back and forth which can occur with managed care folks, regarding what is a reimbursement issue and not a clinical issue. The only materials to put in a patient's chart are the necessity of the patient being at a particular level of care based on your clinical assessment, and any particular reaction the patient generates regarding his or her thoughts or feelings about what's happening with their reimbursement. Only if the patient brings it up as a factor in his or her own clinical progress and treatment does reimbursement become a clinical issue that gets documented in the clinical record itself.

9. Establish liaison between yourself and the patient's insurer. Thus, you could have a relationship that "goes over the head" of the managed care company, which is simply a subcontractor for the insurer.

10. If you believe that a reviewer has conducted him- or herself unprofessionally, ask to speak with his or her supervisor, and/or speak to the insurer itself and inform someone there about your experiences when you were reviewed.

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ASAM CALENDAR

Information about ASAM conferences available at Washington headquarters:
5225 Wisconsin Avenue N.W., Suite 409,
Washington, DC, 20015. ☎ (202) 244-8948

- ❑ **7th Annual Pacific Institute Conference: Honolulu, HI, Jan. 8-14, 1992** ☎ (808) 526-2841
(phone incorrectly listed in Sept.-Oct. issue as area 800)

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- ❑ **River Region Recovery Residences Lecture, Where Science and Addiction Meet: New Orleans, Jan. 15**
1539 Jackson Ave, Ste 201, New Orleans, LA 70130
☎ (504) 529-2863

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- ❑ **Florida Society of Addiction Medicine (FSAM) Annual Meeting: Orlando, FL, Jan. 17-19**
Radisson Hotel Downtown Orlando
Conference on Addiction, c/o Karen Barnum,
PO Box 2411, Jacksonville, FL 32203 ☎ (904) 356-1571

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- ❑ **ASAM/NAATP Patient Placement Criteria Conference: San Diego, Jan. 22-26** *Sheraton Harbor Island Hotel*

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- ❑ **Illinois Society of Addiction Medicine (ISAM): Chicago, Feb. 1** 9:00-12:30, *Women's Athletic Club*
Violet Eggert, MD, 205 W. Touhy Ave, Park Ridge, IL 60068
☎ (708) 698-4722

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- ❑ **12th Betty Ford Center Conference on Chemical Dependency: Rancho Mirage, CA, Feb. 23-25**
3900 Bob Hope Drive, Rancho Mirage, CA 92270
☎ 800-321-3690

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- ❑ **Recovery in the Carolinas, The Carolina Medical Professional Group: Raleigh, NC, Mar. 6-8 (CME program Mar. 7)**
The Professional Group, c/o North Raleigh Psychiatry,
920-A Paverstone Drive, Raleigh, NC 27615
☎ (919) 847-2624

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- ❑ **Society of Behavioral Medicine Symposium on Smoking Cessation: New York City, Mar. 28**
103 South Adams St, Rockville, MD 20850
☎ (301) 251-2790 *(CME's thru Duke Univ.)*

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- ❑ **ASAM 23rd Annual Medical-Scientific Conference: Washington DC, April 3-5**
Ruth Fox Course for Physicians: April 2
Board Meeting: April 1
Ramada Renaissance Hotel, Techworld

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- ❑ **ASAM 2nd National Conference on Adolescent Addiction, San Antonio, June 25-28**
Palacio Del Rio Hilton

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- ❑ **ASAM 5th National Conference on Nicotine Dependence, Seattle, Sept. 17-20** *Seattle Sheraton*

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- ❑ **ASAM Review Course in Addiction Medicine, Chicago, Oct. 8-10** *O'Hare Marriott*
Atlanta, Oct. 22-24 *Marriott Marquis (downtown)*
- ❑ **ASAM/CSAM Review Course in Addiction Medicine, Los Angeles, Nov. 5-7**

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- ❑ **ASAM Certification Examination: Atlanta, Chicago, Los Angeles, Dec. 5, 1992**
(Deadline for applications: Jan. 15, 1992)

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*Calendar includes only meetings that are sponsored or co-sponsored by ASAM (one time listing for co-sponsored conferences). For inclusion on this calendar, please send information directly to Lucy B. Robe, Editor, **at least two months in advance.** To arrange for ASAM to co-sponsor a conference (CME credits) contact Claire Osman **at least three months in advance** at:* ASAM, 12 West 21 St, New York, NY 10010. ☎ (212) 206-6770.

Beginning with the January-February 1992 issue, this newsletter will be sent Third Class instead of First Class Mail. Therefore, conference information should reach ASAM three months in advance..

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