CSAM news
VOL. 36/NO. 3 • WINTER 2009
THE VOICE FOR TREATMENT
QUARTERLY NEWSLETTER OF THE CALIFORNIA SOCIETY OF ADDICTION MEDICINE

CSAM Begins New "Barrier to Treatment Access" Project

Seek help from members to report denials and non-authorizations

By Thomas J. Brady, MD, MBA - Chair, Committee on Access to Treatment

Thomas J. Brady, MD

CSAM is initiating a project to monitor and address barriers to substance use disorder treatment resulting from denials or non-authorizations by patients' third party payers, including managed health care insurance companies, Medi-Cal, and Medicare. When a CSAM member becomes aware of such a denial or non-authorization, he/she is invited to complete a **Barrier to Treatment Access Report Form** and submit it for review and possible action by CSAM's Access to Treatment Committee. Case examples will be collected and scrutinized in order to:

1. **Assist** the provider in securing a patient's treatment authorization and exhausting all levels of appeal.
2. **Advocate** with a specific third party payer or California regulatory agency, the Dept. of Managed Health Care or the Dept. of Insurance, for a treatment authorization on behalf of the patient and provider.
3. **Assess** denial and non-authorization trends, for example, by diagnosis, level of care, or specific third party payer.
4. **Compile** a group of disputed cases to present to California governmental bodies, such as the California Legislature, the Dept. of Managed Health Care, and the Dept. of Insurance, as examples of barriers to substance use disorder treatment.

Obtain a **Barrier to Treatment Access Report Form** from the CSAM website and submit the completed form to the CSAM Barrier to Treatment Access Project via the CSAM website, fax, or email. Periodic reports of third party payer denial and non-authorization trends will be made available on the CSAM website, in email alerts to members, and at www.csam-asam.org and in future issues of CSAM News. ■

(See pages 8-9 of this newsletter for a copy of the form.)

President's Message

By Timmen Cermak, MD

The two years ahead of me look very short, barely enough time to get anything concrete accomplished. Then I remember how much is under way already, and how well functioning our little engine of 400 has become.

The CSAM Education Committee conducted a record breaking State of the Art Conference. We helped train over 70 trainers in SBIRT (Screening, Brief Intervention and Referral to Treatment), using videoconferencing technology with a speaker in Wisconsin. The CSAM staff videoconferenced in Tom McLellan from the White House ONDCP Office on less than 24 hours notice. We held a half-day on adolescent substance dependence and introduced the CSAM Blueprint for Adolescent Drug and Alcohol Treatment in Cali-

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George Vaillant, MD, pictured here having a conversation with CSAM President Tim Cermak during the CSAM State of the Art Conference dessert reception, was the recipient of CSAM's Annual Vernelle Fox Award. The award was presented in recognition of dedication to advancing the science and treatment of the disease of addiction as one of the foremost researchers in the field. Dr. Vaillant is admired for his pivotal work as a poet, visionary, and scientist in revolutionizing the world's view of human development, religion, and spirituality. He has provided inspiration to many as an international educator—able to translate science into enthusiasm and hope for addiction treatment.

President's Message

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fornia. And we hosted our first international speaker, from the Netherlands, during our segment on cannabis. In the process, it was a very profitable conference with over 500 attendees.

The CSAM Access to Treatment Committee is testifying on behalf of parity, fighting to keep medical necessity loopholes from closing so tightly that treatment options are closed off. The committee is also working to create a clearinghouse for collecting examples of denials of care that will help in the protection of parity.

The Public Policy Committee is continually working on a variety of issues, including crafting CSAM's position in the upcoming debate over legalization of marijuana in California. I see this debate as an opportunity for CSAM to serve as a very interested educator and tireless dispenser of science and research. While we know that marijuana is an addictive drug, we are not the experts on legal and social policy. We know that alcohol is an addictive drug, but that does not mean that we know best about the laws that should govern alcohol. What we do know is the damage that alcohol, and marijuana, can do, and the fact that adolescents are at the highest risk of the most damage from both. I believe that CSAM can educate better than it can legislate, and we will be in a better position to do the former if we do not try to do the latter.

While the State of the Art Conference left me with a warm glow, my recent visit to a hearing at the Department of Consumer Affairs (DCA) reminded me that there is an outside world that does not share our empathic view of addiction. SB 1441 (Ridley-Thomas) has initiated a process calling for the creation of uniform standards to be applied to all monitoring programs for the healing arts (physicians, nurses, dentists, psychologists, pharmacists). The DCA has a Substance Abuse Coordination Committee creating these standards. While they appeared to have been creating reasonable standards, at the last minute the committee director edited the standards in a stricter, more punitive direction.

Suddenly all people being monitored were to have 3-5 urine screens a week for the first year. Three minor violations (such as late documentation or missed meetings) during 5 years of monitoring would be considered sufficient to inactivate an individual's license and terminate their participation in a monitoring program. Clearly, a more punitive approach had taken hold. It felt like people were being seen as GUILTY of being an alcoholic or an addict.

Dr. Judith Martin passed the President's Gavel to new CSAM President Tim Cermak, MD on Friday, October 9, 2009 at the CSAM Annual Business Meeting. Also installed at that meeting were two new members of the CSAM Executive Council Jean Marsters, MD and Christy Waters, MD. Dr. Jeff Wilkins was advanced to President-elect.

Here is the problem as I see it. If monitoring programs take such a black and white enforcement oriented approach that not a single participant relapses without ever getting caught, the program will be seen as so restrictive, punitive and unnurturing that not a single person will self-refer. As a result, impaired professionals will go underground and hide until their illness is so out of control that they do some harm, to themselves or to someone else.

If, on the other hand, the monitoring program is seen as firm, but fair and nurturing, it will attract self-referrals. Fewer people will hide until they do harm. The public will actually be better protected, although those who want to run a "black and white" program will have to live with more anxiety. But the public will be better protected.

Now what do you really want? To feel blameless yourself, or to protect to the public as best as possible? ■

Editor's Message

By Itai Danovitch, MD

For the past three years, Dr. Cermak has thoughtfully edited this newsletter. With his ascension to the CSAM presidency, he has decided to pass the baton. Dr. Cermak sought to make this newsletter a medium through which diverse perspectives on vital issues in our field could be represented and expressed. The Winter 2009 Newsletter captures the identity of CSAM—it includes a narrative retelling of addiction medicine's origins, a summary of highlights from CSAM's State of the Art Conference, and a focus on some of the policy challenges in which CSAM is engaged. I plan to follow the course that Dr. Cermak set for this newsletter, and I encourage you join the dialogue by sending us your comments, questions, and critiques.

Substance Use Disorder Insurance Parity Update

By Thomas J. Brady, MD, MBA - Chair, Committee on Access to Treatment

On October 11, 2009 Governor Arnold Schwarzenegger vetoed California Assembly Bill 244 (Beall) Health Care Coverage: *Mental Health Service, otherwise known as the "Parity" Bill*. AB 244 would have required that insurance coverage for the treatment of substance use disorders be equivalent to that provided for other medical illnesses.

Thomas J. Brady, MD

Governor Schwarzenegger justified his veto with the assertion that AB 244 represented an unfunded mandate. While the bill was indeed a mandate its fiscal impact was overestimated. Adding full and equal coverage for alcohol and drug addiction would have increased insurance premiums, but just by 0.2 percent, or about one dollar per month for most families. [1] Economic data show that every dollar spent on alcohol and drug treatment saves seven dollars in medical and other social costs. [2] Chevron reports that it saves ten dollars for every dollar spent on coverage for addiction services.[3]

Fortunately, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*, enacted into law on October 3, 2008, goes into effect January 1, 2010. This federal act stipulates that group health plans nationwide must cover mental health and substance abuse benefits comparably to medical and surgical benefits. Specifically:

1. A group health plan of 50 or more employees that provides both physical and mental health/substance use benefits must ensure that all financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements and limitations placed on physical benefits.
2. Equity in coverage will apply to all financial requirements, including lifetime and annual dollar limits, deductibles, co-payments, coinsurance, and out-of-pocket expenses, and to any treatment limitations, including frequency of treatment, number of visits, days of coverage and other similar limits.

What are the treatment access implications for California patients with Substance Use Disorders? This is difficult to anticipate, in large part because the law includes a loophole that imposes parity only if the patient's health insurance benefit includes coverage for mental health/substance use disorders—there is no fundamental requirement for health insurance plans to provide mental health/substance use disorder coverage.

Contrary to its intent, the new federal parity law ironically may result in greater barriers to treatment access for substance use disorders. Managed care health insurance companies may drop coverage using the loophole, and "medical necessity" criteria may be tightened, resulting in increased insurance denials. In order to scrutinize this possibility, CSAM is introducing a clearinghouse for members, with the purpose of collecting case examples of managed care treatment authorizations being denied or otherwise not authorized. You are urged to fill out a ***Barrier to Treatment Access Report Form*** and send it to CSAM for collecting, monitoring, and addressing. For example, armed with specific case examples, CSAM leadership may approach an individual managed care company in order to question overly restrictive Utilization Review practices, and/or summarize egregious examples of denied treatment to present to the California Legislature, the CA Dept. of Managed Health Care, or the CA Dept. of Insurance. Please see the CSAM Newsletter alert regarding how to obtain a ***Barrier to Treatment Access Report Form*** and where to send in a completed form. ■

Dr. Brady is an at-large member of the CSAM Executive Council and Chair of the Access to Treatment Committee

[1] Substance Abuse and Mental Health Services Administration Study, March 1998
[2] Gerstein, D.R., et al. Evaluation Recovery Services: The California Drug and Alcohol Treatment Assessment. General Report. Submitted to the State of California Dept. of Alcohol and Drug Programs. Chicago: National Opinion Research Center, 1994
[3] Cummings, C.R. Testimony before the subcommittee on national security, international affairs and criminal justice of the committee on government reform and oversight of the U.S. House of Representatives, 1996

Welcome New CSAM Members!

C. Y. Angie Chen, MD - *Palo Alto*
Helen Driscoll, MD - *San Francisco*
Kenneth Lehrman, MD - *Laguna Beach*
Ralph Potkin, MD - *Malibu*
David Sack, MD - *Cerritos*
Gabriel Schonwald, MD - *Redwood City*
Craig Smith, MD - *Los Angeles*
Mark Towns, MD - *Galt*
Ariel Troncoso, MD - *San Jose*

The Evolution of Addiction Medicine and Its San Francisco Roots

By David E. Smith, MD, FASAM, FAACT - Diplomate, American Board of Addiction Medicine

On May 2, 2009, at the annual meeting of the American Society of Addiction Medicine (ASAM), NIDA Director **Dr. Nora Volkow** participated with the leadership of the American Board of Addiction Medicine in conferring Board certification in Addiction Medicine on 1452 physicians in ABAM's first Diplomate ceremony, myself included.

Forty and more years ago, that scene would have been barely imaginable. Addictions were stigmatized solely as moral failings and/or criminal activity.

Alcoholism as a disease was clearly described as long ago as the late 1700s by Dr. Benjamin Rush, a physician and signer of the Declaration of Independence. However, it wasn't until the formation of Alcoholics Anonymous (AA) in the 1930s that the concept spread throughout the United States and then the world. Again, it was a physician, Dr. William Duncan Silkworth, who in *The Big Book* of AA described alcoholism as a disease caused by "an allergic reaction of the body to alcohol" and a compulsion of the mind. In the 1950s, the American Medical Association (AMA) declared that alcoholism was a disease, reaffirming it in 1966. Both initiatives were led by physicians in the New York Society of Alcoholism.

Addiction to other drugs, however, was specifically excluded. In fact, AA emphasized that drug use other than alcohol was not to be disclosed at AA meetings. This prompted the formation of Narcotics Anonymous in California in the 1950s, which was based on similar 12-Step principles but included recovery from all drugs, particularly opiates such as heroin, using the catch phrase "clean and sober."

In the late1960s, the movement to recognize addiction as a disease escalated in California when the Haight Ashbury Free Medical Clinic (HAFMC) was founded in response to the large number of drug-using youths who flocked to the Haight Ashbury for the "Summer of Love," based on the principle that "health care is a right, not a privilege" and "addiction is a disease – the addict has a right to be treated." The San Francisco Medical Society and the California Medical Society provided early support (Heilig, 2009).

Dr. David Breithaupt, from the University of California, San Francisco (UCSF), trained medical students at HAFMC. He recently described battling a system which viewed physicians at the community level as "outlaws caring for sinners and criminals" rather than "physicians treating a chronic disease." It was then illegal to detoxify an addict on an outpatient basis. Nonetheless, **Dr. Donald Wesson** and I determined that a phenobarbitol withdrawal protocol we had developed could be used to detox addicts and instituted its use at HAFMC's Drug Detoxification, Rehabilitation and Aftercare program, in

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David Smith, MD, Founder of the Haight-Ashbury Free Medical Clinic

The Red Vic Movie House in San Francisco one evening during the CSAM State of the Art Conference features the film "Summer of Love" presented by Dr. David Smith.

What is SBIRT? How Do You Do It and Teach It Effectively?

By Ken Saffier, MD

In a typical out-patient visit, how can we best screen for harmful alcohol and drug use? When our validated screening tool is positive, how can we provide brief interventions and referrals to treatment for those who need it? As teachers in residency programs how can we effectively instruct our learners, who are at different levels of experience and expertise?

We live in an exciting time. Whereas, for years physicians have failed to recognize substance use problems in their patients, during the past decade an effective method for patient screening, intervention and referral to treatment has been developed and proven effective. The method is termed "SBIRT": Screening, Brief Intervention, and Referral to Treatment. (See: SBIRT- Understanding its Significance to Addiction Medicine, by Dr. Cermak in the CSAM News, Vol. 35, No.1, Winter 2008.) SBIRT is now being taught to the faculty members in a number of residency programs who are, in turn, teaching residents to incorporate SBIRT into routine medical practice. With this in mind, MERF collaborated with CSAM and a number of residency programs.

Ken Saffier, MD

During the 2009 State of the Art pre-conference workshop., this CSAM-MERF activity was a teaching resource, and received CSAT support to bring faculty from residency programs from the SF Bay Area, California, Oregon, Seattle, and from as far away as Massachusetts.

The morning session, led by Rich Brown, MD, MPH, from the University of Wisconsin reviewed SBIRT, while Jennifer Hettema, PhD, from the University of Virginia, reviewed and integrated motivational interviewing into the presentation. After demonstrations and several practice cases role played and discussed by the attendees in small groups, the workshop focused on the tasks and challenges of teaching SBIRT skills to residents with varying skill levels. Julie Nyquist, PhD, from USC School of Medicine's Division of Medical Education, reviewed the basics of clinical teaching and feedback, while Dr. Hettema demonstrated how motivational interviewing perspectives can be adapted to enhance learning in preceptor-resident interactions. Using two "live" resident-patient demonstration cases with two types of learners, participants role-played and then provided feedback about how effective the resident-patient interactions were. Each case was discussed by each pair, then in small groups, and finally by all participants to refine and improve their SBIRT teaching. This engaging session ended with participants filling out commitment to change statements, each person setting down how he or she expects to implement these strategies and skills in the clinical setting back home.

In a typical out-patient visit, how can we best screen for harmful alcohol and drug use? When our validated screening tool is positive, how can we provide brief interventions and referrals to treatment for those who need it?

The workshop was the first step in an educational research project exploring how faculty and residents can learn to recognize and intervene upon substance use disorders. Many thanks were extended to the Center for Substance Abuse Treatment of SAMHSA for financial support, to MERF which provided scholarships for faculty and residents, and to the CSAM leaders who incorporated this workshop into the State of the Art Conference. ■

Get Instant DOJ CURES-Patient Activity Report (PAR)

On-line access: http://ag.ca.gov/bne/cures.php

In order to obtain access to the PDMP system, Prescribers and Pharmacists must first register with CURES by submitting an application form electronically at **https://pmp.doj.ca.gov/pmpreg/**. In addition, your registration must be followed up with a signed copy of your application and notarized copies of your validating documentation which includes: Drug Enforcement Administration Registration, State Medical License or State Pharmacy License, and a government issued identification. You can mail your application and notarized documents to:

Bureau of Narcotic Enforcement (BNE) Attn: PDMP Registration, P.O. Box 160447, Sacramento, CA 95816

Another option would be to forgo the notary and present your documents in person at any one of our BNE Regional Office locations and our sworn personnel will validate and collect your supporting documentation.

If you want to bring your application in person (to avoid notary fees), the San Francisco Regional Office is at:

2720 Taylor Street, Suite 300, San Francisco 94133 • Phone (415) 351-3374

The Evolution of Addiction Medicine and Its San Francisco Roots

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combination with psychological counseling and recovery groups. A few years later, **Dr. George "Skip" Gay** initiated a substantial federal grant, motivated by the new Nixon White House philosophy that addicted Vietnam War veterans should have treatment.

With the arrest of two Southern California physicians in the late '60s for detoxifying heroin addicts with Valium in a medical outpatient setting, **Dr. Jess Bromley** recommended that we start a professional society. We would then be able to associate nationally with the AMA, through the California Medical Association, which had earlier rejected efforts to get addictions other than alcoholism accepted as diseases.

Another key physician in the early organization of the California Society of Addiction Medicine (CSAM) was **Dr. Max Schneider**, a Southern California gastroenterologist who treated cirrhosis of the liver with associated GI bleeds, and was distressed that the medical system did so little to treat the disease of alcoholism. In fact, all of the founders of CSAM were motivated by this principle – it makes no medical sense to treat the complications of a disease and not treat the underlying chronic medical illness, whether it be a disease of the brain – like addiction – or a disease of the pancreas – like diabetes. 100% of alcoholics and addicts will at some time interface with the medical system.

As an appointee to the AMA committee on alcoholism, I introduced the disease model of addiction to the AMA committee in 1976. I coined the term "Addiction Medicine," and after much debate it was accepted. At the same time, **Dr. Douglas Talbott** from Atlanta, who pioneered the treatment of addicted physicians, introduced the term "addictionology."

In 1981, all of the U.S. regional organizations met at the California Kroc ranch to organize what evolved into the American Society of Addiction Medicine. ASAM ultimately gained acceptance in the AMA House of Delegates as a specialty society.

In 1988, ASAM introduced the motion to the AMA that all drug dependencies, including alcoholism, were diseases and that medical practitioners should base their medical practice on the disease model of addiction. The motion was accepted, and when ASAM expanded its focus to include nicotine/cigarette addiction, with its associated morbidity and mortality, the AMA granted specialty status to ASAM using the ADM code.

The battle to gain broader acceptance of addiction as a brain disease, emphasizing prevention, intervention and treatment by the sociological and political structure in the U.S. is much more difficult and complicated, as witnessed by the current controversy about including parity for addictive disease in the current health care reform debate.

However, as President Obama stated in his book, *The Audacity of Hope*, "past history is not dead and buried, it is not even dead." Addiction medicine's history demonstrates to the next medical generation that they can both continue the battle to help the suffering alcoholic and addict, and further the integration of addiction medicine with mainstream medicine. ■

References:
Heilig, S. 2009. David Smith: *Pioneering Community-Based Health Care. San Francisco Medicine*, September, p. 15
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McLellan, AT, Lewis, DC, and Kleber, HD. 2000. Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance and Outcomes Evaluation. *JAMA*, 284(13):1689-95
Smith, DE. 2000. First Annual Jess W. Bromley Memorial Lecture. *CSAM News*, Fall, p. 6

The CSAM State of the Art Conference Planning Committee from left: Reef Karim, DO, Timmen Cermak, MD, Peter Banys, MD, Karen Miotto, MD, Chair, Judy Martin, MD, Itai Danovitch, MD, Monika Koch, MD, Dana Harris, MD, Phuong Truong, MD, Michael Barack, Ken Saffier, MD, Jean A. Marsters, MD, and David Pating, MD. Not pictured were: Suma C. Singh, MD and Walter Ling, MD.

John Chappel, CSAM Education Pioneer, Honored

At the CSAM 2009 State of the Art Conference CSAM and the Medical Education and Research Foundation (MERF) honored John Nelson Chappel, MD for his role developing the educational tradition of CSAM.

Bestowing the honor to Dr. Chappel provided CSAM and MERF the opportunity to illuminate how his work and values helped lay the foundation of our Society. His contributions to the manner we provide physician education have become a fundamental part of CSAM's genome.

A brief review of an essential and formative era during CSAM's evolution reveals John's influences upon our history: Between 1983 (year of first CSAM certification exam and Review Course) and the early 1990s CSAM's effectiveness providing high-quality physician education advanced a quantum leap forward under the guidance and direction of the architects of CSAM's educational foundation: Dr. Chappel, Dr. Don Gragg, Dr. Garrett O'Connor, Dr. Peter Banys, and Ms. Gail Jara. [Dr. Gragg scrupulously attended to every element at an educational conference. Dr. O'Connor brought 12-step meetings and discussions and exploration of spirituality. Dr. Banys insisted upon evidence-based approaches and the best possible speakers. Ms. Jara coordinated and directed the architects' energies with her masterful and alchemic organizational skills.] Dr. Chappel insisted we maintain our standards while continually striving to improve the educational experience for attendees. While being rigid about time enforcement, John remained ever cheerful, albeit unmovable enforcing it.

If you were to ask Dr. Chappel how to best educate physicians, you would be wise to be prepared for him to turn the question back on you. By design, he would involve you in the process of his response. John resolutely and passionately drummed into us the importance of actively involving learners in the educational process. Whether organizing educational conferences or chairing one of the numerous "Teaching the Teacher" workshops, John advocated passionately for teachers to elicit learners' experiences and then to focus their experiences back on the educational message. John's example, commitment to effective teaching, and preaching the gospel of peer-interactional-learning led CSAM to become an organization devoted to peer education and collegial interaction. Moreover his dedication helped to shape our Society's view of itself and our role in physician education, characteristics that have become an essential part of CSAM's ethic.

Now to the round tables which were originally John's idea and his unassailable passion. Sitting around a table with colleagues, problem solving and learning, satisfied a number

Dr. John Chappel at the CSAM State of the Art Conference in San Francisco on October 8, 2009 with Dr. Garrett O'Connor, Dr. Steve Eickelberg, and Gail Jara.

of John's goals: A collegial atmosphere, camaraderie, and peer teaching and education. As a leader, John taught group facilitators not to impart their knowledge. Rather, he taught facilitators to focus upon enhancing group interaction, group problem solving and learning, and the inclusion of all participants in the process. So effective was he at transmitting his passion that, as a matter of course, we continue to utilize "his" round tables and case-based problem discussion to facilitate experiential-peer-interactive learning. These experiences have been and remain a popular and highly valued feature at CSAM conferences.

Another of Dr. Chappel's essential influences, lest it be summoned to our conscious awareness, can be taken for granted. What I am referring to is his quest to instill Spirituality into our conferences and the learning process. His 12-Step presentations made this topic subject for ongoing discussion and reflection.

Adding to John's legacy, Dr. O'Connor labeled John's time enforcement practice as "looming," which has become an iconic practice at CSAM conferences. Keeping us on track, a CSAM virtue, is another expression of John's respect for both the learner and the educational process.

CSAM's educational soul reflects Dr. Chappel's passion for camaraderie, shared educational/learning experiences, and his love for his peers and patients. Think for a minute how his love of others and obsession for education and learning has influenced the thinking and practices of thousands of physicians — physicians who subsequently provide care for hundreds of thousands of patients; all of whom benefit from Dr. Chappel's authority, passion and love. ■

California Society of Addiction Medicine
Barrier to Treatment Access Report Form

Date: _____

Provider Name: _____ (print)

Provider contact information: _____ (telephone, email)

1. **Reason for treatment barrier:**

   ❑ Treatment request not authorized (informal denial)
   ❑ Denial of authorization request (formal denial)

2. **Third party payer:**

   ❑ Managed Care _____ (company name)
      ❑ HMO benefit plan
      ❑ PPO benefit plan
   ❑ Medi-Cal
   ❑ Medicare
   ❑ Other _____ (detail)

3. Are you a network provider for this third party payer?

   ❑ Yes
   ❑ No

4. **Patient information:**

   Identifier _____
   [Note: Do not use patient's name. Include patient's policy #]

5. **Dispute/Complaint:**

   For example: What treatment service was requested from the third party payer (be specific)?
   What was the outcome of the treatment request?
   What clinical information justified your treatment request (be specific)?

_____
_____
_____
_____
_____
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_____

California Society of Addiction Medicine
Barrier to Treatment Access Report Form

_____

_____

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_____

_____

_____

(Use a separate sheet if necessary.)

6. If you received a formal denial, did you appeal to the fullest extent possible, including an Independent Medical Review?

   ❑ Yes

   ❑ No. If not, why not? _____

   _____

7. Have you filed a complaint or grievance with the third party payer, the CA Dept. of Managed Health Care, or the CA Dept. of Insurance?

   ❑ Yes. If so, with whom (include Complaint File # if known). Describe outcome. _____

   _____

   _____

   ❑ No

8. What are you hoping for CSAM to address with this case?

   _____

   _____

9. Attach **copies** of relevant documents related to this case, such as denials, letters, bills, and explanations of benefits. CSAM cannot return original documents.

10. **Provider signature:**

    _____

Mail, fax, or email this form and any attachments to:

CSAM Barrier to Treatment Access Project

575 Market Street, Suite 2125, San Francisco, CA 94105

Phone: 415-764-4855 • Fax: 415-764-4915 • Email: csam@compuserve.com

CSAM State of the Art Conference 2009

CSAM Conference Chair Karen Miotto, MD is pictured here with Monika Koch, MD, CSAM Chair, Committee on Education, and CSAM President-elect Jeff Wilkins, MD.

New ONDCP Deputy Director Tom McLellan, PhD addressed attendees at the CSAM State of the Art Conference via live video conference from the White House. He spoke on "New Directions in Demand Reduction: Views from the ONDCP".

Community Service Award

Assembly Member Jim Beall who represents California's 24th Assembly District in the San Jose area received CSAM's Community Service Award. He is a strong advocate in the CA Legislature for addiction treatment and insurance parity for mental health and substance abuse treatment.

The Medical Education & Research Foundation (MERF) provided mentored learning experiences for physicians in training and teaching faculty to attend the CSAM State of the Art Conference.

Alcoholism: Vice or Disease? A Conversation with Howard Fields

By Howard Fields, MD, PhD

What if we put cancer patients in jail? It's a ridiculous thought, of course. No one chooses to get cancer. It's a disease whose emergence is dictated by a complex interplay among environment, lifestyle and genetics.

Using the same logic, neuroscientist Howard Fields, MD, PhD — a senior researcher at the UCSF-affiliated Ernest Gallo Clinic and Research Center and director of UCSF's Wheeler Center for the Neurobiology of Addiction — wonders, then, why we punish addicts.

"If you listen to addicts, they say, 'I'm out of control. I can't help it. I can't stop myself. I know I need help.' That's what everyone needs to understand. Most alcoholics would like to cut back on their drinking. But some unconscious force makes them take that fifth or sixth drink even when they know they shouldn't. This is a disease, not a crime."

Howard Fields, MD, PhD

Finding that unconscious force inside the human brain is the holy grail of Fields' research. It's a quest that has little use for the magic wand called willpower that society waves over the addiction problem as both an explanation and a solution. "Blaming a person's lack of willpower is another way of saying it's your fault, that you had a choice," says Fields. "But who chooses to be an addict? And what is willpower but just another manifestation of nerve cell activity?"

> *"The main point is that their brains are different, and that is why they cannot stop drinking once they start."*

If not a failure of willpower, then, what is alcohol addiction? Fields is quick with an answer. "To me, the simplest way of thinking about it is impulsivity. In other words, if there is something immediately available, you ignore the long-term consequences. In fact, the longer term the consequences are, the less influence they will have over your current behavior. This is what we as scientists have to understand: How does your motivation for immediate reward outweigh your ability to wait for a larger pleasure?"

It's a fascinating neurobiological conundrum that all of us either witness or participate in daily. Think about it for a moment. At some point in our lives, almost everyone is exposed to alcohol. Yet most people do not become alcoholics, even those who drink small or moderate amounts daily.

For perhaps 5 percent to 10 percent of us, though, and for reasons as yet unexplained, drinking alcohol becomes an addiction with often disastrous consequences on our health, our freedom and the lives of others. The statistics are grim. In addition to the 17,000 traffic-related fatalities, alcohol abuse in the United States annually causes:

* 1,400 deaths
* 500,000 injuries
* 600,000 assaults
* 70,000 sexual assaults

What is going on inside the heads of these people? society asks with both contempt and rage. Fields has an answer of sorts. "When you compare alcoholics and controls as they decide between an immediate reward and a delayed one, you see that chronic alcoholics are much more impulsive."

Which came first, the drinking or the impulsivity? It's not an idle question, and it's one that Fields cannot yet answer. "We don't know if drinking causes impulsiveness or if innate impulsiveness makes alcoholics drink more."

Still, some of the scientific murkiness is beginning to clear. For example, Fields and his colleagues have found that for those who prefer the delayed reward, there is activity in different regions of the brain than if you prefer the immediate reward. "You can think of it as the neural correlates of the ego (immediate gratification) and superego (long-term benefit)," Fields remarks. The key point is that if there are different paths for processing immediate and delayed gratification, then the underlying neural mechanism and biochemistry must be different as well.

And if you understand these differences, you are closer to understanding what makes alcoholics different. The main point is that their brains are different, and that is why they cannot stop drinking once they start.

In the second part of "Alcoholism: Vice or Disease?" we'll explore the science that is beginning to uncover some of the secrets of impulsivity and how alcohol, for some of us at least, seems to unleash its spontaneous power.

Reprinted from UCSF, Science Café, Part 1 of 3. Read all parts at: http://www.ucsf.edu/science-cafe/conversations/fields/ ■

Save the Dates!

Addiction Medicine Review Course

October 27 - 30, 2010

Newport Beach
Marriott Hotel & Spa

Prepare to take the **American Board of Addiction Medicine (ABAM) Exam**

Exam Date: **Dec. 11, 2010**
Application Deadline: **Jan. 31, 2010**
Late Application Deadline: **Apr. 30, 2010**

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