

Behavioral Health Connecticut Provider Update

Spring 2002

Dear Participating Provider:

BHC continues to grow and expand, with your help and support. In our Fall 2001 newsletter, we reported that final negotiations were underway for BHC to assume responsibility for Aetna HMO members in Connecticut. This process was completed and on January 1, 2002, BHC began managing the behavioral health benefits and paying claims on behalf of Aetna members enrolled in HMO, QPOS, US Access and Open Access plans. The support of our provider network was instrumental in helping BHC acquire this important new contract.

Over the past year, many of you have participated in the BHC credentialing process. We are pleased to inform you that, effective January 1, 2002, BHC assumed the responsibility for credentialing providers for both MedSpan and Aetna products, thus assuring that BHC providers are able to render services to all members currently managed by BHC. The BHC network now consists of more than 1,400 ambulatory providers and 30 facilities.

You have undoubtedly learned that the Connecticut Department of Insurance recently approved the sale of MedSpan Health Options, Inc. to Oxford Health Plans. Please be assured that this change in ownership does not affect your relationship with BHC or your ability to continue to treat MedSpan members. BHC and Oxford are working closely to assure that there is no disruption for members or providers.

I am pleased to announce that St. Francis Care and PATH, PC have become the latest investor members in Behavioral Health Connecticut. Their involvement further strengthens BHC as a provider-sponsored managed behavioral health care company.

Lastly, I would like to thank those of you who participated in the Provider Satisfaction Survey. Your feedback and suggestions are important in shaping BHC operations and helping us continuously improve the quality of the services we provide to members and providers.

Sincerely,

Stephen Larcen, PhD
President

From BHC Medical Director Ben Enowitch, M.D.: Antiepileptic Drugs For Bipolar Disorder

Although the prevalence rate (active cases) of epilepsy remains between 5-8/1000, there has been a plethora of new anti-epileptic agents on the market. Since these drugs are now used off-label in the treatment of bipolar illness, it is important that an update on these products be available for the psychiatrist or primary physician.

For many years – thanks to the pioneering work of Dr. Mogen Schou in Denmark – Lithium was the drug of choice in bipolar disorder. However, rapid cycling states, mixed states, and psychotic-dsythymic condition have been treated with greater success with the newer drugs.

There are only two anti-epileptic agents that have been fully approved for use in psychiatry. They are Carbamazepine (Tegretol) and Valproate (Depakote). Recently the following anti-epileptic drugs have been used off-label: Gabapentin, Lamotrigine, Topiramate, Oxcarbazepine, Zonisamide, Tiagabine, and Levetinacetam. In a recent review by Keck and McElroy, the members of this family of drugs were evaluated:

Carbamazepine (Tegretol, Eptinol, Atretol)

Five controlled studies have shown the efficacy of this drug in active Bipolar I Mania. Two recent maintenance studies have validated use for this purpose.

These studies compare Carbamazepine with Lithium. Comorbid disorder and mood-incongruent delusions responded better to Lithium while mixed episodes and Bipolar II responded better to Carbamazepine

Valproate (Depakote)

Studies have shown evidence that Valproate is suitable for patients with mixed and mood disorders. Findings suggest that Divalproex helps prevent mood episodes in patients with Bipolar Disorder – but data are not conclusive.

Lamotrigine (Lamictal)

Several recently controlled trials indicate that Lamotrigine has anti-depressant properties. Lamotrigine helps prevent reoc-

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currence of depressive symptoms. Evidence is not present to indicate anti-manic properties. There have been several cases where hypomania has been triggered by Lamotrigine treatments. There have also been several cases of Steven-Johnson syndrome observed.

The six other newer antiepileptics being used now in bipolar illness at this point in time, must be considered investigational.

Gabapentin (Neurontin)

Although used in pain management and in anxiety states, it has not been shown to be an effective mono-therapy mood stabilizer.

Topiramate

Although this drug has the advantage of reducing weight gain, and showing some success in reducing flashbacks in Post Traumatic Stress Syndrome, there is only one trial that shows that Topiramate reduced manic symptoms.

Oxcarbazepine (Trileptal)

Although Oxcarbazepine shows fewer side effects and a physiologically more positive pharmacokinetic picture there is no data available to support its efficacy in the treatment of bipolar illness.

Zonisamide (Zonegran)

Only one study of 15 patients who received this drug for manic symptoms is reported. 80% showed moderate improvement. These results require additional studies.

Tiagabine (Gabatril)

Conflicting results in a few case reports could indicate that this drug may be difficult to tolerate.

Levetinacetam (Kepra)

Studies are now underway to determine this drug's potential thymoleptic properties.

In summary, Lithium is still the number one choice for use in bipolar illness. One must monitor blood levels, be alert to diabetes insipidus developing, monitor thyroid for goiter development, and be alert to kidney function. However, Lithium is effective, low cost, and shows anti-suicide properties.

Depakote and Tegretol certainly are effective in mixed-states and in rapid cycling. The remaining drugs in this family need more randomized clinical studies before sufficient evidence is available to determine their efficacy.

Keck, P.E. and McElroy, S.F. Antiepileptic Drugs for Bipolar Disorder: Are There Any Winners? Current Psychiatry Vol. 1, Jan. 2002, p.18-24.

Practice Guidelines

BHC has adopted the American Psychiatric Association (APA) clinical guidelines. These have been adopted after a review of

clinical literature for Major Depressive Disorder and for Substance Abuse.

Major Depressive Disorder Practice Guideline: BHC modified this guideline to specify a timeframe for a medication evaluation. *For patients with moderate to severe major depression, a medication evaluation should be in place by the fourth visit. For patients with mild to moderate major depression, if there is no relief from symptoms within six sessions, a medication evaluation should take place.*

BHC will monitor the following:

- A. Appropriate medication evaluation or referral for medication evaluation if the patient has not shown improvement within the first six sessions of treatment for major depressive disorders.
- B. Patients diagnosed with depression are screened for a co-morbid substance abuse disorder.

2. Substance Abuse Practice Guideline:

BHC Measurements include:

- A. Patients with substance use disorders should be screened for continued use.
- B. Patients with substance use disorders should be screened for depression.
- C. Patients with substance use disorders should be assessed for possible withdrawal.

Copies of the complete guidelines are available from the American Psychiatric Association at 800-368-5777 or at www.psych.org Click on Clinical Resources, then on Practice Guidelines.

As we conduct on-site visits to review treatment records, we will be reviewing to see if screenings are done. If you utilize a specific screening tool for substance use (for example, the AUDIT for alcohol screening) or for depression (for example the Zung or Beck), please include it in the patient's treatment record as documentation of the screening. If you do not use a screening tool but do screen for depression, substance abuse, and withdrawal, as specified in the guidelines, please be sure to document this in the treatment record.

The Outpatient Treatment Report is also an important way for us to track adherence with the practice guidelines. We appreciate your cooperation with these efforts.

Family Intervention for Children and Adolescents in Treatment

“The participation of family members in the assessment and treatment of infants, children, and adolescents is integral to positive clinical outcomes.” (American Academy of Child and Adolescent Psychiatry's Policy Statement on

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Family Intervention in the Assessment and Treatment of Infants, Children, and Adolescents).

BHC recognizes the unique issues which are part of treating children and adolescents, as well as the importance of the child's family being involved in their treatment. Keeping parents informed about their child's treatment and helping them to understand the necessity of their involvement in the treatment are essential. This involvement may require direct participation by the family during assessment and treatment sessions with the child as well as sessions with the parents or other family members

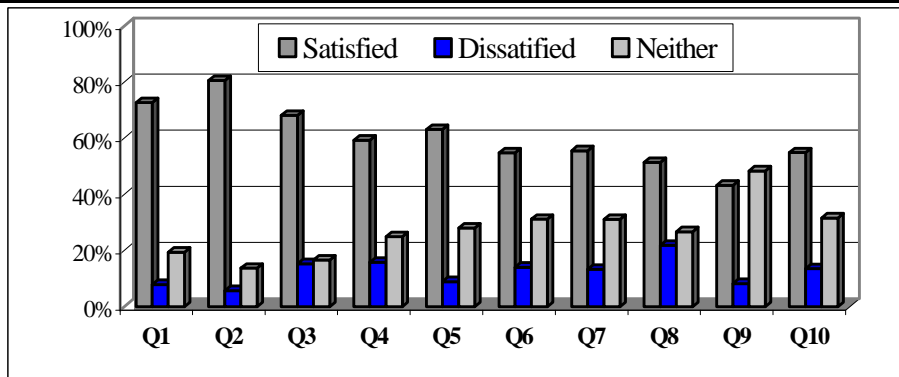
where the child is not present.

BHC's fees have been adjusted to reflect the importance of family sessions. We encourage you to include families as part of your assessment and treatment of children and adolescents, and to utilize the correct codes when seeing families. **CPT code 90847** should be used when the patient and family are present. **CPT Code 90846** should be used for family psychotherapy without the patient present. The claim should be submitted using the child's name and diagnosis. Using the above codes appropriately will result in prompt, accurate payment of your claims.

BHC's 2001 Provider Satisfaction Survey Results

BHC appreciates the many practitioners who took the time to complete our Provider Satisfaction Survey. We use the information obtained to make changes and improve the programs and services we offer. **The results are as follows:**

Measurement	Satisfied	Dissatisfied	Neither
1. Availability of administrative staff for registration	72.69%	7.87%	19.44%
2. Courteousness of staff	80.53%	5.75%	13.72%
3. Timeliness and ease of receiving authorization	68.12%	15.28%	16.59%
4. Timeliness of clinical response to the OTR process	59.28%	15.84%	24.89%
5. Clarity of information	63.11%	8.89%	28.00%
6. Concern of care managers toward members	54.77%	14.07%	31.16%
7. Availability of care managers	55.56%	13.33%	31.11%
8. Ability to contact a care manager	51.41%	21.83%	26.76%
9. Provider education	43.31%	8.28%	48.41%
10. Efficiency of credentialing	54.88%	13.49%	31.63%



Outpatient Processes: BHC has heard your concerns about our OTR and in response, we have made some changes to the OTR process. A new one page OTR, with instructions, has been developed and can be found on our website under the heading "Documents & Forms." In addition, when you call BHC's new toll free dedicated provider line to register a patient you can check member eligibility, current claims status and information about BHC's policies and procedures.

CM Availability: If you have a question about a clinical/care management issue, call BHC and ask to speak to a care manager.

For all other issues, a member service representative is available to assist you.

These changes have all been a result of the comments that we have received from you. We appreciate your comments and are committed to continually improving the quality of services that we provide and to keeping the lines of communication open between BHC and our providers.

Improvements

Three areas were identified as opportunities for improvement. These include, Credentialing, Outpatient Processes and Care Manager availability. Listed below are some changes we have made:

Credentialing: In the past, providers were required to be credentialed by BHC and either Aetna or MedSpan, making this process cumbersome and even frustrating. However, as of January 1, 2002 BHC has been delegated credentialing by both MedSpan and Aetna. From this point forward providers will only need to go through one credentialing process. In addition, the time-frame for recredentialing has changed. Recredentialing will be done three years from the date of BHC's initial credentialing; rather than two years as was formally the case.

Additional Changes of Note

Provider Manual: The BHC Provider Manual has been updated effective January 1, 2002. The manual can be found on the BHC website, www.behavioralhealthct.com, under the heading "Documents and Forms." Providers without internet access can request a hard copy of the manual by calling BHC toll free at 1-877-593-5062.

Outpatient Treatment Report: In response to your comments on our Provider Satisfaction Survey, BHC has shortened its OTR to one page. The form, along with directions for completion, is available on our website under the heading "Documents and Forms."

Dedicated Provider Line: In order to be more responsive to our participating providers, BHC has established a dedicated, toll free telephone line for all provider questions and transactions, regardless of plan or product. The new toll free line, **877 593-5062**, is staffed Monday through Friday 8:00 am to 4:30 pm by a team of representatives trained to address your inquiries concerning member eligibility and benefits; to research the status of a claim; to provide guidance concerning BHC policies and procedures; and, to track your credentialing, recredentialing and network participation status.

Providers are **strongly** encouraged to verify member eligibility and benefits prior to providing an initial service, and are **required** to register all ambulatory care prior to submitting a claim. BHC's Provider Service Representatives are available to assist you with these functions.

Claim Submission: BHC has assumed claim adjudication and payment responsibility for the Aetna HMO, QPOS, USAccess, and Open Access plans for services rendered after January 1, 2002. These claims should be sent directly to BHC; all claims for MedSpan products should continue to be sent directly to MedSpan.

Claims for Aetna plans listed above should be mailed to the following address:

**Behavioral Health Connecticut
Attn: Claims Department
181 Patricia M. Genova Dr.
Newington, CT 06111**

Claims for all MedSpan plans should be mailed to the following address:

**MedSpan Health Options, Inc.
PO Box 340950
Hartford, CT 06134**

Please review BHC's Provider Manual (referenced above) for a detailed description of BHC's claim policies and procedures.

Treatment Record Review Reminder

BHC is in the process of conducting treatment record reviews of high volume providers. BHC utilizes NCQA standards in reviewing records. You may be contacted, to schedule a time that is convenient for you to have one of BHC's quality consultants visit your location. Once an appointment has been scheduled you will be sent a confirmation letter stating the date, time, and individual charts that will be reviewed. BHC thanks you for your understanding and cooperation in this matter.

Further Information



For further information about BHC, our new provider manual, newsletter and forms, please visit our website at www.behavioralhealthct.com

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