

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Clinical Pathway: Bipolar Disorders	Utilization Management
Date: 2-00 Reviewed by QI Committee: 9-06, 9-07 Revised by QI Committee: 9-06	Page: 1 of 5 Policy Number: UM-8.4

Purpose: The purpose of this policy is to provide guidance to Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) staff and providers when providing clinical services to patients with Bipolar Disorders. This policy provides suggestions and recommended practices but does not prescribe treatment. The provider should consider these guidelines in the treatment of a patient but may depart from them when clinically indicated.

Policy:

1.0 Definition of Bipolar Disorder

- 1.1 Bipolar I disorder is a mood disorder characterized by one or more manic or mixed episodes, usually accompanied by Major Depressive episodes. Bipolar II disorder is a mood disorder characterized by one of more Major Depressive episodes accompanied by at least one Hypomanic episode. Bipolar disorders are defined by the most recent episode (e.g., manic vs. depressed) as well as severity (e.g., mild to severe and with or without psychotic symptoms).
- 1.2 A manic episode is characterized by a distinct period of abnormally and persistently elevated, expansive, or irritable mood. Symptoms can include: Inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual, flight of ideas (racing thoughts), distractibility, increase in goal-directed activity or psycho-motor agitation, and/or excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., buying sprees, sexual indiscretions, foolish business investments).

2.0 Evaluation

Appropriate evaluation for Bipolar disorder needs to rule-out differential diagnoses. The following evaluation should be completed by the end of the patient’s second session.

- 2.1 A thorough medical exam to rule out symptoms related to a general medical condition.
- 2.2 Psychosocial evaluation including:
 - 2.2.1 Developmental history, especially with regards to any academic problems, which may be indicative of an Attention Deficit Disorder
 - 2.2.2 Comprehensive chemical dependency history to include both current and lifetime use of drugs and alcohol. Manic type symptoms may be related to substance abuse disorder (e.g., cocaine, methamphetamines, hallucinogens, etc.) and individuals with mood disorders tend to self-medicate with drugs and/or alcohol.
 - 2.2.3 History of any suicidal, homicidal, and/or aggressive behaviors and consequences (e.g., hospitalization, arrest, etc) and current suicidal or homicidal ideation.
 - 2.2.4 Family history, as mood disorders tend to be seen across generations.

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- 2.2.5 Prior treatment history including outpatient therapy, hospitalization, drug or alcohol treatment. Special attention should be given to medication history including type, dosage, when taken, for how long, compliance, and response. Certain anti-depressants may induce manic symptoms.
- 2.3 Full Mental Status Exam with particular emphasis on any thought disturbance (e.g., hallucinations and/or delusions).
- 2.4 History of mood lability.
- 2.5 Evaluation of current level of functioning including:
 - 2.5.1 Sleep
 - 2.5.2 Appetite
 - 2.5.3 Job/School Performance
 - 2.5.4 Relationships

3.0 Diagnosis

If the following criteria are met, a diagnosis of Bipolar may be given. Ongoing evaluation should clarify diagnosis further as to type and severity.

- 3.1 Criteria met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode (most recent).
- 3.2 There has previously been at least one Manic, Hypomanic, or Mixed Episode.
- 3.3 The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 3.4 The mood symptoms in Criteria 3.1 and 3.2 are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not otherwise Specified.
- 3.5 The mood symptoms in Criteria 3.1 and 3.2 are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: If a definitive diagnosis cannot be made after complete psychosocial evaluation and psychiatric evaluation the patient should be referred for psychological testing to help differentiate diagnosis.

4.0 Intervention

- 4.1 Medication Management

A psychiatric referral should be made as soon as a clinician has determined a diagnosis of a Bipolar disorder or the need to further rule out a diagnosis of Bipolar disorder (by the end of session two). This referral should be done prior to any further psychotherapy.

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- 4.2 The following are practice guidelines related to the use of medications
- 4.2.1 Initial Acute Phase Treatment – Manic Episode
- 4.2.1.1 Select mood stabilizer based on *subtype*
- Classic mania or hypomania with euphoric mood* – Lithium or Depakote
- Mixed episode or dysphoric mood* – Depakote or Lithium or Tegretol
- Mania with rapid cycling* – Depakote or Tegretol
- 4.2.1.2 Add adjunctive treatments based on *symptoms and severity*
- Psychotic* – Add medium or high potency anti-psychotic to mood stabilizer. Add Benzodiazepine if additional sedation needed.
- Mania with insomnia or agitation* – Add benzodiazepine to mood stabilizer. If inadequate response, add anti-psychotic.
- Hypomania with insomnia or agitation* – Add benzodiazepine to mood stabilizer.
- 4.2.1.3 Atypical antipsychotic medications, including Zyprexa, Seroquel, Abilify, and Geodon are being studied as possible treatments for bipolar disorder. Evidence suggests they may be helpful as mood stabilizers for people who do not respond to lithium or anticonvulsants.
- 4.2.2 Initial Acute Phase Treatment – Major Depressive Episode
- 4.2.2.1 Select treatments based on *symptoms and severity*
- Psychotic* – Mood stabilizer plus antidepressant plus antipsychotic. Consider ECT.
- Severe* – Mood stabilizer plus antidepressant. Consider ECT.
- Mild to Moderate* – Mood stabilizer plus antidepressant or mood stabilizer alone.
- 4.2.3 Inadequate Response to Initial Acute Treatment – Manic Episode
- 4.2.3.1 No response after 1-3 weeks of an adequate initial dose of
- Lithium* – add or switch to Depakote.
- Depakote* – add or switch to Lithium.
- Tegretol* – Add or switch to Lithium or switch to Depakote
- 4.2.3.2 Partial response after 2-4 weeks of an adequate initial dose of
- Lithium* – add Depakote or Tegretol
- Depakote* – add Lithium
- Tegretol* – add Lithium
- If still inadequate try Depakote plus Tegretol or Depakote plus Tegretol plus Lithium.

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Atypical anti-psychotic agents have also been found to be effective in combination with typical mood stabilizers (Lithium and Depakote), or even on their own, though combination is preferred. These medications include: Seroquel, Zyprexa, Abilify, Risperdol, and Geodon.

4.3 Psychotherapy

As of the third session (following initiation of medication management), a treatment plan needs to be established which addresses the following issues:

- 4.3.1 Medication compliance (discuss special situations such as pregnancy)
If medication compliance is poor take time to address patient's concerns, increase frequency of visits, and further educate patient and family regarding Bipolar disorder. Recommend bibliotherapy.
- 4.3.2 Current life events (cognitive-behavioral and interpersonal strategies, as appropriate).
- 4.3.3 Avoiding substance use (concurrent treatment of substance abuse, when present, including the use of addiction support groups, as appropriate).
- 4.3.4 Maintaining regular sleep habits (behavior principles regarding prevention of insomnia).
- 4.3.5 Managing stress and stimulation (management of moods—e.g., anger management).
- 4.3.6 Education about disorder (important for the patient and family members).
- 4.3.7 Enhancing social and independent living skills (structured skills training, as needed).
- 4.3.8 Ensuring coordination of care between prescribing and non-prescribing behavioral health care practitioners, as well as with the primary care physician.

5.0 Case Management

Ongoing case management is expected for patients diagnosed with Bipolar disorder. This involves:

- 5.1 Coordinating care with Primary Care Physician, Psychiatrist, and Therapist
Monitoring blood levels.
- 5.2 Developing community resources such as Bipolar support groups or the Alliance for the Mentally Ill.
- 5.3 Getting consent to involve family members or other support individuals in treatment.
- 5.4 Requesting Intensive Case Management services if patient is non-compliant with treatment.

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American Psychiatric Association, Treating Bipolar Disorder A Quick Reference Guide, APA, Washington DC (2002).

URAC Standard

UM 1 – Review Criteria Requirements