MENTAL HEALTH

Utilizing Claims Analysis to Understand Your Members' Mental Healthcare Journey With Major Depressive Disorder and Bipolar I Disorder

abbvie

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More Than 1 in 5 Adults in the US Experience a Mental Health Disorder[1]

MDD is a serious mental health condition that affects an individual's ability to feel, think, and go about their everyday tasks. It can impact sleep habits, appetite, and ability to enjoy life.[2]

Bipolar (BP) disorder is a serious mental health condition that causes unusual shifts in mood, ranging from extreme highs—defined as mania or manic episodes—to lows or depressive episodes.[3]

- BP I disorder is characterized by a clinical course of recurring mood episodes:[4]
  - **Manic episodes** are a distinct period lasting **at least 1 week** during which symptoms are present most of the day, nearly every day, or that are so severe that the person needs immediate medical care. The occurrence of at least one manic episode is necessary for a diagnosis of BP I disorder
  - **Depressive episodes** are a period of depressed mood or loss of interest or pleasure, along with other symptoms, for at least 2 weeks

MDD and BP I disorder can cause an array of symptoms which can lead to impaired quality of life[2,3,5]

MDD[2]

- Continued feelings of sadness, hopelessness, pessimism, emptiness, guilt, or worthlessness ⇔
- Thoughts of death or suicide or suicide attempts ⇔
- Fatigue, lack of energy ⇔
- Insomnia or other sleep issues such as waking up very early or sleeping too much ⇔
- Anxiety, irritability, restlessness
- Lack of interest or joy in hobbies and activities ⇔
- Changes in appetite, leading to weight loss or weight gain ⇔
- Moving, talking, or thinking more slowly
- Forgetfulness ⇔
- Trouble concentrating, thinking clearly, or making decisions ⇔

BP I Disorder[3]

Depressive episode symptoms

- Feeling down, sad, worried, worthless, anxious, guilty, empty, or hopeless ⇔
- Lack of interest, or no interest, in activities ⇔
- Feeling tired, low energy ⇔
- Forgetfulness ⇔
- Indecisiveness
- Difficulty concentrating ⇔
- Changes in sleep, either sleeping too much or too little ⇔
- Changes in appetite, either eating too much or too little ⇔
- Thoughts of death and/or suicide ⇔

Manic episode symptoms

- Intense feelings of euphoria, excitement, or happiness
- Appearing abnormally jumpy or wired
- Having excessive energy
- Insomnia or restlessness (a decreased need for sleep) ⇔
- Speaking fast or being unusually talkative
- Having racing or jumbled thoughts
- Distractibility
- Inflated self-esteem
- Doing impulsive, uncharacteristic, or risky things like having unsafe sex or spending a lot of money
- Increased agitation and irritability ⇔

⇔ Depressive symptoms can be shared between MDD and BP I disorder.

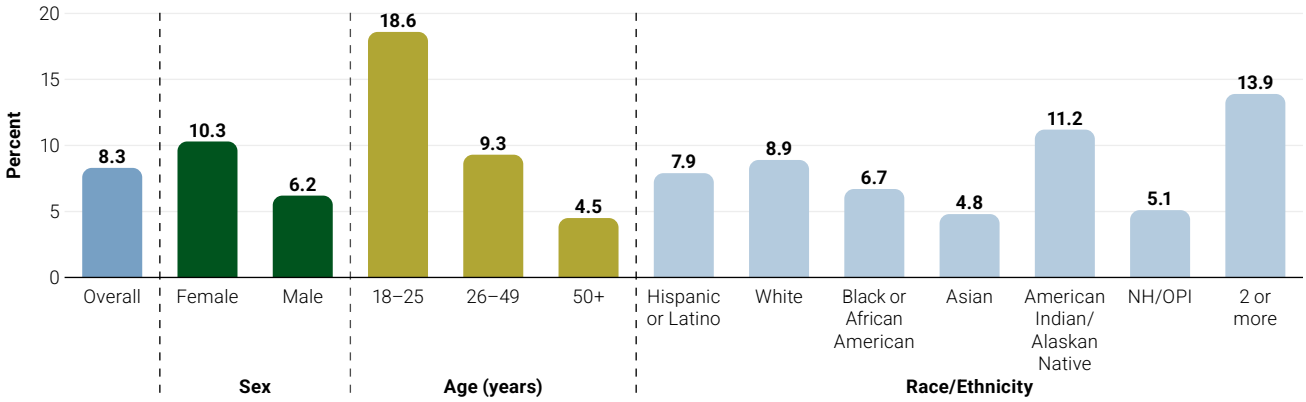
Impaired quality of life due to MDD and BP I disorder can reduce productivity and negatively affect an individual's ability to perform daily activities.[2]

Individuals May Experience Depressive and Bipolar Episodes Throughout Their Most Productive Years[5]

In 2021, an estimated 21.0 million adults in the US had at least 1 major depressive episode, representing 8.3% of all US adults[5,6]

- Depression is a leading cause of disability in the US[7]
- According to the National Institute of Mental Health, the prevalence of a major depressive episode is higher among adult females (10.3%) compared to males (6.2%)[5]
- The prevalence within adults is highest among individuals aged 18–25 years (18.6%)[5]

Latest Prevalence Data From NIH of Major Depressive Episodes Among US Adults in 2021[5]*

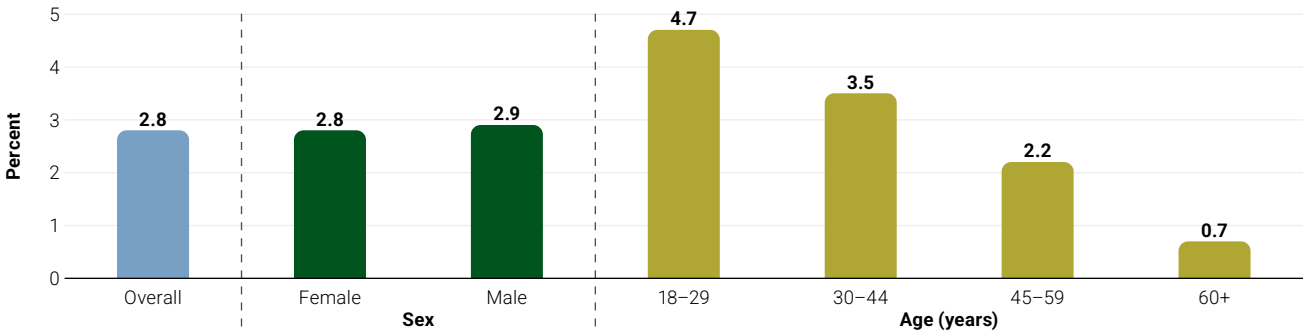


An estimated 2.8% of adults in the US are affected by a BP disorder[8]

BP I disorder has a long and complex journey in which those affected experience episodes of depressive states, placing them at a higher risk for disablement and recurrence.[8]

- BP disorder is one of the leading causes of disability worldwide[9]
- Based on diagnostic interview data from National Comorbidity Survey Replication (NCS-R), the 1-year prevalence of BP disorder among adults was similar for men (2.9%) and women (2.8%)[8]
- Individuals with BP disorders are most vulnerable between the ages of 18 and 44 years[8]

Latest Prevalence Data From NIH of Bipolar Disorder Among US Adults[8†]



NH/OPI=Native Hawaiian/Other Pacific Islander; NIH=National Institutes of Health.

*Data courtesy of Substance Abuse and Mental Health Services Administration.
†Data from NCS-R.

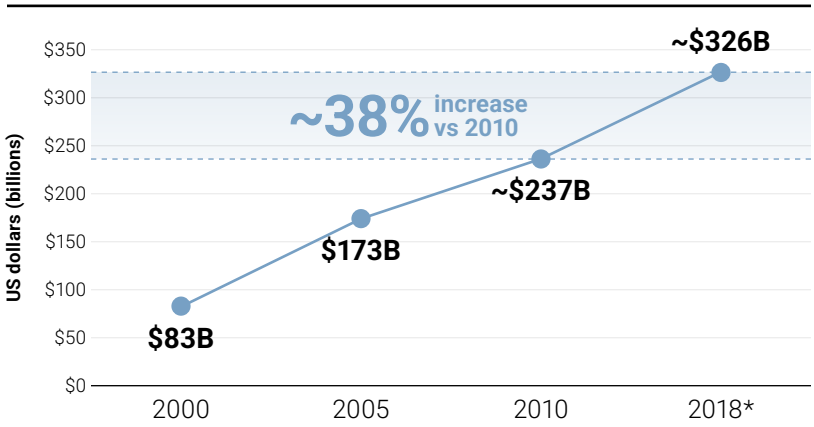
Healthcare Utilization Rates and Costs Continue to Increase for Individuals With MDD and BP I Disorder

Economic burden of MDD[10]

A study evaluating the incremental economic burden of adults with MDD in the US between 2010 and 2018 illustrated a consistent increase in direct and indirect costs:*

- The economic burden of MDD among US adults was an estimated $326 billion in 2018†
- Indirect and comorbidity costs accounted for ~85% of total costs for MDD

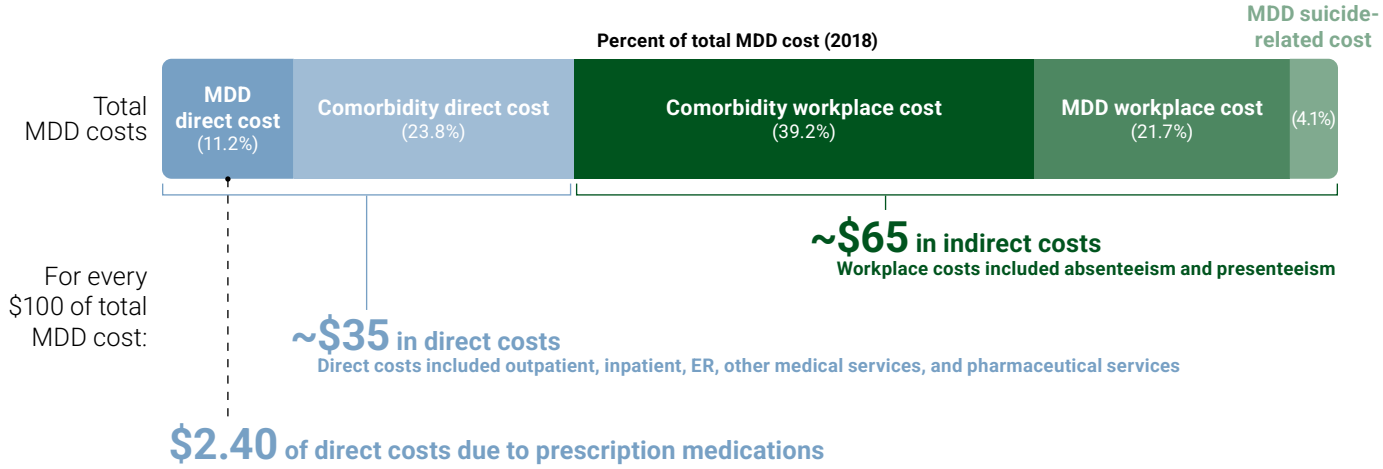
Total Annual Costs Attributed to Adults With MDD[10]‡



Key direct cost burden changes between 2010 and 2018:[10]

- **15.1%** increase in outpatient ($42,940 vs $49,428)
- **19.2%** increase in inpatient ($23,150 vs $27,605)
- **104.7%** increase in emergency room (ER) ($5,545 vs $11,349)

- Indirect and MDD comorbidity costs accounted for the majority of total MDD costs[10]



With an increasing number of working adults experiencing MDD, identifying ways to reduce costs could translate into significant reductions in the economic burden. Effectively treating MDD could reduce direct and indirect costs by reducing presenteeism and absenteeism.[10]

*This study used a framework for evaluating the incremental economic burden of adults with MDD in the US that combined original and literature-based estimates, comparing MDD-related costs between 2010 and 2018. **Key study limitations:** the relationship between presenteeism and absenteeism was based on costs in 2002, which might have evolved over time. The National Survey on Drug Use and Health (NSDUH) data do not contain the exact age for all respondents. The claims data did not allow for direct estimation of costs for individuals aged ≥65 years. The data did not allow for analysis of beneficiaries covered under certain types of managed care plans. Potentially important cost categories were not incorporated into the methodology, thereby resulting in understated estimates. The use of claims data in the study relied on 2015 results for a 2018 burden-of-illness estimate.[10]

†2018 costs adjusted to 2020 values.

‡Inclusive of both direct and indirect costs associated with MDD.

Economic burden of BP I disorder[11]

A US study estimated the national economic burden of BP I disorder in 2015 as $202 billion, of which 23% was associated with direct healthcare costs.*

- Select direct healthcare costs included:[11]

~$16.5 billion
in outpatient

~$13.3 billion
in inpatient

~$11.5 billion
in pharmacy

- Direct total healthcare costs were estimated based on 107,943 commercially insured, 9,436 Medicare-insured, and 84,640 Medicaid-insured patients with BP I disorder who, on average, incurred $17,468, $30,757, and $20,764 in direct healthcare costs, respectively[11]
- **Key study limitation:** Data presented are based on patients with a recorded diagnosis of BP I disorder; therefore, patients with BP I disorder and not yet diagnosed were not included with the cohort study sample, which could impact results[11]

A 2020 systematic review provided an updated report of the economic burden of BP disorder in the US, including cost and healthcare resource utilization estimates compared with previous reviews, to highlight the following key drivers of direct costs for those with BP I disorder:[12]

- Frequent psychiatric interventions
- Nonadherence to BP-related medication
- The presence of comorbid medical or psychiatric conditions
- Sub-optimal clinical management due to a misdiagnosis of unipolar depression following a BP disorder diagnosis

The key drivers of cost in BP I disorder were tightly associated with barriers to optimal care management. Providing comprehensive care and improved access to care can help mitigate costs that occur due to unnecessary treatment steps and contracting restrictions.[12]

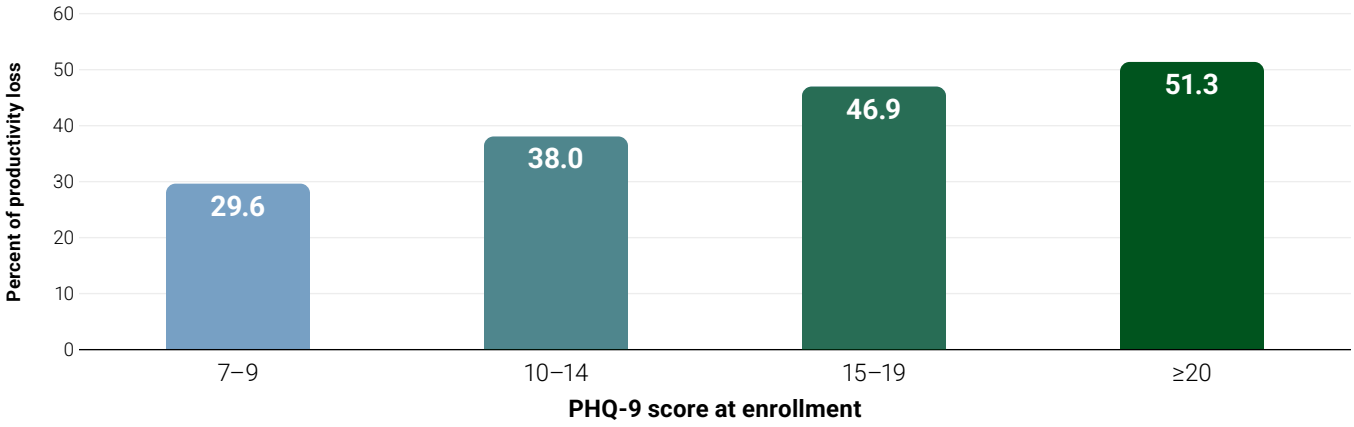
*Two cohorts were defined as the BP I disorder cohort and the nonbipolar I cohort. The BP I disorder cohort comprised all adult patients from the Truven Health Analytics MarketScan databases with at least one diagnosis of BP I disorder. The nonbipolar cohort had no documented diagnosis of any type of BP disorder. Direct healthcare costs were assessed using 3 large US claims databases. They were estimated using a retrospective matched cohort design. They included medical and pharmacy costs and were assessed separately for insured (commercial, Medicare, and Medicaid coverage) and uninsured individuals.[11]

The Magnitude of Work Impairment and Productivity Loss in MDD and BP I Disorder

A 2011 study investigated the relationship between a continuum of depression symptom severity and the magnitude of productivity loss in a large, heterogeneous, and representative sample of outpatients initiating treatment for depression.[13]*

According to the study, the relationship between depression symptom severity and productivity loss among 771 patients who initiated treatment for depression showed a significant linear relationship.[13]

Productivity Loss (Absenteeism and Presenteeism Combined) by PHQ-9 Score at Enrollment: Percent of Work Time Missed or Impairment at Work in Past 7 Days[13]



With every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65% (*P*<0.001), illustrating the strong linear relationship between depression symptom severity and the combination of work loss and productivity impairment.

Minor levels of depression can still be associated with a significant loss of productivity.

*Data were obtained from patients participating in the DIAMOND (Depression Improvement Across Minnesota: Offering a New Direction) initiative, a statewide quality improvement collaborative to provide enhanced depression care. The study utilized the PHQ-9 Questionnaire for Depression Scoring and Interpretation Guide, which tracks patients' overall depression severity as well as improvement of specific symptoms with treatment on a daily basis. **Key Study Limitation:** this study lacked detailed data on other health conditions that might be associated with work loss and productivity reported.[13]

According to a 2010 cross-sectional survey of patients diagnosed with BP I disorder† and subjects without a history of BP I disorder, respondents with BP I disorder reported lower levels of work productivity and were more likely to miss work and have worked reduced hours.[14‡]

- BP I disorder respondents vs those without BP I disorder who reported missing work during the previous week were significantly more likely to report that they missed work because they were too upset, depressed, or nervous (30.6 vs 1.7%, respectively; *P*<0.001)
- Respondents with BP I disorder reported higher scores (i.e., greater negative effect on workplace productivity) on the Endicott Workplace Productivity Scale

MDD and BP I disorder were both associated with lower work functioning, including more absences and more impaired work productivity; therefore, ensuring your members receive proper care is critical to workplace productivity.

PHQ-9=Patient Health Questionnaire-9.

†With at least 2 episodes of mania in their lifetime and at least 1 episode of mania within the previous 2 years.

‡**Key Study Limitations:** Subjects included in the BP I disorder group were being treated by psychiatrists and employed; therefore, results are not representative of the total population of BP I disorder subjects. Recall bias is a limitation inherent in questionnaire-based studies.[14]

Leveraging Medical and Pharmacy Claims Data May Help You Better Understand the Impact of Mental Health Conditions on Your Organization

The data queries in this guide can help you better define your organization's member population affected by MDD and/or BP I disorder and uncover ways to improve their access to quality care:

1. Identify members with an MDD and/or BP I disorder diagnosis
   - **a.** How many members are affected by MDD and/or BP I disorder?

2. Evaluate financial burden of mental health conditions on your organization
   - **a.** What is the true cost of MDD and/or BP I disorder in my organization?

3. Understand if members impacted by mental health conditions are receiving proper care
   - **a.** How many members have sought acute care services for a mental health–related concern?
   - **b.** How many members go to their PCPs seeking mental health–related care?
   - **c.** How many members were or are under the care of a mental health specialist?
   - **d.** How many members are receiving medications for an MDD and/or BP I disorder diagnosis?
   - **e.** How many members are adherent to their prescribed treatment plan?

Improving benefit plan design and understanding claims processing

Analyzing healthcare resource utilization data to determine barriers to effective care and adapting benefit plan designs accordingly

Understanding the claim submission and review process

PCP=primary care provider.

Leveraging Claims Analysis to Understand and Improve Members' Mental Healthcare Journey

1. How many members are affected by MDD and/or BP I disorder?

Objective: To understand the prevalence of MDD and/or BP I disorder within your organization

Identification: Utilize disease category codes and filter for MDD and/or BP I disorder

Code description	ICD-10 codes[15]
MDD, recurrent	F33.0–F33.4, F33.8–F33.9
Bipolar disorder	F31.0–F31.9

Intervention: Provide members who have MDD and/or BP I disorder with resources that outline benefits, care plans, and additional support programs that are available for them

2. What is the true cost of MDD and/or bipolar I disorder in my organization?

Objective: To determine the overall spend on mental health conditions

Identification: Consider evaluating both the medical and the pharmacy cost categories to capture mental health condition–related cost trends over time

Medical costs	Pharmacy costs
Inpatient Care	Retail Prescription Drugs
Outpatient Care	Specialty Medications
Emergency Care	Pharmacy Benefit Management Costs
Physician Services	
Diagnostic and Laboratory Services	
Mental Health and Behavioral Health Services	

Intervention: Review your utilization data for mental health conditions, including MDD and BP I disorder, to gain a better understanding of the burden among your members. Talk to your healthcare plan advisors about ways to improve mental health care and treatment coverage for your organization

ICD-10=International Classification of Diseases, 10th Revision.

3. How many members have sought acute care services for a mental health–related concern?

Objective: To understand how frequently members require urgent treatment for their mental health conditions

Identification: Consider data approaches to identify members with a mental health condition and filter the data set by place of service. This may provide differential costs across various places of care

Place of service description	Place of service code[16]
Walk-in Retail Health Clinic	17
Off Campus-Outpatient Hospital	19
Urgent Care Facility	20
Inpatient Hospital	21
On Campus-Outpatient Hospital	22
Emergency Room – Hospital	23

Intervention: Members who have sought acute care services for a mental health–related concern may need follow-up to confirm that they have connected with their PCPs or psychiatrists for ongoing care

4. How many members go to their PCPs seeking mental health–related care?

Objective: To capture the proportion of members that receive mental health–related care from their PCPs

Identification: Consider earlier data approaches to identify members with a diagnosed mental health condition (MDD and/or BP I disorder) and filter the data set based on provider type, reason for visit, and date of service. This may indicate if individuals with mental health conditions are receiving related care from their PCPs

Code description	Specialist code[17]
Nurse Practitioner, Adult Health	363LA2200X
Nurse Practitioner, Family	363LF0000X
Physician, Family Practice	207Q00000X
Physician, General Practice	208D00000X
Physician, Internal Medicine	207R00000X

Intervention: Work with your healthcare plan advisors on ways to improve care coordination between PCPs and psychiatrists to ensure that members are adequately managed for their mental health conditions and that appropriate protocol is established when a referral to a psychiatrist is needed

5. How many members were or are under the care of a mental health specialist?

Objective: To determine if members are receiving specialized care for their mental health condition

Identification: Consider earlier data approaches to identify members with a diagnosed mental health condition and filter the data set based on provider type, reason for visit, and date of service. This may indicate whether individuals with mental health conditions are receiving proper care

Code description	Specialist code[17]
Clinical Psychologist	103TC0700X
Licensed Clinical Social Worker	1041C0700X
Licensed Professional Counselor	101YP2500X
Physician, Psychiatry	2084P0800X
Nurse Practitioner, Psychiatric/Mental Health	363LP0808X
Psychologist	103T00000X

Intervention: Work with your benefit care design to ensure adequate numbers of in-network mental health specialists and coverage for psychiatric services

6. How many members are receiving treatments for their MDD and/or BP I disorder diagnosis?

Objective: To determine if members are receiving treatments to manage their mental health condition

Identification: Consider using pharmacy claims data and filter by drug class. This may provide insights to medication utilization pattern

Agents used for MDD[18]

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Atypical antidepressants
- Tricyclic antidepressants
- Monoamine oxidase inhibitors (MAOIs)
- Other medications including mood stabilizers and antipsychotics as add-on therapy to antidepressants

Agents used for BP I disorder[3]

- Mood stabilizers
- Antipsychotics
- Antidepressants in certain circumstances

Intervention: Work with your pharmacy benefit advisors to evaluate your current formulary coverage to ensure members have access to comprehensive mental health treatment options

7. How many members are adherent to their prescribed treatment plan?

Objective: To evaluate medication adherence among members with mental health conditions

Identification: Consider utilizing pharmacy fill rates for medications or drug class identified previously to estimate members' treatment adherence

Intervention: Ensure your benefit plan provides access to a comprehensive formulary for members to have adequate and individualized treatment plans to encourage adherence

Employers Can Provide Support by Taking Action to Reduce Mental Health Burden Among Employees, Which May Reduce Productivity Losses[19]

- Educate your leaders about mental health awareness and best practices for promoting employee health and well-being
- Provide employees with a wide variety of options for where, when, and how they work to enhance their performance
- Evaluate your health plan coverage to include comprehensive mental health treatment and care coverage. Drive improved access by minimizing step-through requirements and authorization barriers
- Use member feedback to evolve your existing employer-led mental health programs by proactively expanding related services and treatments

Ensure you are creating a mental health–friendly workplace for your employees

A 2022 workplace report on mental health in America found that:

- 86% of human resources (HR) professionals indicate that offering mental health resources can increase employee retention[20]
- HR professionals in the healthcare sector (61%) are most likely to indicate that their staff experience more mental health struggles than other industries, in large part due to pandemic-induced stress at work[20]
  - Industries such as the nonprofit sector (47%), government/public administration/military (41%), and education (39%) claim that their employees are more likely to experience mental health issues than other industries
- Nearly 9 in 10 HR professionals (88%) believe offering mental health resources can increase productivity, while 78% say offering such resources can boost organizational return on investment[20]

The International Labour Organization and the U.S. Department of Labor Recommend the 4 A's of a Mental Health–Friendly Workplace[21]

1 Awareness

Build awareness and a supportive culture by conducting mental health training and antistigma campaigns and informing all employees of available resources.

2 Accommodations

Make it simple for employees to request and use reasonable accommodations and other workplace supports, such as adjustments or modifications that enable people with disabilities to perform the essential functions of a job efficiently and productively.

3 Assistance

Advertise the services available to assist employees, such as an employee assistance program (EAP), stress management training, or other supports. In addition to increased employee productivity, the benefits of EAPs include reduced medical costs, turnover, and absences.

4 Access

Ensure access to mental health services by assessing the specific mental health benefits covered by your health insurance programs, including access to treatment and support.

Healthcare Resource Utilization Data: Shifting From a Reactive to Proactive Benefit Plan Design

Using healthcare resource utilization data to highlight key gaps and barriers in members' care journey

Consider the following questions:

1. **What are the most prevalent disease states?**
   - Consider reviewing a series of disease category codes as a way of determining prevalence
2. **What is the impact of the identified disease states on the overall spend?**
   - Consider using medical and pharmacy claims data as a way of determining direct spend
3. **Are members using the optimal care pathway for the identified disease states?**
   - Consider using medical claims filtered by site of service (ambulatory vs acute) as a way of determining spend by utilization category
   - Consider using medical claims filtered by provider type as a way to determine utilization by provider type
   - Consider using pharmacy claims filtered by drug class as a way of determining disease-specific treatment utilization patterns
   - Consider using pharmacy fill rates as a way of estimating disease-specific treatment adherence patterns
4. **What are the true costs of a disease state?**
   - Consider evaluating both the medical and the pharmacy cost categories as a way of estimating total spend by disease category. Although reducing spend in 1 category may increase spend in another (e.g., increasing pharmacy spend may lead to decreased medical spending), the goal is providing access to high-quality care at the lowest cost

Adapting the benefit plan design based on findings

Consider the following questions when planning next steps:

1. **Which components of the benefit plan design advance accessibility, and which create barriers?**
2. **Have any of the high-prevalence disease states advanced to the point that they require a redesign of benefit plan coverage?**
3. **What types of employer-led and/or ancillary programs could be implemented to increase awareness, education, and engagement?**

Benefit plan design partners can be a resource in reviewing findings and developing improved care management strategies.

Understanding the Medical Claims Submission and Review Process May Provide Insight Into Employees' Complex Care Journeys

What is a claim?[22]

A medical claim is an invoice sent by a provider to a health insurance company after a patient receives care (e.g., doctor's visit, ER visit, hospitalization, etc.). A claim details the services that the patient received and cost of care, along with the associated charges applied by the provider.

What is claim processing?[22]

The claims process is complex and involves multiple checkpoints before a claim can be approved. After a claim passes through all these checkpoints without issues, the insurance company approves it and processes any payments. A claim will be denied or sent back for more information if it does not pass a checkpoint.

What are the steps in medical claims processing?[22]

Step 1: Submission

The provider's billing department submits a claim to a clearinghouse or the insurance company for processing.

Step 2: Initial review

Claims are routed through an algorithm to ensure they are free of duplicate charges, typos, illegible content, and inaccurate data and are filed within the deadline period.

- The most common issues with claims are inaccurate or inconsistent provider/facility information

Step 3: Eligibility

An active insurance plan is verified by checking the patient's name and policy number against the insurance database.

Step 4: Network

An in-network eligibility check is performed by checking the provider/facility information against the insurance database.

Step 5: Repricing

A negotiated rate is applied to the patient's services.

Step 6: Benefits adjudication

Insurance plan benefits are compared to services received to determine coverage.

Step 7: Medical necessity review

Services received are evaluated for medical necessity in accordance with industry best practices.

Step 8: Risk review

A claim is flagged as low risk or high risk for insurance fraud based on the type of service rendered, individual line-item charges, and the total charges on the bill.

Step 9: Payment

A payment is made to the provider for the covered amount based on negotiated rates (Step 5) and the patient's benefit coverage (Step 6).

Step 10: Explanation of benefits (EOB)

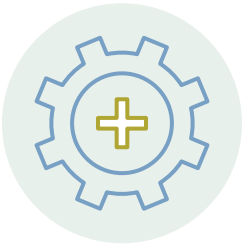
An EOB is sent to the patient detailing what the doctor billed, what the insurance paid, and what the patient may owe.

Step 11: Bill

The provider will send a bill to the patient if payment is due based on the amount and services listed on the EOB.

The submission and review of claims involve many steps. Providing resources to assist members in navigating the process and removing the barriers to care can be done by working with benefit plan partners.

AbbVie's Employer Strategies Focus on Improving Workforce Health and Productivity by Addressing:

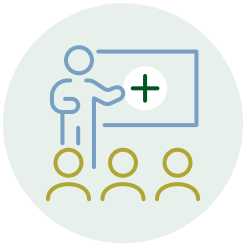


Disease State Awareness

Raising awareness of the burden and impact of disease

Access to Treatment

Establishing and expanding access to treatment



Engagement and Educational Support

Developing connections to promote engagement and educational support

For additional information and support, contact your AbbVie Account Executive.

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