

# Position Statement on Level of Care Criteria for Acute Psychiatric Treatment

Approved by the Board of Trustees, March 2020

Approved by the Assembly, April 2020

“Policy documents are approved by the APA Assembly and Board of Trustees. . . These are . . . position statements that define APA official policy on specific subjects. . .” – *APA Operations Manual*

### Issue:

Providing psychiatric inpatient care to patients with acute psychiatric symptoms is often a challenge given limited hospital beds and availability of community services. While length of stay (LOS) for inpatient services varies by state and county, the median length of stay for inpatient psychiatric care has declined from 42 days in 1980 to about seven days in 2014. This decrease is in part due to more effective treatments becoming available, along with greater recognition of patient preferences for outpatient services and involvement of patients and families in treatment/discharge planning activities. At the same time, both public and commercial payers have contributed to these trends via reduced payments to hospitals and the use of stringent utilization review (UR) practices to restrict inpatient services. Requiring prior authorization and concurrent review for inpatient psychiatric services with application of medical necessity criteria to determine whether care is approved or denied has enabled managed care organizations to tightly control access to and duration of inpatient psychiatric care.

Studies have shown the period immediately following discharge from inpatient psychiatric care carries substantial risks of serious and even life-threatening events. Utilization review that limits inpatient length of stay to the minimum "medically necessary" can lead to premature discharge and adverse outcomes including relapse and hospital readmission, homelessness, violent behavior, criminal justice involvement, and all-cause mortality including suicide. These risks are especially concerning given the high rates of failed transitions from inpatient to outpatient mental health care: 42%-51% of adults and 31%-45% of youth do not receive any outpatient mental health treatment for their disorder within 30 days of inpatient discharge.

The APA is recommending the following principles related to use of criteria to determine appropriate level of care in inpatient and partial hospital settings, as well as recommendations for when review is warranted and the necessary education and training to properly implement the principles.

### APA Position:

**The APA recommends the following principles are incorporated in any tools used to assess appropriate level of care when conducting utilization review of acute psychiatric care:**

- 1. Prior authorization and concurrent review, along with the application of medical necessity criteria, should not be applied by payers or their designated utilization review (UR) agents to all inpatient psychiatric admissions. There is no similar standard in medical care requiring that**

the payer approve inpatient care for every patient within a broad category of illness and this approach should be considered a violation of the Mental Health Parity and Addiction Equity Act.

2. For each psychiatric service (e.g., inpatient, PHP, IOP, residential, ambulatory, etc.), UR agents should use a single standard, based on the domains outlined in #3, for determining medical necessity for admission, continued stay, discharge determinations, and retrospective review of psychiatric services. Within each domain is a rating scale to measure changes in status.
3. UR and medical necessity criteria for mental health services should take into consideration patient needs and risk factors in multiple domains including:
  - a. For adults:
    - i. Risk of harm;
    - ii. Functional status;
    - iii. Co-morbidity;
    - iv. Level of stress and support in the recovery environment;
    - v. Treatment and recovery history;
    - vi. Engagement and recovery status; and
    - vii. Social determinants of health
  - b. For children and adolescents, information from all of the following domains must be considered in a developmentally appropriate context:
    - i. Risk of harm;
    - ii. Functional status;
    - iii. Co-morbidity;
    - iv. Environmental stress and support in recovery environment;
    - v. Resiliency and treatment history;
    - vi. Acceptance and engagement in child/adolescent and caregivers; and
    - vii. Social determinants of health
4. UR and medical necessity criteria should provide for the selection of the safest and most effective level of care to treat the patient's overall condition. When there is doubt between inpatient and community-based levels of care, the criteria should allow the treating psychiatrist to provide inpatient care if it is likely to be safer and more effective.
5. Comprehensive services for all populations should be available at every level of the continuum. When less intensive services are not available, the higher level of care should be offered. In all circumstances, patient and family preferences regarding the setting of care should be given priority.
6. Managed care organizations should not have formal or informal policies that identify maximum lengths of stay for partial hospital programs (PHPs), intensive outpatient programs (IOPs), and residential programs. If there is no defined maximum allowable duration of PHP, IOP, and residential services in the corresponding benefit package, UR staff should be instructed to authorize sufficient duration of PHP, IOP, and residential services to allow the patient to achieve identified treatment goals and safely transition to the recommended next level of care.
7. UR and medical necessity criteria should not include a requirement that providers must demonstrate or provide evidence that an adult or child presents an imminent danger to self or

others as a prerequisite for approving admission to or continued inpatient mental health care. Absence of imminent danger must not preclude admission or continued inpatient care.

8. UR and medical necessity criteria should not include a requirement that the provider demonstrates or provides evidence of the adult or child's potential for active participation in treatment and/or benefit from treatment to justify authorization of continued care unless the managed care organization has a similar requirement for surgical/medical care.

The APA recommends that UR efforts incorporate triggers for when appropriate review is warranted:

1. A managed care organization's UR practices should prioritize a patient's needs and adopt a quality improvement focus. These practices should include patient-centered and quality-related triggers that identify when individual cases require prior authorization and/or concurrent review. These triggers should aim to identify:
  - a) high-need patients for whom further information is needed regarding recent service use and potential new resources; and
  - b) type of documentation needed to assess risk assessment, care, and discharge planning.

The APA recommends education, training, and evaluation efforts in this area:

1. Intensive and ongoing education and training is needed for both UR agents and clinicians using the guiding principles to ensure implementation is consistent, transparent, and used as intended.
2. Level of care criteria should be evaluated to support the reliability and validity of their use in meeting patients' treatment needs and improving outcomes.

**Authors:** Grayson Norquist, MD, MSPH; Jeremy Musher, MD; Jerry Halverson, MD, DFAPA; Karen Pierce, MD; Margaret Balfour, MD, PhD; Matthew Schneider, MD; Robert Batterson, MD; Thomas E. Smith, MD