

2011 MEDICAL NECESSITY AND LEVEL OF CARE DETERMINATION CRITERIA

APS Healthcare, Inc. believes that patients are best treated in the least restrictive environment consistent with the patient's symptoms, supports and safety requirements. The goal of treatment is the restoration of the patient to optimal functionality and independence.

This document is intended to be a starting point and common reference for clinical discussion and is based on a literature review of scientific evidence (see reference list at end of document). As such, it focuses on the patient's clinical history, presenting symptoms and available resources in recommending a level of care. However, in addition, the APS clinical staff reviewing the clinical information must consider the following issues when applying the criteria to a given individual: age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. When a Care Manager determines that the requested service meets these criteria, this care shall be authorized. In those instances where a Case Manager determines that the clinical symptoms of the patient do not meet these Criteria and, is therefore unable to authorize care, the case is forwarded to an APS Medical Director or Physician Advisor for review. APS P&P UM.001; Utilization Management Decisions, is followed in these instances.

APS also recognizes that resources for the full continuum of care do not exist in all local delivery systems. In such cases, APS may recommend a higher level of care than medically necessary in order to assure safe, effective treatment. "Medical Necessity" is used here to describe care which is determined to be effective, appropriate and necessary to treat a given patient's disorder.

Review for each level of care determination proceeds in a logical progression to confirm:

- the presence of a properly diagnosed mental health or substance abuse disorder amenable to the proposed course of treatment,
- symptoms are of a sufficient severity/complexity to meet the required criteria for admission to (or continued stay at) the requested level of care,
- the treatment is consistent with nationally accepted medical standards and there is no equally effective, less restrictive setting available to treat the patient's current clinical condition

APS attempts to avoid being too prescriptive and has generally not included discharge criteria, programmatic content, mandatory treatment interventions etc., in these criteria. However, when a patient's level of stability/progress indicates that treatment can be safely and effectively treated at a lower level of care, discharge to a lower level of care shall be recommended.

An integral part of our Quality Improvement program is an annual review of these criteria, which examines developments in the professional literature as well as obtaining input from providers. We welcome your comments and suggestions at any time.

APS follows the criteria developed by the American Society of Addiction Medicine (ASAM) for making utilization decisions for the Treatment of Substance Abuse Disorders. These criteria are contained in the following publication:

ASAM PPC-2R, ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, 2001.

This can be ordered by directly via the ASAM website:

<http://www.asam.org/PatientPlacementCriteria.html>

or by calling ASAM Publications at 1-800-844-8948.

APS HEALTHCARE, INC. MEDICAL NECESSITY AND LEVEL OF CARE

DETERMINATION CRITERIA TABLE OF CONTENTS

DEFINITIONS FOR LEVELS OF CARE
PSYCHIATRIC SERVICES.....4

23-HOUR OBSERVATION
ALL TYPES OF CARE, ALL AGE GROUPS.....5

INPATIENT (ACUTE CARE)
PSYCHIATRIC: (ADULT, CHILD, ADOLESCENT).....6

PARTIAL HOSPITALIZATION
PSYCHIATRIC CARE: (ADULT, CHILD/ADOLESCENT).....7

INTENSIVE OUTPATIENT THERAPY
PSYCHIATRIC CARE: (ADULT, CHILD/ADOLESCENT).....8

OUTPATIENT CARE
PSYCHIATRIC/CARE.....9

RESIDENTIAL TREATMENT (RTC)
PSYCHIATRIC CARE: CHILD/ADOLESCENT.....10

RESIDENTIAL TREATMENT (RTC)
PSYCHIATRIC CARE: ADULT.....11

ELECTROCONVULSIVE THERAPY (ECT).....12

PSYCHOLOGICAL TESTING.....13

BIBLIOGRAPHY.....15-17

DEFINITIONS FOR LEVELS OF CARE

APS Healthcare, Inc. recognizes the following as distinct levels of care:

Psychiatric Services:

- 1 **Acute Inpatient**—The highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.
- 2 **Residential Treatment**—Care provided at a subacute level with skilled nursing care. These may be intermediate care facilities (ICF) or have other licensing designations that may vary by state.
- 3 **Partial Hospital**—An intensive, non-residential, level of service where multidisciplinary, medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and, generally, less than eight hours) daily. It is generally offered on weekdays, but may be offered up to seven days per week.
- 4 **Intensive Outpatient**—Multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These services range from 90 minutes, to four hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies.
- 5 **Outpatient**—The least intensive level of service. Typically provided in an office setting from 60 to 90 minutes (for group therapies) per day.
- 6 **23-Hour Observation**—“23-hour beds” are defined as a period of up to 23 hours during which assessment and stabilization services are provided at less than an acute level of care. These are generally indicated for those situations where a patient appears to be at risk for harm to self or others, but does not clearly require admission to an inpatient setting. This level of care offers an opportunity for re-assessment and the gathering of additional data which may support the appropriateness of admission to a non-inpatient setting.

23-Hour Observation

(ALL TYPES OF CARE, ALL AGE GROUPS)

A. Medical Necessity—(*All* must be met to consider for treatment.)

- 1 The patient must have been assessed, to a reasonable degree of medical certainty, as having a psychiatric illness or substance abuse disorder by a licensed health professional.
- 2 Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and patient.

B. Admission Criteria

1. The presenting clinical problem likely represents a transient disruption of the patient's clinical baseline which may stabilize such that an alternative treatment setting may be appropriate within 23 hours.

and

2. The presenting clinical problem represents a clear, proximal risk of harm to self or others.

Inpatient (Acute Care)

PSYCHIATRIC: (ADULT, CHILD, ADOLESCENT*)

A. Medical Necessity—(*All* are required to consider for admission.)

- 1 The patient must have been diagnosed with a psychiatric illness by a licensed mental health professional.
- 2 Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and patient.

B. Admission Criteria—(Any *one* criterion sufficient to recommend admission.)

- 1 Patient presents with suicidal ideation and intention, which represent significant risk of harm, medically significant self-mutilation, and/or a recent lethal attempt to harm self, such that 24-hour/day hospitalization and observation are necessary for the patient's safety.
- 2 Patient presents with a recent history of grossly disruptive/delusional and/or violent behavior representing clear and present danger of serious harm to others.
- 3 The patient's psychiatric condition severely impairs his/her basic functional capacity as evidenced by disorganized, uncontrolled thinking/behavior that represents a genuine and proximal risk of danger to self such that 24-hour/day nursing and medical treatment is required.
- 4 Diagnosis and/or treatment is/are clearly unsafe or impossible to provide in an ambulatory setting and can only be accomplished with 24 hour intensive nursing and medical care.

C. Continuing Care Criteria—(Any *one* criterion sufficient to recommend continuing care.)

- 1 Daily physician and staff progress notes clearly describe the patient's lack of progress despite adequate clinical intervention and/or the emergence of new symptoms sufficient to meet acute care criteria.
- 2 Daily physician progress notes indicate serious medical complications of pharmacotherapy or other somatic treatments such that transition to a lower level of care would represent a clear risk of harm.
- 3 Daily progress notes indicate that attempts to transition to a lower level of care have resulted in a reemergence of symptoms sufficient to meet acute care criteria.

* **Additional Child/Adolescent Criterion**—(*Must* be met for continuing care.) Documented evidence of significant family (caretaker/guardian) involvement at least three times weekly **or** documented evidence that such is medically contraindicated.

Partial Hospitalization (PHP)

PSYCHIATRIC CARE: (ADULT, CHILD/ADOLESCENT)*

A. Medical Necessity—(*All* are required to consider for admission.)

- 1 The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
- 2 Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and patient.

B. Admission Criteria—(*All* criteria must be met to recommend admission.)

- 1 The patient's mental condition requires skilled medical and nursing observation (e.g. serial mental status checks, medication administration, vital sign monitoring) and is likely to improve with this intervention.
- 2 Clinical documentation clearly indicates that the patient could not be treated safely at a lower level of care (for example, deterioration in functioning while being treated at an Intensive Outpatient level of care) **or** that partial hospitalization is necessary in order to prevent deterioration in the patient's condition likely to require acute, inpatient psychiatric care.
- 3 The patient is sufficiently medically stable so as to not require 24-hour/day nursing availability/monitoring.
- 4 The patient's psychosocial supports are such that the patient can be supervised and maintained without clinical supervision for that period of time outside the program.
- 5 The patient's condition requires multidisciplinary intervention for four (or more) hours daily and more than three days per week.

C. Continuing Care Criteria—(*All* criteria must be met to recommend continuing care.)

- 1 Despite adequate treatment, the patient continues to exhibit signs and symptoms that led to the admission, or new problems have emerged which themselves meet the criteria for PHP admission.
- 2 The patient's problems must be clearly documented in the medical record and there must be a progress note by the provider for each day of treatment.
- 3 There must be clear clinical documentation that transition of the patient to a lower level of care would result in exacerbation or re-emergence of symptoms sufficient to meet PHP admission criteria.

- **Additional Child/Adolescent Criterion**—(*Must* be met to recommend continuing care)

There is documented evidence of significant family (caretaker/guardian) involvement at least twice weekly or clear documentation that such is medically contraindicated.

Intensive Outpatient Therapy

PSYCHIATRIC CARE: (ADULT, CHILD/ADOLESCENT)*

This level of care includes services at lesser levels of acuity than partial hospitalization. It is intended to be provided for more than 90 minutes, but less than four hours daily. It may be offered at least three days per week.

A. Medical Necessity—(*All* are required to consider for treatment.)

- 1 The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
- 2 Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and patient.

B. Admission Criteria—(*All* criteria must be met to recommend treatment.)

- 1 There is documentation of significant and acute deterioration in social, occupational, educational or family functioning.
- 2 The proposed treatment plan specifically addresses the symptoms needing improvement in order to stabilize the patient, prevent further deterioration and prevent the need for a more restrictive/intensive level of care.
- 3 The patient requires a multidisciplinary treatment plan/program and can access other supports outside the program, as needed. 's condition will benefit from the proposed interventions.
- 4 There is at least moderate impairment (a GAF less than 60).

C. Continuing Care Criteria—(*All* criteria must be met to recommend continuing care.)

- 1 The patient continues to exhibit signs and symptoms consistent with admission criteria as evidenced by progress notes for each day the patient receives services from the Intensive Outpatient program.
- 2 The treatment plan and progress notes reflect ongoing interventions that are likely to alleviate these impairments.
- 3 When the patient's condition fails to demonstrate sustained improvement, the treatment plan addresses this lack of improvement and includes revised interventions that are likely to alleviate the patient's impairments.
- 4 Clinical documentation supports that attempts to transition to a lower level of care would likely result in decompensation or exacerbation of the illness.

- **Additional Criterion For Children/Adolescents:** There is clear documented evidence of significant family (caretaker/guardian) involvement with and adherence to treatment **or** clear evidence that this is contraindicated.

Outpatient Care

PSYCHIATRIC CARE

This level of care is the least intensive level of treatment and represents the majority of care delivered. It is intended to describe services ranging from 15 minutes (e.g. medication management) up to 90 minutes (e.g. group therapy) in length which are generally not provided more frequently than twice weekly.

A. Medical Necessity—(*All* are required to consider for treatment.)

- 1 The patient must have been diagnosed with a psychiatric or Substance dependence disorder by a licensed mental health professional or equivalent licensed substance abuse professional.
- 2 Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to initiation of treatment following a face to-face encounter between the professional and patient.

B. Admission Criteria—(*All* must be met to recommend treatment.)

1. As a consequence of a DSM-IV diagnosis, the individual is experiencing significant impairment in functioning in one or more of the following areas:
 - social,
 - occupational,
 - educational or
 - family role.
2. The proposed treatment plan is focused on:
 - adaptive responses to present impairments,
 - clearly defined and measurable goals and
 - Meeting these goals within a defined time frame.
3. The patient has the requisite cognitive and emotional skills necessary to benefit from the proposed treatment plan.

C. Continuing Care Criteria—(*All* must be met to recommend continuing care.)

- 1 There is evidence that the patient is working to complete treatment goals and is attending sessions as scheduled.
- 2 The patient continues to exhibit impairment requiring further treatment (GAF <70).
- 3 The treatment plan clearly addresses the impairments necessitating ongoing care as well as current time-frames for meeting treatment objectives
- 4 If the GAF is > 70, the patient has a diagnosis of a persistent DSM-IV disorder which requires maintenance treatment to avoid recurrence of symptoms.

Residential Treatment (RTC)

PSYCHIATRIC CARE: (CHILD/ADOLESCENT)

(**Note:** Residential Treatment is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents who have long-term illnesses not likely to respond to short-term interventions. They should provide, in addition to diagnostic and treatment services, instruction and support toward attainment of basic living skills, which will enable them to live in the community upon discharge.)

A. Medical Necessity—(*All* are required to consider for admission.)

- 1 The child or adolescent has been diagnosed with a psychiatric disorder by a licensed mental health professional.
- 2 Symptoms of this illness accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3 The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and patient.

B. Admission Criteria—(Both 1 and 2 *and either* 3 or 4 are sufficient to recommend treatment.)

1. There is clear clinical evidence that the child/adolescent has a severe mental illness, which requires a level of intensity of services not available in the community.
2. The illness or disorder is likely to improve with active treatment.
3. Without this intervention, there is clear evidence that the child/adolescent will likely decompensate and represent a proximal risk of serious harm to self or others
OR
4. There is severe impairment in psychosocial functioning, due to the DSM-IV psychiatric disorder, in one or more of the following areas: educational, family or social/peer group.

C. Continuing Care Criteria—(*All* must be met to recommend continuing care.)

- 1 The patient continues to exhibit signs and symptoms consistent with admission criteria.
- 2 There is a complete, multidisciplinary, individualized treatment plan, which includes input from the patient and family.
- 3 The treatment plan defines clear, measurable objectives leading to a goal of return to the community.
- 4 There is documented evidence of active psychiatric care which is symptom-focused and specific to the child/adolescent's diagnosis.
- 5 There is documented evidence of active family therapy at least weekly **or** clearly documented evidence that such is either impossible or medically contraindicated.

Residential Treatment (RTC)

PSYCHIATRIC CARE: (ADULT)

(**Note:** Residential Treatment is defined as 24-hour/day, voluntary, short-term, supervised level of care provided either to adults with psychiatric illnesses previously not responsive to short-term interventions and/or those requiring crisis stabilization as an alternative to inpatient hospitalization.)

B. Medical Necessity—(Both 1 and 2 are required to consider for admission.)

1. The adult has been diagnosed with a psychiatric disorder following an in-person assessment by a licensed mental health professional prior to admission to RTC.
2. Symptoms of this illness accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV-TR).

Admission Criteria—(Both 1 and 2 *and either* 3 or 4 are sufficient to recommend treatment.)

1. There is clear clinical evidence that the adult has a severe mental illness, which requires a level of supervision and intensity of services not available at a less intensive level of care.
2. The illness or disorder is likely to improve with active treatment.
3. There is clear evidence that, without this level of intervention the patient's condition will worsen to the point such that he/she will require inpatient hospitalization.

OR

4. There is severe impairment in psychosocial functioning, due to the DSM-IV psychiatric disorder, representing potential inability to safely care for self.

C. Continuing Care Criteria—(*All* must be met to recommend continuing care.)

5. The patient continues to exhibit signs and symptoms consistent with admission criteria.
6. There is a multidisciplinary, individualized treatment plan, which includes input from the patient, family, and/or other support systems.
7. The treatment plan includes specific, quantifiable objectives, with a focus on reintegration back into the community.
8. There is documented evidence of active psychiatric assessment and treatment which is symptom-focused and specific to the adult's diagnosis.
9. Except when clinically contraindicated, the treatment plan must include active participation by the patient's family and/or other support systems.
10. The patient is making measurable progress toward treatment goals and there is a reasonable expectation of continued progress at this level of care OR when a patient is not making measurable progress, there are appropriate revisions to the treatment plan.

Electroconvulsive Therapy (ECT)

(Note: A course of treatment is generally 6 to 12 ECT. If there is no discernible clinical improvement after 6 to 10 treatments, indications for continued ECT should be formally reassessed. The determination of whether ECT should be administered within an inpatient or outpatient setting is made separately based on the patient's clinical symptoms as they relate to APS' other levels of care criteria).

A. Medical Necessity - (All are required to consider for treatment)

1. The patient must have been diagnosed with a psychiatric illness by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV) and must be amenable to ECT.
3. The diagnosis must be based upon a face-to-face evaluation between the professional and patient
4. The psychiatrist who will perform the proposed ECT has completed a face to face evaluation of the patient prior to his recommendation of the procedure.

B. ECT Criteria - (meeting one of the 3 criterion, is sufficient for recommendation for treatment)

1. Two (or more) courses of medication at maximum doses for an adequate length of time have been ineffective or the symptoms require a rapid response from one of the following diagnostic conditions:
 - Major depression
 - Mania
 - Catatonia
2. When the member has a history of a positive response to ECT and a lack of response to medications in the past

Co-morbid medical conditions preclude the use of psychotropic medication trials {Note: When it is determined that ECT is an appropriate treatment modality, APS will make an additional determination as to whether this treatment can be safely and effectively rendered on an ambulatory basis, or requires the intensity of services of a higher level of care. This decision will be based on the patient's clinical condition and will follow criteria for the level of care where ECT is to be rendered.}

Psychological Testing

APS Healthcare, Inc. believes that requests for psychological testing are best handled when the purpose of the testing, the extent of testing, the instruments to be used, and the use of results and recommendations are understood by both parties. The goal of outpatient testing is an increased understanding of the patient not readily available by other means. This can include the patient's diagnosis, dynamics, therapeutic capabilities, or treatment planning recommendations. Psychological testing has a wide variety of instruments and techniques as well as post-test interpretation of the results that need to be included in request evaluations.

Testing for purposes other than psychological/psychiatric treatment is often excluded from insurance coverage. Examples of this type of testing include occupational placement testing, disability testing, educational testing, neurological testing and forensic testing. Requests for neuro-psychological testing with possible indicators of organic damage or history of head trauma, anoxia, heavy metal exposure or diagnosis secondary to a medical condition may be coordinated with the member's medical plan under the mixed medical protocol. Neurological testing that establishes an organic basis for the changes in psychological functioning will continue to follow the protocol for mixed medical management.

A. Medical Necessity - (must meet *all* of the following criterion)

1. The patient must have been diagnosed with a psychiatric illness by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must be based upon a face-to-face evaluation between the professional and patient.
4. The request for psychological testing must come from a licensed behavioral healthcare provider who has questions that can only be answered by psychological testing.
5. The request for neuropsychological testing must come from a licensed behavioral healthcare provider who has questions that can only be answered by neuro-psychological testing. A neurologist may also request neuro-psychological testing.

B. Psychological Testing Criteria -(needs to meet criterion 1 and 2, 3, or 4)

- 1 The results of the testing may, with reasonable medical certainty, lead to necessary revisions in an individual's treatment plan; and
- 2 Diagnosis and treatment approaches fluctuate, contradictory information is evident and clinical direction requires an increased understanding of the member: or

Psychological Testing (continued)

- 1 The member's therapeutic response is significantly different from the anticipated response and additional assessment and investigation has failed to alter the therapeutic dynamics; or
- 2 Significant disruption in the member's performance of life skills which is not accounted for by assessment, history, diagnosis, or ongoing observation.

Bibliography

American Association of Community Psychiatrists: Level of care utilization system for psychiatric and addiction services. May 17, 1997

Best (&Worst) Practices in Private Sector Managed Mental Healthcare Part I: Level of Care Criteria. National Mental Health Association. May 1999.

Child and Adolescent Level of Care Utilization System. American Association of Community Psychiatrists, American Academy of Child and Adolescent Psychiatry. Draft 1.4 May 1998

Harrison PA, Asche SE: Comparison of substance abuse treatment outcomes for inpatients and outpatients. *J Subst Abuse Treat* 17 (3):207-20 (October 1999)

Lennon-Horvitz M, Normand S, Gaccione P, Frank RG: Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997)

Leon SC, Lyons JS, Christopher NJ, Miller SI: Psychiatric hospital outcomes of dual diagnosis patients under managed care. *AM J Addict* 7 (1):81-6 (Winter 1998).

Lieberman PB, McPhetres EB, Elliott B, Egerter E, Wiitala S: Dimensions and predictors of change during brief psychiatric hospitalization. *Gen Hosp Psychiatry* 15(5):316-24 (Sep 1993).

Lieberman PB, Wiitala SA, Elliott B, McCormick S, Goyette SB: Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization? *Am J Psychiatry* 155(7):905-9 (Jul 1998)

Lyons J, O'Mahoney M, Miller S, Neme J, Kabat J, Milleer F: Predicting Readmission to the Psychiatric Hospital in a Managed Care Environment: Implications for Quality Indicators. *Am J Psychiatry* 154:337-340 (1997).

Maden A: Risk assessment in psychiatry. *Br J Hosp Med* 56:78-82 (1996).

Maynard C, Cox GB: Psychiatric hospitalization of persons with dual diagnoses: estimates from two nation surveys. *Psychiar Serv* 49(12):1615-7 (Dec 1998)

McGrady B, Langenbucher J: Alcohol treatment and health care system reform. *Archives of General Psychiatry* 53:737-746 (1996).

McLellan A, Hagan T, Meyers K, Randall M, Durell J: "Intensive" outpatient substance abuse treatment: comparisons with "traditional" outpatient treatment. *J. of Addictive Disorders* 16:57-84 (1997).

Mohr WK: Unexpected outcomes of childhood psychiatric hospitalization. *Issues Mental Health nurs* 19(2): 153-71 (Mar-Apr 1998)

Moore D: Utilization management and outpatient treatment. *Psychiatric Annals* 22:373-377 (1992).

Moos RH, Finney JW, Moos BS: Inpatient substance abuse care and the outcome of subsequent community residential and outpatient. *Addiction* 95 (6):833-46 (Jun 2000).

Myrick H, Anton, R: Clinical Management of Alcohol Withdrawal. *CNS Spectrum*, 5(2):22-32 (Feb 2000).

Nelson EA, Maruish ME, Axler JL: Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatric Ser* 51(7):885-9 (May 1999)

Noak J: Assessment of the risks posed by people with mental illness. *Nurs Times* 93:34-36 (1997)

Oxley STI, Van Meter S: The assessment and management of the suicidal patient. *Jrnl Prac Psych and Behav Health* 327-335 (1996).

Pfeiffer SI, O'Malley DS, Shott S: Factors associated with the outcome of adults treated in psychiatric hospitals: a synthesis of findings. *Psychiatr Serv* 47 (3): 263-9 (Mar 1996).

Pottick K, Hansell S, Gutterman E, Raskin White H: Factors associated with inpatient and outpatient treatment for children and adolescents with serious mental illness. *J AM Acad Child Adolescents Psychiatry* 34(4):425-433 (Apr 1995).

Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors, American Psychiatric Association, November, 2003.

Practice Guideline for the Treatment of Patients with Bipolar Disorder, American Psychiatric Association, April, 2002, Guideline Watch, November, 2005.

Practice Guideline for the Treatment of Patients with Major Depressive Disorder, American Psychiatric Association, Second Edition, April, 2000, Guideline Watch, September, 2005.

Practice Guideline for the Treatment of Patients with Schizophrenia, American Psychiatric Association, February, 2004.

Practice Guideline for the Treatment of Patients with Eating Disorders, American Psychiatric Association, May, 2006

Practice Guideline for the Psychiatric Evaluation of Adults, American Psychiatric Association, May, 2006

Practice Guideline for the Treatment of Patients with Substance Abuse Disorders, American Psychiatric Association, Second Edition, May, 2006

Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder. American Academy of Child and Adolescent Psychiatry, 1997.

Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, American Academy of Child and Adolescent Psychiatry, November, 1998.

Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Abuse Disorders, American Academy of Child and Adolescent Psychiatry, June, 2005

Practice Parameters for the Assessment and Treatment of Children and Adolescents with Suicidal Behaviors, American Academy of Child and Adolescent Psychiatry, April, 2001.

Raskin R, Novacek J, Bahlinger D, Firth L: A model for evaluating intensive outpatient behavioral health care programs. *Psychiatr Serv* 47:1227-1232 (1996).

Reinharz D, Lesage AD, Contandopolous AP: Cost-effectiveness analysis of psychiatric deinstitutionalization. *Can J Psychiatry* 45(6): 533-8 (Aug 2000).

Rissmiller DA, Steer RA, Friedman M, DeMercurio R: Prevalence of malingering in suicidal psychiatric inpatients: a replication. *Psychol Rep* 84(3 Pt. 1):726-30 (June 1999).

APS Healthcare Inc., © 2007 MNC PAG Final version 4-11-07.doc - 19 Adopted 10-21-98 Revised 12/16/01 Revised 3-23-2006

Roy-Byrne P, Russo J, Rabin L, Fuller K, Jaffe C, Ries R, Dagadakis C, Avery D: A brief medical necessity scale for mental disorders: reliability, validity, and clinical utility. *J Behav Health Serv Res* 25(4):412-24 (Nov 1998).

Russell V, Mai F, Busby K, Attwood D, Davis M, Brown M: Acute day hospitalization as an alternative to inpatient treatment, *Canadian J. of Psychiatry* 41:629-637 (1996).

Ryan T: Perceived risks associated with mental illness: beyond homicide and suicide. *Soc Sci Med* 46:287-297 (1998).

Safer DJ: Adolescent/adult differences in suicidal behavior and outcome. *Ann Clin Psychiatry*. 9(1): 61-6 (Mar 1997).

Sledge WH, Tebes J, Rakfeldt J, Davidson L, Lyons L, and Druss B: Day hospital/crisis respite care versus inpatient care, Part I: Clinical outcomes. *Am J Psychiatry* 153:1065-1073 (1996).

Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, Roth LH, Siver E: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Arch Gen Psychiatry* 55:393-401 (1998).

Thomas et al: Shortening length of stay without increasing recidivism on a university-affiliated inpatient unit. *Psychiatric Serv* 47:996-998 (1996).

Washton A: Evolution of intensive outpatient treatment as a legitimate treatment modality. *J Addict Dis* 1997:21-27

Weinberg A, et al: Severity of psychiatric disorders in day hospital and in-patient admissions. *Acta Psychiatr Scand*. 98(3); 250-3 (Sep 1998)

Weinstein S, Gottheil E, Sterling R: Randomized comparison of intensive outpatient vs. individual therapy for cocaine users. *J. of Addictive Disorders* 16: 41-56 (1997).