

Journal of
**Psychiatric
Practice**[®]

Volume 27
Number 4
July 2021

www.psychiatricpractice.com

Editor: John M. Oldham, MD



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Medical Necessity Letter
to Improve Access to
Care for Our Patients**

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The Journal of Psychiatric Practice is
indexed by MEDLINE, CINAHL,
PsycINFO, EMBASE, and IPA

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Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients

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This column explains the value of developing routine medical necessity letters to help patients maximize the likelihood of securing insurance approval for medically necessary services for the treatment of mental and substance use disorders, including psychotherapeutic treatment. The structure proposed for such medical necessity letters is based on the terms of the Mental Health Parity and Addiction Equity Act and the landmark verdict in the federal class action known as *Wit v. United Behavioral Health/Optum*. (*Journal of Psychiatric Practice* 2021;27:288–295)

KEY WORDS: mental health parity, insurance, medical necessity, generally accepted standards, *Wit v United Behavioral Health*

In treating individuals with mental and substance use disorders, clinicians (psychiatrists, psychotherapists, psychologists, social workers, or other clinicians/providers) count on few certainties when addressing the myriad combination of issues often presented by their patients. Diagnosis can be challenging, medications may or may not be effective, and clinical progression seldom follows predictable or direct linear paths. Perhaps the only relatively likely occurrence associated with mental health treatment is a near-inevitable struggle with insurance companies over approval for treatment and overwhelming complexity in patients' efforts to secure timely insurance coverage for medically necessary care. This is often especially true for access to outpatient psychotherapy and for access to intermediate levels of care such as residential treatment, intensive outpatient programs, and partial hospital programs.¹

What can clinicians do for their patients beyond wishing them luck with their insurers? Based on the authors' considerable experience with these issues from multiple perspectives ranging from law to clinical practice to personal and organizational experiences with such advocacy, we recommend that clinicians provide patients with a medical necessity letter. Such a letter can be an essential tool in patients' dealings with insurers, empowering patients to

preempt or reverse insurance denials by reinforcing the basis of case-specific clinical decisions and establishing the clinician's assessment of the treatment as "medically necessary."

AREN'T THINGS GETTING BETTER WITH MENTAL HEALTH INSURANCE COVERAGE?

Recent reports are not encouraging. In a study by Davenport et al² published by Milliman in November 2019, significant disparities were reported along numerous dimensions: (a) inpatient access is over 5 times worse for behavioral health than for medical and surgical care, (b) outpatient disparities are over 6 times worse, and (c) absence of in-network options for children resulted in out-of-network office visits for behavioral health care at a rate 10 times higher than for an out-of-network primary care office visit. Kaiser Health News cited a 2021 report by the Government Accountability Office (GAO) as "cast[ing] doubt on whether insurers are abiding by a federal law requiring parity in insurance coverage, which forbids health plans from passing along more of the bill for

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The authors declare no conflicts of interest.

DOI: 10.1097/PRA.0000000000000563

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mental health care to patients than they would for medical or surgical care.”³

In the 13 years since Congress passed the Mental Health Parity and Addiction Equity Act [formally, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)], there has been increasing awareness of its mandate that health insurers must provide substantially equivalent access to care for mental and substance use disorders compared with physical health care. Most states have also passed laws reinforcing the federal legislation. The 2020 Consolidated Appropriations Act required insurance entities, in effect, to make public their own compliance with the requirements of the federal mental health parity law. And most importantly, several high-profile lawsuits have been brought and won against major national insurers, reinforcing the protections promised by the Parity Act.

Perhaps the most significant ruling since the passage of the MHPAEA has been *Wit v United Behavioral Health (UBH)/Optum*,⁴ which was the subject of the previous psychotherapy column in this journal.⁵ In that case, the court found the insurance company’s use of access-to-care guidelines that failed to meet generally accepted standards of effective treatment to be so egregious that it (a) imposed a 10-year injunction on UBH/Optum requiring that coverage comply with generally accepted care standards, (b) appointed a Special Master to oversee the level of care determinations for outpatient, intensive outpatient, and residential treatment, and (c) required the insurer to review and correct determinations made on 60,000 claims for these levels of care. In their 2019 paper on the liability phase verdict in the *Wit* case, Appelbaum and Parks⁶ extracted from the judge’s 106-page verdict 8 principles of effective evaluation and treatment of mental and substance use disorders that meet generally accepted standards. Concisely put, effective treatment:

- (1) Treats underlying problems and not just the current presenting problem.
- (2) Treats co-occurring conditions.
- (3) Uses a multidimensional assessment to determine level of care such as those developed by professional organizations.
- (4) Is individualized and without arbitrary limits on duration.

- (5) May be to maintain functional capacity or prevent deterioration.
- (6) Should be both safe and effective.
- (7) Addresses special needs of children and adolescents when making level of care decisions.
- (8) Errs on the side of caution by using a higher level of care when there is ambiguity about the appropriate level of care.

While parity is required by law, insurers often base their denials on lack of “medical necessity,” overruling a clinician’s determination of the proper course of treatment. Such denials often conflict with 1 or more of the 8 elements of effective treatment cited above. Frequent causes for claim denials include:

- Dispute regarding the clinician’s diagnosis.
- Improper use of access-to-care standards that limit treatment to crisis stabilization when generally accepted standards of care would support treatment that addresses co-occurring and underlying disorders, the risk of recurrence, and the ongoing treatment needs of chronic disorders (see elements 1, 2, and 5 above).
- Assertion that treatment, especially longer term treatment, should be discontinued due to insufficient progress (see elements 2, 4, and 5 above).
- Assertion that treatment should be discontinued because progress in treatment necessitates step-down to a lower level of care regardless of whether such action is equally safe and effective or might impede achieving recovery or addressing underlying issues (see elements 1, 2, 4, 6, and 8 above).
- Inappropriate reliance on flawed treatment guidelines that are not developed by professional societies with knowledge of generally accepted standards and that limit access to care to a single dimension of acuity/severity instead of multidimensional guidelines that are not distorted by incentives to arbitrarily limit care and minimize cost (see element 3 above).
- Assertion that risks to the safety of the patient and others fail to justify continued treatment at an inpatient or intermediate level care (eg, insufficient level of suicidal or homicidal ideation or absence of a recent suicide attempt); (see elements 1, 3, 5, 6, and 8 above).

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Beyond denials related to medical necessity, the availability of in-network providers is dramatically worse for behavioral health treatment than for treatment of medical and surgical disorders.² Out-of-network exceptions are sometimes approved by insurers (eg, “single case agreements”), although the processes to secure such exceptions may be both arduous and hidden from policy holders. Insurers create significant obstacles to accessing medically necessary treatments that meet generally accepted standards, including psychotherapy.

While federal and state parity laws should make access to medically necessary treatment more timely and less burdensome, many, probably most, patients still encounter substantial obstacles. However, preemptive use of a medical necessity letter can often make a difference in gaining access to insurance reimbursement.

WHOSE PATIENTS ARE THEY ANYWAY?

In struggles to obtain authorization, it is often easy to lose sight that those we treat are our patients, not those of the insurance entity with which they are contracted for coverage. A medical necessity letter appropriately qualifies the clinician’s training, experience, and judgment, as well as the treatment plan to which clinician and patient agree.

As Dr William E. Bennett Jr, Associate Professor of Pediatrics at the Indiana University School of Medicine, wrote in a 2019 *Washington Post* opinion essay: “Insurance companies aren’t doctors. So why do we keep letting them practice medicine?”⁷ Indeed.

THE MEDICAL NECESSITY LETTER: A POWERFUL TOOL IN YOUR CLINICAL PRACTICE

Appendix A presents a template for a medical necessity letter, Appendix B presents suggested text for potential inclusion in a medical necessity letter, and Appendix C presents an information sheet to share with patients. There are 4 key elements in an effective medical necessity letter: (1) a statement of provider credentials; (2) a description of your practice, including level of experience and expertise in treating people with specific mental and substance use disorders; (3) a

clinical assessment of the patient, especially unique aspects of the patient’s presentation, history, or living circumstances; (4) most importantly, an explanation as to why the course of treatment is “medically necessary,” including the rationale (clinical decision-making process) justifying that treatment.

The first 2 components specify your credentials and practice experience. For psychiatrists, this section might reference medical school, residency, fellowship training, hospital affiliations, years in practice, peer-reviewed publications, relevant experience and practice focus with respect to the specific patient, and any other description of your qualifications that inform your professional judgment. Comparable statements of credentials may be used by other clinicians. This introduction can be reused with each medical necessity letter, with occasional updates as appropriate.

The third element is the substantiated clinical assessment. Substantiation is critical: a conclusory opinion lacking a rationale is more likely to be challenged by reviewers hired by an insurance company. Your assessment must specify the patient’s diagnoses with specific identifiers, including the presence of co-occurring conditions that complicate response to treatment (eg, comorbid disorders, adverse childhood experiences, recent trauma or adversity). It should specify the duration of your relationship with the patient, essential aspects of the patient’s medical history, and related observations (which may include self-harming behavior, arrests, or violence in the home) that informed your professional formulation of the recommended treatment plan. Also important to include are peer-reviewed standards and clinical practice guidelines that inform your judgment that the recommended course of treatment is consistent with accepted standards of care. It is neither necessary nor appropriate to speculate on the probability of success with any particular course of treatment, nor to explore any “what ifs” regarding the potential evolution of the treatment.

The fourth and most salient element describes your planned course of treatment and the statement that you have determined that course of treatment to be *medically necessary*. Whenever possible, link your recommendation for medically necessary treatment with a professional society’s multidimensional assessment instrument, such as

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the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)⁸ or the Child and Adolescent Level of Care Utilization System (CALOCUS)⁸ developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria⁹ and/or cite relevant clinical practice guidelines.^{10–12} It can also be very helpful to reference the relevant principles from the *Wit* verdict⁴ (see examples above and Appendix B). Overall, by providing such information, you are making the medical necessity letter not just your opinion but also linking it to the generally accepted standards of care and treatment in the field. Your clinical judgment is buttressed with impartial criteria representing generally accepted standards. It is also useful to identify potential, specific harms that could occur without the planned treatment and any clinical gains that have so far been achieved that may be lost. This is not a recommendation for clinical approval, nor the persuasive presentation of evidence for evaluation by others. Rather, it is the logical conclusion of a letter that introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your clinical determination. Inclusion of the words “determined to be medically necessary” is essential.

Medical necessity letters are powerful tools in your clinical practice. They do require some time and effort, but, having mastered the skill and designed a template for reuse, they are worth the effort. Individual patient letters may vary in length depending on complexity and circumstances, as well as the rationale for the recommended course of treatment. Keep in mind that a submission to an insurance entity generally requires consent of the patient, which should be noted early in the letter. Review of the letter with a patient is often a helpful step in strengthening the therapeutic alliance. The letter should be printed on letterhead with your contact information and may be addressed “To Whom It May Concern.”

Until insurers are forced to move toward full compliance with the mental health parity law, provision of a “medical necessity letter” based on the guidelines presented here can improve your patients’ odds of success with insurers. Patients

should be encouraged to include a copy of the letter with their insurance claim filings. And, if necessary, the medical necessity letter will prove helpful in appeals or subsequent litigation. [Although some may suggest submitting medical necessity letters only after claims are denied and appeals are pending, the proactive preparation of a letter and submission with original claims may help to avoid the original denial and associated frustration. Note that appeals processes vary significantly by insurer and are often complex. Thus, patients are well-advised to seek the advice of insurance claims experts before pursuing appeals (see patient handout in Appendix C for further information)]. Finally, as the treatment plan evolves, it may be appropriate to send follow-up medical necessity letters.

ADDITIONAL INSURANCE ADVICE FOR YOUR PATIENTS

Although the MHPAEA requires that obstacles to access to treatment of mental and substance use disorders not be substantially more stringent than those to access treatment of medical and surgical disorders, the reality of access to care falls far short of this standard. Every patient deserves a medical necessity letter and orientation to the existence of laws and resources available to support them. Organizations such as The Kennedy Forum provide the latest information on this and other laws through their websites www.thekennedyforum.org and www.dontdeny.org, as well as other resources such as the blog post “10 Steps to Securing Insurance Coverage for Mental Health Claims” (www.thekennedyforum.org/blog/10-steps-to-securing-insurance-coverage-for-mental-health-care/).

In closing, the combination of available resources and the increasing impact of the MHPAEA—complemented by a medical necessity letter—mean that patients do not need to settle for a “no” from their health insurer when seeking medically necessary treatment. A key step in helping them get to a “yes” is including a medical necessity letter as part of your standard practice.

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APPENDIX A: TEMPLATE FOR A MEDICAL NECESSITY LETTER (ON LETTERHEAD; 1-2, PAGES WILL BE SUFFICIENT)

Date

To Whom It May Concern:

This letter describes my clinical assessment and the medically necessary treatment for my patient [patient]. I have been treating [patient] since approximately [date].

[Provider credentials and practice]—include a brief summary of your training, medical or other professional school, residency, fellowship and internship training, hospital affiliations, years in practice, peer-reviewed publications in the area in question, relevant specialties relevant to the specific patient, and any other description of your qualifications that inform your professional judgment. The information included here will establish your qualifications to make the clinical determination to be described below.

[Substantiated clinical assessment]—include a brief summary of your diagnosis/assessment, focusing on the particulars relevant to the medically necessary treatment that you have determined is appropriate including:

- Related observations that informed your determination of the treatment plan.
- Peer-reviewed standards and medical treatment guidelines that informed your judgment. (Guidelines may include LOCUS,⁸ CALOCUS,⁸ ASAM,⁹ DSM-5,¹³ Psychiatry Online guidelines,¹⁰ AACAP primary case guidelines,¹¹ Nice (UK) guidelines,¹² and institutional guidelines.) To the extent that this particular patient's needs vary from or are atypical vis-à-vis standards and guidelines, it would be helpful to include relevant commentary.
- Considerations related to standards of care and other references based on the *Wit v United Behavioral Health* lawsuit (see Appendix B “Suggested Text for Potential Inclusion in a Medical Necessity Letter”). (It is neither necessary nor appropriate (a) to speculate on the probability of success with any particular course of treatment, (b) to explore any “what ifs” regarding the potential evolution of the treatment, or (c) to assess whether or not the insurance policy will cover the treatment. Your current assessment is sufficient.)

[Course of treatment]—description of the course of treatment that you have determined to be medically necessary, including:

- Summary rationale for your medical decision-making.
- When possible, link your recommendation for medically necessary treatment to a professional society multidimensional assessment instrument, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)⁸ or the Child and Adolescent Level of Care Utilization System (CALOCUS)⁸ developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria.⁹ Also include reference to the relevant elements of effective treatment from the *Wit* lawsuit (specific suggestions are provided in Appendix B to this article).
- Be sure to use the words “**determined to be medically necessary**”; leave no doubt that “medically necessary” is the standard for your treatment decision.
- Identify (a) specific harms that could occur, (b) avoidable risks that could be mitigated, and/or (c) clinical gains that could be lost absent your planned course of treatment.
- This letter is neither a recommendation for approval nor the persuasive presentation of evidence for evaluation by others. Rather, it introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your (by now, obviously qualified) determination.

Sincerely,
[signature]

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APPENDIX B: SUGGESTED TEXT FOR POTENTIAL INCLUSION IN A MEDICAL NECESSITY LETTER (FROM *WIT V UNITED BEHAVIORAL HEALTH* LAWSUIT)

The case *Wit v United Behavioral Health*⁴ identified a range of ways in which legitimate mental health claims were wrongly denied. Below is a selection of the findings of that case, along with suggested comments that may be appropriate to include in a medical necessity letter.

<i>Eight principles of effective treatment from Wit v United Behavioral Health</i> ⁶	<i>Suggested Text for Potential Inclusion in a Medical Necessity Letter</i>
Effective treatment requires treatment of the individual’s underlying condition and is not limited to alleviation of the individual’s current symptoms	“My treatment plan considers treatment of <i>[patient’s]</i> underlying condition, not merely alleviation of symptomology.”
Effective treatment requires treatment of co-occurring conditions	“My treatment plan considers co-occurring symptomatology relevant to a determination as to level and type of care.”
Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective. For example, placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care	“The appropriate level of care for <i>[patient]</i> reflects my professional assessment for its treatment efficacy, patient safety, and overall management of this patient’s medical needs.”
When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care	“My treatment decision regarding the level of care reflects appropriate medical caution after having evaluated <i>[patient’s]</i> individual requirements.”
Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration	“Certain services I have determined are required include those needed for <i>[patient]</i> to maintain day-to-day functioning and to prevent deterioration.”
Appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient	“My determination of the treatment duration is based on <i>[patient’s]</i> individual needs.”
The unique needs of children and adolescents must be taken into account when making level of care decisions	“My treatment plan reflects particular care for the unique needs of <i>[children / adolescents]</i> that may be different from those of adults.”
The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment	“My determination as to the medically appropriate level of care reflects an overall assessment of the patient, based on my <i>[days / weeks / months / years]</i> of observation.” and/or “My determination as to the medically appropriate level of care is consistent with that recommended using the LOCUS (or ASAM or other professional society) criteria for determining level of care.”

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APPENDIX C: PATIENT HANDOUT—A FEW WORDS ON INSURANCE COVERAGE

Health insurance coverage for mental health care, including treatment for substance use disorders and a wide range of other conditions, may not be as straightforward as claims for physical health care. Below you'll find information and suggested additional resources that may be helpful in filing claims and in securing coverage that you are entitled to—under your policy and under the law.

Insurers Must Treat Mental Health Care in the Same Way They Treat Physical Health Care

In 2008, Congress passed an important law, the Mental Health Parity Act that requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer. Since the passage of this law, there is increasing awareness of mental health parity. Several states have passed laws reinforcing the federal legislation (for information about legislation passed in specific states, visit www.thekennedyforum.org/about/parity-progress).

Claims Denials Are Too Common

Despite the legal protections afforded by the Mental Health Parity Act, insurers continue denying claims for mental health care for a wide range of reasons, including:

- Dispute regarding the clinician's diagnosis.
- Assertion that treatment should be discontinued for either insufficient progress ("it's not working") or for past achievement of progress ("it's worked and therefore no longer appropriate").
- Focus on crisis stabilization, not sustained care.
- Determination that the care is not "medically necessary."

Also, don't be discouraged by an insurer's published treatment criteria. In certain cases, such criteria may not be representative of generally accepted standards of medical care or may violate the Mental Health Parity Act.

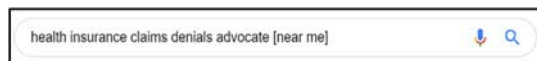
Securing a "Medical Necessity" Letter

A "medical necessity letter" provided by your clinician may be helpful documentation in dealing with insurance claims, specifically:

- At the time of filing a new claim, include a copy of the medical necessity letter.
- Retain a copy for potential use in appealing a denial or even in litigation. Note that insurers typically limit the number of appeals that can be filed and that sending a letter after a denial may be considered as an appeal—seek advice from an appeals expert to be sure.

Appealing Denials

If you receive a denial after submission of a claim, you have the possibility of filing an appeal. Such appeals processes vary significantly by insurer and are often complex. Patients should seek the advice of an expert in insurance claims before pursuing an appeal. See suggestion for Internet search below.



IMPORTANT: In any conversation you have with an insurer customer service representative, be sure to say that your questions or inquiries are NOT appeals. Insurers may limit the number of appeals and have been known to "count" inquiries as appeals already used.

Additional Resources

Great starting points to learn about resources for dealing with insurers and mental health claims are www.dontdeny.me and www.thekennedyforum.org. These sites offer information such as:

- Your rights under federal and state laws.
- Links to mental health care service providers, claims advocates, lawyers, and other resources.
- Blog post: "Ten Steps to Ensuring Insurance Coverage for Mental Health Care."

In addition to the claims advocacy resources noted above, there are a growing number of attorneys who can help with unlawful claims, many of whom work on contingency. See suggestion for Internet search below.



Bottom line: resources are available to help!

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