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Adult Antipsychotic Monitoring for Behavioral Health Inpatient Providers

A Federal Requirement with Direct Clinical Impact

Section 203 of the Consolidated Appropriations Act of 2024 establishes federal requirements for Drug Utilization Review (DUR) to assess the appropriate use, monitoring, and reassessment of antipsychotic medications across Medicaid care settings, including inpatient behavioral health [3].

This mandate is operationalized through Drug Utilization Review (DUR), which evaluates whether antipsychotic therapy is:

- Clinically appropriate
- Adequately monitored
- Reassessed over time [3]

In the inpatient setting, antipsychotics are frequently initiated, restarted, or escalated during acute stabilization, making hospitalization a key starting point for ongoing antipsychotic therapy.

Clinical reality: Inpatient providers play a key role in ensuring therapy is appropriately initiated, monitored early, and clearly transitioned across care settings.

What Is Required Under Section 203 (In Practice)

In practice, these elements reflect key components of appropriate antipsychotic management:

- Clear, documented indication at initiation
- Baseline or early metabolic monitoring when feasible
- Clinical interpretation of findings, not just documentation
- Clear and complete discharge communication
- Defined treatment intent and follow-up plan [3]

These actions determine whether therapy is appropriately continued, modified, or discontinued after discharge, and they are evaluated through retrospective DUR review.

Appropriate Use, Medication Selection, and Early Risk

Antipsychotic therapy should be supported by a clear clinical indication, based on FDA-approved use or a well-documented clinical rationale. When considering antipsychotic therapy:

- Use guideline-supported pharmacologic and non-pharmacologic interventions when appropriate
- Document prior treatment trials, including response and tolerability
- If used for a non–FDA-approved indication, ensure a clear clinical rationale after alternative therapies have been considered
- Document the indication, prior treatment trials, and expected benefit [2]

Antipsychotics differ in metabolic risk profiles, with some agents associated with greater risk for weight gain and metabolic disturbance [6]. Because therapy initiated during hospitalization often persists after discharge, agent selection has important implications for cumulative metabolic risk

Clinical pearl: Antipsychotic therapy should be intentional. Use after appropriate treatment trials and thoughtful agent selection at initiation remains critical, as it shapes ongoing therapy and long-term outcomes.

Cardiometabolic Risk and Monitoring During Inpatient Care

Patients with serious mental illness commonly have underlying cardiometabolic risk, including obesity, insulin resistance, dyslipidemia, and cardiovascular disease [4]. Antipsychotic therapy may further contribute to metabolic burden and progression of disease [4].

Second-generation antipsychotics are associated with weight gain, glucose dysregulation, and lipid abnormalities [1,6]. These effects may begin early in treatment, with changes in weight or insulin sensitivity emerging within the first few weeks and preceding laboratory abnormalities [4,6]. Even brief hospitalizations may capture the initial phase of metabolic change.

Monitoring during hospitalization supports early risk identification and safe transition of care (1). Key parameters include:

- Weight or body mass index (BMI)
- Blood pressure
- Fasting glucose or HbA1c
- Lipid panel when feasible

These should be obtained early in admission, when feasible, and reassessed during hospitalization based on clinical status, with greater attention given to higher-risk patients [1,4].

At discharge, documentation should clearly include monitoring completed, identification and interpretation of abnormalities, and a defined follow-up plan with a responsible provider and therapy duration [1,4].

Clinical pearl: Early metabolic changes during admission may represent the beginning of longer-term risk and should inform ongoing monitoring and follow-up [4]. Even incomplete data remains clinically meaningful when it is clearly documented and communicated at transition of care.

Abnormal Findings: Action Is Expected

Metabolic abnormalities should inform care and may represent developing metabolic dysfunction [4]. Clinical response should include:

- Evaluation of medication contribution
- Consideration of therapy adjustment
- Clear communication of findings and recommended actions at discharge
- Defined follow-up plan

Clinical pearl: Documentation alone is not sufficient. Abnormal findings should inform clinical action.

Dementia: Highest Risk, Highest Scrutiny

In patients with dementia:

- Antipsychotics are not FDA-approved for dementia-related psychosis
- Use is associated with an increased risk of mortality and cerebrovascular events
- Risk increases with dose and duration of use [5]

Clinical use should:

- Be limited to severe, safety-related behaviors
- Follow trials of non-pharmacologic approaches when feasible
- Include clear documentation of risk-benefit rationale
- Incorporate a plan for reassessment and potential deprescribing

Clinical pearl: Without clear transition planning, short-term use may become chronic therapy in a high-risk population.

Transitions of Care and Reassessment (Including Deprescribing)

Transitions of care represent a critical point in the medication lifecycle and are a key focus of DUR review under Section 203. Antipsychotics initiated for acute symptom management during hospitalization may be unintentionally continued after discharge if clinical context, monitoring, and treatment intent are not clearly communicated.

Ensuring timely access to medications at discharge is a critical component of transitions of care. This includes completing required prior authorizations, resolving insurance barriers, and confirming that patients can obtain their prescribed medications before leaving the hospital. Any questions concerning antipsychotic coverage with Kentucky Medicaid can be found here: Kentucky Medicaid Preferred Drug List Prior Authorization Criteria.

At discharge, documentation should clearly include:

- Indication and clinical rationale
- Response to therapy during admission
- Monitoring results and any identified abnormalities
- Required follow-up, responsible provider, and timing [3]

Treatment intent should be clearly defined (e.g., short-term stabilization vs ongoing therapy beyond admission). Ongoing reassessment of therapy is a key component of appropriate antipsychotic management. Providers should evaluate whether continued use remains appropriate and identify opportunities for dose reduction or deprescribing, particularly when:

- Symptoms have stabilized
- Ongoing benefit is unclear
- Risks may outweigh benefits [2,5]

Clinical pearl: If reassessment and potential deprescribing are part of discharge planning, antipsychotic therapy often continues by default rather than through deliberate clinical decision-making.

Clinical Takeaways

Section 203 establishes expectations for appropriate use, monitoring, and reassessment of antipsychotic therapy, which are evaluated through DUR review. Because DUR relies on claims data and does not capture clinical reasoning, documentation is essential to support the appropriateness of therapy when care is reviewed. Providers should:

- Use a clear clinical indication
- Perform and interpret metabolic monitoring
- Act on abnormal findings
- Reassess therapy and de-prescribing when appropriate
- Define and communicate treatment intent
- Ensure documentation reflects clinical rationale, monitoring, and follow-up

These actions support intentional, appropriate therapy, rather than default continuation after discharge.

KEY COMPLIANCE RISKS:

Unclear indication | Missing or incomplete monitoring

Failure to act on abnormal findings | Lack of ongoing reassessment

Inadequate documentation

Questions / Additional Information

Please direct any questions to KYMFFS@medimpact.com for FFS members and to KYMCOPBM@medimpact.com for MCO members.

References

1. American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, & North American Association for the Study of Obesity. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care, 27*(2), 596–601.

https://diabetesjournals.org/care/article/27/2/596/28450/Consensus-Development-Conference-on-Antipsychotic

2. Chen, S., Barner, J. C., & Cho, E. (2021). Off-label antipsychotic use patterns among Texas Medicaid adults, 2013–2016. *Journal of Comparative Effectiveness Research, 10*(14), 1045–1053. https://doi.org/10.2217/cer-2021-0048
3. Congressional Research Service. (2024). *Medicaid and Medicare provisions in the Consolidated Appropriations Act of 2024 (Report R48075)*. https://crsreports.congress.gov/product/pdf/R/R48075
4. DeJongh, B. M., Meyer, A. M., et al. (2021). Clinical pearls for monitoring and treating antipsychotic-induced metabolic syndrome. *Mental Health Clinician, 11*(6), 311–319. https://pmc.ncbi.nlm.nih.gov/articles/PMC8582768/
5. Kim, Y., Krause, T. M., Samper-Ternent, R., & Teixeira, A. L. (2025). Antipsychotic use in older adults with dementia in community and nursing facility settings. *Journal of the American Medical Directors Association, 26*(3), 105463. https://doi.org/10.1016/j.jamda.2024.105463
6. Pillinger, T., McCutcheon, R. A., Vano, L., Mizuno, Y., Arumuham, A., Hindley, G., & Correll, C. U. (2020). Comparative effects of 18 antipsychotics on metabolic function in patients with schizophrenia: A systematic review and network meta-analysis. *The Lancet Psychiatry, 7*(1), 64–77. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30416-X/fulltext