# Clinical UM Guideline

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| **Subject:** | Eating and Feeding Disorder Treatment | | |
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## Description

This document provides medical necessity criteria for levels of care relating to eating and feeding disorder treatment. Treatment of eating and feeding disorders is dependent on an eating and feeding disorder diagnosis based on current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or International Classification of Diseases (ICD-10-CM) criteria.

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) has expanded the types of conditions classified as Feeding and Eating Disorders. The levels of care described below provide guidance about the characteristics of each level of care that is needed to treat any feeding and eating disorder. Anorexia nervosa receives substantial attention because this condition can become apparent as a life threatening condition requiring hospital care. The guideline is called eating and feeding disorder because anorexia nervosa has long been called an eating disorder. Bulimia nervosa also may present as a medical emergency needing hospitalization. Services such as residential care, Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP) can make essential contributions to recovery. Outpatient care plays a very important role in the treatment of all feeding and eating disorders. Disorders such as binge eating disorder, avoidant/restrictive food intake, pica and rumination disorder are thought to be treated largely with individual therapy. Obesity is not included as a mental disorder in DSM-5. Obesity is associated with a wide range of genetic, physiological, behavioral, and environmental factors that contribute to the development of obesity (excess body fat) in any given individual.

There is variation in the availability of services in different geographic and regional areas. If an indicated service is not available within a member's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level. Continuing any level of care depends on the persistence of findings that lead to admission as well as attention to the person-centered treatment plan so that as much medical progress as each person's circumstances allow is made toward shared goals.

**Note:** Please see the following related documents for additional information:

- CG-BEH-03 Psychiatric Disorder Treatment
- CG-BEH-04 Substance-Related and Addictive Disorder Treatment
- CG-MED-19 Custodial Care

## Clinical Indications

**Acute Inpatient**

**Medically Necessary:**

*Severity of Illness Criteria*
Acute inpatient treatment is considered **medically necessary** when the member has A and one or more of B-K:

A. Member's clinical condition is of such severity that daily member medical evaluation by a physician or other provider with prescriptive authority is indicated; **and**

B. Physical changes caused by the eating disorder and with **one or more** of the following:
   1. For adults, heart rate less than 40 beats per minute (BPM) or blood pressure less than 90/60mm Hg or temperature less than 97.0 F; **or**
   2. For children and adolescents, heart rate near 40 BPM or orthostatic pulse or blood pressure changes (greater than 20 BPM increase in heart rate or 10-20mm Hg drop in blood pressure) or blood pressure less than 80/50mm Hg; **or**
   3. For adults, blood sugar (glucose) less than 60 mg/dl; potassium less than 3 mEq/L; or other electrolyte imbalance; **or**
   4. For children and adolescents, potassium less than 3mEq/L, or magnesium less than 1.5 mg/dL or phosphorous less than 1.5 mg/dL; **or**
   5. Dehydration; **or**
   6. Hepatic, renal or cardiovascular organ failure; **or**
   7. Poorly controlled diabetes needing acute treatment; **or**
   8. Uncontrollable vomiting or hematemesis (vomiting blood); **or**

C. Increased suicide risk which includes plan with high lethality or intent; suicidal ideation or a recent suicide attempt or aborted attempt with other risk factors for suicide; **or**
   For adults, weight as a percentage of healthy body weight: less than 85% or body mass index (BMI) less than 16.
   For children and adolescents, weight as a percentage of healthy body weight less than 85% or BMI percentile less than 5%; **or**

D. Acute weight decline with food refusal even if not less than 85% of healthy body weight or BMI percentile less than 5%; **or**

E. Structured need for eating/gaining weight: needs supervision during and after all meals or nasogastric/special feeding modality; **or**

F. Purging behavior (laxatives and diuretics):
   1. Needs supervision during and after all meals and in bathrooms; **or**
   2. Unable to control multiple daily episodes of purging that are severe, persistent and disabling, despite appropriate trials of outpatient care, even if routine lab test results reveal no obvious metabolic abnormalities; **or**

G. Co-occurring disorders: Any existing psychiatric and/or substance abuse disorder that would require hospitalization; **or**

H. Motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts:
   1. Very poor to poor motivation; **or**
   2. Member preoccupied with intrusive repetitive thoughts; **or**
   3. Member uncooperative with treatment or cooperative only in highly structured environment; **or**

I. Environmental stress:
   1. Severe family conflict or problems or absence of family so member is unable to receive structured treatment in home; **or**
   2. Member lives alone without adequate support.

*Continued Stay Criteria*

Acute inpatient treatment is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C**:**

A. Member evaluation by a physician or other provider with prescriptive authority occurred on each day; **and**

B. Progress with the eating disorder symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable; **or**

C. There is no access to residential care or partial hospital care if this is needed.

**Not Medically Necessary:**

Eating and feeding disorder acute inpatient treatment is considered **not medically necessary** when the above criteria are not met.

**Residential Treatment Center**

**Medically Necessary:**

*Severity of Illness Criteria*
Residential treatment center is considered **medically necessary** when the member has A and B or one of C-I:

A. Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**
B. If weight restoration is the goal,
   Adult weight is less than 85% of estimated healthy weight or BMI less than 16.
   For children and adolescents, 85% of estimated healthy body weight or BMI percentile less than 5%; **or**
C. There are no signs or symptoms of acute medical instability that would require daily physician evaluation, intravenous fluids or multiple daily lab tests; **or**
D. Structured treatment with 24 hour nursing needed for eating/gaining weight: Needs supervision at all meals or will restrict eating; **or**
E. Purging behavior (laxatives and diuretics): The member can ask for and use support from others or can use some cognitive or behavioral skills to stop from purging; **or**
F. Co-occurring disorders: Another psychiatric or substance use disorder is present that also requires 24 hour structured treatment; **or**
G. If suicidality is present, the level of risk can be safely managed at this level of care; **or**
H. Motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts:
   1. Poor to fair motivation; **or**
   2. Member preoccupied with intrusive repetitive thoughts 4 to 6 hours a day; **or**
   3. Member cooperative with treatment in a highly structured environment; **or**
I. Environmental stress: Severe family conflict or problems or absence of family so member is unable to receive structured treatment in home; member lives alone without adequate support.

*Continued Stay Criteria*
Residential treatment center is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

A. Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**
B. Progress with the eating disorder symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable; **or**
C. There is no access to partial hospital care if this is needed.

**Not Medically Necessary:**

Eating and feeding disorder residential treatment center is considered **not medically necessary** when the above criteria are not met.

**Partial Hospitalization Program**

**Medically Necessary:**

*Severity of Illness Criteria*
Partial hospitalization program is considered **medically necessary** when the member has A and B or one of C-H and I-K:

A. Member's clinical condition is of such severity that an evaluation by a physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**
B. If weight restoration is the goal, the member's weight is greater than 80% of estimated healthy body weight range; **or**
C. Structure for part or most of the day is needed to eat/gain weight; **or**
D. Co-occurring disorders: If another psychiatric or substance use disorder is present it can also be appropriately managed at this level of care; **or**
E. Purging behavior (including but not limited to vomiting, laxatives, diuretics): The member can reduce the incidence of purging in this setting and does not have significant medical complications; **or**
F. Environmental stress: Others are able to provide at least limited support and structure; **or**
G. Motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts: partial motivation; member preoccupied with intrusive repetitive thoughts more than three hours a day; **or**
H. Geographic availability of treatment program: Partial hospitalization treatment program is convenient for patient to participate from home; **and**
I. Suicidality can be safely managed at this level of care; **and**
J. There are no comorbid psychiatric disorders that require hospitalization; **and**
K. There are no signs or symptoms of acute medical instability that would require daily physician evaluation, intravenous fluids or nasogastric feeding, or multiple daily lab tests.

*Continued Stay Criteria*
Partial hospitalization program is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B:

A. Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**
B. Progress with the eating disorder symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

**Not Medically Necessary:**

Eating and feeding disorder partial hospitalization program is considered **not medically necessary** when the above criteria are not met.

**Intensive Outpatient Program**

**Medically Necessary:**

*Severity of Illness Criteria*
*Intensive outpatient program is considered **medically necessary** when the member has A and one or more of B-H:*

A. Member's clinical condition is of such severity that a psychiatric evaluation by a physician or other provider with prescriptive authority is indicated at admission; **and**
B. If weight restoration is the goal, the member's weight is over 80% of estimated healthy body weight range but there are no signs or symptoms of acute medical instability that would require intensive medical monitoring; **or**
C. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder; **or**
D. If suicidal ideation is present, the risk is low enough for the member to be safely treated at this level of care; **or**
E. The member has sufficient structure outside of this program to eat/gain weight; **or**
F. Purging behavior (laxatives and diuretics):
    1. The member can reduce purging and does not have significant medical complications; **or**
G. Motivation to recover:
    1. The individual has fair motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts; **or**
H. Environmental stress:
    1. Others are able to provide adequate emotional and practical support and structure.

Should also have all of the following:

A. Significant impairment in one or more spheres of personal functioning; **and**
B. The clear potential to regress further without specific intensive outpatient program services; **and**
C. The need for direct monitoring less than daily but more than weekly; **and**
D. Specific deficits that are directly related to services rendered; **and**
E. Significant variability in day to day capacity to cope with life situations.

*Continued Stay Criteria*
Intensive outpatient program is considered **medically** necessary when the member continues to meet Severity of Illness criteria and has A and B:

A. Member evaluation by a physician or other provider with prescriptive authority occurs in response to treatment issues such as medication effectiveness, side effects and other medical problems; **and**
B. Progress with the eating disorder symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

**Not Medically Necessary:**

Eating and feeding disorder intensive outpatient program is considered **not medically necessary** when the above criteria are not met.

**Outpatient Treatment**

**Medically Necessary:**

*Severity of Illness Criteria*
Outpatient treatment is considered **medically necessary** when the member has one or more of the following:

A. Medically stable; **or**
B. Specific symptoms or disturbances of mood and/or behavior are present, with functional impairment, which are consistent with the DSM/ICD diagnosis listed, and these disturbances/symptoms are likely to improve with treatment; **or**
C. If weight restoration is the goal, the member's weight is over 85% of estimated healthy body weight range and there are no signs or symptoms of acute medical instability that would require more extensive medical monitoring; **or**
D. Self- sufficient in eating/gaining weight; **or**
E. If a comorbid psychiatric disorder or substance use disorder is present, it is also appropriate for outpatient treatment; **or**
F. The member demonstrates motivation for treatment and is capable of benefiting from the treatment approach planned; **or**
G. Fair to good motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts; **or**
H. Others able to provide adequate emotional and practical support and structure; **or**
I. Lives near treatment setting.

***Note:*** *The severity of illness factors important for distinguishing between Partial Hospitalization Program, Intensive Outpatient Program and OutpatientTreatment are the members' level of insight, social support, motivation, and ability to self-control eating disorder symptoms.*

*Continued Stay Criteria*
Outpatient treatment is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has the following:

A. Progress with the eating disorder symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

**Not Medically Necessary:**

Eating and feeding disorder outpatient treatment is considered **not medically necessary** when the above criteria are not met.

## Coding

*Coding edits for medical necessity review are not implemented for this guideline. Where a more specific policy or guideline exists, that document will take precedence and may include specific coding edits and/or instructions. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

## Discussion/General Information

Eating disorders are characterized by a persistent disturbance of eating or behaviors related to eating. This disturbance results in altered consumption or absorption of food. Signification impairments are seen in physical health and psychosocial functioning. The specific disorder most likely to be life threatening is

anorexia nervosa. Individuals with anorexia lose more weight than is healthy for their age and height. The disorder is associated with an intense fear of gaining weight or becoming "fat" even when an individual with anorexia is under weight for height and age. Anorexia is characterized by a disturbance in the way body weight or shape are experienced such that body weight has an excessive influence on self-evaluation or the affected individual fails to adequately recognize the seriousness of being underweight.

Many individuals with anorexia also have bulimia symptoms. Bulimia nervosa is an illness in which an individual binges on food or has regular episodes of overeating and feels a loss of control. The individual then uses different methods such as vomiting or abusing laxatives to prevent weight gain. In the United States it is estimated that approximately 0.5% of adolescent girls have anorexia nervosa and 1%-2% meet diagnostic criteria for bulimia nervosa (Rosen, 2010). Medical conditions associated with eating disorders can include gastrointestinal disorders, endocrine disorders, other psychiatric disorders including substance abuse, and cardiac conditions including blood pressure and pulse changes. Although about 50% of individuals with child and adolescent onset eating disorders will recover and many of the remaining population improve, a troubling minority of individuals will have a chronic illness often associated with malnutrition. Some people with chronic eating disorders will need custodial services. Anorexia nervosa is associated with excess mortality relative to the general population with sudden death and suicide common causes of death.

A reliable determination of expected body weight is critical for diagnosis and management of eating disorders. A commonly agreed upon method for expected body weight calculation such as the BMI percentile method is recommended for children and adolescents (Le Grange, 2012; DSM-5). Weight estimation methods for adults include the BMI and Weight for Stature method. According to Golden and colleagues (2012), the Weight for Stature method and BMI methods are not necessarily equivalent. These workers concluded that it remains to be determined which method better predicts meaningful clinical outcomes. Healthy body weight is a calculation based on height, gender, and age. BMI is a measure of body fat based on height and weight that applies to adult men and women. The American Psychiatric Association (APA) in their 2006 guideline for Treatment of Patients with Eating Disorders uses weight as a percentage of healthy body weight in determining appropriate levels of care for eating disorders. The APA notes that weight level alone should not be used as a sole criterion from discharge from one level of care to another and other factors should be appropriately considered. The DSM-5 (2013) cites BMI in determining appropriate levels of care for eating disorders. At this time, there is no concrete conversion of BMI to percentage of healthy body weight.

Treatment for disorders such as binge eating disorder and avoidant/restrictive food intake disorder (ARFID), pica and rumination disorder is often individual therapy given in outpatient settings (Hay, 2014). Treatment of these feeding and eating disorders outside of the office setting is related to rare instances of medical complications such as life threatening fluid and electrolyte disturbance similar to those seen with anorexia (see severity of illness criteria for examples) and risk of suicide (described with each level of care). The levels of care described in this guideline describe illness features and the services necessary to manage any feeding and eating disorder. Regardless of the feeding and eating disorder diagnosis, outpatient treatment, including family therapy in the case of anorexia, is critical to the healing process.

Systematic assessments are thought to enhance the quality of eating disorder treatment. DSM-5 made changes in the diagnosis of eating disorders, changes that appear to improve reliability (Sysko, 2012) and reduce the frequency of the diagnosis of Eating Disorder Not Otherwise Specified (Machado, 2013). The Eating Disorder Assessment (EDA) for DSM-5 (American Psychiatric Association) is a free, readily available semi-structured interview for adults that provides an eating disorder diagnosis based on current symptoms (Sysko, 2015). The EDA-5 is supported by training materials and is available electronically. Self-report scales can be helpful for monitoring treatment and measuring outcome. The Eating Disorder Inventory (EDI), Eating Pathology Symptoms Inventory (EPSI) and Eating Disorder Questionnaire (EDE-Q) are broadly applicable eating disorder instruments that have been used to evaluate adults. The EDI and the EDE-Q have been modified for use in children and adolescents (the EDI-C and YEDE-Q, respectively). Parent report instruments are also available and appear to be especially relevant to assess small children. Practitioners will want to tailor the use of self-report and parent rating approaches to specific practice circumstances including alignment with DSM-5.

Feeding and eating disorder treatment should not be primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a pre-determined number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the member's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the member's illness.

In some geographical areas, state regulations allow non-physicians to treat members at inpatient facilities. In these documents, such non-physicians with prescriptive authority who are operating within the scope of their license may be substituted where the criteria specifies a physician.

At each level of care, different facilities and programs offer and provide different services. However, common features should exist across all levels of care. For example, all levels of care should coordinate care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's primary care physician, providing treatment to the member. Coordination of care is also useful when clinicians provide treatment to others such as family members. Treatment should be individualized rather than determined by a programmatic time frame. The programming should be consistent with the member's language, cognitive, speech and/or hearing abilities. If medication is being used it should be documented what is being used. If medication is not being used when an indication exists, there should be documentation as to why it is not being used. Discharge planning should be in place across all levels of care including identification of the range of community/family resources.

The staff at each level of care should be able to provide care that is appropriate to the clinical needs of each member receiving treatment. The staff members should be properly licensed to provide the treatment requested. At the acute inpatient level, a physician directs and coordinates care and can visit at least daily, 7 days per week. In a residential treatment center, an evaluation should be done by a qualified physician within 48 hours, and physical exam and lab tests should be completed unless done prior to admission. Skilled nursing care (either by a registered nurse or licensed vocational nurse/licensed practical nurse) must be available on-site for at least 8 hours daily with 24 hour medical availability to manage medical problems if medical instability is identified as a reason for admission to this level of care. In a residential treatment center, there should be individual treatment with a qualified physician at least once a week including medication management if indicated and individual treatment with a licensed behavioral health clinician at least once a week. In a partial hospitalization program, programs operate under the direction of a physician and a program leader. The physician provides supervision of the clinical needs of the members enrolled in the program and the program leader is responsible for the overall clinical and administrative operations of the program. Physicians should have face to face contact on admission for an evaluation and thereafter as clinically indicated, at least 1 time a week. Coordination of care with the member's primary care provider must take place in any situation where there are medical comorbidities. A member of the clinical staff serves in a case management capacity to coordinate the member's treatment within the program and works consistently with the member (and family as indicated) and follows the course of clinical treatment from admission through discharge. Physicians need to be available for consultation with other staff and for face to face evaluations with members during program hours or available 24 hours a day, 7 days a week by telephone outside of program hours. Staff members must possess appropriate academic degrees, licensure, or certification as well as experience with the particular populations treated as defined by program function and applicable state regulations. Core clinical staff members may include: psychiatrists, psychologists, social workers, counselors, addiction counselors, medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, non-degreed individuals, students and interns may be included. In an intensive outpatient program, a psychiatric evaluation by a physician should be done by the third day of attendance (unless stepping down from a higher level of care) and thereafter as needed. For medication management, a qualified physician, psychiatric nurse practitioner (or physician extender or independently licensed clinician as permitted by law or health plan benefits) as appropriate prescribes the medication.

There are also distinct differences between facilities and programs in other types of services provided. At the inpatient level of care there should be a multidisciplinary assessment with a person-centered treatment plan

addressing nutritional, psychological, social, medical, and substance abuse needs. Relevant medical tests including lab tests (electrolytes, chemistry, complete blood count [CBC], thyroid) and electrocardiogram (ECG) may be done on admission and follow up tests done for any abnormality requiring intervention. Individual therapy may be provided at least once per week, family therapy at least once per week for adults and twice per week for children/adolescents (unless contraindicated, with documentation for the reason). There should also be a nutritional plan with target weight range and refeeding plan to achieve gain of 1 to 2 pounds per week (if low body weight is a reason for admission).

In a residential treatment center, a physical exam and lab tests should be done within 72 hours if not done prior to admission. Within 7 days, an individualized problem-focused treatment plan should be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation, and this needs to be reviewed at least once a week for progress. Treatment would include the following at least once per day and with lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy, plus at least once weekly individual therapy. Family supports should be identified and contacted within 72 hours and family/primary support person included in family therapy at least weekly for adults, twice weekly for children and adolescents, unless contraindicated.

In a partial hospitalization program, multidisciplinary treatment should be provided at least 6 hours a day, 5 days a week. All services should consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, and individual and family therapy. Involvement of significant others and/or peers (as available and with the signed consent when appropriate) should be addressed at admission and reflected in the program services offered. Engaging the family and/or support persons (for example, a significant other) including family therapy (for adults, children and adolescents at least once a week) should be expected, unless contraindicated as described in the medical records. Clearly delineated procedures must be present to address any other medical needs such as substance withdrawal. A member of the clinical staff serves in a case management capacity to coordinate the member's treatment within the program, and will work consistently with the individual (and family as indicated) and follow the course of clinical treatment from admission through discharge. A clinical record is to be maintained for each member admitted. This has to include the following elements: initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of partial hospitalization program is needed with clear goals which are achievable within the timeframe of the program, medication management, progress notes, and a discharge summary.

In an intensive outpatient program, treatment services should be offered at least 3 treatment hours per day, at least 3 times per week. With symptom improvement, a gradual decrease in services per week may occur to help plan for successful discharge and greater independent functioning. In some cases an evidence-based, time-limited treatment protocol is provided for a given condition which may include a given number of sessions over several weeks. A comprehensive clinical assessment is done on admission that includes cognition/mental status, emotional/psychological function, activities of daily living, historical data (including social, medical and occupational histories), cultural issues, spirituality, and medical screening. The treatment plan will be updated and individualized following previous treatment either from a higher or lower level of care. All services should consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, and individual and family therapy. For children and adolescents, family therapy should be provided at least 1 time each week, unless clinically contraindicated. Family therapy, especially for children and adolescents, and group therapy, is individualized to meet the member’s needs, based on specific clinical needs or functional level. The staff should have experience with the patient-specific care issues as defined by program function and applicable state regulations. A clinical record is to be maintained for each member admitted. This has to include the following

elements: initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of intensive outpatient program is needed with clear goals which are achievable within the timeframe of the program, medication management, progress notes, and a discharge summary.

For members in an outpatient program, treatment goals should target resolution of specific symptoms or stabilization of mood and/or behavior consistent with the DSM/ICD diagnoses listed and also target specific domains of functional impairment. If substance abuse/dependence is a diagnosis or indicated to be present, a substance use evaluation should be performed and treatment offered. Community/natural supports and resources should be identified and utilized or skills to develop community/natural supports is a treatment goal, including school/work interventions, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities. Treatment should not be duplicative of services being provided by another clinician for the same reasons/diagnoses.

## Definitions

Acute Inpatient: Treatment in a hospital unit that includes 24-hour nursing and daily active treatment under the direction of a physician.

Residential Treatment Center: Twenty-four (24) hours per day specialized treatment involving at least one physician visit per week in a facility-based setting.

Partial Hospitalization Program: Structured, short-term outpatient treatment modality that offers nursing care and active treatment in a program that operates 6 hours per day, 5 days per week. Around-the-clock care would not be necessary.

Intensive Outpatient Program: Structured treatment that includes a combination of individual, group and family therapy in a treatment plan for members living in the community with problems responsive to a facility-based program of care delivered a few hours a day. Programs of this type have been identified by the state of New York as Intensive Psychiatric Rehabilitation Treatment (IPRT), Continuing Day Treatment (CDT) and by the state of Connecticut as Extended Day Treatment.

Outpatient Treatment: A behavioral health professional licensed to practice independently provides care to individuals in an outpatient, often an office, setting. Around-the-clock care would not be necessary.

## References

**Peer Reviewed Publications:**


1. Golden NH, Yang W, Jacobson MS, et al. Expected body weight in adolescents: comparison between weight-for-stature and BMI methods. Pediatrics. 2012; 130(6):e1607-1613.
2. Gowers SG, Clark AF, Roberts C, et al. A randomised controlled multicentre trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability - the TOuCAN trial. Health Technol Assess. 2010; 14(15):1-98.
3. Gowers SG, Clark A, Roberts C, et al. Clinical effectiveness of treatments for anorexia nervosa in adolescents: randomised controlled trial. Br J Psychiatry. 2007; 191:427-435.
4. Hartmann A, Weber S, Herpertz S, et al. Psychological treatment for anorexia nervosa: a meta-analysis of standardized mean change. Psychother Psychosom. 2011; 80(4):216-226.
5. Hebebrand J, Himmelmann GW, Wewetzer C, et al. Body weight in acute anorexia nervosa and at follow-up assessed with percentiles for the body mass index: implications of a low body weight at referral. Int J Eat Disord. 1996; 19(4):347-357.

6. Le Grange D, Doyle PM, Swanson SA, et al. Calculation of expected body weight in adolescents with eating disorders. Pediatrics. 2012; 129(2):e438-446.
7. Le Grange D, Fitzsimmons-Craft EE, Crosby RD, et al. Predictors and moderators of outcome for severe and enduring anorexia nervosa. Behav Res Ther. 2014; 56:91-98.
8. Lemmens HJ, Brodsky JB, Bernstein DP. Estimating ideal body weight--a new formula. Obes Surg. 2005; 15(7):1082-1083.
9. Machado PP, Gonçalves S, Hoek HW. DSM-5 reduces the proportion of EDNOS cases: evidence from community samples. Int J Eat Disord. 2013; 46(1):60-65.
10. Madden S, Miskovic-Wheatley J, Wallis A, et al. A randomized controlled trial of in-patient treatment for anorexia nervosa in medically unstable adolescents. Psychol Med. 2015; 45(2):415-427.
11. Sysko R, Glasofer DR, Hildebrandt T, et al. The eating disorder assessment for DSM-5 (EDA-5): development and validation of a structured interview for feeding and eating disorders. Int J Eat Disord. 2015; 48(5):452-463.
12. Sysko R, Roberto CA, Barnes RD, et al. Test-retest reliability of the proposed DSM-5 eating disorder diagnostic criteria. Psychiatry Res. 2012; 196(2-3):302-308.

**Government Agency, Medical Society, and Other Authoritative Publications:**

1. Agency for Healthcare Research and Quality. Management of eating disorders. Evidence Report/Technology Assessment. 2006 April. Publication No. 06-E010. Available at: http://archive.ahrq.gov/downloads/pub/evidence/pdf/eatingdisorders/eatdis.pdf. Accessed on February 1, 2018.
2. American Psychiatric Association. Practice guideline for treatment of patients with eating disorders. 2006. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf . Accessed on February 1, 2018.
3. American Psychiatric Association. Guideline watch: Practice guideline for the treatment of patients with eating disorders. 2012. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders-watch.pdf. Accessed on February 1, 2018.
4. American Society of Addiction Medicine. Public Policy Statement on Co-occurring Addictive and Psychiatric Disorders. 2000. Available at: http://www.asam.org/docs/publicy-policy-statements/1co-occurring-disorders-12-00.pdf?sfvrsn=0. Accessed on February 1, 2018.
5. Association for Ambulatory Behavioral Health Care. Standards and Guidelines for Partial Hospitalization Programs. 5th Ed. Portsmouth, VA. 2012.
6. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA. 2013. Available at: http://dsm.psychiatryonline.org/book.aspx?bookid=556. Accessed on February 1, 2018.
7. Hay P, Chinn D, Forbes D, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Aust N Z J Psychiatry. 2014; 48(11): 977-1008.
8. Herpertz-Dahlmann B, van Elburg A, Castro-Fornieles J, Schmidt U. ESCAP Expert Paper: new developments in the diagnosis and treatment of adolescent anorexia nervosa – a European perspective. Eur Child Adolesc Psychiatry. 2015; 24(10):1153-1176.
9. Joint Commission on Hospital Accreditation. Approved: new requirements for residential and outpatient eating disorders programs. Effective July 1, 2016, for Behavioral Health Care Accreditation Program. Jt Comm Perspect. 2016; 36(1):4-9.
10. Lock J, La Via MC; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with eating disorders. J Am Acad Child Adolesc Psychiatry. 2015; 54(5):412-425. Available at: http://www.jaacap.com/article/S0890-8567%2815%2900070-2/pdf. Accessed on February 1, 2018.

11. Mee-Lee, D. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. American Society of Addiction Medicine. 2013. pp 250 and 266-267.
12. Rosen DS. American Academy of Pediatrics Committee on Adolescence. Identification and management of eating disorders in children and adolescents. Pediatrics. 2010; 126(6):1240-1253.
13. Walsh BT, Sysko R, Glasofer DR, et al. Handbook of Assessment and Treatment of Eating Disorders. 1st ed. American Psychiatric Association Publishing. 2016.

## Websites for Additional Information

1. Centers for Disease Control. Growth charts. September 2010. Available at: http://www.cdc.gov/growthcharts/. Accessed on February 1, 2018.

## Index



## History

| Status | Date | Action |
|---|---|---|
| Reviewed | 02/27/2018 | Medical Policy & Technology Assessment Committee (MPTAC) review. |
| Reviewed | 02/23/2018 | Behavioral Health Subcommittee review. The document header wording updated from "Current Effective Date" to "Publish Date." Updated References section. |
| Revised | 02/02/2017 | MPTAC review. |
| Revised | 01/20/2017 | Behavioral Health Subcommittee review. Updated formatting in Clinical Indications section. Incorporation of service descriptions that take into consideration a member's medical needs. Updated Discussion/General Information and References sections. |
| | 11/07/2016 | Updated definition of Intensive Outpatient Program. |
| Reviewed | 02/04/2016 | MPTAC review. |
| Reviewed | 01/29/2016 | Behavioral Health Subcommittee review. Updated Discussion/General Information, Definitions, and Reference Sections. |
| Revised | 05/07/2015 | MPTAC review. |
| Revised | 04/30/2015 | Behavioral Health Subcommittee review. Multiple clarifications to Medical Necessity Criteria. Updated Description and Discussion/General Information, Definitions and References. Title changed to Eating and Feeding Disorder Treatment. |
| Revised | 08/14/2014 | MPTAC review. |
| Revised | 08/08/2014 | Behavioral Health Subcommittee review. Multiple clarifications to Medical Necessity Criteria. Updated Description, Discussion/General Information and References. Title changed to "Feeding and Eating Disorder Treatment." |
| Revised | 02/13/2014 | MPTAC review. |
| Revised | 02/07/2014 | Behavioral Health Subcommittee review. Removed indications of Axis from Clinical Indications. Updated References. |
| New | 08/08/2013 | MPTAC review. |
| New | 07/26/2013 | Behavioral Health Subcommittee review. Initial document development. Clarification to Clinical Indications Partial Hospitalization Program, Intensity of Service. Updated References. The Behavioral Health Medical Necessity Criteria effective January 1, 2013 was split apart into specific subject matter clinical UM guidelines. |

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.