Category: Utilization Management

Code: UM 2.0 Attach X Eating Disorders

Subject: Eating Disorders: Level of Care Criteria

Purpose: The purpose of this policy is to describe the criteria used by BHP in medical necessity determinations for Eating Disorders.

Policy: BHP Care Management (CM) staff use the following level of care guidelines for Eating Disorder treatment services.

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for healthcare services. Healthcare services must be ordered by a physician, physician assistant, nurse practitioner, or behavioral health practitioner. Healthcare services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

PURPOSE:

The intent of this criteria document is to ensure care is medically necessary

GUIDELINES:

Medical Necessity Criteria – Must satisfy either of the following: I or II

I. Care is court ordered;

II. Medical criteria for admission and continued stay in the appropriate level of care – must satisfy both of the following: A and B, not C

A. Meets the diagnostic criteria for a *DSM* Feeding and Eating Disorder; and

B. Presence of one or more characteristics in a category in Table 1 satisfies the requirement for the level of care.

C. Ongoing substance use or abuse that would preclude or decrease the effectiveness of treatment may merit discharge from the requested level of care and need for substance abuse evaluation or treatment.

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[i]	Level 4: Residential Treatment Center	Level 5: Hospitalization
Medical status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	For adults: Heart rate < 60 mg/dl; potassium < 3 mEq/L; electrolyte imbalance; temperature < 97.0°F; dehydration; hepatic, renal, or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes. For children and adolescents: Heart rate near 40 bpm, orthostatic blood pressure changes (> 20 bpm increase in heart rate or >10 mmHg to 20 mmHg drop), blood pressure <80/50 mmHg, hypokalemia[ii], hypophosphatemia, or hypomagnesemia
Suicidality[iii]	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk
Weight as percental of health body weight[iv]	Generally >85%	Generally >80%	Generally >80%	Generally <85% acute weight decline with food refusal even if not <85% of healthy body weight	
Motivation to recovery, including cooperativeness, insight, and ability to control obsessive	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intensive, repetitive thoughts[v] >3 hours/day	Poor to fair motivation; patient preoccupied with intrusive repetitive thoughts 4-6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts; patient uncooperative with treatment or cooperative only in a highly structured environment.
Co-Occurring disorders (substance use, depression, anxiety)	Presence of comorbid conditions may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization
Structure needed for eating/gaining weight	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after meals or nasogastric/special feeding modality

Ability to control compulsive exercising	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care		
Purging behavior (laxative and diuretics)	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization		Can ask for and use support from others or the cognitive behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities
Environmental stress	Others able to provide adequate emotional and practical support and structure	Others able to provide at least limited support and structure	Severe Conflict or problem or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system	
Geographic availability of treatment program	Patient lives near treatment setting	Treatment program is too distant for patient to participate from home		

DEFINITIONS:
DSM: The most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health disorders.

BACKGROUND:
This criteria document is based on expert professional practice guidelines.

Severe disturbances in eating behaviors are the primary characteristics of Eating Disorders. Anorexia Nervosa is defined as a refusal to maintain normal body weight, even at the very minimum. Bulimia Nervosa is composed of repeated binge eating episodes followed by inappropriate behaviors to compensate for the binge eating (such as, but not limited to, self-induced vomiting, misuse of laxatives or other medications, fasting, excessive exercise).

An eating disorder treatment program is a multifaceted program, with a multidisciplinary treatment team including a medical physician, nutritionist or registered dietitian and at least one psychiatrist and one psychologist, who provide medical management and behavioral interventions including individual, cognitive and family therapy.

All non-hospital based providers of mental health or chemical dependency treatment must be licensed for the services being requested.

REFERENCES:
1 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013.
2 Kaplan, Harold I., M.D., Sadock, Benjamin J., Pocket Handbook of Clinical Psychiatry, Second Edition, p 157-160, 1996
3 Treatment of Psychiatric Disorders, Glen O. Gabbard, Second Edition, Volume 1, p. 2083-2239, 1995.
4 Minnesota Statute 62Q.535 Coverage for Court-ordered Mental Health Services.
5 Yager J, Devlin MJ, Halmi KA, et al. Practice guideline for the treatment of patients with eating disorders (3rd ed.). 2006. American Psychiatric Association (APA) Practice Guidelines. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf . Accessed 07-02-19.
6 Hilber A, Hoek HW, Schmidt R. Evidence-based clinical guidelines for eating disorders: international comparison. Curr Opin Psychiatry 2017, 30:423–437. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5690314/pdf/coip-30-423.pdf Accessed 08-12-19

Internal References:

Source: PreferredOne

Date Effective: 12/13/2019

Date Revised: 12/13/2019

Date Evaluated by Clinical Team: December 2019, December 2020, December 2021

Revision Tracking

Date Revised	**Revision Type** List all applicable: - Minor changes (Use this when changes are related to staff titles, names of reports or systems, etc). - Change in process/procedure - Change in requirements - New attachments or forms added - Updated documentation to clarify policy - Other	**Details of Revision Made**
12/13/19	New Guideline	New Guideline

Footnotes for Table 1: Level of Care Guidelines for Patients with Eating Disorders

In general, a given level of care should be considered for patients who meet one or more criteria under a particular level. These guidelines are not absolutes, however, and their application requires physician judgment.

[i] This level of care is most effective if administered for at least 8 hours/day, 5 days/week; less intensive care is demonstrably less effective (101).

[ii] If the patient is dehydrated, whole-body potassium values may be low even if the serum potassium value is in the normal range; determine concurrent urine specific gravity to assess for dehydration.

[iii] Determining suicide risk is a complex clinical judgment, as is determining the most appropriate treatment setting for patients at risk for suicide. Relevant factors to consider are the patient's concurrent medical conditions, psychosis, substance use, other psychiatric symptoms or syndromes, psychosocial supports, past suicidal behaviors, and treatment adherence and the quality of existing physician-patient relationships. These factors are described in greater detail in the APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (84).

[iv] Although this table lists percentages of expected healthy body weight in relation to suggested levels of care, these are only approximations and do not correspond to percentages based on standardized values for the population as a whole. For any given individual, differences in body build, body composition, and other physiological variables may result in considerable differences as to what constitutes a healthy body weight in relation to "norms." For example, for some patients, a healthy body

weight may be 110% of the standardized value for the population, whereas for other individuals it may be 98%. Each individual's physiological differences must be assessed and appreciated. For children, also consider the rate of weight loss. Finally, weight level per se should never be used as the sole criterion for discharge from inpatient care. Many patients require inpatient admission at higher weights and should not be automatically discharged just because they have achieved a certain weight level unless all other factors are appropriately considered. See text for further discussion regarding weight.
[v] Individuals may experience these thoughts as consistent with their own deeply held beliefs (in which case they seem to be ego-syntonic and "overvalued") or as unwanted and ego-alien repetitive thoughts, consistent with classic obsessive-compulsive disorder phenomenology.

---

[i] This level of care is most effective if administered for at least 8 hours/day, 5 days/week; less intensive care is demonstrably less effective (101).

[ii] If the patient is dehydrated, whole-body potassium values may be low even if the serum potassium value is in the normal range; determine concurrent urine specific gravity to assess for dehydration.

[iii] Determining suicide risk is a complex clinical judgment, as is determining the most appropriate treatment setting for patients at risk for suicide. Relevant factors to consider are the patient's concurrent medical conditions, psychosis, substance use, other psychiatric symptoms or syndromes, psychosocial supports, past suicidal behaviors, and treatment adherence and the quality of existing physician-patient relationships. These factors are described in greater detail in the APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (84).

[iv] Although this table lists percentages of expected healthy body weight in relation to suggested levels of care, these are only approximations and do not correspond to percentages based on standardized values for the population as a whole. For any given individual, differences in body build, body composition, and other physiological variables may result in considerable differences as to what constitutes a healthy body weight in relation to "norms." For example, for some patients, a healthy body weight may be 110% of the standardized value for the population, whereas for other individuals it may be 98%. Each individual's physiological differences must be assessed and appreciated. For children, also consider the rate of weight loss. Finally, weight level per se should never be used as the sole criterion for discharge from inpatient care. Many patients require inpatient admission at higher weights and should not be automatically discharged just because they have achieved a certain weight level unless all other factors are appropriately considered. See text for further discussion regarding weight.

[v] Individuals may experience these thoughts as consistent with their own deeply held beliefs (in which case they seem to be ego-syntonic and "overvalued") or as unwanted and ego-alien repetitive thoughts, consistent with classic obsessive-compulsive disorder phenomenology.