Subject: **Acute Inpatient Treatment for Eating Disorders***

Effective Date: **December 15, 2015**

Department(s): **Utilization Management**

Policy: Acute inpatient treatment for eating disorders is reimbursable under plans administered by QualCare, Inc. when medical necessity criteria delineated in this policy are met.

Objective: To provide proper and consistent reimbursement and to define the indications for admission to and continued treatment in acute inpatient treatment for eating disorders.

Procedure: Eating disorders are among the most challenging psychiatric disorders to treat and require a truly biopsychosocial integrated approach to treatment. Medical Documentation should support that the following services are needed: Around-the-clock intensive psychiatric/medical and nursing care including continuous observation and monitoring; acute treatments to control behavior and symptoms requiring stabilization; acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others; daily monitoring of psychiatric medication effects and side effects; a contained environment for specific treatments that could not be safely done in a less restrictive setting, as evidenced by the following admission or continued stay criteria being met:

Criteria for Admission to acute inpatient treatment for substance use disorders:

All of the following must be met:

1. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
2. One or more of the following criteria must be met:
   A. The individual has medical instability with abnormalities in some or all vital signs: heart rate (less than 40 in adults or less than 50 in children/adolescents) temperature (less than 97 F), blood pressure (less than 90/60 mm Hg in adults or less than 80/50 for children/adolescents), orthostatic pulse increase (more than 20 beats per minute), orthostatic blood pressure decrease (more than 10-20 mm), OR
   B. The individual has abnormal relevant lab values secondary to the Eating Disorder such as low serum glucose (less than 60 mg/dl), electrolyte imbalances, low potassium (less than 3.2 mEq/L), low phosphorus, or low magnesium, OR
   C. The individual has significant medical symptoms secondary to the Eating Disorder such as evidence of dehydration, significantly impaired liver, kidney, or heart function; or poorly controlled diabetes needing acute stabilization, OR
   D. The Individual has significant decrease in Ideal Body Weight, as indicated by one of the following:
      i) A Body Mass Index (BMI) less than 16, OR
      ii) For children and Adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents,
      iii) BMI is greater than 16 and less than 30, AND there is evidence of one of the following:
         a) Weight loss or fluctuation of two or more pounds per week, OR
         b) Weight loss associated with medical instability unexplained by any other medical condition
   E. The individual's eating disorder symptoms require around the clock medical/nursing intervention.
      i) For issues of imminent risk of harm to self or others, OR

ii) There is a need to provide immediate interruption of food restriction, excessive exercise, binging and purging, and/or use of laxatives/diet pills/diuretics, OR

iii) To avoid impending life threatening harm due to medical consequences, OR

iv) To avoid impending life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes),

F. In addition to a primary eating disorder that requires treatment at this level of care, there is a co-occurring psychiatric disorder and/or risk of self-harm requiring 24 hour medical /nursing intervention.

NOTE: Prompt family involvement is expected at every level of treatment plan development, including initial assessment, therapy to achieve treatment goals and discharge planning, unless doing so is clinically contraindicated.

Criteria for Continued Stay

All of the following must be met:

1. One or more of the following criteria must be met:
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms, insight, biological measures, and family/significant other participation , identified and assessed at least three times a week, demonstrating a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   B. If the treatment plan implemented is not leading to measurable clinical improvements and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan that address specific barriers to achieving improvement, when clinically indicated, OR
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
2. All of the following must be met:
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process. Treatment goals are updated on an ongoing basis with participation of family/significant others.

B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

C. Continued stay is not primarily due to a lack of external supports.

NOTES:

For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks. The treatment plan is not based on a pre-established programmed plan or time frames.

Discharge planning will start at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Eating disorder inpatient care should be driven by the severity of symptoms present, the level of risk to the patient, and the severity of physical and psychological complications that would require 24-hour medical management and monitoring.

Most individuals with uncomplicated Bulimia Nervosa or a Binge-Eating Disorder do not meet medical necessity criteria for this level of care unless there are:

- Severe disabling symptoms that have not responded to a less intensive level of care, and /or
- Serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, or the appearance of uncontrolled vomiting).

References

Lock, J. & La Via, M.C., and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, 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.

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Practice Parameters, The American Academy of Child and Adolescent Psychiatry, Washington, DC, http://www.aacap.org/cs/clinical_care_quality_improvement/practice_parameters.

American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May, 2013.

Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry, June 2010.

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National Institute for Clinical Excellence, Eating Disorders, Clinical Guide 9, January 2004.

American Academy of Family Physicians, Diagnosis of Eating Disorder in Primary Care, Table 6, Level of Care Criteria for patients with eating disorders, 2003.

Redacted from Cigna Standards and Guidelines/
Medical Necessity Criteria for treatment of Behavioral Health and Substance Use Disorders
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*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.