Subject: **Intensive Outpatient Treatment for Eating Disorders***

Effective Date: **December 15, 2015**

Department(s): **Utilization Management**

Policy: Intensive outpatient 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 intensive outpatient treatment for eating disorders.

Procedure: Expectations for Intensive Outpatient Treatment for Eating Disorders:

Individuals who are at this level of care:

- Are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
- Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills
- Live in the community without the restrictions of a 24-hour supervised setting during non-program hours
- Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

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: a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community and who can maintain some ability to fulfill family, student, or work activities, as evidenced by the following admission or continued stay criteria being met:

Medical Necessity Criteria - Intensive Outpatient Treatment for Eating Disorders

Criteria for Admission

All of the following must be met

1. All elements of Medical Necessity must be met.
2. The individual has a documented primary 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,
3. Current medical issues can be safely managed in an intensive outpatient level of care
4. The individual is demonstrating difficulties in functioning secondary to an eating disorder to the extent that:
   A. The individual has demonstrated an inability to maintain a healthy weight and/or medical stability without frequent structured interventions of greater intensity/frequency than in routine outpatient treatment for eating disorders, OR
   B. The individual has documented evidence of repeated relapses, and inability to carry out treatment plan objectives in routine outpatient treatment for eating disorders. OR
   C. The individual cannot reduce incidents of purging in an unstructured setting. The individual requires some degree of structure for eating full meals and gaining weight but not as much as typically provided in a partial hospitalization program.
5. The individual is mentally and emotionally capable to actively engage in the treatment program.

6. The individual is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.
7. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
8. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR- If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

Criteria for Continued Stay

All of the following must be met

1. The individual continues to meet all elements of medical necessity.
2. **One or more of the following criteria must be met:**
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and 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 in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, 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.
3. **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.
   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**.** Individuals progress in their treatment at different rates. Medical necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

Family Involvement-The treatment should be family-centered with both the patient and the family included in all aspects of care. Therefore prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

-Assessment – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

-Family therapy is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.

* If the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.

* Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

Discharge planning- will start at the time of admission and include:

-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.

- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

Intensive Outpatient programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.

References

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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.