NEW DRAFT

**Subject:** **Partial Hospitalization for Eating Disorders***

**Effective Date:**

**Department(s):** **Utilization Management**

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**Policy:** Partial hospitalization 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 partial hospitalization for eating disorders.

**Procedure:** Expectations for Partial Hospitalization for Eating Disorders:

Individuals who are at this level of care:

- Are typically in a structured treatment program 5 days per week.
- At a minimum, 20 hours of scheduled programming extended over at least five (5) days per week are to be provided.
- 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, other than age appropriate limitations for children and adolescents.
- 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, as evidenced by the following admission or continued stay criteria being met:

**Medical Necessity Criteria** - Partial Hospitalization for Eating Disorders

Criteria for Admission

A. All of the following must be met:

1.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

2.The individual is mentally and emotionally capable to actively engage in the treatment program and is able to comply with the requirements and structure of a partial hospital program, as demonstrated by ALL of the following:

i) The individual is expressing willingness to engage in treatment.

ii) 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.

iii) The individual has a support system that includes individuals 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.

3.Current medical Issues can be safely managed in a partial hospital level of care, AND

B. One or more of the following must be met:

1. The individual is demonstrating significant impairments in functioning secondary to an eating disorder to the extent that:

i) The individual is not able to complete daily routine social, family, school, and/or work activities, AND

ii) The individual is not able to employ the necessary coping skills to compensate for this.- OR

2. The individual requires a structured program to avoid complications of a co-existing medical condition (e.g., pregnancy, uncontrolled diabetes). –OR

3. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24-hour monitoring environment.

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:

   D. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   F. 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.

The Discharge Plan starts 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 within 7 days of discharge date.
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

This level should not be confused with sub-acute "Day Programs" where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

References


1) American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2014. http://psychiatryonline.org/guidelines.aspx
2) Practice Parameters, The American Academy of Child and Adolescent Psychiatry, Washington, DC, http://www.aacap.org/cs/clinical_care_quality_improvement/practice_parameters
3) American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May, 2013.
4) Standards & Guidelines for Partial Hospitalization Programs, Fifth Edition, Association for Ambulatory Behavioral Healthcare (AABH), 2012
5) Definition of Partial Hospitalization. The National Association of Private Psychiatric Hospitals and the American Association for Partial Hospitalization, Psychiatric Hosp. 21(2):89-90, 1990
6) Outpatient Hospital Psychiatric Services, Medicare Benefit Policy Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)
7) Medicare Hospital Manual, Section 230.7, Outpatient Partial Hospitalization Programs (PHP), Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), 2000
8) Practice Guidelines for the Treatment of Psychiatric Disorders, Treatment of Patients with Eating Disorders, Third Edition, American Psychiatric Association Publishing, 2010.
9) National Institute for Clinical Excellence, Eating Disorders, Clinical Guide 9, January 2004.
10) American Academy of Family Physicians, Diagnosis of Eating Disorder in Primary Care, Table 6, Level of Care Criteria for patients with eating disorders, 2003.

Approved By/Date:

*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.