MEDICAL POLICY  
No. 91007-R8

**EATING DISORDERS**

| Effective Date: June 27, 2016 | Review Dates: 1/93, 8/96, 4/99, 12/01, 12/02, 11/03, 11/04, 10/05, 10/06, 10/07, 8/08, 8/09, 8/10, 8/11, 8/12, 8/13, 5/14, 5/15, 5/16 |
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**Summary of Changes**

Clarifications:
- Several edits were made to the policy to comply with Mental Health Parity.

Deletions:
- Pg. 3, Hospitalization, Eating Disorders, Section I, Admission - Severity of Need, E, The patient’s eating disorder behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., outpatient or partial hospital) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting.
- Pg. 5, Psychiatric Partial Hospitalization, Eating Disorders, Section I, Guidelines for Admission, D, The individual has failed an adequate trial of treatment in a less intensive setting such as an intensive outpatient program or needs this level of care to prevent hospitalization or there is clinical evidence that the individual is not likely to respond in a less-intensive setting.
- Pg. 7, Residential Subacute Treatment, Eating Disorders, Section I, Residential Admission Criteria – Severity of Need, F, The patient’s eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., partial hospital or intensive outpatient) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in a less-intensive setting than residential, the patient must:
  a. Be in a treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinical appropriate or feasible), nutritional counseling, and medication if indicated, and
  b. Have significant impairment in social or occupational functioning, and
  c. Require changes in the treatment plan that cannot be implemented in a less-intensive setting.

Additions:
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**POLICY/CRITERIA**

**Hospitalization, Eating Disorders**
Because of the severity of co-existing medical disorders, the principal or primary treatment of some eating disorders may be medical/surgical. In these instances, medical/surgical benefits and InterQual criteria will apply.

*Note:* For Medicaid/ Healthy Michigan Plan products, medical benefits and coverage will apply if individual is admitted to an acute medical care hospital.

**Acute Psychiatric Inpatient** - The highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.
Criteria for Inpatient Psychiatric Admission

The specified requirements for severity of need and intensity of service must be met to satisfy the criteria for admission.

Note: Criteria for inpatient psychiatric care does not apply to Medicaid/Healthy Michigan Plan members. Services are managed through the local community mental health authority.

I. Admission - Severity of Need

Criteria A and one of criteria B, C, D must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The disorder can be expected to improve and/or deterioration ceased by medically necessary and appropriate treatment according to prevailing medical standards. Eating disordered patients with coexisting psychiatric disorders may be considered for admission to an inpatient level of care based on severity of need relative to either the eating disorder, the other psychiatric disorder (e.g. severe depression with high risk for suicide), or both. In the event that it is the eating disorder that requires active treatment at the inpatient level of care, then admission to an eating disorder specific inpatient program would be expected.

B. One of the following:

1) The adult patient presenting with medical instability, such as: bradycardia (less than 40); hypotension (less than 90/60 mm Hg, including orthostatic blood pressure changes (greater than 20 beats per minute increase in heart rate or greater than 20 mm mercury drop); glucose (less than 90 mg/dl); hypokalemia or other electrolyte imbalance; and/or poorly controlled diabetes.

2) The child or adolescent patient with unstable medical presentation, such as: bradycardia or hypotension, including orthostatic blood pressure changes; hypokalemia or other electrolyte imbalance; and/or poorly controlled juvenile diabetes.

3) The patient’s weight will be significantly below ideal, e.g., 75% of Ideal Body Weight (IBW) or less, or Body Mass Index (BMI) of 16 or below. However, if body weight is significantly greater than 75% of IBW (or BMI significantly greater than 16), Criterion B can be met if there is evidence of any one of the following:

a) weight loss of >15% in one month, OR
b) the patient’s rapidly approaching a weight at which medical
instability occurred in the past, OR

c) a child or adolescent patient having a body weight <85% of IBW
during a period of rapid growth. Additionally, the individual’s
growth curve should be taken into account.

C. The patient with Anorexia Nervosa requires 24-hour medical/nursing
intervention to provide immediate interruption of the food restriction,
excessive exercise, purging and/or use of laxatives/diet pills/diuretics to
avoid imminent, serious harm due to medical consequences or to
avoid imminent, serious complications to a co-morbid medical
condition.

D. In patients with bulimia, the patient’s condition requires 24-hour
medical/nursing intervention to provide immediate interruption of the
binge/purge cycle to avoid imminent, serious harm due to medical
consequences or to avoid imminent, serious complications to a co-
morbid medical condition (e.g., pregnancy, uncontrolled diabetes).

II. Admission - Intensity and Quality of Service

Criteria A and B must be met to satisfy the criteria for intensity of service:

A. The evaluation of the patient will be performed by the attending physician
will occur within 24 hours following the admission. This psychiatric
evaluation should also assess for any co-morbid psychiatric disorders,
which will also be addressed in the treatment plan. There must be the
availability of an appropriate initial medical assessment and ongoing
medical management to evaluate and manage co-morbid medical
conditions. Family and/or support systems should be included in the
process of assessment, barring clinical contraindication.

B. This care must provide active psychiatric treatment that includes 24-hour
access to medical/nursing intervention to immediately interrupt food
restriction, excessive exercise, purging and/or use of laxatives/diet
pills/diuretics, and to avoid imminent, serious harm due to medical
consequences or to avoid imminent, serious complications to a co-
morbid medical condition (pregnancy or uncontrolled diabetes, for
example).

III. Continued Stay Criteria

Criteria A, B, C, D and either E or F must be met to satisfy the criteria for
continued stay.
A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), OR
   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), OR
   3) the progressive increases in hospital privileges have exacerbated the psychiatric symptoms thereby necessitating continued hospitalization, OR
   4) the rare instance when the patient’s reaction to medication is so severe that it requires daily monitoring and/or adjustment by the attending psychiatrist.

B. The current treatment plan includes documentation of diagnosis (DSM-5), individualized goals, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system’s involvement occurring at least once per week, unless clinically contraindicated. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient’s post-hospitalization needs.

C. The current or revised treatment plan is yielding significant, measurable improvement in the symptoms and/or issues meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

E. The patient’s weight remains <75% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

F. In the case of children/adolescents, and involuntarily hospitalized adults, there is evidence of a continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required. For voluntary adult patients, collaboration and progress are non-negotiable elements of continued treatment.
Psychiatric Partial Hospitalization, Eating Disorders

Psychiatric Partial Hospitalization - An intensive non-residential level of service where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to an inpatient setting, meeting for more than four hours (and, generally, less than eight hours) daily.

Note: Criteria for psychiatric partial hospitalization care does not apply to Medicaid/Healthy Michigan Plan members. Services are managed through the local community mental health authority.

I. Guidelines for Admission

Criteria A, B, C and D must be met.

A. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified.

B. There is evidence of all of the following:
   1) The individual has the capacity for reliable attendance and active participation in the treatment plan, AND
   2) The individual is capable of developing and implementing a safety plan to address those times when not in attendance at the partial program, AND
   3) The individual has support systems available to assist them when not at the partial hospital if necessary.

C. The individual is medically stable to the extent that constant medical monitoring is not required. The individual requires a moderate degree of structure for eating full meals and gaining weight but not so much that 24 hour per day monitoring is required.

D. The individual is <85% of IBW or the individual requires a structured program to avoid complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes). For children and adolescents, persistent failure to gain, or weight decline, due to restricted intake. Growth charts should be utilized for children and adolescents.

II. Guidelines for Continued Stay

(Both A and B must be met)

A. The individual continues to meet all basic elements of medical necessity.
B. The individual has participated in the development of an individualized treatment plan, which includes both treatment modalities, as well as short-term, achievable treatment goals; the plan will identify specific
timelines for achievement of these goals, and will encompass the outline of the discharge plan. Despite active participation by the individual and evidence of some progress, the treatment plan implemented has not led to enough improvement in the individual’s condition such that he/she cannot yet safely move to and sustain improvement in a less restrictive level of care as evidenced by:

1) The individual continues to suffer from symptoms and/or behaviors that led to this admission, OR
2) The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment

Residential Subacute Treatment, Eating Disorders

Residential Treatment – Treatment provided in a state-licensed subacute facility with structured, licensed health care professionals. This treatment must be medically-monitored and must include access to the following: (i) medical services twenty-four hours per day, seven (7) days per week, (ii) nursing services twenty-four (24) hours per day, seven (7) days per week, and (iii) physician emergency on call availability twenty-four (24) hours per day, seven (7) days per week.

Note: Criteria for residential subacute treatment does not apply to Medicaid/Healthy Michigan Plan members. Services are managed through the local community mental health authority.

I. Residential Admission Criteria – Severity of Need (All criteria must be met):

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Unspecified Eating Disorder. There is clinical evidence that the patient’s condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment; AND

B. If Anorexia Nervosa and weight restoration is goal, weight between 75%-85% of estimated ideal weight range and no signs or symptoms of acute medical instability that would require daily physician evaluation. If body weight is equal to or greater than 85% of ideal body weight (IBW), this criterion can be met if there is evidence of any one of the following:

1) Weight loss of fluctuation of greater than 10% in the last 30 days, OR
2) The patient is within 5 - 10 pounds of a weight at which physiologic instability occurred in the past, OR
3) A child or adolescent patient rapidly losing weight and approaching 85% of IBW during a period of rapid growth. Additionally, the individual’s growth curve should be taken into account
C. In anorexia, the patient’s malnourished condition requires 24-hour residential staff intervention to provide interruption of the food restriction, excessive exercise, purging, and/or use of laxatives/diet pills/diuretics to avoid imminent further weight loss. In Bulimia or eating disorder not otherwise specified, the patient’s condition requires 24-hour residential staff intervention to provide interruption of the binge and/or purge cycle to avoid imminent, serious harm due to medical consequences or to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation); **AND**

D. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder; **AND**

E. Significant functional disruption from usual/baseline status in at least 2 two domains (school/work, family, activities, activities of daily living [ADLs]) related to the eating disorder; **AND**

F. Based on past treatment history, usual level of functioning and comorbid psychiatric disorders, there is a reasonable expectation that the patient will benefit from this level of care; **AND**

G. The patient’s current living environment has severe family conflict and/or does not provide the support and access to therapeutic services needed. Specifically there is evidence that the patient has the need for supervision seven days per week/24 hours a day to address eating disorder behaviors which may include excessive food restricting, binging, purging, exercising, and/or use of laxatives, diet pills, and diuretics. Additionally, the family/support system cannot provide this level of supervision along with a less-intensive level of care setting.

**II. Residential Treatment – Core Components (All components must be met):**

A. Face-to-face evaluation by a qualified physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family members and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible; **AND**

B. Physical exam and lab tests completed prior to admission and the program provides supervision seven days per week/24 hours per day to assist with the development of internal controls to prevent excessive food restricting, binging, purging, exercising, and/or use of laxatives/diet pills/diuretics, including 24 hour on-site nursing and medical availability to manage medical problems if risk for medical instability identified as a reason for admission to this level of care; **AND**

C. An individualized plan of active psychiatric treatment and residential living support is provided within five (5) days. This treatment must be medically monitored, with 24-hour medical availability. This plan includes:
1) At least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, **AND**

2) Psychotropic medications, if medically indicated, to be used with specific target symptoms identified, **AND**

3) Evaluation and management for current medical problems, **AND**

4) Evaluation and treatment for concomitant substance use issues, **AND**

5) Linkage and/or coordination with the patient’s community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated

D. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the patient’s PCP/pediatrician, providing treatment to the patient, and where indicated, clinicians providing treatment to other family members, is documented; **AND**

E. Treatment would include the following at least once per day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, supervised meals and activity group therapy plus at least once weekly individual therapy and meal planning activities with properly licensed providers; **AND**

F. Observation and assessment by a board-certified psychiatrist at two times per week or more frequently if change to medication regime. Observation and oversight to medical care will be available as necessary; **AND**

G. A discharge plan is completed within one week that includes who the outpatient providers will be as well as linkage/coordination with the patient’s community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated

H. The treatment is individualized and not determined by a programmatic timeframe. It is expected that patients will be prepared to receive the majority of their treatment in a community setting

III. Continuing Care Criteria (All must be met to recommend continuing care):

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, **OR**

2) The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), **OR**

3) That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment
B. For adult patients, collaboration and progress are non-negotiable elements of continued treatment; **AND**

C. There is evidence that the treatment plan is focused on the eating disorder behaviors and precipitating psychosocial stressors that are interfering with the patient’s ability to participate in a less-intensive level of care; **AND**

D. If low body weight is a reason for admission, target weight for safe treatment on an outpatient basis listed and weight gain of 1-2 pounds per week documented; **AND**

E. Progress toward treatment goals is documented as shown by motivation on the part of the patient and family, adherence to treatment recommendations including weight gain and acceptance of recommended dietary caloric intake if low body weight was a reason for admission and control of binging and purging or non-purging bulimic symptoms, but treatment goals that would allow continued treatment at a lower level of care have not been achieved; if progress not achieved then the treatment plan has been adjusted in a manner that is likely to achieve progress toward meeting treatment goals or treatment goals have been adjusted which is documented in daily progress notes written and signed by the provider; **AND**

F. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible; **AND**

G. There is evidence of a continued inability to adhere to a meal plan and maintain control over restricting of food or urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required

**MEDICAL NECESSITY REVIEW**

☑️ Required  ☐ Not Required  ☐ Not Applicable

**APPLICATION TO PRODUCTS**
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** This policy applies to insured HMO/EPO plans.
- **POS:** This policy applies to insured POS plans.
- **PPO:** This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO:** For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL:** For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.

MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will not apply.

DESCRIPTION

The purpose of this policy is to delineate benefits for eating disorders under medical or behavioral health coverage.

CODING INFORMATION

ICD-10 Codes that may apply:
- F50.00   Anorexia nervosa, unspecified
- F50.01   Anorexia nervosa, restricting type
- F50.02   Anorexia nervosa, binge eating/purging type
- F50.2   Bulimia nervosa
- F50.8   Other eating disorders
- F50.9   Eating disorder, unspecified
- Z72.4   Inappropriate diet and eating habits

CPT/HCPCS Codes

Codes not specified - see criteria

REFERENCES

American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006, American Psychiatric Association

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