Eating Disorders

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Developed By: Medical Necessity Criteria Committee

I. Description

Eating disorders are illnesses having to do with disturbances in eating behaviors, especially the consuming of food in inappropriate quantity and frequency. Eating disorders include bulimia nervosa (BN), anorexia nervosa (AN), binge eating disorder (BED), avoidant/restrictive food intake disorder, and other specified or unspecified eating disorder. Eating disordered patients often do not fit into one discreet category but will manifest symptoms of one or more of the disorders along a continuum. For example, individuals with a primary diagnosis of anorexia nervosa may show bulimic symptoms at times and vice versa. Because of the complicated nature of eating disorders, a comprehensive approach to treatment, using evidenced based interventions, is recommended.

There is no consensus as to the cause of eating disorders, which appear to result from multiple factors—psychological, biological and social. These may include parental neglect and/or abuse, sexual abuse, trauma, and poor stress management skills. A family history of depression, anxiety, obsessive compulsive traits, as well as substance abuse, is also often present. Cultural factors include increasing pressure to obtain an "ideal" weight or body type. All eating disorders appear with increased frequency in first-degree relatives and identical twins.

These individuals are at increased risk for mental health conditions e.g. depression, anxiety, suicidality. These individuals are also at increased risk for medical conditions e.g. cardiac arrhythmia, cardiac failure and death, impaired renal function, serious gastrointestinal and metabolic disturbances, and fluid disturbance including ketosis, hypovolemia, electrolyte imbalance, acid base imbalance. Individuals who binge eat are also at higher risk for diabetes, morbid obesity, hypertension, and related illnesses.

Diagnosis: Appropriate diagnosis is made according to diagnostic criteria in the current *Diagnostic and Statistical Manual of Mental Disorders.*

Determining Level of Care/Assessment Notes: Medical evaluation of the patient prior to initiating treatment is especially important to determine the appropriate level of care. This evaluation may be done by a pediatrician or family physician and should include: body weight, height, vital signs, relevant laboratory results, hormonal, cardiac and metabolic status. If patient displays abnormal vital signs, hospitalization may be indicated. The decision to hospitalize should take into account psychological, behavioral, and medical factors. Of particular concern is a decline in oral intake and weight despite outpatient or partial hospitalization interventions, prior history of weight instability, and co-morbid psychological and/or medical conditions.

II. Criteria: CWQI BHC-0004A – Eating Disorder Inpatient Hospitalization (EDIP)

A. Program Requirements for Eating Disorder Inpatient Hospitalization:

Treatment must include **ALL** of the following:

1. Facility is licensed as an acute care general hospital or an acute care freestanding hospital.
2. Family sessions, when appropriate, are conducted in a timely manner.
3. The treatment plan is structured to resolve the acute symptoms and provide medical stabilization in the most time-efficient manner possible, consistent with sound clinical practice.
4. Coordination with relevant outpatient providers.
5. Discharge planning begins early in treatment.

B. Admission Criteria for Eating Disorder Inpatient Hospitalization:

Inpatient treatment is indicated for patients with an eating disorder diagnosis and **1 or more** of the following are present:

1. For adults, **1 or more** of the following must be met:
    a. Weight is less than 75 percent of ideal body weight or BMI is less than 16.
    b. Acute weight decline with food refusal even if not below 75 percent of healthy body weight.
    c. Any of the following sustained medical complications: bradycardia <40, blood pressure <90/60 mmHg, body temperature <97, potassium level <3, electrolyte imbalance, dehydration, or evidence of cardiac, hepatic or renal compromise per laboratory testing.
2. For children and adolescent, **1 or more** of the following must be met:
    a. Weight is less than 75 % of healthy body weight or BMI percentile is 5 or less per CDC growth charts.
    b. Pediatric patients with a BMI greater than the fifth percentile but have significantly failed to maintain their growth trajectory
    c. Heart rate near 40 bpm, orthostatic blood pressure changes (>10 - 20 mm hg, >20 bpm increase in pulse), blood pressure <80/50 mmHg, hypokalemia, hypophosphatemia, or hypomagnesemia
3. Patient is at risk for refeeding syndrome

4. Poorly controlled diabetes or unstable glucose levels needing acute treatment
5. The presence of any psychiatric or substance use condition that would necessitate hospitalization
6. Suicidality: Specific plan with high lethality or intent, or recent failed or aborted suicide attempt with continued suicidal ideation
7. Uncontrolled vomiting which puts the patient at acute medical risk, e.g., hematemesis or nasogastric/specialty feeding modality.

III. Criteria: CWQI BHC-0004B – Eating Disorder Residential Treatment (EDRT)

A. <u>Program Requirements for Eating Disorder Residential Treatment:</u>
Treatment must include **ALL** of the following:

1. Facility holds licensure and/or accreditation for the level and type of care provided
   a. Facilities in Oregon must be licensed under OAR 309-039-0570 or OAR 309-032-1100 through 309-032-1230.
   b. Facilities outside of Oregon must hold accreditation from the Joint Commission on Accreditation of Healthcare organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF).
2. 24 hour supervision by mental health treatment staff, including at least one nurse onsite or on-call at all times, to assist with medical issues, crisis intervention and medication.
3. Treatment plans must be individualized, not determined by programmatic duration, and include an appropriate mix of modalities (i.e. family, group, individual, exposure, nutritional therapies).
4. Patient must be involved in a structured treatment program for at least 8 hours, 5 days a week under the supervision of a licensed mental health professional.
5. Regular psychiatric involvement, including evaluation within 72 hours of admission. Once weekly review by a psychiatrist or psychiatric nurse practitioner to occur until discharge along with ongoing medication monitoring.
6. Face-to-face family therapy, a minimum of once weekly. If this is not possible, clinical evidence must be given and an acceptable alternative offered.
7. Patient must be staying overnight at the facility.
8. Aftercare treatment planning for the reintegration of the patient into the home, school, work and community begins early in treatment. Continued care will not be authorized solely for lack of aftercare availability.

B. <u>Admission Criteria for Eating Disorder Residential Treatment:</u>
Residential treatment is indicated if the patient does not require inpatient treatment and **ALL** of the following are met:

1. A lower level of care has been, or is expected to be, unsuccessful.
2. 24 hour structured treatment is required in order to stabilize the patient's symptoms, with **1 or more** of the following:

a. Weight restoration is needed, with the patient's weight being less than 85% of healthy body weight (for children and adolescents weight is less than 85% of healthy body weight or BMI percentile is 5 or less per CDC growth charts) or there is evidence of acute weight decline with food refusal
b. Patient is medically compromised or there is potential for serious medical complications without 24 hour structured treatment to address eating disorder symptoms. Examples may include a patient who is pregnant and unable to interrupt binge/purge behaviors or caloric restriction; diabetic individuals misusing or manipulating insulin due to eating disorders; or other biomedical concerns that require monitoring only available at this level of care.
c. The severity of family conflict is such that a patient is unable to receive structured treatment in the home or the patient lacks an adequate support system. Family should be actively involved in treatment, including face-to-face (or approved alternative) unless there is evidence and documentation as to reasons why family therapy is contraindicated.

3. The treatment plan clearly states what benefits the patient can expect to receive by participating in the program. The goals of treatment cannot be based solely on the need for structure and support.
4. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.
5. Treatment goals include how the patient is working toward developing an identity independent of the eating disorder. For recent readmissions, the treatment plan clearly states what will be done differently to address risk factors that led to the readmission, identifies additional interventions, builds upon previous treatment and promotes increased use of skills to support a successful transition to a lower level of care.

Note: Compensatory behaviors are not expected to be resolved at the residential level of care though progress is seen in the ability to use supports or skills to inhibit compensatory behaviors.

IV. Criteria: CWQI BHC-0004C – Eating Disorder Partial Hospitalization (EDPHP)

A. <u>Program Requirements for Eating Disorder Partial Hospitalization:</u>

Treatment must include **ALL** of the following:

1. Facility holds licensure and/or accreditation for the level and type of care provided
    a. Facilities in Oregon must be licensed under OAR 309-019-0100 through 309-019-0220.
    b. Facilities outside of Oregon must hold accreditation from the Joint Commission on Accreditation of Healthcare organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF)
2. Regular psychiatric medication reviews. Any changes in the patient's mental status should be shared with the psychiatrist so that appropriate changes or modifications can be made to the medication regimen.

3. Family therapy should be included in treatment goals, unless there is evidence and documentation as to reasons why it is contraindicated.
4. Patient must be involved in a structured treatment program for at least 4 hours per day.
5. The treatment focus should be on strengthening coping skills and social supports, with the intention of moving the patient to the outpatient level of care where there is greater opportunity to apply life skills gained in treatment in a home environment.
6. The patient's outpatient therapist should be involved in treatment and discharge planning. In the event that a patient does not have an outpatient therapist, efforts to secure an outpatient provider should begin upon admission.

B. **Admission Criteria for Eating Disorder Partial Hospitalization:**

Partial Hospitalization is indicated if the patient does not require a higher level of care and **ALL** of the following are met:

1. A lower level of care has been, or is expected to be, unsuccessful.
2. Generally, weight is greater than 80% of healthy body weight, and intensive external structure is needed for weight restoration and/or management of compensatory behaviors.
3. The patient can reduce the incidents of compensatory behaviors in this setting and does not have medical complications requiring a higher level of care. The patient may still need supervision or prompting for meal plan compliance and interruption of compensatory behaviors.
4. Co-occurring disorders can be safely managed at this level of care.
5. The treatment plan clearly states what benefits the patient can expect to receive by participating in the program. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems. The treatment plan includes exploration of and engagement in activities outside of the eating disorder as a factor of recovery. The goals of treatment cannot be based solely on the need for structure and support.
6. Services are provided at the lowest level of intensity (including number of days per week) necessary to maintain the patient's stability and recovery as the patient progresses in the ability to function independently. The treatment plan includes opportunities outside of the structured treatment program for the patient to independently practice learned skills.
7. The patient is reasonably able to access supports when outside of programming (support groups, social supports, and/or professional supports). Patient's support system is adequately involved to provide at least some structure and support in the recovery process.

V. Criteria: CWQI BHC-0004D – Eating Disorder Intensive Outpatient Program (EDIOP)

A. **Program Requirements for Eating Disorder Intensive Outpatient:** Treatment must include **ALL** of the following:

1. Facility holds licensure and/or accreditation for the level and type of care provided
    a. Facilities in Oregon must be licensed under OAR 309-019-0100 through 309-019-0220.
    b. Facilities outside of Oregon must hold accreditation from the Joint Commission on Accreditation of Healthcare organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF).
    c. Appropriately licensed medical and mental health professionals may provide Intensive Outpatient Services within the scope of their individual licenses.
2. Family therapy should be included in treatment goals, unless there is evidence and documentation as to reasons why it is contraindicated.
3. The treatment focus should be on strengthening coping skills and social supports, with the intention of moving the patient to the outpatient level of care to integrate recovery skills into everyday life and maintain treatment gains from higher levels of care.
4. The patient's outpatient therapist should be involved in treatment and discharge planning. In the event that a patient does not have an outpatient therapist, efforts to secure an outpatient provider should begin upon admission.

B. **Admission Criteria for Eating Disorder Intensive Outpatient:**
Intensive Outpatient treatment is indicated if the patient does not require a higher level of care and **ALL** of the following are met:

1. A lower level of care has been, or is expected to be, unsuccessful.
2. Generally, weight is more than 80% of healthy body weight and the patient does not require intensive medical monitoring.
3. The patient demonstrates fair motivation for recovery with the ability to reduce episodes of compensatory behaviors and access supports when outside of the treatment program.
4. The treatment plan clearly states what benefits the patient can expect to receive by participating in the program. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems. The treatment plan includes exploration of and engagement in activities outside of the eating disorder as a factor of recovery. The goals of treatment cannot be based solely on the need for structure and support.
5. Services are provided at the lowest level of intensity (including number of days per week) necessary to maintain the patient's stability and recovery as the patient progresses in the ability to function independently. The treatment plan includes opportunities outside of the structured treatment program for the patient to independently practice learned skills.
6. The patient's support system is able to provide adequate support and structure.

VI. Continued Care Criteria for Eating Disorder Inpatient Hospitalization, Residential, Partial Hospitalization, or Intensive Outpatient Program:

A. Continued authorization is indicated when **ALL** of the following are met:
   1. The patient continues to meet admission criteria for the current level of care
   2. The patient has not progressed enough in treatment to be safely moved to a lower level of care or there has been an emergence of additional problems that meet admission criteria.
   3. The patient is actively participating in treatment, is showing increased ability to independently manage symptoms, and is expected to improve to a point where a lower level of care is appropriate.
   4. The treatment plan includes exploration of and engagement in activities outside of the eating disorder as a factor of recovery.
   5. The patient's progress towards achievable and reasonable recovery goals is demonstrated and described in objective terms. When limited progress is noted, modifications are made to the treatment plan in effort to promote progress towards achievable recovery goals.

VII. Discharge Criteria for Eating Disorder Inpatient Hospitalization, Residential, Partial Hospitalization, or Intensive Outpatient Program:

A. Termination of continued authorization is indicated when **1 or more** of the following are met:

   1. The patient no longer meets admission criteria for the proposed level of care.
   2. The patient's treatment goals and objectives for the current level of care have been substantially met.
   3. The patient meets criteria for a less restrictive level of care (e.g. Eating Disorder Partial Hospitalization, Intensive Outpatient, or Outpatient Treatment).
   4. The patient's physical condition necessitates transfer to a medical facility.
   5. The patient is not making progress towards treatment goals at the current level of care (consider referral to another program or another form of treatment).

VIII. Criteria: CWQI: BHC-0004E – Eating Disorder Outpatient Services (EDOP)

Treatment should include coordinating services among all providers: improving the individual's coping and problem solving skills; teaching cognitive behavioral skills; normalizing eating patterns; group therapies designed to improve the patient's knowledge about and attitude toward eating, exercise, and body image; identifying and enacting social supports; and teaching methods of stress reduction (e.g. relaxation techniques, self-soothing, etc.) without resorting to bingeing, purging, or restricting behaviors.

A. <u>Continued Care Criteria for Eating Disorder Outpatient Treatment:</u>

Continued authorization is indicated when **ALL** of the following are met:

1. The treatment plan establishes achievable recovery goals appropriate to the patient's symptoms, resources, and functioning.
2. Treatment is provided at the lowest level of intensity (including frequency and duration of outpatient sessions and duration of the treatment episode) necessary to maintain the patient's stability and achieve progress toward appropriate treatment goals.
3. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.
4. Plus **1 or more** of the following:

    i. Continued measurable improvement in symptoms and/or functioning as evidenced by improvement in behavioral outcome measures.
    ii. Continued progress toward development of skills to prevent relapse.
    iii. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include **1 or more** of the following:
        1. Need for medication evaluation
        2. Need for psychosocial interventions (e.g. support groups)
        3. Possibility of co-occurring conditions that may require alternative treatment (e.g. medical conditions, substance abuse, personality disorders)
    iv. If there is a clear risk of deterioration with no further treatment, appropriate maintenance treatment is covered. If continued treatment is intended primarily to prevent deterioration, and significant improvement in symptoms is not expected, treatment should be provided at the least intensive level required to prevent deterioration.

A. <u>Discharge Criteria for Eating Disorder Outpatient Treatment:</u>

Termination of continued authorization is indicated by **1 or more** of the following:

1. Patient's treatment plan goals and objectives have been substantially met.
2. Patient has returned to previous functioning and has developed appropriate relapse prevention skills.
3. Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist or another form of treatment)
4. Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

IX. Annual Review History

Review Date	Revisions	Effective Date
05/2013	Annual Review. Added table with review date, revisions, and effective date. Added admission criteria related to refeeding syndrome. Removed reference to DSM IV.	05/2013
05/2014	Annual Review. Added program requirements for PHP and IOP.	05/2014
05/2015	Annual Review. Added program requirements addressing comorbid substance use disorder.	05/2015
07/2016	Annual Review. Added criteria distinguishing different levels of sub-acute care.	07/2016
06/2017	Annual Review. Added references. Added program requirements.	09/2017
07/2018	Annual Review. Minor language edits.	08/18

X. References

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