

Origination Date: 3/17/09	Revision Date(s): 8/18/09, 4/20/10, 5/26/11
Developed By: Medical Criteria Committee	



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Date: 05/26/11

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) and eating disorder not otherwise specified (EDNOS). 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 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.

Diagnostic Criteria:

Anorexia nervosa (DSM IV-TR: 307.1) is indicated by ALL of the following:

1. Inability to maintain body weight above 85 percent of normal body weight for age and height.
2. Intense fear of gaining weight, even though underweight.
3. Disturbance in the way one experiences body weight or shape, excessive influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
4. Absence of at least three consecutive menstrual cycles in post-menarchial females (Amenorrhea).

There are two subtypes of anorexia nervosa:

1. Restricting type: During the current episode of anorexia nervosa, weight loss is achieved primarily through dieting, fasting or excessive exercise. The patient has not regularly engaged in binge-eating or purging behavior (e.g., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

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2. Binge-eating/Purging type: During the current episode of anorexia nervosa, the patient has regularly engaged in binge-eating or purging behavior, or both (e.g., self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Bulimia nervosa (DSM-IV-TR 307.51) is indicated by ALL of the following:

1. Recurrent episodes of binge eating, characterized by consuming large amounts of food in discrete time periods, and a sense of losing control over eating in the episode.
2. Compensatory behavior to prevent weight gain, such as self-induced vomiting, laxative misuse, diuretics, enemas, or other medications, fasting or excessive exercise.
3. Binge eating and compensatory behaviors occur, on average, at least twice a week for three months.
4. Body shape and weight unduly influence self-evaluation.
5. Disturbance does not occur exclusively during episodes of anorexia nervosa.

There are two subtypes of bulimia nervosa:

1. Purging type: During the current episode of bulimia nervosa, the patient has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
2. Non-purging type: During the current episode of bulimia nervosa, the patient has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Eating Disorder, Not Otherwise Specified (DSM-IV-TR 307.50) is evidenced by ONE OR MORE of the following:

1. All criteria for anorexia nervosa are met except that the individual (for females) has regular menses, or despite significant weight loss, the individual's current weight is in the normal range.
2. All criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory behaviors occur at a frequency of less than twice a week or for a duration of less than three months.
3. There is regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food.
4. There is repeated chewing and spitting out, but not swallowing, of large amounts of food.
5. Binge eating disorder: Recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa

Determining Level of Care/Assessment Notes: 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, 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.

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Generally speaking, if a patient's weight is more than 85 percent of ideal body weight (IBW), outpatient intervention is recommended. A more intensive level of care is indicated if patient demonstrates medical instability.

Criteria for Admission to Inpatient Mental Health Hospitalization:

Inpatient treatment is indicated if ONE OR MORE of the following are present:

1. weight is less than 75 percent of IBW
2. orthostatic blood pressure changes are >20 mm hg
3. bradycardia <40, tachycardia >110, body temperature <97
4. dehydration as evidenced by electrolyte imbalance, hypovolemia, etc.
5. evidence of hepatic or renal compromise per laboratory testing
6. uncontrolled vomiting which puts the member at acute medical risk, e.g., hematemesis

Criteria for Admission to Mental Health Residential, Partial Hospitalization Program (PHP), or Intensive Outpatient Program (IOP):

Residential or Partial Hospitalization treatment is indicated if the patient does not require inpatient treatment and ONE OR MORE of the following are present:

1. Outpatient treatment has been—or is expected to be--unsuccessful
2. The patient's symptoms cannot be managed in an outpatient setting due to any of the following:
 - a. Instability of mood or behavior.
 - b. Cognitive impairment.
 - c. Lack of reliability in terms of medication management and/or keeping outpatient appointments.
 - d. Pregnant patients who are unable to interrupt binge/purge behaviors or caloric restriction, both of which may result in serious medical complications.
 - e. Binge eating and purging 3 or more times a day, with severe impairment in functioning.
 - f. Compensatory behaviors (e.g., vomiting, over exercise, laxative or diuretic abuse) cannot be managed in an outpatient treatment setting and do not meet medical necessity criteria for admission to inpatient mental health hospitalization
3. A coexisting mental disorder prevents the patient from successfully engaging in outpatient treatment.

Criteria for Continued Stay in Inpatient Mental Health Hospitalization, Mental Health Residential, Partial Hospitalization, or Intensive Outpatient Program:

Continued authorization is indicated by ALL of the following:

1. The patient continues to meet admission criteria for the current level of care
2. The patient is actively participating in treatment and is expected to improve to a point where a lower level of care is appropriate.

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3. Progress in meeting treatment goals can be clearly demonstrated and described in objective terms. Changes in interventions are implemented when there is a lack of progress.

Medical Necessity Criteria for admission to Outpatient Services:

Outpatient treatment is indicated if ALL of the following are met:

1. The patient does not require inpatient, residential, partial hospital, or intensive outpatient services
2. The patient has symptoms which interfere with functioning and/or create medical risk.

Medical Necessity Criteria for Continued Treatment in Outpatient Services

Treatment should include coordinating services among all providers, improving the individual's coping and problem solving skills, teaching cognitive behavioral skills, empathic nursing approaches, 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.

Continued authorization is indicated by ALL of the following:

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. **Note:** *While extended outpatient visits (75-90 minutes) may be appropriate on occasion for crisis management, the routine use of extended outpatient visits lacks empirical support and is not covered. Special circumstances may be discussed with an ODS Behavioral Health Care Coordinator in advance.*
3. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.

Plus 1 or more of the following:

4. Continued measurable improvement in symptoms and/or functioning. Patients must demonstrate progress in treatment as evidenced by an increase in GAF score and improvement in behavioral outcome measures.
5. Continued progress toward development of skills to prevent relapse.
6. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of
 - a. Need for medication evaluation
 - b. Possibility of underlying Axis II condition
 - c. Need for psychosocial interventions (i.e., support groups)

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- d. Possibility of co-occurring conditions that need attention (e.g. medical conditions, substance abuse)
7. 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. Periodic treatment plan updates may be required to track patient's progress.

Termination Criteria:

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

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

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