INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don’t have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®\(^1\).

INSTRUCTIONS FOR USE

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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\(^1\) Optum is a brand used by United Behavioral Health and its affiliates.
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**Pre-Service Notification**
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

**COVERAGE RATIONALE**

Available benefits for **Anorexia Nervosa and Bulimia Nervosa** include the following services:
- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**Binge-Eating Disorder, Pica, Rumination Disorder or Avoidant/Restrictive Food Intake Disorder (ARFID)** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, may be excluded from the member’s benefit plan. Please check the member’s specific benefit plan requirements. When excluded from the benefit plan, indications for coverage are limited to circumstances where:
- **Binge-Eating Disorder, Pica, Rumination Disorder or ARFID** is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis;

When **Binge-Eating Disorder, Pica, Rumination Disorder or ARFID** is covered according to the member’s specific benefit plan and when mental health treatment is indicated, available benefits include the following services:
- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association, 2013).

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

All services must be provided by or under the direction of a properly qualified behavioral health provider.
Indications for Coverage

Eating Disorders: General

A. Initial evaluation common criteria and best practices
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
   - Optum recognizes the American Academy of Child & Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders (2015):
     - http://www.aacap.org > Practice Parameters
   - Early recognition of eating disorders is necessary to prevent complications and chronicity (Campbell and Peebles, 2014).
   - The first priority when evaluating patients with eating disorders is to identify emergency medical conditions that require hospitalization and stabilization (Harrington et al., 2015).
   - Validated, short, self-report measures that can be useful screening instruments for eating disorders include (American Academy of Child & Adolescent Psychiatry, 2015):
     - Eating Disorder Examination-Questionnaire (EDE-Q);
     - Eating Disorder Inventory (EDI);
     - Eating Attitudes Test (EAT)
     - Kids’ Eating Disorder Survey (KEDS);
     - Child-Eating Attitudes Test (CHEAT);
     - Eating Disorder Examination-Questionnaire, Children’s Version (ChEDE-Q);
     - Eating Disorders Inventory for Children (EDI-C)
   - A positive screening for an eating disorder should be followed by a comprehensive diagnostic evaluation, including laboratory testing and imaging studies as indicated (American Academy of Child & Adolescent Psychiatry, 2015).
     - The best-characterized and most commonly used structured interview for assessing disordered eating behaviors and eating-related psychopathology is the Eating Disorder Examination (EDE); the EDE is reliable for patients down to 12 years of age. A child version for individuals < 14 years of age is also available (American Academy of Child & Adolescent Psychiatry, 2015).
     - The Bulimia-Test-Revised (BULIT-R) is a measure specific to bulimia nervosa (American Academy of Child & Adolescent Psychiatry, 2015).
     - Parental reports about the child’s behavior are an important component of the evaluation process (American Academy of Child & Adolescent Psychiatry, 2015).

B. Treatment planning common criteria and best practices
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
   - Optum recognizes the American Academy of Child & Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders (2015):
     - http://www.aacap.org > Practice Parameters
   - While different metrics for recovery exist in the literature, most agree (e.g., Campbell and Peebles, 2014):
     - Behavioral recovery includes normalizing eating patterns and the return of flexibility in eating;
     - Psychological recovery includes improved self-esteem and age-appropriate functioning;
     - Physical recovery includes weight restoration, return of menses and/or pubertal progression, and reversal of most or all organ damage
• Treatment efforts focusing on weight restoration, reduction of blame, and active incorporation of caregivers and families have emerged as particularly effective (Campbell and Peebles, 2014).

• Severe acute physical signs and medical complications need to be treated (American Academy of Child & Adolescent Psychiatry, 2015).
  o Most physical abnormalities can be reversible with adequate diet and restoration of a healthy weight; however, some clinical abnormalities may be irreversible in those with longstanding anorexia nervosa or other low-weight eating and feeding disorders (American Academy of Child & Adolescent Psychiatry, 2015).

• Treatment should be based on multiple factors, including medical and symptom severity, course of illness, psychiatric comorbidity, and the availability of psychosocial and familial support (Harrington et al., 2015).
  o Treatment success may be dependent on development of a therapeutic alliance with the patient, involvement of the patient’s family, and close collaboration among those providing treatment (Harrington et al., 2015).

C. Outpatient psychosocial interventions are the initial treatment of choice for individuals with eating disorders (American Academy of Child & Adolescent Psychiatry, 2015; Society for Adolescent Health and Medicine, 2015; American Psychiatric Association, 2012).

• There is no evidence that psychiatric hospitalization for eating disorders is more effective than outpatient treatment, and no studies have been randomized or have compared residential and day treatment to outpatient treatment in adolescents (American Academy of Child & Adolescent Psychiatry, 2015; Madden et al., 2015a).
  o Decisions about admission should be based on a comprehensive clinical assessment that takes into account the seriousness of the patient’s physical and emotional health, rapidity of weight loss, available outpatient resources, and family circumstances (Society for Adolescent Health and Medicine, 2015).
  o When more intensive programs are clinically necessary, the negative impacts, such as separation from family and community, can be mitigated by keeping length of stay short, using the lowest safe level of care, involving families in programming, and using experienced staff (American Academy of Child & Adolescent Psychiatry, 2015).

• Psychotherapy can be particularly helpful once malnutrition has been corrected and weight gain has begun (American Psychiatric Association, 2012).

Anorexia Nervosa

A. Evaluation and Treatment Planning

• Anorexia nervosa symptoms may be expressed differently by children and adolescents when compared to adults (American Academy of Child & Adolescent Psychiatry, 2015)

• In anorexia nervosa, the potential presence of at least one other significant psychiatric comorbid condition is high, for both adolescents and adults (American Academy of Child & Adolescent Psychiatry, 2015).

B. Differential diagnosis for anorexia nervosa includes (American Psychiatric Association, 2013):

• Medical conditions (e.g., gastrointestinal disease, hyperthyroidism);
• Major depressive disorder;
• Schizophrenia;
• Substance use disorders;
• Social anxiety disorder (social phobia), obsessive-compulsive disorder, and body dysmorphic disorder;
• Bulimia nervosa;
• Avoidant/restrictive food intake disorder.

C. For anorexia nervosa, findings from studies suggest that family therapy, particularly family-based treatment (FBT - sometimes referred to as Maudsley Family Therapy), is effective and superior when compared to individual therapies for children and adolescents, and may be useful for older patients as well (American Academy of Child & Adolescent Psychiatry, 2015; American Psychiatric Association, 2012).
• FBT typically consists of 10 to 20 family meetings over a 6- to 12-month treatment course (Lock and Le Grange, 2013).
• There is evidence that FBT is both highly efficient and can decrease the need for hospitalization (American Academy of Child & Adolescent Psychiatry, 2015).
• Individual approaches, such as adolescent-focused therapy (AFT) and cognitive behavioral therapy (CBT), can also be beneficial, particularly in patients for whom FBT is not an acceptable option (American Academy of Child & Adolescent Psychiatry, 2015).
• Admission for medical stabilization followed by outpatient FBT has reported similar treatment outcomes to more prolonged admission for weight restoration (Madden et al., 2015b).

D. Hospitalization should be considered for initial treatment of any seriously malnourished patient to allow for daily monitoring of key markers such as weight, heart rate, hydration, etc. (Harrington et al., 2015).
• Indications for hospitalization may include (Harrington et al., 2015):
  o Significant electrolyte abnormalities;
  o Arrhythmias or severe bradycardia;
  o Rapid persistent weight loss in spite of outpatient therapy;
  o Serious comorbid medical or psychiatric conditions, including suicidal ideation


E. Studies have shown only limited benefit of medications in the treatment of anorexia nervosa (American Academy Of Child & Adolescent Psychiatry, 2015; Harrington et al., 2015; American Psychiatric Association, 2012).
• Antidepressants may help mitigate symptoms of depression and suicidal ideation; however, they have not proved beneficial in facilitating weight restoration or preventing relapse (Harrington et al., 2015).
• While potentially useful for comorbid conditions such as anxiety, controlled studies have not demonstrated significant benefit of antipsychotic medications. Further study is necessary to determine their efficacy on core symptoms in patients with anorexia nervosa (American Academy Of Child & Adolescent Psychiatry, 2015; Dold et al., 2015; Harrington et al., 2015; American Psychiatric Association, 2012).

Bulimia Nervosa

A. Evaluation and Treatment Planning
• Self-injury, substance abuse, and other impulsive and risk-taking behaviors may be common in individuals with bulimia nervosa, particularly among adults and older teens (American Academy of Child & Adolescent Psychiatry, 2015).

B. Differential diagnosis for bulimia nervosa includes (American Psychiatric Association, 2013):
• Anorexia nervosa, binge-eating/purging type;
• Binge-eating disorder;
• Kleine-Levin syndrome;
• Major depressive disorder, with atypical features;
• Borderline personality disorder

C. Outpatient treatment of bulimia nervosa is recommended, except when there are complicating factors, such as serious general medical problems or suicidal behaviors, or severe disabling symptoms that do not respond to outpatient treatment (American Psychiatric Association, 2012).
• Cognitive behavioral therapy (CBT) is recommended as the most effective and best-studied intervention for patients with bulimia nervosa (American Psychiatric Association, 2012);
• Interpersonal therapy (IPT) is also recommended, particularly for patients who do not respond to CBT (American Psychiatric Association, 2012);
• Limited studies have favored family-based treatment (FBT) among adolescents with bulimia nervosa (American Academy of Child & Adolescent Psychiatry, 2015).

D. Studies have suggested that antidepressants may be beneficial in decreasing the frequency of binge eating and purging, particularly among adult patients who refuse or do not have an optimal response to CBT (American Academy of Child & Adolescent Psychiatry, 2015; Harrington et al., 2015; American Psychiatric Association, 2012).

Binge-Eating Disorder

A. Evaluation and Treatment Planning
• Binge-eating disorder is distinguished from bulimia nervosa in that binge eating episodes are not associated with inappropriate compensatory behaviors (American Academy of Child & Adolescent Psychiatry, 2015).
• Parental interviews and other collateral reports are often necessary for making a definitive diagnosis (American Academy of Child & Adolescent Psychiatry, 2015).
• In adults, binge-eating disorder may be associated with depressive disorders, anxiety disorders, posttraumatic stress disorder, impulse control disorders, substance use disorders, and personality disorders (American Academy of Child & Adolescent Psychiatry, 2015).

B. Differential diagnosis for binge-eating disorder includes (American Psychiatric Association, 2013):
• Bulimia nervosa;
• Obesity;
• Bipolar and depressive disorders;
• Borderline personality disorder

• Interpersonal therapy (IPT) and dialectical behavior therapy (DBT) may also be considered for some adult patients, while preliminary studies support the use of IPT in adolescents (American Academy of Child & Adolescent Psychiatry, 2015; Agency for Healthcare Research & Quality, 2015; American Psychiatric Association, 2012).

D. Studies have suggested that antidepressants may be beneficial in decreasing the frequency of binge eating and purging, and may be particularly useful for patients not responding to an initial trial of psychotherapy or those with major depression or another comorbid disorder responsive to antidepressant medications (Agency for Healthcare Research & Quality, 2015; Harrington et al., 2015; American Psychiatric Association, 2012).

Pica, Rumination Disorder, and Avoidant/Restrictive Food Intake Disorder (ARFID)

A. Evaluation and Treatment Planning
• For pica, rumination disorder, and ARFID, a multidisciplinary treatment approach including both medical providers and experienced behavioral specialists is generally recommended, with involvement dependent on the severity of the condition (Kelly et al., 2014).
• Physical examination and clinical assessments with attention to serious complications are important in the clinical evaluation of pica (Freidl and Attia, 2016).
  o Pica is most commonly seen in individuals with developmental disabilities (Freidl and Attia, 2016).
  o Although pica may occur in those with other psychiatric disorders or medical conditions, a separate diagnosis is made when the severity of the eating behavior warrants specific clinical management (American Psychiatric Association, 2013).
• Rumination as a symptom may occur in association with other eating disorders, including anorexia and bulimia nervosa (Freidl and Attia, 2016).
o If the rumination behavior occurs exclusive of another eating disorder or a medical condition and the severity of the behavior necessitates clinical attention, then a diagnosis of rumination disorder is warranted (American Psychiatric Association, 2013).

- Distinguishing features for ARFID, in comparison to anorexia nervosa, include a lack of fear of weight gain, no shape or weight concerns, and no specific focus on weight loss (American Academy of Child & Adolescent Psychiatry, 2015).

B. Differential diagnosis for pica, rumination disorder, or ARFID may include (American Psychiatric Association, 2013):
- Anorexia nervosa;
- Bulimia nervosa;
- Obsessive-compulsive disorder;
- Other medical conditions (e.g., gastrointestinal conditions);
- Reactive attachment disorder;
- Schizophrenia spectrum disorders;
- Specific neurological/neuromuscular, structural, or congenital disorders and conditions associated with feeding difficulties;
- Specific phobia, social anxiety disorder, and other anxiety disorders.

C. Treatment
- Much of the empirical evidence for behavioral treatment of pica has been among individuals with co-occurring developmental disability (Freidl and Attia, 2016).
  - Behavioral treatments, especially those combining reinforcement and response reduction procedures, are well-established treatments for pica (Hagopian et al., 2011; Freidl and Attia, 2016).
- Behavioral approaches for treatment of rumination disorder are supported by a number of case reports; however no controlled trials have been reported to date (Freidl and Attia, 2016).
- For children and adolescents with ARFID, there are no empirical studies to guide treatment, but use of CBT and family interventions may be helpful (American Academy of Child & Adolescent Psychiatry, 2015).
- Evidence-based pharmacological treatments for pica, rumination disorder, and ARFID are lacking (Kelly et al., 2014).

### APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>F50.00</td>
<td>Anorexia nervosa, unspecified</td>
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<tr>
<td>F50.01</td>
<td>Anorexia nervosa, restricting type</td>
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<tr>
<td>F50.02</td>
<td>Anorexia nervosa, binge-eating/purging type</td>
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<td>F50.2</td>
<td>Bulimia nervosa</td>
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<td>F50.81</td>
<td>Binge eating disorder</td>
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<td>F50.82</td>
<td>Avoidant/restrictive food intake disorder</td>
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<td>F50.89</td>
<td>Other specified eating disorder</td>
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<td>F50.9</td>
<td>Eating disorder, unspecified</td>
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<td>F98.3</td>
<td>Pica of infancy and childhood</td>
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<td>F98.21</td>
<td>Rumination disorder of infancy</td>
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<tr>
<td>R11.10</td>
<td>Vomiting, unspecified</td>
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<tr>
<td>F98.29</td>
<td>Other feeding disorders of infancy and early childhood</td>
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<td>Procedures Codes</td>
<td>Description</td>
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<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary procedure)</td>
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<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
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<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
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<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
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<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes</td>
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<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)</td>
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without room and board, per diem

H0025  Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)

H0035  Mental health partial hospitalization, treatment, less than 24 hours

H2001  Rehabilitation program, per 1/2 day

H2011  Crisis intervention service, per 15 minutes

H2012  Behavioral health day treatment, per hour

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REFERENCES


### REVISION HISTORY

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<th>Action/Description</th>
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<tr>
<td>11/2016</td>
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<tr>
<td>01/2017</td>
<td>Guideline published on InSite</td>
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<tr>
<td>12/20/2017</td>
<td>Annual review performed. Formatting updated: instructions for use removed, benefit considerations condensed, plan definitions removed, links to common criteria removed, DSM classification removed and additional resources section removed. Coding and references updated. No substantive changes to clinical content.</td>
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<td>06/13/2018</td>
<td>Revised CDG to reflect the inclusion of Feeding disorders.</td>
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<tr>
<td>06/17/2019</td>
<td>Annual Update: Updates to formatting, codes, references</td>
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