FEEDING AND EATING DISORDERS

Policy Number: BH803FED0618 **Effective Date**: June 13, 2018

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Relevant Diagnoses

- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder (ARFID)

Related Clinical Policies & Guidelines

- Other Specified and Unspecified Disorders

BENEFIT CONSIDERATIONS

Before using this policy, please check the member's specific benefit plan requirements and any federal or state mandates, if applicable.
This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

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.

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

EVIDENCE-BASED CLINICAL GUIDELINES

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 & 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)
- Validated eating disorder screening measures for use in younger children include (American Academy of Child & Adolescent Psychiatry, 2015):
  - 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 & Peebles, 2014):
  - Behavioral recovery includes normalizing eating patterns and the return of flexibility in eating;
  - Psychological recovery includes improved self-esteem and age-apropriate 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 & Peebles, 2014)
- Severe acute physical signs and medical complications need to be treated (American Academy of Child & Adolescent Psychiatry, 2015)
  - 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 availabilty of psychosocial and familial support (Harrington, et al 2015)
  - 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)
  - 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)
  - 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 malnurtition 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 (e.g., Lock & 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 (e.g., 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):
        - Significant electrolyte abnormalities;
        - Arrhythmias or severe bradycardia;
        - Rapid persistent weight loss in spite of outpatient therapy;
        - Serious comorbid medical or psychiatric conditions, including suicidal ideation
    - Some data suggests that, when indicated, use of nasogastric tube feeding is more efficient than other approaches in promoting short-term weight gain in the context of hospitalization for weight restoration (American Academy of Child & Adolescent Psychiatry, 2015; Kells & Kelly-Weeder, 2016; (American Psychiatric Association, 2012).

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

C. Studies in adults with binge-eating disorder recommend cognitive behavioral therapy (CBT), primarily for achieving abstinence and reducing binge frequency (American Academy of Child & Adolescent Psychiatry, 2015; Agency for Healthcare Research & Quality, 2015; American Psychiatric Association, 2012)
- 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 & Attia, 2016)
    - Pica is most commonly seen in individuals with developmental disabilities (Freidl & Attia, 2016)
    - 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 clincial management (American Psychiatric Association, 2013)
- Rumination as a symptom may occur in association with other eating disorders, including anorexia and bulimia nervosa (Freidl & Attia, 2016)
    - 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 epirical evidence for behavioral treatment of pica has been among individuals with co-occurring developmental disability (Freidl & Attia, 2016)
    - Behavioral treatments, especially those combining reinforcement and response reduction procedures, are well-established treatments for pica (Hagopian, et al 2011; Freidl & 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 & 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 guideline 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 policies and guidelines may apply.

CPT Code	Description
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)

HCPCS Code	Description
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem

HCPCS Code	Description
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), 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
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
S0201	Partial hospitalization services, less than 24 hours**,** per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

ICD-10 Diagnosis Code	Description
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge-eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F98.3	Pica of infancy and childhood
F98.21	Rumination disorder of infancy
R11.10	Vomiting, unspecified
F98.29	Other feeding disorders of infancy and early childhood

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*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

HISTORY/REVISION INFORMATION

Date	Action/Description
11/2016	Version 1 - Draft
01/2017	Guideline published on inSite
12/20/2017	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.
6/13/2018	Revised CDG to reflect the inclusion of Feeding disorders.