INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California (“Optum-CA”).

When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs)) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee’s specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.
While this Coverage Determination Guideline does reflect Optum’s understanding of current best practices in care, it does not constitute medical advice.

### Key Points

- According to the DSM, Anorexia Nervosa is a form of eating disorder whose essential features include a refusal to maintain a minimally normal body weight, an intense fear of gaining weight, and a significant disturbance in the perception of the shape or size of one’s body. *(Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association (DSM-5), 2013)*)
- Benefits are available for covered services that are not otherwise limited or excluded.
- Pre-notification is required for inpatient, residential treatment, partial hospital/day treatment programs, intensive outpatient programs, and home-based outpatient treatment.
- Services should be consistent with evidence-based interventions and clinical best practices as described in Part III, and should be of sufficient intensity to address the member’s needs *(UnitedHealth Care, Certificate of Coverage (COC), 2007, 2009 & 2011)*.

### PART I: BENEFITS

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

**Benefits**

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

**Covered Services**

**Covered Health Service(s) – 2001**

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What’s Not Covered--Exclusions.
Covered Health Service(s) – 2007, 2009 and 2011

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Pre-Service Notification

Admissions to an inpatient, residential treatment center, intensive outpatient home-based 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.

Limitations and Exclusions

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee’s benefit document that prevails.

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member’s Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

**Additional Information**

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):

- Services that deviate from the indications for coverage summarized earlier in this document.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program without evidence-based treatment of acute symptoms.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program that does not provide adequate nursing care and monitoring, or physician coverage.
- The use of psychological or neuropsychological testing when a diagnostic or treatment planning question can be answered by means of a standard interview and behavior rating scale assessment.

Please refer to the enrollee’s benefit document for ASO plans with benefit language other than the generic benefit document language.
PART II: CLINICAL BEST PRACTICE

Evaluation and Treatment Planning

1. The initial evaluation:

1.1. Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services (i.e., the “why now” factors).

1.2. Focuses on the member’s specific needs.

1.3. Identifies the member’s goals and expectations.

1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:

1.5.1.1. The member's chief complaint;

1.5.1.2. The history of the presenting illness;

1.5.1.3. The “why now” factors leading to the request for service;

1.5.1.4. The member’s mental status;

1.5.1.5. The member's current level of functioning;

1.5.1.6. Urgent needs including those related to the risk of harm to self, others, or property;

1.5.1.7. The member's use of alcohol, tobacco, or drugs;

1.5.1.8. Co-occurring behavioral health and physical conditions;

1.5.1.9. The history of behavioral health services;

1.5.1.10. The history of trauma;

1.5.1.11. The member’s medical history and current physical health status;

1.5.1.12. The member’s developmental history;

1.5.1.13. Pertinent current and historical life information including the member’s :

1.5.1.13.1. Age;

1.5.1.13.2. Gender, sexual orientation;

1.5.1.13.3. Culture;

1.5.1.13.4. Spiritual beliefs;

1.5.1.13.5. Educational history;

1.5.1.13.6. Employment history;
1.5.1.13.7. Living situation;
1.5.1.13.8. Legal involvement;
1.5.1.13.9. Family history;
1.5.1.13.10. Relationships with family, and other natural resources;
1.5.1.13.11. The member’s strengths;
1.5.1.13.12. Barriers to care;
1.5.1.13.13. The member’s instructions for treatment, or appointment of a representative to make decisions about treatment;
1.5.1.13.14. The member’s broader recovery, resiliency and wellbeing goals.

1.6. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.

1. Evaluation of Anorexia

1.1. The psychiatric evaluation should determine the presence of any of the following (Klein & Attia, 2016):

1.1.1. Core features

1.1.1.1. Persistent restriction of energy intake that leads to an abnormally low body weight

1.1.1.2. Intense fear of gaining weight or becoming fat, or persistent behavior that prevents weight gain

1.1.1.3. Distorted perception of body weight and shape

1.1.2. Associated features

1.1.2.1. Relentless pursuit of thinness

1.1.2.2. Obsessive preoccupation with food (e.g., collecting recipes or hoarding food)

1.1.2.3. Fear or restricted repertoire of certain foods (e.g., low calorie foods)

1.1.2.4. Overestimating number of calories consumed

1.1.2.5. Overusing condiments and/or artificially sweetened products

1.1.2.6. Food-related rituals (e.g., cutting food into small pieces or refusing to mix different types or colors of food on the plate)

1.1.2.7. Concerns about eating in public leading to social withdrawal
1.1.2.8. Exercise-related rituals (e.g., walking or running a set distance each day; swimming a specified number of laps in a pool)

1.1.2.9. Restlessness or hyperactivity

1.1.2.10. Limited insight into or denial of core clinical features

1.1.2.11. Resistance to treatment and weight gain

1.1.2.12. Inhibited expression of emotions

1.1.2.13. Feelings of ineffectiveness

1.1.2.14. Poor sleep

1.1.2.15. Low libido

1.1.2.16. Dysphoria (e.g., depressed or anxious mood)

1.1.2.17. Inflexible thinking, behavioral rigidity, perfectionism and need to control (e.g., purchasing food only in certain stores or from certain salespeople, inability to accommodate to changes in schedule or environment).

1.2. Children and adolescents may report the desire to be thin, but may state they are trying to eat less, avoid fattening foods, and exercise more for health reasons. Others may deny body image or weight concerns. It is important to determine if the member’s behaviors match his/her self report (AACAP Practice Parameter, 2015).

1.3. Adults in particular may present with anxiety, depression, or somatic discomfort due to medical complications such as pain with eating, bloating, or inability to keep food down. Because of the shame associated with Anorexia, there may be an attempt to conceal thinness by wearing bulky clothes, hiding objects in their clothes and drinking water (Klein & Attia, 2016).

1.4. Detailed information about the following should also be gathered as part of the psychiatric evaluation (Klein & Attia, 2016):

1.4.1. Height and weight

1.4.1.1. Current body weight and desired weight. Clinicians should measure weight and height as well as ask about them.

1.4.1.2. Recent weight changes, lifetime highest and lowest weights at adult height, stability of weight over time, and history of efforts to control weight and shape.
1.4.1.3. A chronology should be established to determine whether current symptoms are acute or chronic.

1.4.1.4. Frequency of self-weighing

1.4.1.5. Consider that at present, there is little scientific basis for using weight alone as a marker of severity (AACAP Practice Parameter, Eating Disorders, 2015).

1.4.1.6. The use of longitudinal growth charts (e.g., CDC and WHO growth charts) and deviations from them may be used along with other height and weight considerations described above (AACAP Practice Parameter, Eating Disorders, 2015).

1.5. Meal pattern (Klein & Attia, 2016):

1.5.1. Estimate typical daily caloric and nutrient (carbohydrates, fat, and protein) intake from both foods and beverage, and assess pattern of consumption, including times, amounts, and context.

1.6. Present and past eating disorder symptoms (Klein & Attia, 2016):

1.6.1. Dietary restriction

1.6.2. Attitudes about food, eating, body weight, and shape including fear of becoming fat and resistance to gaining weight.

1.6.3. Binge eating

1.6.4. Compensatory behaviors such as purging (e.g., self-induced vomiting or misuse of laxatives, diuretics, or enemas), fasting, and exercise.

1.6.5. Ritualistic eating behaviors (e.g., cutting food into extremely small pieces or refusing to mix different types or colors of food on the plate)

1.7. Self evaluation, self esteem, and perception of body weight and shape (Klein & Attia, 2016)

1.8. Menstrual status (Klein & Attia, 2016):

1.8.1. Last menstrual period

1.8.2. Regularity of menses

1.8.3. Weight at first menses

1.9. Prescription medications (Klein & Attia, 2016):

1.9.1. Oral contraceptives can produce bleeding that simulates menstrual periods
1.9.2. Emetics may be used to purge

1.10. Anorexia treatment history (Klein & Attia, 2016):
   1.10.1. Psychotherapy
   1.10.2. Pharmacotherapy
   1.10.3. Self-help groups

1.11. Family history of eating disorders and other psychopathology (Klein & Attia, 2016).

1.12. Interpersonal problems should be evaluated. There is no evidence that families cause eating disorders however, there are families who are not supportive and who may contribute to problems with self-esteem and body image (Klein and Attia, 2015).

1.13. The member should be evaluated for the presence of self-harm and any conditions that may co-occur with Anorexia (Klein & Attia, 2016).
   1.13.1. Suicidality may accompany Anorexia, including suicidal ideation, actions to prepare for an attempt, or impulsive non-fatal self-harm.
   1.13.2. In patients with anorexia nervosa, comorbid substance use disorders and a history of sexual abuse are often associated with suicide attempts.
   1.13.3. Hospitalization for patients with suicidality should be considered, depending upon the estimated level of risk. A specific suicide plan of high lethality or intent indicates the need for hospitalization.
   1.13.4. The evidence indicates that 8 to 27 percent of Anorexia patients have a lifetime history of attempted suicide.

1.14. Patients with Anorexia often suffer from (Klein & Attia, 2016):
   1.14.1. Body Dysmorphic Disorder
   1.14.2. Anxiety disorders
   1.14.3. Obsessive-compulsive disorder
   1.14.5. Mood disorders
   1.14.6. Substance use disorders
   1.14.7. Disruptive, impulse control, and conduct disorders
   1.14.8. Personality Disorders
1.14.9. Psychotic Disorders

2. Restlessness, fidgeting, impaired attention, concentration, and thought process can indicate cognitive impairment related to medical complications of low weight and/or purging (Klein & Attia, 2015).

3. Differential Diagnosis

3.1. Bulimia Nervosa — Bulimia and Anorexia are both marked by overvaluation of body shape and weight. In addition, patients with Bulimia binge eat and purge, as do many patients with Anorexia. Making the correct diagnosis is essential for treatment (Klein & Attia, 2016).

3.1.1. The key distinguishing feature of Anorexia is an abnormally low body weight (body mass index <18.5 kg/m2), given the patient’s age, sex, developmental level, and physical health.

3.1.2. Patients with Bulimia usually maintain a body weight at or above a minimally normal level.

3.1.3. The low weight that occurs in Anorexia is accompanied by physical symptoms (e.g., reduced cardiac mass and bone density) that are not found in Bulimia.

3.2. Avoidant/Restrictive Food Intake Disorder — These patients have poor energy and nutritional intake that can lead to low body weight. However, ARFID is due a lack of interest in food, aversion to the sensory characteristics of food, or concern about aversive consequences of eating (e.g., choking or vomiting) (Klein & Attia, 2016).

3.2.1. By contrast, Anorexia is accompanied by fear of gaining weight or becoming fat, and disturbance in the way that body weight and shape are perceived and experienced.

3.3. Other Specified Feeding or Eating Disorder — For patients who meet some but not all of the diagnostic criteria for Anorexia, clinicians can diagnose Other Specified Feeding or Eating Disorder, along with the reason that the criteria are not met.

3.3.1. As an example, obese patients who demonstrate the signs and symptoms of Anorexia during rapid weight loss to a normal weight are given the diagnosis, “Other Specified Feeding or Eating Disorder, atypical Anorexia”.

3.4. Other disorders — Specific symptoms of anorexia nervosa are similar to symptoms that occur in (Klein & Attia, 2016):
3.4.1. Major Depression – Decreased weight often occurs in MDD. However, the weight loss is due to loss of appetite and is not intentional, and reluctance to gain weight and distorted body image are not present.

3.4.2. Social phobia – Patients with either Social Phobia or Anorexia may be embarrassed to eat in public. However, patients with Social Phobia recognize that the fear is excessive or unreasonable, and they are not emaciated.

3.4.3. Obsessive-Compulsive Disorder – Obsessions and compulsions regarding food can occur in both Anorexia and OCD. However, patients with OCD are not emaciated and recognize that the preoccupations and behaviors are excessive or unreasonable.

3.4.4. Body Dysmorphic Disorder – Patients with Anorexia may be excessively preoccupied with an imagined defect in body appearance, as occurs in BDD. However, the preoccupation in Anorexia concerns body weight or shape, whereas in BDD the imagined defect typically involves the face or head. In addition, BDD does not manifest with emaciation and a fear of becoming fat.

3.4.5. Psychotic disorders – Psychotic patients may have delusions about food (e.g., food is poisoned), refuse to eat, and lose weight. In contrast to Anorexia, psychosis usually do not include fear of gaining weight or distorted body image.

3.4.6. Attention-Deficit/Hyperactivity Disorder – Restlessness and impaired concentration are common to ADHD and Anorexia. However, in Anorexia, these symptoms are typically due to low weight and improve with normalization of body weight.

3.4.7. Other Conditions – If the diagnosis of Anorexia is not clear, the medical evaluation should account for general medical illnesses that can present with weight loss, malabsorption, or secondary amenorrhea.

4. Medical Evaluation of Anorexia

4.1. Medical history — The most common medical symptoms of anorexia nervosa are (Forman & Yager 2016):

4.1.1. Amenorrhea
4.1.2. Infertility
4.1.3. Exertional fatigue
4.1.4. Weakness
4.1.5. Cold intolerance
4.1.6. Palpitations
4.1.7. Dizziness
4.1.8. Abdominal pain and bloating
4.1.9. Constipation
4.1.10. Swelling of the feet
4.1.11. Irritability is often present as well

4.2. Physical Examination — Within the context of a complete physical examination, key measures include weight and height, vital signs (heart rate, blood pressure both supine and standing, temperature), cardiovascular assessment, and skin examination (Forman & Yager 2016).

4.3. Common physical signs — Common signs in patients with anorexia nervosa are (Mehler, Yager & Solomon, 2016):

4.3.1. Low body mass index (<17.5)
4.3.2. Emaciation (body weight less than 70 percent of ideal body weight)
4.3.3. Hypothermia (core temperature <95°F)
4.3.4. Bradycardia (pulse <60 beats per minute)
4.3.5. Hypotension (systolic blood pressure <90 mmHg and/or a diastolic blood pressure <50 mmHg)
4.3.6. Hypoactive bowel sounds
4.3.7. Xerosis (dry, scaly skin)
4.3.8. Brittle hair and hair loss
4.3.9. Other signs that are often present include brittle nails, pressure sores, yellow skin (hypercarotenemia, especially palms), lanugo hair, cyanotic and cold hands and feet, edema (ankle and periorbital), and heart murmur from mitral valve prolapse.

4.4. Laboratory assessment — Tests should be guided by the symptoms and findings on the physical examination. Laboratory tests indicated for all patients with anorexia nervosa include (Forman & Yager 2016):

4.4.1. Serum electrolytes
4.4.2. Blood urea nitrogen
4.4.3. Serum creatinine
4.4.4. Serum glucose
4.4.5. Serum calcium, phosphorous, and magnesium
4.4.6. Thiamine
4.4.7. Serum albumin
4.4.8. Liver function tests (aspartate aminotransferase, alanine aminotransferase, and alkaline phosphatase)
4.4.9. Internationalized Normalized Ratio (INR)
4.4.10. Complete blood count (CBC) including differential
4.4.11. Thyroid stimulating hormone (TSH)
4.4.12. Electrocardiogram (ECG)
4.4.13. Urinalysis for specific gravity
4.4.14. Echocardiogram for patients for patients with a body mass index <14 or for members with cardiac symptoms (e.g., bradycardia <40 bpm).
4.4.15. Dual-energy x-ray absorptiometry (DEXA) to measure bone density for patients amenorrheic for greater than six months.
4.4.16. Patients with significant cognitive impairment may need magnetic resonance imaging (MRI) of the brain.

5. Acute vs. Chronic Anorexia

5.1. The provider should determine whether the member’s Anorexia is acute or chronic by identifying the following:
5.1.1. Lifetime duration of illness (i.e., number of years with living Anorexia) (Pike, Yager &Solomon, 2016);
5.1.2. Age at the time initial treatment was sought (Pike, Yager &Solomon, 2016);
5.1.3. History of relapse after period of remission (relapse defined as 3 consecutive months at baseline weight or BMI below 17.5 after 85% of weight gain or normal BMI achieved) (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2009).
5.1.4. Recent weight changes, lifetime highest and lowest weights at adult height, stability of weight over time, and history of efforts to control weight and shape. A chronology will help determine whether current symptoms are acute or chronic (Forman & Yager 2016).
5.1.5. History of interventions that have been successful, unsuccessful, or partially successful for the member (Pike, Yager & Solomon, 2016).

5.1.6. Any medical problems such as osteoporosis or cardiac damage that need to be managed;

5.2. If the member is identified as having a chronic form of Anorexia, an overall clinical picture of the member should be gathered in order to develop a tailored and realistic individual treatment expectations with the member that may include:

5.2.1. Returning the member to their baseline weight or a safe individualized weight goal guided by laboratory results and/or biopsychosocial history findings rather than solely by ideal body weight or BMI; and

5.2.2. Identifying a level of functioning that is compatible with the member’s baseline level of functioning and the ability to function within the context of the member’s lifestyle.

6. Treatment Planning

6.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:

6.1.1. The short- and long-term goals of treatment;

6.1.2. The type, amount, frequency and duration of treatment;

6.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;

6.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;

6.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

6.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.

6.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
6.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

6.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.

6.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

6.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.

6.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.

6.5.3. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Treatment Interventions

First-line treatment for Anorexia consists of weight restoration with nutritional rehabilitation in addition to outpatient individual, group and family psychotherapy. Depending on the severity of the member’s symptoms, medical and pharmacological interventions may be included.

Psychiatric hospitalization, day programs, partial hospitalization programs, and residential programs for eating disorders should be considered only when outpatient interventions have been unsuccessful or are unavailable (AACAP Practice Parameter, Eating Disorders, 2015).

1. Medical Management

1.1. Hospitalization may be indicated for patients with any one or more of the following (Forman & Yager 2016):

1.1.1. Unstable vital signs

1.1.2. Bradycardia less than 30 beats per minute (resting, awake heart rate)
1.1.3. Bradycardia less than 40 beats per minute and hypotension or symptoms of lightheadedness
1.1.4. Hypothermia (core temperature <35°C or 95°F
1.1.5. Cardiac dysrhythmia other than sinus bradycardia
1.1.6. Weight less than 70 percent of ideal body weight, especially if weight loss was rapid
1.1.7. Marked dehydration
1.1.8. Acute medical complication of malnutrition (e.g., syncope, seizures, cardiac failure, liver failure, pancreatitis, or electrolyte disturbance)
1.1.9. The need for nasogastric refeeding.
   1.1.9.1. Nasogastric refeeding should be an intervention of last resort for members unable to cooperate with oral refeeding or if there is a grave medical danger. Refeeding should be carried out within applicable medical and regulatory guidelines (APA, 2006).
   1.1.9.2. Moderate to severe refeeding syndrome
      1.1.9.2.1. Marked edema
      1.1.9.2.2. Serum phosphorous <2 mg/dL
1.2. Care and/or consultation with a physician with an expertise in the treatment the medical complications associated with Anorexia should be accessible in all levels of care (Meher, Yager & Solomon, 2016).
1.3. Outpatient follow-up should occur within three to five days for patients discharged after an acute hospitalization for medical complications along with nutritional rehabilitation.
1.4. Patients may require medical oversight as they are often at risk for refeeding syndrome for the first few weeks after consistent weight restoration and weight gain have started.
1.5. Weekly to monthly primary care follow-up is prudent to examine patients for signs of the refeeding syndrome, check phosphate, other electrolyte levels, and liver function tests; and to monitor weight gain.
1.6. For patients with chronic anorexia nervosa, a repeat DEXA scan every two years to monitor bone mineral density and response to treatment for osteoporosis is recommended (Forman & Yager 2016).
1.7. Repeat ECG and echocardiograms are not required after initial evaluation unless cardiac symptoms persist despite weight restoration, as many cardiac complications are resolved with weight restoration. If new cardiac symptoms develop (e.g., bradycardia <40 bpm), or if there were significant abnormalities present on the initial tests ECG monitoring and/or cardiology consultation may be indicated (Forman & Yager 2016).

2. Nutritional Rehabilitation

2.1. Nutritional rehabilitation is indicated for all malnourished patients with anorexia nervosa (Steinglass, 2016).

2.2. The goal of nutritional rehabilitation is to restore a minimally normal weight. The weekly target for controlled weight gain generally varies according to the setting (Steinglass, 2016):

- **Inpatient** – 2 to 3 pounds (0.9 to 1.4 kg) per week
- **Partial hospital** – 1 to 2 pounds (0.5 to 0.9 kg)
- **Outpatient** – 0.5 to 1 pound (0.2 to 0.5 kg)

2.3. Caloric intake at the beginning of nutritional rehabilitation is typically 30 to 40 kcal/kg body weight/day. Daily calories are advanced by about 200 to 400 kcal every two to four days; caloric intake may eventually progress up to 70 to 100 kcal/kg/day (Steinglass, 2016).

2.4. Nutritional rehabilitation is often accomplished solely through oral intake of regular food; energy dense liquid dietary supplements may be prescribed if patients cannot consume enough food to meet their caloric goals. Enteral (nasogastric tube) feeding is occasionally indicated and total parenteral (intravenous) nutrition is rarely indicated for extremely underweight patients or highly refractory patients who steadfastly refuse to eat a sufficient amount of food to gain weight (Steinglass, 2016).

2.5. The refeeding syndrome is a rare but potentially fatal complication that can occur when nutritional rehabilitation is too aggressive. Other complications of nutritional rehabilitation include refeeding edema and constipation (Steinglass, 2016).

2.6. Clinicians administering nutritional rehabilitation should monitor vital signs; weight; cardiovascular, gastrointestinal, and pulmonary systems; and laboratory tests (serum electrolytes, glucose, phosphorous, magnesium, and liver function tests) (Steinglass, 2016).
2.7. Patients with anorexia nervosa who restore their weight initially require a maintenance diet of approximately 45 to 50 kcal/kg of body weight/day, which is eventually tapered to 30 kcal/kg/day. Relapse is less likely to occur with maintenance diets that include highly caloric foods and a greater variety of food (Steinglass, 2016).

3. **Psychotherapy**

3.1. Psychotherapy may include individual, family and group therapy approaches with the following considerations:

3.1.1. Cognitive Behavioral Therapy encourages patients to change the dysfunctional cognitions (thoughts and beliefs about body weight and shape) and behavioral disturbances (eg, excessive food restriction) that perpetuate anorexia nervosa, and places less emphasis upon the factors that caused the disorder (Forman, 2016).

3.1.2. Family Therapy and a specific type of family therapy is family-based treatment (also called the Maudsley method), which is used for adolescents and focuses upon weight gain; the treatment initially places parents in charge of making decisions about appropriate eating and related behaviors, with the support of a family therapist. As patients begin to improve, control over eating is gradually transferred back to them, and other issues related to family functioning are addressed (Forman, 2016).

3.1.3. A reasonable alternative to family-based treatment is systemic family therapy, which focuses upon general family functioning and processes (Forman, 2016).

3.1.4. Adolescent-focused therapy (AFT), an individual therapy focused on individuation and self-efficacy, can be useful. AFT encourages the adolescent to manage her or his own eating and weight gain through the relationship with the therapist. In addition, the main focus of AFT is to encourage an increased awareness and tolerance of emotions, particularly negative ones (AACAP Practice Parameter, Eating Disorders, 2015).

3.1.5. For members with chronic forms of Anorexia, treatment goals may focus on returning the member to their baseline weight or achieving a weight that is safe for the member rather than the member’s ideal body weight.
3.1.6. Psychotherapy such as CBT may not be indicated for patients who are medically unstable, psychotic or suicidal patients.

4. Pharmacotherapy

4.1. The standard treatment for patients acutely ill with anorexia nervosa is nutritional rehabilitation plus psychotherapy. However, patients not gaining weight despite standard treatment are candidates for adjunctive pharmacotherapy (Walsh, 2016).

4.2. For acutely ill patients not gaining weight with nutritional rehabilitation plus psychotherapy, adjunctive treatment with olanzapine 2.5 mg to 10 mg per day, rather than other medications is recommended (Walsh, 2016).

4.3. Mild to moderate comorbid depressive or anxiety disorders often resolve with standard treatment consisting of nutritional rehabilitation plus psychotherapy. For severe comorbid disorders that do not respond to standard treatment, it is reasonable to initially try a selective serotonin reuptake inhibitor (SSRI). Severe depression that is unresponsive to an SSRI may perhaps respond to a second-generation antipsychotic (Walsh, 2016).

4.4. Bupropion should not be used because it is associated with a higher incidence of seizures in patients with eating disorders. Medical complications of anorexia nervosa should also be considered (Walsh, 2016).

4.5. Psychopathology about body image and food generally does not respond to pharmacotherapy (Walsh, 2016).

Discharge Planning

1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.

1.1. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:

1.1.1. An appropriate discharge plan is in place prior to discharge;

1.1.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;

1.1.3. The member agrees with the discharge plan.

1.2. For members continuing treatment, the discharge plan includes:
1.2.1. The discharge date;
1.2.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
1.2.3. The names of the providers who will deliver treatment;
1.2.4. The date of the first appointment including the date of the first medication management visit;
1.2.5. The name, dose and frequency of each medication;
1.2.6. A prescription sufficient to last until the first medication management visit is provided;
1.2.7. An appointment for necessary lab tests is provided;
1.2.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;
1.2.9. Recommended self-help and community support services;
1.2.10. Information about what the member should do in the event of a crisis prior to the first appointment.
1.2.11. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.
1.2.12. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.
1.2.13. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
1.2.14. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
1.2.15. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.

1.3. For members not continuing treatment, the discharge plan includes:
1.3.1. The discharge date;
1.3.2. Recommended self-help and community support services;
1.3.3. Information about what the member should do in the event of a crisis or to resume services.

1.3.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

**PART III: LEVEL OF CARE CRITERIA**

**Common Admission Criteria for All Levels of Care**

1. **Admission Criteria**

   1.1. The member is eligible for benefits.

   **AND**

   1.2. The member’s condition and proposed services are covered by the benefit plan.

   **AND**

   1.3. Services are within the scope of the provider’s professional training and licensure.

   **AND**

   1.4. The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission).

   1.4.1. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

   **AND**

   1.5. The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) require the intensity of services provided in the proposed level of care.

   **AND**

   1.6. Co-occurring behavioral health and medical conditions can be safely managed.

   **AND**

   1.7. Services are:

   1.7.1. Consistent with generally accepted standards of clinical practice;
1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum’s best practice guidelines;

1.7.4. Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member’s presenting problems within a reasonable period of time.

1.8.1. Improvement of the member’s condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.

1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member’s recovery, resiliency and wellbeing.

AND

1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.

2. **Common Continued Service Criteria for All Levels of Care**

2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:

2.1.1. Supervised and evaluated by the admitting provider;

2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;

2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.

AND

2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.
AND

2.4. The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.

3. **Common Discharge Criteria for All Levels of Care**

3.1. The continued stay criteria are no longer met. Examples include:

3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.

3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.

3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.

3.1.4. The member requires medical-surgical treatment.

3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.
Outpatient
Assessment and diagnosis and active behavioral health treatments that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

1. Admission Criteria
   1.1. (See Common Criteria for All Levels of Care)
   
   AND

   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.
   
   AND

   1.3. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

2. Continued Service Criteria
   2.1. (See Common Criteria for All Levels of Care)

3. Discharge Criteria
   3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices
   4.1. Evaluation & Treatment Planning

   4.1.1. (See Common Clinical Best Practices for All Levels of Care)

   4.1.2. The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include:

   4.1.2.1. The goals of treatment;

   4.1.2.2. The member’s preferences;

   4.1.2.3. Evidence from clinical best practices which supports frequency and duration;
4.1.2.4. The need to monitor and manage imminent risk of harm to self, others, and/or property.

4.1.3. The provider informs the member of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
Intensive Outpatient Program

A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment in an Intensive Outpatient Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

1. Admission Criteria

   1.1. (See Common Criteria for All Levels of Care)

   AND

   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

   AND

   1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include:

      1.3.1. Assessment requires frequent interaction with the member and observation of the member with others.

      1.3.2. The treatment plan must be frequently changed which requires that the provider have face-to-face interactions with the member several times a week.

   OR

   1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.

1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those the help the member:

1.5.1.1. Maintain their current living situation;

1.5.1.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.

1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with an Intensive Outpatient Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member’s recovery.

OR

1.10. Routine attendance at the Intensive Outpatient Program is hindered by the lack of transportation.

2. Continued Service Criteria
(See Common Criteria for All Levels of Care)

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices
4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The responsible provider and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than three (3) treatment days after admission.

4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
Partial Hospitalization Program
A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

The course of treatment in a Partial Hospital Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria
1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

AND

1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:

1.3.1. Assessment requires frequent interaction with the member, and observation of the member with others.

1.3.2. The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1. Maintain their current living situation;
1.5.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.
1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with a Partial Hospital Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member’s recovery.

OR

1.10. Routine attendance at the Partial Hospital is hindered by the lack of transportation.

1. Continued Service Criteria
   1.1. (See Common Criteria for All Levels of Care)

2. Discharge Criteria
   2.1. (See Common Criteria for All Levels of Care)

3. Clinical Best Practices
   3.1. Evaluation & Treatment Planning
      3.1.1. (See Common Clinical Best Practices for All Levels of Care)
3.1.2. The psychiatrists and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.

3.1.3. During admission, a psychiatrist is available to consult with the program during and after normal business hours.

3.1.4. A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.

3.2. Discharge Planning

3.2.1. (See Common Clinical Best Practices for All Levels of Care)
Residential Treatment Center

A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.

The course of treatment in a Residential Treatment Center is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)  

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. The “why now” factors leading to admission cannot be safely, efficiently or effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors. Examples include:

1.3.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.3.2. Psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

1.4. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

1.4.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
1.4.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

1.4.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

2. **Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

\[\text{AND}\]

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. **Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

4. **Clinical Best Practices**

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate with the member’s needs, no later than 24 following admission.

4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs at least weekly commensurate with the member’s needs.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.
Inpatient

A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The “why now” factors leading to admission, and/or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

1.2.1. A life-threatening suicide attempt;
1.2.2. Self-mutilation, injury or violence toward others or property;
1.2.3. Threat of serious harm to self or others;
1.2.4. Command hallucinations directing harm to self or others.

OR

1.3. The “why now” factors leading to admission suggest that the member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Example include:

1.3.1. A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
1.3.2. A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

OR

1.4. The “why now” factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:
1.4.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.4.2. Psychosocial and environmental problems that threaten the member’s safety or undermines engagement in a less intensive level of care.

**OR**

1.5. The “why now” factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

2. **Continued Service Criteria**

   2.1. (See Common Criteria for All Levels of Care)

   **AND**

   2.2. Treatment is not primarily for the purpose of providing custodial care.

   Services are custodial when they are any of the following:

   2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

   2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

   2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. **Discharge Criteria**

   3.1. (See Common Criteria for All Levels of Care)

4. **Clinical Best Practices**

   4.1. Evaluation & Treatment Planning

   4.1.1. (See Common Clinical Best Practices for All Levels of Care)

   4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.

   4.1.3. During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.

   4.2. Discharge Planning

   4.2.1. (See Common Clinical Best Practices for All Levels of Care)
4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.

PART IV: ADDITIONAL RESOURCES

Clinical Protocols
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline.

Peer Review
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

Second Opinion Evaluations
Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance
Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

PART V: DEFINITIONS

Anorexia Nervosa Anorexia Nervosa is a form of eating disorder whose essential features include a refusal to maintain a minimally normal body weight, an intense fear of gaining weight, and a significant disturbance in the perception of the shape or size of his/her body.

Cognitive Behavioral Therapy (CBT) A classification of therapies that are predicated on the idea that behavior and feelings are caused by thoughts.

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance-related disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.
**Inpatient** A secured and structured hospital-based service that provides 24-hour nursing care and monitoring, assessment and diagnostic services, treatment, and specialty medical consultation services with an urgency that is commensurate with the member’s current clinical need.

**Intensive Outpatient Program** A freestanding or hospital-based program that maintains hours of service for at least 3 hours per day, 2 or more days per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down.

**Mental Illness** Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

**Nutritional Counseling** A form of treatment in which the primary goal is the modification of what the member eats as well as relevant eating habits and attitudes. It is usually implemented by dietitians.

**Outpatient** Visits provided in an ambulatory setting.

**Partial Hospital/Day Treatment Program** A freestanding or hospital-based program that maintains hours of service for at least 20 hours per week, and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care, or as a step down from a more intensive level of care.

**Prevailing Medical Standards and Clinical Guidelines** means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

**Refeeding** Increasing nutritional intake and restoring weight to within a normal range in the treatment of anorexia nervosa.

**Refeeding Syndrome** Refeeding Syndrome - Metabolic disturbances that occur as a result of reinstitution of nutrition to members who are starved or severely malnourished. These metabolic disturbances can, in turn, cause severe medical complications including cardiac failure, edema, and coma.

**Residential Treatment Center** A facility-based or freestanding program that provides overnight services to members who do not require 24-hour nursing care and monitoring offered in an acute inpatient setting but who do require 24-hour structure.

**Scientific Evidence** means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

### PART VI: REFERENCES

PART VII: CODING

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

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Limited to place of service (POS)? ☐ Yes  X No
Limited to specific provider type? □ Yes  ✗ No

Limited to specific revenue codes?  ✗ Yes  □ No

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<thead>
<tr>
<th>Revenue Code Range</th>
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<td>100-160</td>
<td>(Range describes various all-inclusive inpatient services)</td>
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<tr>
<td>900-919</td>
<td>(Range describes various unbundled behavioral health treatments/services)</td>
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<tr>
<td>1000-1005</td>
<td>(Range describes various sites that provider 24-hour services)</td>
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PART VIII: HISTORY

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<tr>
<th>Revision Date</th>
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<th>Revision Notes</th>
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<tr>
<td>10/2014</td>
<td>G. Niewenhous</td>
<td>Version-2 Final</td>
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<tr>
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