

Treatment of Bulimia Nervosa

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2001 Generic UnitedHealthcare COC/SPD

2007 Generic UnitedHealthcare COC/SPD

2009 Generic UnitedHealthcare COC/SPD

2011 Generic UnitedHealthcare COC/SPD

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Related Coverage Determination Guidelines:

Anorexia Nervosa

Binge Eating Disorder

Related Medical Policies:

Level of Care Guidelines

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, Bulimia Nervosa is a form of eating disorder whose essential features include recurrent binge eating (i.e., eating in a discrete period of time an amount of food that is larger than most people would consume during a similar period of time) and inappropriate compensatory behaviors to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives, diuretics, other medications, enemas, fasting or excessive exercise). The binge eating and inappropriate compensatory behaviors both occur an average of once per week for 3 months and the disturbance does not occur exclusively during an episode of Anorexia Nervosa. (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.

Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011

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;
- 1.5.1.14. The member's strengths;
- 1.5.1.15. Barriers to care;
- 1.5.1.16. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
- 1.5.1.17. 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.

2. Evaluation of Bulimia

- 2.1. The psychiatric evaluation should determine the presence of any of the following (Engell, Steffen & Mitchell, 2016):

Core features

- 2.1.1. Binge eating – Eating an amount of food in a discrete period of time that is definitely larger than most people would eat under similar circumstances (e.g., enough food for about 2 meals/2000 calories until uncomfortable). During the episode, patients feel they have no control over their eating.
- 2.1.2. Inappropriate compensatory behavior to prevent weight gain, such as self induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- 2.1.3. Binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for three months.
- 2.1.4. Excessive concern about body weight and shape.
- 2.1.5. The typical sequence of behavior in Bulimia consists of:
 - 2.1.5.1. Calorie restriction
 - 2.1.5.2. Binge eating
 - 2.1.5.3. Self-induced vomiting

Associated features

- 2.1.6. Body weight in Bulimia is usually within or above the normal range.

- 2.1.7. Patients often restrict their diet between binge eating episodes to influence body weight or shape.
- 2.1.8. Bulimia is usually accompanied by other behavioral health conditions.
- 2.2. Detailed information about the following should also be gathered as part of the psychiatric evaluation (Engel, Steffen & Mitchell, 2016):
 - 2.2.1. Height and weight
 - 2.2.2. Current height and weight (patients with Bulimia may have a normal weight as compared to patients with Anorexia)
 - 2.2.3. Lifetime highest and lowest weights at adult height, patterns of weight fluctuation
 - 2.2.4. Desired weight
 - 2.2.5. Frequency of self-weighing
- 2.3. Meal pattern
 - 2.3.1. Food intake when patient is not binge eating
- 2.4. Detail of present and past eating disorder symptoms
 - 2.4.1. Dietary restriction
 - 2.4.2. Attitudes about food, eating, body weight, and shape including fear of becoming fat and resistance to gaining weight.
 - 2.4.3. Binge eating behavior, including frequency, types and amounts of food eaten, and whether patients feel they cannot control their eating during binges.
 - 2.4.4. Compensatory behaviors such as purging (e.g., self-induced vomiting or misuse of laxatives, enemas, diuretics, or diet pills), prolonged fasting, excessive exercise, and chewing and spitting out food.
 - 2.4.5. Attitudes about body, weight, shape, food and eating.
 - 2.4.6. Ritualistic eating behaviors (e.g., cutting food into extremely small pieces or refusing to mix different types or colors of food on the plate).
 - 2.4.7. Level of self-esteem and the degree to which it depends upon body weight and shape.
 - 2.4.8. Family history of eating disorders and other psychopathology (Klein & Attia, 2016).

- 2.5. 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).
- 2.6. The member should be evaluated for the presence of suicidality, self-harm and any conditions that may co-occur with Bulimia (Engel, Steffen & Mitchell, 2016):
 - 2.6.1. Suicidality may accompany Bulimia, including suicidal ideation, actions to prepare for an attempt, or impulsive non-fatal self-harm.
 - 2.6.2. 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.
- 2.7. Patients with Bulimia often have comorbidities such as:
 - 2.7.1. Anxiety disorders
 - 2.7.2. Posttraumatic Stress Disorder
 - 2.7.3. Depressive Disorders
 - 2.7.4. Substance Use Disorders
 - 2.7.5. Personality Disorders (e.g., Borderline Personality Disorder)
- 2.8. Commonly used instruments to measure symptoms of Bulimia include (Engel, Steffen & Mitchell, 2016):
 - 2.8.1. Bulimia Test-Revised (BULIT-R; 36 items),
 - 2.8.2. Eating Disorder Inventory-3 (EDI-3; 91 items)
 - 2.8.3. Body Shape Questionnaire (34 items)
 - 2.8.4. Three-Factor Eating Questionnaire (TFEQ; 51 items),
 - 2.8.5. Eating Disorders Questionnaire (EDQ; 108 items), and
 - 2.8.6. Eating Disorder Examination-Questionnaire (EDE-Q; 38 items)
- 2.9. **Medical Evaluation of Bulimia**
 - 2.9.1. **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, skin, oropharyngeal, and abdominal examination (Mitchell & Zunker, 2016).

- 2.9.2. **Laboratory assessment** — Tests should be guided by the symptoms and findings on the physical examination. Laboratory tests indicated for all patients with Bulimia should include (Mitchell & Zunker, 2016):
 - 2.9.2.1. Serum electrolytes
 - 2.9.2.2. Blood urea nitrogen
 - 2.9.2.3. Serum creatinine
 - 2.9.2.4. Complete blood count including differential
 - 2.9.2.5. Liver function tests
 - 2.9.2.6. Urinalysis
- 2.9.3. Severely ill patients with Bulimia warrant additional tests (Mitchell & Zunker, 2016):
 - 2.9.3.1. Serum calcium, magnesium, and phosphorous
 - 2.9.3.2. Electrocardiogram (ECG)
 - 2.9.3.3. For patients with suspected pancreatitis, clinicians should check serum amylase, fractionated for salivary gland isoenzyme.
 - 2.9.3.4. Persistent amenorrhea should be investigated with luteinizing hormone, follicle-stimulating hormone, prolactin, and beta-human chorionic gonadotropin.
 - 2.9.3.5. Suspected laxative abuse can be assessed by checking stool or urine for bisacodyl, emodin, aloe-emodin, and rhein.
- 2.9.4. **Common physical signs** — Common signs in patients with Bulimia are (Mitchell & Zunker, 2016):
 - 2.9.4.1. Tachycardia
 - 2.9.4.2. Hypotension (< 90 mm Hg systolic)
 - 2.9.4.3. Xerosis (dry skin)
 - 2.9.4.4. Parotid gland swelling
 - 2.9.4.5. Erosion of dental enamel
 - 2.9.4.6. Hair loss
 - 2.9.4.7. Edema
 - 2.9.4.8. Scarring or calluses on the dorsum of the hand
- 2.9.5. **Gastrointestinal** — Gastrointestinal complications include (Mitchell & Zunker, 2016):

- 2.9.5.1. Parotid and submandibular (salivary) gland hypertrophy, with puffy or swollen cheeks
 - 2.9.5.2. Loss of gag reflex
 - 2.9.5.3. Esophageal dysmotility
 - 2.9.5.4. Abdominal pain and bloating
 - 2.9.5.5. Heme-stained teeth
 - 2.9.5.6. Mallory-Weiss syndrome (esophageal tears)
 - 2.9.5.7. Esophageal rupture (Boerhaaves' syndrome)
 - 2.9.5.8. Gastroesophageal reflux disease (GERD)
 - 2.9.5.9. Gastric dilation
 - 2.9.5.10. Diarrhea and malabsorption
 - 2.9.5.11. Constipation
 - 2.9.5.12. Pancreatitis
- 2.9.6. **Renal and Electrolytes** — The most common complications of Bulimia related to electrolyte imbalances include (Mitchell & Zunker, 2016):
- 2.9.6.1. Dehydration
 - 2.9.6.2. Hypokalemia (low potassium)
 - 2.9.6.3. Hypochloremia (low chloride)
 - 2.9.6.4. Metabolic alkalosis (high serum bicarbonate)
 - 2.9.6.5. Hypomagnesemia (low magnesium)
 - 2.9.6.6. Hypophosphatemia (low phosphate)
 - 2.9.6.7. Hyponatremia (low sodium)
- 2.9.7. **Cardiac** — Cardiac complications are rare in patients with Bulimia, but may include (Mitchell & Zunker, 2016):
- 2.9.7.1. Hypotension and orthostasis
 - 2.9.7.2. Sinus tachycardia
 - 2.9.7.3. Palpitations
 - 2.9.7.4. Edema
 - 2.9.7.5. Electrocardiogram (ECG) changes
 - 2.9.7.6. QT prolongation
 - 2.9.7.7. Arrhythmia

- 2.9.7.8. Cardiac toxicity or myopathy from Emetine (ipecac abuse)
- 2.9.8. **Skeletal muscle** — Chronic abuse of ipecac may damage skeletal muscle. Symptoms include
 - 2.9.8.1. generalized weakness, especially in the neck and proximal muscles of the extremities;
 - 2.9.8.2. tenderness;
 - 2.9.8.3. slurred speech; and
 - 2.9.8.4. difficulty with tasks requiring muscular activity (e.g., climbing stairs).
 - 2.9.8.5. Normal muscular activity is slowly restored following discontinuation of ipecac.
- 2.9.9. **Endocrine** — Endocrine complications of Bulimia involve the reproductive and skeletal systems
 - 2.9.9.1. There may be an association between Bulimia and diabetes.
 - 2.9.9.2. Severe complications can occur in patients with Bulimia and comorbid diabetes.
- 2.9.10. **Dental** — Gastric acid in vomit softens and erodes dental enamel, which may cause sensitivity to hot and cold temperatures in food and drinks.
 - 2.9.10.1. Some patients exhibit decalcification of the teeth (perimyolysis), particularly on the lingual, palatal, and posterior surfaces.
 - 2.9.10.2. Teeth may also become discolored and gum disease may occur.
- 2.9.11. **Skin** — A dermatologic complication is scarring or calluses on the dorsum of the hand due to pressure of the teeth against the skin while stimulating the gag reflex to induce vomiting.
 - 2.9.11.1. Self-injurious behavior is common in Bulimia, and patients may show acute or chronic signs of trauma from cuts or burns.
- 2.9.12. **Other** — Other medical complications include
 - 2.9.12.1. fluctuation of body weight,
 - 2.9.12.2. vitamin deficiencies,
 - 2.9.12.3. aspiration pneumonitis, and
 - 2.9.12.4. conjunctival hemorrhage.

3. Diagnosis

- 3.1. Diagnosis in children and adolescents may be more challenging than diagnosis in adults. A loss of control may be a more valid marker of Bulimia than calories consumed in children and adolescents (AACAP, 2015).
- 3.2. Binge eating may also occur less frequently in younger patients because children may not have access and control of food the way adults do (AACAP, 2015).
- 3.3. Differential diagnosis for Bulimia includes Anorexia, binge/purge type, subthreshold Bulimia, purging disorder, Binge Eating Disorder, Major Depressive Disorder, central nervous system tumors, Kleine-Levin syndrome, Kluver-Bucy syndrome and gastrointestinal pathologies (AACAP, 2015).
- 3.4. The provider should determine whether the member's Bulimia Nervosa is persistent by assessing:
 - 3.4.1. The length of time the member has had Bulimia Nervosa; and
 - 3.4.2. The history of and response to treatment.
 - 3.4.3. A persistent form of Bulimia Nervosa is typically characterized by an enduring course of illness despite appropriate treatment.
 - 3.4.4. If the member is identified as having a persistent form of Bulimia Nervosa, the provider may need to consider whether treatment in the proposed level of care can be reasonably expected to improve the member's condition. If so, the treatment plan may need to focus on helping the member regain a baseline level of functioning rather than achieving a cessation of symptoms.

4. Treatment Planning

- 4.1. 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:
 - 4.1.1. The short- and long-term goals of treatment;
 - 4.1.2. The type, amount, frequency and duration of treatment;
 - 4.1.3. 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;

- 4.1.4. How the member's family and other natural resources will participate in treatment when clinically indicated;
- 4.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
- 4.2. 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.
 - 4.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 4.3. 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.
- 4.4. 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.
- 4.5. The treatment plan and level of care are reassessed when the member's condition improves, worsens or does not respond to treatment.
 - 4.5.1. When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - 4.5.2. 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.
 - 4.5.3. 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 Bulimia includes nutritional rehabilitation, psychotherapy, and pharmacotherapy, as well as monitoring patients for medical complications. The following describes best practice interventions for Bulimia:

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

1. Medical Management

- 1.1. The medical complications that occur in patients with Bulimia affect many organ systems, and depend upon the method and frequency of purging or misuse of laxatives, diuretics, or enemas (Mitchell & Zunker, 2016).
- 1.2. Medical management includes appropriate medical intervention for each complication identified in the medical evaluation including the discontinuation of binge eating and purging.
- 1.3. Some medical complications require inpatient treatment on an internal medicine, psychiatric, or combined unit. The choice depends upon the patient's medical and psychiatric status and available resources.
- 1.4. Hospitalization may be indicated for patients with Bulimia for any one or more of the following (Foreman, 2016):
 - 1.4.1. Unstable vital signs (e.g., bradycardia near 40 beats per minute; blood pressure <80/50 mmHg)
 - 1.4.2. Compromised cardiac, hepatic, or renal functioning
 - 1.4.3. Acute medical complication of malnutrition (e.g., syncope, seizures, cardiac failure, or pancreatitis)
 - 1.4.4. Electrolyte disturbances (hypokalemia, hyponatremia, or hypophosphatemia)
 - 1.4.5. Acute psychiatric emergencies (e.g., suicidal ideation or behavior, or acute psychosis)
 - 1.4.6. Comorbid psychiatric conditions and associated symptoms (e.g., depressive, substance use, or anxiety disorders) require hospitalization
 - 1.4.7. Acute food refusal
 - 1.4.8. Uncontrollable binge eating and purging
 - 1.4.9. There is no evidence that psychiatric hospitalization for eating disorders is more effective than outpatient treatment (AACAP Practice Parameter, Eating Disorders, 2015).
 - 1.4.10. Care and/or consultation with a physician with an expertise in the treatment the medical complications associated with Bulimia should be accessible in all levels of care (Meher, Yager & Solomon, 2016).
 - 1.4.11. Outpatient follow-up should occur within three to five days for patients discharged after an acute hospitalization for medical complications along with nutritional rehabilitation.

2. Nutritional Rehabilitation

- 2.1. Nutritional rehabilitation aims to restore a structured and consistent meal pattern that typically takes the form of three meals and two snacks per day (Mitchell, 2016).
- 2.2. For patients with Bulimia, nutritional counseling is used with other treatment modalities to control binge eating as well as inappropriate compensatory behavior such as purging. This includes supervision before and after meals (Mitchell & Zunker, 2016).

3. Psychotherapy

3.1. Cognitive Behavioral Therapy

- 3.1.1. Cognitive-behavioral therapy (CBT) is indicated as first-line treatment for patients with Bulimia.
- 3.1.2. Use of CBT requires sufficient motivation, cognitive capacity, emotional stability, and energy to participate in therapy and complete agreed upon tasks.
- 3.1.3. Patients with comorbid personality disorders, particularly borderline personality disorder, may be less responsive to CBT and less responsive to treatment in general.
- 3.1.4. For patients with Bulimia who are overweight or obese, CBT can reduce binge eating and purging. However, CBT is generally not indicated for reducing weight.
- 3.1.5. Clinicians should set realistic expectations about the goals of therapy, and consider augmenting CBT with other approaches that address healthy lifestyle changes and appetite awareness.
- 3.1.6. Contraindications — Contraindications to treating bulimia nervosa with CBT include (Mitchell, 2016):
 - 3.1.6.1. Medical instability (needs to be stabilized prior to commencing CBT).
 - 3.1.6.2. Suicidal ideation or behavior (needs to be stabilized prior to CBT).
 - 3.1.6.3. Psychosis (psychotic patients are not candidates for most psychotherapies including CBT although concurrent bulimia nervosa and psychosis is rare)
- 3.1.7. The goals of CBT include (Pike, Yager & Solomon, 2016):
 - 3.1.7.1. Weight gain (increasing food quantity and variety)
 - 3.1.7.2. Changing distorted perceptions of body weight and shape
 - 3.1.7.3. Reducing fears of becoming fat
 - 3.1.7.4. Reducing importance of thinness relative to other areas of life, such as family, work, friends and recreation

- 3.1.7.5. Improving interpersonal relationships
- 3.1.7.6. Understanding the onset and maintenance of Bulimia
- 3.1.7.7. Developing problem solving skills
- 3.1.7.8. Relapse prevention
- 3.1.8. Every effort should be made to locate a facility that meets the patient's clinical needs that is accessible to parents and family members in order for full participation in family sessions and other contact identified in the treatment plan (Optum, QRG, 2012).
- 3.1.9. 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).

4. Pharmacotherapy

- 4.1. CBT plus an antidepressant is indicated for patients who either fail to show an early response to CBT alone (e.g., after six outpatient sessions), or who are depressed and unable to actively collaborate with the clinician using CBT alone.
- 4.2. First-line treatment is the selective serotonin reuptake inhibitor (SSRI) fluoxetine (Crow, 2016).
- 4.3. Second-line treatment for patients who do not tolerate or respond to fluoxetine is a different SSRI (e.g., citalopram, fluvoxamine, and sertraline) (Crow, 2016).
- 4.4. Third-line treatment, in order of preference, includes a tricyclic antidepressant (e.g., desipramine, imipramine, or nortriptyline), topiramate, trazodone, or a monoamine oxidase inhibitor (MAOI; e.g., phenelzine) (Crow, 2016).
- 4.5. Bupropion can cause seizures in patients with Bulimia and is contraindicated for patients with Bulimia (Crow, 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 that 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)

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

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.

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.

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.

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

1. American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Treatment of Children and Adolescents with Eating Disorders, May, 2015. Retrieved from www.aacap.com.
2. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013.
3. American Psychiatric Association, Practice Guideline for the Treatment of Patients with Eating Disorders, 2005. Retrieved from http://www.psychiatryonline.com/pracGuide/pracGuideTopic_12.aspx
4. Association for Ambulatory Behavioral Healthcare, Standards and Guidelines for Partial Hospital Programs, 2012.
5. Centers for Medicaid and Medicare Local Coverage Determination, Psychiatric Inpatient Hospitalization, 2015. <http://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA&>

6. Centers for Medicaid and Medicare Local Coverage Determination for Psychiatric Partial Hospitalization Program, 2015.
<http://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA&>
7. Crow, S. Bulimia nervosa in adults: Pharmacotherapy. Retrieved from www.uptodate.com on April 10, 2015.
8. Engel, S., Steffen, K., Mitchell, J. Bulimia nervosa in adults: Clinical features, assessment, and diagnosis. Retrieved from www.uptodate.com on April 10, 2015.
9. Generic UnitedHealthcare Certificate of Coverage, 2001.
10. Generic UnitedHealthcare Certificate of Coverage, 2007.
11. Generic UnitedHealthcare Certificate of Coverage, 2009.
12. Generic UnitedHealthcare Certificate of Coverage, 2011.
13. Mitchell, J., Bulimia nervosa in adults: Cognitive-behavioral therapy (CBT). Retrieved from www.uptodate.com on April 10, 2015.
14. Mitchell, J., and Zunker, C., Bulimia nervosa and binge eating disorder in adults: Medical complications and their management. Retrieved from www.uptodate.com on April 10, 2015.
15. National Institute for Health and Clinical Excellence. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders, 2004. Retrieved from <http://www.nice.org.uk/CG009>.
16. Optum Level of Care Guidelines, 2015.

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.

Limited to specific CPT and HCPCS codes?	X Yes <input type="checkbox"/> No
90791	Psychiatric diagnostic evaluation
90791 plus interactive add-on code (90785)	Psychiatric diagnostic evaluation (interactive)
90832	Psychotherapy, 30 minutes with patient and/or family
90832 plus interactive add-on code (90785)	Psychotherapy, 30 minutes with patient and/or family (interactive)
90832 plus pharmacological add-on code (90863)	Psychotherapy, 30 minutes with patient and/or family (pharmacological management)
90834	Psychotherapy, 45 minutes with patient and/or family member
90834 plus interactive add-on code (90785)	Psychotherapy, 45 minutes with patient and/or family member (interactive)
90834 plus pharmacological add-on code (90863)	Psychotherapy, 45 minutes with patient and/or family member (pharmacological management)
90837	Psychotherapy, 60 minutes with patient and/or

	family member
90837 plus interactive add-on code (90785)	Psychotherapy, 60 minutes with patient and/or family member (interactive)
90837 plus pharmacological add-on code (90863)	Psychotherapy, 60 minutes with patient and/or family member (pharmacological management)
90839	Psychotherapy for crisis, first 60 minutes
90839 plus interactive add-on code (90785)	Psychotherapy for crisis, first 60 minutes (interactive)
90846	Family psychotherapy without the patient present
90847	Family psychotherapy, conjoint psychotherapy with the patient present
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90853 plus interactive add-on code (90785)	Group psychotherapy (other than of a multiple-family group) (interactive)
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
H0015	Intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapy
H0035	Mental health partial hospitalization, treatment, less than 24 hours
S0201	Partial hospitalization services, less than 24
S9480	Intensive outpatient psychiatric services, per die

DSM-5 Codes	ICD-10 Codes	Applicable Diagnoses
307.51	F50.2	Bulimia Nervosa

Limited to place of service (POS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Limited to specific provider type?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Limited to specific revenue codes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
100-160	(Range describes various all-inclusive inpatient services)
900-919	(Range describes various unbundled behavioral health treatments/services)
1000-1005	(Range describes various sites that provider 24-hour services)

PART VIII: HISTORY

Revision Date	Name	Revision Notes
4/2014	L. Urban	Version 1-Final
10/2014	G. Niewenhous	Version 2-Final
10/2015	L. Urban	Version 3-Final
6/2016	L. Urban	Version 4-Final