# Eating Disorder Treatment Services Criteria

Applicable to insured members in the State of Connecticut subject to state law SB1160

## Treatment of Individuals with Eating Disorders:

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### APA Guideline and Guideline Watch for Eating Disorder Treatment:

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[http://psychiatryonline.org/guidelines.aspx](http://psychiatryonline.org/guidelines.aspx)

### Association for Ambulatory Behavioral Healthcare’s Standards and Guidelines for Partial Hospitalization Programs, Fifth Edition (2012)

- Eating Disorder Partial Hospitalization Program (PHP)
- Eating Disorder Intensive Outpatient Program (IOP)

The Standards and Guidelines for Partial Hospital Programs are copyrighted by the Association for Ambulatory Behavioral Healthcare but the organization has approved of the Anthem Medical Necessity Criteria for Connecticut included in this document.
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Eating disorder Partial Hospitalization Program (PHP) – Adult

Medically Necessary:

To qualify, Covered Individual’s symptoms or condition must meet the diagnostic criteria for a DSM or ICD Eating Disorder Diagnosis for partial hospitalization program (PHP) treatment that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual’s plan document.

Target Populations:
Persons with any or all of 1, 2, 3, or 4 may benefit:

1. Individuals at risk for inpatient hospitalization who require the ongoing, intensive services of partial hospitalization treatment, due to acute debilitating symptoms or risk of harm to self or others. These persons may have been screened by primary care physicians, individual therapists, community agencies or other healthcare professionals. In some cases they may contact the program directly on the advice of a peer or family member to determine whether or not this level of care is medically appropriate; and/or

2. Individuals displaying a significant and progressive decline in functioning compared to baseline, and who require the intensity and structure of PHP to avert further deterioration. Such acute states frequently follow serious crises or situational stressors. A less intensive level of care may have been tried and is judged to be insufficient to provide the medically necessary treatment the individual requires, and there is a reasonable expectation that the individual is likely to make timely and practical improvement; and/or

3. Individuals whose life circumstances require management of risk to self-harm, and a significant increase in functioning and symptom reduction in order to achieve present role expectations and reduce the risk of the loss of home, job, or family without the intensive intervention of PHP treatment. This target group is typical of many first episodes of care patients referred either from emergency departments or inpatient facilities; and/or

4. Individuals experiencing behavioral health symptoms or clinical conditions that severely and persistently impair their capacity to function adequately on a day-to-day basis, in spite of efforts to achieve these goals through treatment in a less intensive level of care. The intensity of the partial hospitalization level of care is medically necessary and the individual is judged to have the capacity to make timely and practical improvement. These individuals may be unable to achieve dramatic degrees of functional improvement but may be able to make significant progress in the achievement of personal self-respect, quality of life, and increased independence.

Within each target group, specific situational factors may exacerbate an individual’s clinical condition requiring this level of intervention. They may include but are not limited to: major losses such as job, home, divorce, or death of a significant other; Severe isolation; trouble family dynamics or stressors; financial or environmental devastation; challenging new physical conditions; or other traumatic life events.

Admission Criteria
Must have all of the following 1-6, to qualify (criteria 1-6 from AABH Guideline)

1. Current DSM or ICD Eating Disorder Diagnosis that is consistent with symptoms: The individual exhibits serious or disabling symptoms related to this condition, or exacerbation of a severe and persistent eating disorder, or severe and persistent symptoms and impairments that have not improved or cannot be adequately addressed in a less intensive level of care.

2. Level of Functioning: Marked impairments in multiple areas of his/her daily life are evident. This may include marked impairments that preclude adequate functioning in areas such as self-care, or other more specific role expectations such as bill paying, working, cleaning, problem solving, decision-making, contacting supports, taking care of others, addressing safety issues, medication compliance, or managing time in a meaningful way.
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3. **Risk/Dangerousness:** The individual is not imminently dangerous to self or others and is able to exercise adequate control over his/her behavior to function outside of 24 hour custodial care. However, the individual may exhibit some identifiable risk for harm to self or others yet is able to develop and practice a safety plan with the structured intensive support of PHP treatment.

4. **Social Support System:** The individual is or can be connected with a community-based network, which supports them within their home environment. The member may present with impaired ability to access or use caretaker, family or community support. In some cases a socially isolated person with serious debilitation symptoms may benefit. In other cases, an individual from a trouble family may benefit as well. Minimal ability to set goals to work toward the development of social support is often a requirement for participation. In some cases, removal from a given residence or placement in a residential treatment setting may be a precondition for treatment.

5. **Readiness For Change:** The presence of significant denial or pre-contemplation regarding change may often be anticipate due to the acute circumstances surrounding an admission. The individual must however have the capacity for minimum engagement in the identification of goals for treatment, and willingness to try to participate actively in relevant components of the program. Initially, due to mental health and substance use disorder symptoms, the individual may only be able to agree to begin treatment, and may require close monitoring, support and encouragement to achieve and sustain active and ongoing participation.

6. **Level of Care Rationale:** a) the individual has relapsed or failed to make significant clinical gains in a less intensive level of care; or b) less intensive levels of care are judged insufficient to provide the treatment necessary; or c) the individual is ready for discharge from an inpatient setting, but is judged to be in continued need of ongoing intensive therapeutic interventions, daily monitoring, and support that cannot be provided in a less intensive level of care.

   *In addition, must have one or more of the following, 7 – 13, to qualify (criteria 7-13 from the APA Guideline for the Treatment of Eating Disorders):*

7. If Anorexia Nervosa and weight restoration is goal, the covered individual’s weight is over 80% of estimated ideal weight range but there are no signs or symptoms of acute medical instability that would require intensive medical monitoring.

8. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder. If suicidal ideation is present, the criteria for acute inpatient treatment are not met.

9. Motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts: partial motivation; member preoccupied with intrusive repetitive thoughts more than 3 hours a day.

10. Co-occurring disorders: if another psychiatric or substance use disorder is present it can also be appropriately managed at this level of care.

11. Structure for part or most of the day needed to eat/gain weight.

12. Purging behavior (laxatives and diuretics): The covered individual can reduce purging and does not have significant medical complications.

13. Environmental stress: others are able to provide at least limited support and structure.

Exclusion Criteria (From AABH Guideline):
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1. Is uninterested or unable due to their illness to engage in identifying goals for treatment and/or declines participation as mutually agreed upon in the treatment plan; or
2. Is imminently at risk of suicide or homicide and lacks sufficient impulse/behavioral control and/or minimum necessary social support to maintain safety and requires hospitalization; or
3. Has cognitive dysfunction that precludes integration of newly learned material and behavioral change; or
4. Has a condition that does not benefit from partial hospitalization services, e.g. some individuals with social phobia or severe manic states who are not presently amenable to group treatment services; or
5. Has primarily social, custodial, recreational, or respite needs; or
6. Has consistently displayed an unwillingness or incapacity to adhere to reasonable program expectations or personal responsibilities which are detrimental to the group and will not contract for behavioral change prior to attending the program.

Intensity of Service (IS)
Must have all of the following to qualify:
1. At a minimum scheduled programming provided at least eight (8) hours daily/ five (5) days a week (APA Practice Guideline)
2. All services must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, individual and family therapy.
3. Involvement of the family, significant others and/or peers (as available and with signed consent) should be addressed in the mission and reflected in the program services offered.
4. Distribution of written and visual resources is strongly recommended.
5. Recommended that a formal method of collecting feedback through perceptions of care surveys or the equivalent should be routinely completed by all clients before discharge.
6. Programs operate under the direction of a physician and a program leader. The physician provides supervision of the clinical needs of the individuals enrolled in the program; the program leader is responsible for the overall clinical and administrative operations of the program.
7. Staff members must possess appropriate academic degrees, licensure, or certification as well as experience with the particular populations treated as defined by program function and applicable state regulations. Core clinical staff members may include: psychiatrists, psychologists, social workers, counselors, addiction counselors, medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, non-degreed individuals, students and interns may be included. A dietitian is involved in nutritional rehabilitation and weight restoration.
8. Staff to client ratios may vary from 1:3.5 to 1:8 depending on acuity and programming.
9. Physicians should have face to face contact on admission for an evaluation and thereafter as clinically indicated. Clearly delineated procedures must be present for detoxification, withdrawal and other medical needs. Coordination of care with the member’s primary care provider will take place in any situation where there are medical comorbidities. Physicians need to be available for consultation with other staff and for face to face evaluations with members during program hours or by telephone outside of program hours to be available 24 hours a day, seven days a week.
10. A member of the clinical staff serves in a case management capacity to coordinate the member’s treatment within the program, who will work consistently with the individual (and family as indicated) and follow the course of clinical treatment from admission through discharge.
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11. A clinical record is to be maintained for each member admitted. This has to include the following elements: initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of PHP is needed with clear goals which are achievable within the timeframe of the program, medication management, progress toes and a discharge summary.

Discharge planning begins at the time of admission with the identification of specific discharge criteria. 

Continued Stay Criteria (CS)
Must have one or more of the following to qualify:
1. Symptoms continue to impair multiple areas of daily functioning;
2. Impaired judgment, awareness, and skill deficits place one at a significant risk for further functional deterioration;
3. Individual displays an inability to cope with significant crises or stressors and/or otherwise lacks the necessary skills to cope with marked symptoms;
4. There is a continued significant risk for harm to self or others;
5. Poor insight, skills, judgment, and/or awareness inhibits their return to critical baseline functioning.

Must also have 1-3 and one or more of 4-8 to qualify:
1. Successful engagement in the clinical process
2. Active attendance and participation
3. Capacity to respond successfully to therapeutic interventions
4. Continued need for medication monitoring and intervention
5. Capacity to make progress in the development of coping skills to meet baseline functional needs;
6. Need for support and guidance in handling a major life crisis;
7. Continued need for managing risk accompanied by capacity to follow a safety plan;
8. A commitment to developing and following through on a recovery oriented discharge plan.

May need to continue in PHP instead of IOP if a number of these are present:
1. Daily medication and overall symptom monitoring is needed;
2. Immediate behavioral activation and monitoring is needed
3. Potential for self-harm is significant and requires daily observation and safety planning;
4. Coping skill deficits are severe and require daily reinforcement;
5. A crisis situation is present and requires daily monitoring;
6. Family situation is volatile and requires daily observation and client instruction and support;
7. Mood lability is extreme with potential to create destructive relationship or environmental consequences;
8. Hopelessness or isolation is a dominant feature of clinical presentation with minimal current supports;
9. Daily substance use monitoring is needed;
10. Need for rapid improvement to return to necessary role expectations is present.

Not Medically Necessary:
Eating disorder partial hospitalization program (PHP) treatment is considered not medically necessary when the above criteria are not met.
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Eating Disorder Intensive Outpatient Program (IOP) – Adult

Medically Necessary:

To qualify, Covered Individual’s symptoms or condition must meet the diagnostic criteria for a DSM or ICD Eating Disorder Diagnosis for intensive outpatient program (IOP) treatment that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual’s plan document.

Target Populations
Persons with any or all of 1,2,3 or 4 may benefit:
1. Individuals with moderate symptoms that result in significant personal distress and moderate impairment in functioning.
2. Individuals for which there is a strong likelihood of further regression and decreased functioning without IOP level services.
3. Individuals who require frequent but not daily monitoring and often have some limitations in ability to benefit from active treatment.
4. Individuals who either are discharging from partial hospitalization or inpatient care who have moderate symptoms and require further stabilization or require more structure and intensive treatment than traditional outpatient treatment who do not have severe symptoms that require partial hospital or inpatient level care.

Severity of Illness (SI)
1. Behavioral Health Condition, with mental health signs and symptoms: The individual has moderate symptoms and also may have a comorbid medical or substance use disorder with moderate symptoms and acuity.
2. Level of Functioning: Moderate impairment in at least one area of his/her daily life is evident. This may include moderate impairments that result in minimally adequate functioning in areas such as self-care, or other more specific role expectations such as bill paying, working, cleaning, problem solving, decision-making, contacting supports, taking care of others, addressing safety issues, medication compliance, or managing time in a meaningful way.
3. Risk/Dangerousness: The individual is not imminently dangerous to self or others and is able to exercise adequate control over his/her behavior to function outside of 24 hour custodial care.
4. Social Support System: The individual is or can be connected with a community-based network, which supports them within their home environment. The member may have minimal or limited social supports.
5. Level of Care Rationale: a) the individual has relapsed or failed to make significant clinical gains in outpatient care; or b) outpatient care is judged insufficient to provide the treatment necessary; or c) the individual is ready for discharge from an inpatient or partial hospital program setting, but is judged to be in continued need of ongoing stabilization in order to further improve or prevent relapse and maintain symptoms to at least a minimal functional level.

Must also have one or more of the following, 6 – 12, to qualify:

6. If Anorexia Nervosa and weight restoration is goal, the covered individual’s weight is over 80% of estimated ideal weight range but there are no signs or symptoms of acute medical instability that would require intensive medical monitoring.
7. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder. If suicidal ideation is present, the risk is low enough for the member to be safely treated at this level of care.
8. The individual has fair motivation to recover, including cooperativeness, insight and ability to control obsessive thoughts.
9. Co-occurring disorders: if another psychiatric or substance use disorder is present it can also be appropriately managed at this level of care.
10. The member has sufficient structure outside of this program to eat/gain weight.
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11. Purging behavior (laxatives and diuretics): The covered individual can reduce purging and does not have significant medical complications.
12. Environmental stress: others are able to provide adequate emotional and practical support and structure.

Intensity of Service (IS)
Must have all of the following to qualify:
1. At a minimum, three (3) hours of programmed treatment services at least three (3) days a week are provided. The frequency of services may decrease as the covered individual is being transitioned to outpatient care.
2. All services must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, individual and family therapy.
3. Involvement of the family, significant others and/or peers (as available and with signed consent) should be addressed in the mission and reflected in the program services offered.
4. In addition to the scheduled hours of the program, the program must be able to offer or arrange for 24-hour crisis services to meet emergent or urgent needs of the individual receiving care.
5. Staff members must possess appropriate academic degrees, licensure, or certification as well as experience with the particular populations treated as defined by program function and applicable state regulations. Core clinical staff members may include: psychiatrists, psychologists, social workers, counselors, addiction counselors, medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, non-degreed individuals, students and interns may be included.
6. Staff to client ratios may vary from 1:7 to 1:12 depending on acuity and programming.
7. A member of the clinical staff serves in a case management capacity to coordinate the member's treatment within the program, who will work consistently with the individual (and family as indicated) and follow the course of clinical treatment from admission through discharge.
8. A clinical record is to be maintained for each member admitted. This has to include the following elements: initial assessment, physician orders, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of IOP is needed with clear goals which are achievable within the timeframe of the program, medication management, progress notes and a discharge summary.
9. Discharge planning begins at the time of admission with the identification of aftercare needs and arrangement for services to meet those needs.

Continued Stay Criteria (CS)
Must have all of the following to qualify:
1. Symptoms are moderate and continue to impair daily functioning
2. The covered individual does not have a high likelihood of relapse to severity of symptoms that would require treatment at an inpatient or partial hospital program level of care.
3. Stability cannot be maintained with regular outpatient treatment. If weight gain is a target of treatment, the member’s weight is not at or over 85% of their estimated ideal weight.

Not Medically Necessary:

Eating disorder intensive outpatient program (IOP) treatment is considered not medically necessary when the above criteria are not met.