Regence Oregon and Utah | Regence Idaho and select counties of Washington

Medical Policy Manual Behavioral Health, Policy No. 28

Eating Disorder Residential Treatment

Effective: November 1, 2022

Next Review: January 2023
Last Review: October 2022

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Residential treatment (RTC) is a 24-hour sub-acute treatment setting that is licensed as a residential treatment center by the appropriate agency to provide residential treatment and is under 24-hour care with an attending psychiatrist or psychiatric extender available for consultation 24/7.

MEDICAL POLICY CRITERIA

Notes: Submission of a behavioral health intake form is required for initial intake, concurrent review, stepdown request to a lower level of care, and discharge confirmation.

I. An Eating Disorder Residential Treatment (RTC) program admission provided under the supervision of an attending psychiatrist or psychiatric extender may be indicated when all of the following (A. – B.) are met:

   A. All of the following intensity of service criteria (1. – 12.) are met:

      1. The facility is licensed by the appropriate state agency.

      2. There is an expectation that the member's history and physical examination is completed within 48 hours of admission (unless completed within 72 hours

prior to admission or if the member is transferred from an acute inpatient level of care).

3. There is expectation that drug screens and relevant lab tests (electrolytes, chemistry, CBC, thyroid and ECG, etc.) are completed upon admission and as clinically indicated and are documented in the medical record.
4. The attending provider is a psychiatrist, a licensed psychiatric nurse practitioner, or physician assistant with formal practice agreement with a psychiatrist (when permitted by state laws) who is responsible for diagnostic evaluation within 48 hours of admission. After the initial diagnostic evaluation, there is an expectation that the physician, or physician extender provides and documents monitoring and evaluation at least weekly. The attending provider must be available 24 hours per day, 7 days per week.
5. There is an expectation that within 72 hours of admission, following a multidisciplinary assessment that includes input from recent treating providers, an individualized treatment plan (ITP) is developed and documented in the medical record. The ITP should use evidence-based concepts, where applicable, and be amended as needed for changes in the individual's clinical condition. The ITP should include, but is not limited to, identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, need for supportive living placement to continue recovery, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. Treatment programming includes an expectation of at least one individual counseling session per week, or more as clinically indicated, which is documented in the medical record.
7. There is an expectation that evaluations of the member by a licensed behavioral health provider are performed daily and are documented in the medical record.
8. Treatment programing is multidisciplinary and includes clinical services provided daily that comprehensively address the needs identified in the member's treatment plan. In addition, the program is operated with licensed clinical staff who are trained and experienced in the medical and psychiatric treatment of Eating Disorders.
9. Mental health and medical services are available on-site (or off-site by arrangement) 24 hours per day, 7 days per week.
10. On-site registered nursing care available 24 hours a day, 7 days a week with full capabilities for all appropriate interventions in medical and behavioral health and emergencies that occur on the unit.
11. On-site, licensed clinical staff is available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.

12. There is an expectation that nutritional planning including target weight range and planned interventions by a registered dietitian is undertaken and documented in the medical record.

B. All of the following severity of illness criteria (1. – 2.) are met:

1. All the following are met (a. – g.):

a. The member has been given a severe Eating Disorder diagnosis according to the most recent DSM criteria which will be the primary focus of daily active treatment.

b. There is reasonable expectation that treatment at this level of care will meaningfully impact the presenting symptoms/behaviors leading to the admission.

c. The treatment is not primarily for the convenience of the provider or member (e.g. lack of housing options, respite care or custodial needs)

d. The member has significant functional impairment in more than one area that requires 24-hour monitoring and intervention: Home, School/Work, Health/Medical, maintaining safe behaviors towards self or others, inability to maintain healthy eating and exercise behaviors despite active, recent attempts to self-manage in a less restrictive setting.

e. Member is able to function independently and actively participate in group and individual therapy.

f. Treatment could not be effectively provided at a lower level of care (supported by clinical documentation) OR The member's home environment is not conducive to treatment/recovery, such that treatment at a lower level of care is unlikely to be successful OR no safe lower level of care is available.

g. The family members and/or support system are committed to change through participation in the treatment process as appropriate.

2. One or more of the following:

a. Member requires 24-hour structure and supervision at each meal to prevent disordered eating patterns (food restriction, binging/purging, etc.) that member's family or support system are unable to provide at a less restrictive level of care.

b. Member requires 24-hour observation to interrupt/avoid compensatory behaviors such as: excessive exercise, food restriction, purging, taking laxatives/diuretics/diet pills that would otherwise lead to imminent medical risks, complications or deterioration of a co-morbid medical condition.

c. In addition to a primary eating disorder requiring active treatment, member presents with a co-occurring psychiatric disorder requiring active treatment or risk of harm that requires 24-hour supervision.

II. Continued stay in an Eating Disorder Residential Treatment (RTC) program provided under the supervision of an attending psychiatrist may be indicated when all of the following are met (A. – F.):

A. The member continues to meet admission criteria (I.A. – B.).

B. There is reasonable expectation that continued treatment provided at this level of care will produce improvement that is sustainable after discharge.

C. Family participation (see Policy Guidelines):

1. For Adults: Family treatment is encouraged when clinically appropriate. Family treatment is available to be provided at an appropriate frequency when clinically warranted.

2. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.

D. The individual and family are involved to the best of their ability in the treatment and discharge planning process.

E. The member continues to demonstrate motivation for change, interest in and ability to actively engage in their behavioral health treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments actively developing discharge plan and other markers of treatment engagement. If member is not engaged, there are documented interventions by the treatment team to address.

F. There is evidence of active discharge planning.

POLICY GUIDELINES

FAMILY PARTICIPATION

Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

DAYTIME OUTINGS

For purposes of discharge planning and when clinically indicated, members may participate in daytime outings, during non-program hours, of up to eight hours per outing, with family, guardians, authorized representatives or other supportive individuals, to assess current conflicts, skills development and ability to tolerate a return to his/her living environment and other issues relevant to the unique member.

CUSTODIAL CARE

The following definition of custodial care by the Centers for Medicare & Medicaid Services (CMS) is applicable in support of the policy criteria:[11]

> Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using

the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, [consider] the level of care and medical supervision required and furnished. [The decision is not based] on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

Initial Request:

- Pre-Authorization Request Form
- Supporting clinical documentation, including:
  - Initial evaluation/Intake Assessment
  - Nursing Assessment/ History & Physical (if available)
  - Recent lab results
  - Any additional supporting clinical evidence, if available (example: letters from outpatient providers supporting this level of care)
- Preliminary Individualized Treatment Plan

Request for Extension/Concurrent Review:

- Supporting clinical documentation, including:
  - Recent psychiatric evaluation
  - MD Notes
  - Treatment Plan/Progress Reports
  - Any other supporting clinical evidence

CROSS REFERENCES

1. Eating Disorder Inpatient Treatment, Behavioral Health, Policy No. 25
2. Eating Disorder Intensive Outpatient, Behavioral Health, Policy No. 26
3. Eating Disorder Partial Hospitalization, Behavioral Health, Policy No. 27
4. Psychiatric Inpatient Hospitalization, Behavioral Health, Policy No. 29
5. Psychiatric Intensive Outpatient, Behavioral Health, Policy No. 30
6. Psychiatric Partial Hospitalization, Behavioral Health, Policy No. 31
7. Psychiatric Residential Treatment, Behavioral Health, Policy No. 32

REFERENCES

1. American Academy of Child and Adolescent Psychiatry. Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers. 2010. [cited 9/26/2022]. 'Available from:' https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf.

2. American Academy of Child and Adolescent Psychiatry, Practice Parameters, Washington, DC. [cited 9/26/2022]. 'Available from:' https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx.
3. American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2018. [cited 9/26/2022]. 'Available from:' http://psychiatryonline.org/guidelines.aspx.
4. *American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May 2013*, pp.
5. Association for Ambulatory Behavioral Healthcare: Partial hospitalization programs [cited 9/26/2022]. 'Available from:' https://aabh.org/standards-guidelines/.
6. Association for Ambulatory Behavioral Healthcare: Intensive Outpatient Program. [cited 9/26/2022]. 'Available from:' https://aabh.org/standards-guidelines/.
7. *Medicare Benefit Policy, Outpatient Hospital Psychiatric Services, Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)*, pp.
8. Mental Health America, Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions, June 2015. [cited 9/26/2022]. 'Available from:' https://www.mhanational.org/issues/position-statement-44-residential-treatment-children-and-adolescents-serious-mental-health.
9. Harrington BC, Jimerson M, Haxton C, et al. Initial evaluation, diagnosis, and treatment of anorexia nervosa and bulimia nervosa. *Am Fam Physician.* 2015;91(1):46-52. PMID: 25591200
10. Mee-Lee D SG, Fishman MJ, Gasfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Shange Companies®*, 2013, pp.
11. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §110 - Custodial Care.

CODES

Codes	Number	Description
CPT	None	
HCPCS	None	
Revenue Code	1001	Residential Treatment, Psychiatric

Date of Origin: *January 2019*