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

NOTE: This policy is not effective until May 1, 2019.

Medical Policy Manual Behavioral Health, Policy No. 28

Eating Disorder Residential Treatment

Effective: May 1, 2019

Next Review: January 2020
Last Review: January 2019

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 by the appropriate agency to provide residential treatment and is under 24-hour care and monitoring of an attending psychiatrist.

MEDICAL POLICY CRITERIA

Notes: For expectations regarding patient evaluation and components of treatment, please refer to the Policy Guidelines section below.

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

   A. All the following must be met (1-8):

      1. 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.

      2. The member is able to actively participate in and comply with treatment at this level of care.

3. There is reasonable expectation that treatment at this level of care will meaningfully impact the presenting symptoms/behaviors leading to the admission.
4. The treatment is not primarily for the convenience of the provider or member (e.g. lack of housing options, respite care or custodial needs)
5. 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.
6. Member can function independently and is able to effectively participate in structured group and individual therapy.
7. Either 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.
8. The family members and/or support system are committed to change through participation in the treatment process as appropriate.

B. One or more of the following:

1. 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.
2. 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.
3. 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-H):

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

D. The member continues to demonstrate motivation for change, interest in and ability to actively engage in his/her 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.

E. Continued stay is not primarily due to a lack of external supports, housing or custodial care. (See Policy Guidelines)

F. Lack of external supports alone is not sufficient for continued treatment at this level of care.

G. There is evidence of active discharge planning.

H. The member's family and/or support system is willing to engage in the treatment process through family therapy as appropriate.

POLICY GUIDELINES

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

Treatment Expectations

Initial psychiatric diagnostic evaluation should be completed by a psychiatrist within 48 hours of admission with a preliminary treatment plan. Patients should receive, at a minimum, weekly face-to-face assessments by a psychiatrist with evidence of active treatment. Active treatment should be multidisciplinary, including a minimum of 6 hours/day of programming, daily assessment by a licensed behavioral health clinician and weekly member therapy by a licensed therapist. The residential unit should be staffed with a licensed behavioral health clinician who is on site and available 24/7. Nursing care must also be available on site 24/7. Psychiatrist should be available for consultation 24/7. For children/adolescents, family therapy should be provided once weekly, at a minimum. If the daily program are primarily activities that are recreational or

diversional in nature, this does not qualify as 'active treatment' in a residential treatment facility. Authorization of residential treatment is based on clinical appropriateness/necessity of that level of care, and not based on a pre-set number of days or program presented by a facility. Residential treatment is not intended to act as a substitute for housing or supportive living in the community.

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. 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.
2. Harrington, BC, Jimerson, M, Haxton, C, Jimerson, DC. Initial evaluation, diagnosis, and treatment of anorexia nervosa and bulimia nervosa. *Am Fam Physician*. 2015;91(1):46-52. PMID: 25591200
3. 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 1/9/2019]; Available from: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf
4. American Academy of Child and Adolescent Psychiatry, Practice Parameters, Washington, DC. [cited 1/9/2019]; Available from: https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx
5. American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2018. [cited 1/9/2019]; Available from: http://psychiatryonline.org/guidelines.aspx
6. American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May 2013.
7. Association for Ambulatory Behavioral Healthcare: Partial hospitalization programs [cited 1/9/2019]; Available from: https://www.aabh.org/copy-of-partial-hospitalization-pro
8. Association for Ambulatory Behavioral Healthcare: Intensive Outpatient Program. [cited 1/9/2019]; Available from: https://www.aabh.org/copy-of-partial-hospitalization-pro
9. 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).
10. Mental Health America, Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions, June 2015. [cited 1/9/2019]; Available from: http://www.mentalhealthamerica.net/positions/residential-children

11. Behavioral Health Levels of Care, Milliman Care Guidelines®, 22nd Edition, Seattle, WA, MCG Health, LLC, 2018.

CODES

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

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