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Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Eating Disorders – Anorexia Nervosa

Criteria

Inpatient Care
Kaiser Permanente has elected to use the MCG* Care Guideline: Anorexia Nervosa, Adult: Inpatient Care (B-001-IP) and Anorexia Nervosa, Child or Adolescent: Inpatient Care (B-016-IP) for medical necessity determinations.

Partial Hospitalization
Kaiser Permanente has elected to use the MCG* Care Guideline: Anorexia Nervosa: Partial Hospitalization Program (B-KP-001-PHP v2 eff 12.01.2021) for medical necessity determinations.

Intensive Outpatient
Kaiser Permanente has elected to use the MCG* Care Guideline: Anorexia Nervosa: Intensive Outpatient Program (B-KP-001-IOP v2 eff 12.01.2021) for medical necessity determinations.

Acute Outpatient
Kaiser Permanente has elected to use the MCG* Care Guideline: Anorexia Nervosa: Outpatient Care (B-KP-001-AOP v2 eff 12.01.2021) for medical necessity determinations.

Residential Care
Kaiser Permanente has elected to use the MCG* Care Guideline: Anorexia Nervosa: Residential Care (B-KP-001-RES v2 eff 12.01.2021) for medical necessity determinations.

For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under Quick Access.

***MCG manuals are proprietary and cannot be published and/or distributed**. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363 or access the MCG Guideline Index using the link provided above.

If requesting this these services, please send the following documentation to support medical necessity:
- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
In January 2006, Kaiser Permanente adopted and integrated into its clinical review criteria, the MCG (formerly Milliman) Care Guidelines for determining appropriate levels of care based on symptoms and functional

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impairment. These criteria are independently developed and based on a review of the scientific literature, expert input, and clinical practice. In addition, the MCG Care Guidelines are updated yearly. Kaiser Permanente Behavioral Health Services operationally defines clinically indicated services as "services for mental health conditions that are having a clinically significant impact on an individual's social, medical, and/or occupational functioning."
Inpatient anorexia nervosa services are provided or authorized with the overall goals of assessing and stabilizing the member's acute symptoms, in order that treatment can be continued effectively in a less restrictive and disruptive level of care. Under specific circumstances (e.g. initiation of ECT), the inpatient level of care may be required for safe administration of certain treatments.

Inpatient anorexia nervosa treatment is utilized when it is the most appropriate and effective level of care that can safely be provided for the member's immediate condition. Service authorization is based on the member's contract and the MCG Care Guidelines for inpatient mental health treatment. When treating children or adolescents, the parents or guardians must be included in both the evaluation and treatment planning processes, except for children age 13 or older who refuse to have a parental figure involved.

Applicable Codes

To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check.

Date Created	Date Reviewed	Date Last Revised
6/30/2010	7/6/2010 MDCRPC, 5/3/2011 MDCRPC, 3/6/2012MDCRPC,1/08/2013MDCRPC, 11/05/2013MPC, 2/04/2014MPC, 12/02/2014MPC, 10/06/2015MPC, 10/04/2016MPC, 08/01/2017MPC, 06/05/2018MPC, 06/04/2019MPC, 06/02/2020MPC, 06/01/2021MPC , 06/07/2022MPC , 06/06/2023MPC	07/06/2021

MDCRPC Medical Director Clinical Review and Policy Committee
MPC Medical Policy Committee

Revision History	Description
12/01/2015	Revised criteria to reflect GHC hybrid policy
03/31/2016	Removed 60-day notice
02/07/2017	MPC approved to adopt MCG 20th Ed. guidelines for Inpatient & Acute Outpatient Care; MPC approved to adopt hybrid (GHC/MCG) guidelines for Residential, Partial Hospital and Intensive Outpatient
09/05/2017	MPC approved to adopt KP-MCG hybrid criteria for all levels of care
06/02/2020	Removed diagnosis codes
07/06/2021	MPC approved to adopt MCG 25th Edition for Anorexia Nervosa, Adult: Inpatient Care (B-001-IP) and Anorexia Nervosa, Child or Adolescent: Inpatient Care (B-016-IP). MPC approved to adopt MCG 25th Edition with modifications (hybrid) for Anorexia Nervosa: Partial Hospitalization Program (B-KP-001-PHP), Anorexia Nervosa: Intensive Outpatient Program (B-KP-001-IOP), Anorexia Nervosa: Outpatient Care (B-KP-001-AOP) and Anorexia Nervosa: Residential Care (B-KP-001-RES). Requires 60-day notice, effective date 12/01/2021.

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