Clinical Review Criteria
Eating Disorders – Anorexia Nervosa

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Criteria
Inpatient Care
Kaiser Permanente has elected to use the MCG* Anorexia Nervosa: Inpatient Care (B-KP-001-IP) for medical necessity determinations.

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

Intensive Outpatient
Kaiser Permanente has elected to use the MCG* Anorexia Nervosa: Intensive Outpatient (B-001-IOP) for medical necessity determinations.

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

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

*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 by our Behavioral Health department, you may request a copy of the criteria that is being used to make the coverage determination. Call the Behavioral Health unit for more information regarding the case under review.

The following information was used in the development of this document and is provided as background only. It 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 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.

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<tr>
<th>Date Created</th>
<th>Date Reviewed</th>
<th>Date Last Revised</th>
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MDCRPC Medical Director Clinical Review and Policy Committee

MPC Medical Policy Committee

**Revision History**

<table>
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<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>12/01/2015</td>
<td>Revised criteria to reflect GHC hybrid policy</td>
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<tr>
<td>03/31/2016</td>
<td>Removed 60 day notice</td>
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<tr>
<td>02/07/2017</td>
<td>MPC approved to adopt MCG 20th Ed. guidelines for Inpatient &amp; Acute Outpatient Care; MPC approved to adopt hybrid (GHC/MCG) guidelines for Residential, Partial Hospital and Intensive Outpatient</td>
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**Codes**

DSM-5: 307.1, F50.01, F50.02
DSM-IV: 307.1
ICD 10: F50.00, F50.01, F50.02, F50.9
ICD 9: 307.1