8.40 STRUCTURED DAY TREATMENT SERVICES

8.401 Eating Disorder Partial Hospitalization Program (Adult and Adolescent)

Description of Services: Eating Disorder partial hospitalization is a nonresidential treatment program for eating disorders that may or may not be hospital-based. The program provides clinical diagnostic and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu that is specifically tailored to the treatment of eating disorders, nursing, psychiatric evaluation and medication management, nutritional counseling, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans for at least 6 hours per scheduled day. This can be accomplished on a specialized unit or a unit with a specific, specialized tract/program that relies on evidence based approaches to the treatment of these complex disorders. The individual should be evaluated by a board certified/eligible psychiatrist by the end of the second day of entering the program, and monitored no less than once per week thereafter. The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services, professional monitoring, control and protection.

Eating disorder partial hospital treatment may be appropriate when a patient does not require the more restrictive and intensive environment of a 24-hour inpatient setting, but does need up to eight hours of clinical services to provide continued stabilization and monitoring of behavior issues such as food restricting, purging, over-exercising, use of laxatives/diet pills/diuretics, to avoid imminent serious harm due to medical consequences or co-morbid medical or psychiatric complications such as complications of refeeding syndrome. Partial hospitalization is used as a time-limited response to stabilize acute symptoms. As such, it can be used both as a transitional level of care (i.e., step-down from inpatient) as well as a stand-alone level of care to stabilize a deteriorating condition and avert hospitalization. Treatment efforts need to focus on the individual's response during treatment program hours, as well as the continuity and transfer of treatment gains during the individual's non-program hours in the home/community. Eating disorder partial hospital treatment is separate and distinct from general psychiatric social rehabilitation programs or day treatment programs, which also focus on maximizing an individual's level of functioning (e.g., self-sufficiency, communication skills, social support network), but are usually less eating disorder/psychiatrally-based, located in a community setting, and focus more on the development or enhancement of an individual's coping skills necessary for daily social and occupational functioning. Family involvement from the beginning of treatment is important unless contraindicated. Frequency of interventions and treatment modalities should occur based on individual needs. Nutritional counseling is required. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Important: While level of care determinations are considered in the context of an individual's treatment history; Beacon Health Options never requires the attempt of a less intensive treatment as a criterion to authorize any service.
## Admission Criteria

### All of the following criteria are necessary for admission:

1. The individual demonstrates symptomatology of an Eating Disorder diagnosis as listed in the most recent version of the DSM that requires and can reasonably be expected to respond to therapeutic intervention at the partial care level of care. Evaluation needs to include an assessment of co-occurring psychiatric and substance abuse issues.

2. There is evidence of patient’s capacity and support for reliable attendance at the Eating Disorder partial hospital program.

3. There is an adequate social support system available to provide the stability necessary for maintenance in the program OR the individual demonstrates willingness to assume responsibility for his/her own safety outside program hours.

4. There is continued daily monitoring and medical coordination needed of potential risks or medical instability related to Eating Disorders, but not to the extent a 24 hour a day setting is required. Some indicators may include:
   - Pulse < 40 bpm
   - Blood Pressure < 90/60 mmHg or significant orthostatic changes > 20 mmHg
   - Blood glucose < 60mg/dL
   - Potassium < 3 mEq/L or other electrolyte imbalance (magnesium, phosphate, sodium)
   - Temperature < 97.0 degrees F
   - Severe dehydration
   - Renal, cardiovascular or other organ damage
   - Poorly controlled Diabetes Mellitus
   - Although weight alone should not be the sole criterion for admission or discharge at this level of care, the individually calculated ideal body weight is generally >85% (or BMI of 16 or more) at this level, combined with other objective evidence of medical complications that if not monitored at the partial hospital level of care may require higher level of care.
   - Requires enteral tube feeding or parenteral feeding in a structured inpatient acute setting and is unable to utilize these mechanisms safely at a less restrictive level of care.
   - Pregnancy with potential risk to mother’s or fetus’ health
   - Refeeding syndrome

5. There may be a risk to self, others, or property (e.g. inability to undertake self-care including appropriate feeding and nutritional intake; mood, thought or behavioral disorder interfering significantly with activities of daily living; suicidal ideation or non-intentional threats or gestures; risk-taking or other self-endangering behavior) which is not so serious as to require 24-hour medical/nursing supervision, but does require structure
The patient’s condition requires a comprehensive, multi-disciplinary, multi-modal course of treatment, including routine medical observation/supervision and nutritional counseling to effect significant regulation of medication and/or routine nursing observation and behavioral intervention to maximize functioning and minimize risks to self, others and property.

7. The treatment plan needs to clearly state what benefits the individual can reasonably expect to receive in the program specific to eating behaviors; the goals of treatment cannot be based solely on need for structure and lack of supports.

8. A nutritional assessment is completed on admission and if low body weight is a reason for admission then specific dietary intake and target weight goals are identified, with a weekly measurement of weight and daily charting of calorie intake/percentage of dietary intake goals.

9. Coordination with other treating providers including the PCP, outpatient psychiatrist, outpatient therapist is provided to support transition to ongoing community based care following discharge from partial hospitalization.

### Psychosocial, Occupational, and Cultural and Linguistic Factors

*These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions.*

### Exclusion Criteria

*Any of the following criteria are sufficient for exclusion from this level of care.*

1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service or a primary mental health setting is required.

2. The individual does not voluntarily consent to admission or treatment or does not meet criteria for involuntary admission to this level of care.

3. The individual has medical conditions or impairments that would prevent beneficial utilization of services.

4. The individual exhibits a serious and persistent mental illness consistent throughout time and is not in an acute exacerbation of the mental illness;

5. The individual requires a level of structure and supervision beyond the scope of the program (e.g., considered a high risk for non-compliant behavior and/or elopement).
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<tr>
<th>Clinical Criteria</th>
<th>Continued Stay Criteria</th>
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6. The individual can be safely maintained and effectively treated at a less intensive level of care.

7. The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

8. The focus of treatment is primarily for peer socialization and group support.

9. The individual was not evaluated by a board certified/eligible psychiatrist by the end of the second day of entering the program, and/or the psychiatric visits do not occur with the frequency the individual requires to reduce symptom exacerbation.

**All of the following criteria are necessary for continuing treatment at this level of care:**

1. The individual’s condition continues to meet admission criteria at this level of care;

2. The multi-disciplinary discharge planning process starts from the assessment and tentative plan upon admission, and includes the patient and family/significant other as appropriate. A bio-psycho-social outpatient team should be collaborated with or created if not already in place (including physical health practitioner, behavioral health therapist, psychiatrist, & nutritional expert). Firm aftercare appointments should be in place.

3. The individual’s treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.

4. Treatment planning is individualized and appropriate to the individual’s changing condition with realistic and specific goals and objectives stated. Treatment planning is active and includes family or other support systems (unless contraindicated), face to face meetings with the psychiatrist, and social, occupational and interpersonal assessment. Family sessions as appropriate need to occur in a timely manner. Monitoring by the psychiatrist should occur at the frequency appropriate to the individual’s Eating Disorder status but no less than weekly thereafter. Education on healthy skills should be included (e.g. CBT or DBT skills, healthy exercise protocols, healthy meal selection etc.). Expected benefits from all relevant modalities, including family and group treatment, are documented.

5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not been met.

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Reviewed: 7/15/13, 11/18/13, 11/17/14, 2/5/15, 11/17/15
Revised: 2/5/15

This criterion is consistent with NCD and/or LCD.

Beacon Health Options Policies and Procedure and Medical Necessity Criteria cover the operations of all entities within the BVO Holdings, LLC corporate structure, including but not limited to Beacon Health Strategies LLC, Beacon CBHM LLC and ValueOptions, Inc.
<table>
<thead>
<tr>
<th>Clinical Criteria</th>
<th>Discharge Criteria</th>
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<td>yet been achieved or adjustments in the treatment plan to address lack of progress are evident.</td>
<td><strong>Any of the following criteria are sufficient for discharge from this level of care:</strong></td>
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<td>7. Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan.</td>
<td>1. The individual's documented treatment plan, goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at a lower level of care.</td>
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<td>8. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.</td>
<td>2. The individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care.</td>
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<td>9. Patient is actively participating in treatment.</td>
<td>3. The individual, family, guardian and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment.</td>
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<td>10. Coordination with relevant outpatient providers should be implemented.</td>
<td>4. Consent for treatment is withdrawn, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.</td>
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<td>Discharge Criteria</td>
<td>5. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured.</td>
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<td>Any of the following criteria are sufficient for discharge from this level of care:</td>
<td>6. The patient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care despite treatment planning changes.</td>
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<td>1. The individual's documented treatment plan, goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at a lower level of care.</td>
<td>7. There is a discharge plan with follow-up appointments in place prior to discharge.</td>
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