



Treatment of Eating Disorders

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of Eating Disorders. Symptomology as well as behavioral health implications and Measurable Health Outcomes are discussed. The CPG also outlines the organizations that WellCare aligns with on Eating Disorders.

OVERVIEW

The most common Eating Disorders include: Anorexia Nervosa, Binge Eating Disorder, and Bulimia. These disorders typically appear during the teen years or young adulthood however one can develop earlier or later in life. The National Institute of Mental Health reports that among 13 to 17 year olds, almost 3 percent suffer from an Eating Disorder; girls are more than two and a half times as likely as boys to have an Eating Disorder.¹ Factors that may be involved in developing an Eating Disorder include genetics, environment (fitting an 'ideal' body type), peer pressure, history or physical or sexual abuse, and emotional health. Eating Disorders can be found among all ages however major risk factors for the development of an Eating Disorder include:

- **Age.** More common during teens and early 20s.
- **Gender.** Teenage girls and young adult women are most at risk – they are also the most likely to be treated. Teenage boys and young men are less likely to seek help; they account for 1 out of 10 people diagnosed.
- **Family history.** Having a parent or sibling with an Eating Disorder increases the risk.
- **Dieting.** Dieting that is extreme can lead to an Eating Disorder.
- **Changes.** High stress times of change (e.g., going to college, starting a new job, or getting divorced).
- **Vocations and activities.** Eating Disorders are common among gymnasts, runners, wrestlers and dancers.²

Treatment options for an Eating Disorder may include psychotherapy, medicine (e.g., antidepressants, anti-anxiety drugs), and nutritional counseling and weight restoration. Related conditions associated with Eating Disorders include: depression, anxiety, borderline personality disorder, obsessive compulsive disorder, and substance use.²

Anorexia Nervosa

Anorexia usually begins during the teen years or young adulthood. It is more common in females but is also seen in males; among females the disorder is largely seen in those who are White, are high academic achievers, and have a goal-oriented family or personality. People with anorexia may view themselves as overweight, even when they are dangerously underweight. Of all mental disorders, anorexia nervosa has the highest mortality rate. While many die from complications associated with starvation, others may die due to suicide; suicide is much more common in those with anorexia than with most other mental disorders.²

A diagnosis of anorexia includes the following to be present in an individual:³

- Have an intense fear of gaining weight or becoming fat, even when she is underweight
- Refusal to keep weight at what is considered normal for age and height (15% or more below the normal weight)
- Have a body image that is very distorted, be very focused on body weight or shape, and refuse to admit the seriousness of weight loss
- Have not had a period for three or more cycles (in women)

Anorexia is characterized by the following:^{2,3}

- A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
- Intense fear of gaining weight
- Distorted body image, a self-esteem that is heavily influenced by perceptions of body weight and shape, or a denial of the seriousness of low body weight
- Severely limit the amount of food they eat, or eat and then make themselves throw up
- Cutting food into small pieces or moving them around the plate instead of eating
- Exercising all the time, even when the weather is bad, they are hurt, or their schedule is busy
- Going to the bathroom right after meals
- Refusing to eat around other people
- Using pills to make themselves urinate (water pills or diuretics), have a bowel movement (enemas and laxatives), or decrease their appetite (diet pills)

Physical symptoms that may develop over time including the following:²

- Thinning of the bones (osteopenia/osteoporosis)
- Mild anemia and muscle wasting and weakness
- Brittle hair and nails
- Dry and yellowish skin
- Growth of fine hair all over the body (lanugo)
- Severe constipation
- Low blood pressure, slowed breathing and pulse
- Damage to the structure and function of the heart
- Brain damage
- Multi-organ failure
- Drop in internal body temperature, causing a person to feel cold all the time
- Lethargy, sluggishness, or feeling tired all the time
- Infertility

The cause of anorexia nervosa is not known however factors may include genetics and hormones. As with other Eating Disorders, societal attitudes that promote thin body types may also contribute. Additional risk factors include:²

- Being more worried about, or paying more attention to, weight and shape
- Having an anxiety disorder as a child
- Having a negative self-image
- Having eating problems during infancy or early childhood
- Having certain social or cultural ideas about health and beauty
- Trying to be perfect or overly focused on rules

Binge Eating Disorder

Binge-Eating Disorder is the most common Eating Disorder in the United States. People with Binge-Eating Disorder lose control over their eating. Unlike bulimia, binge-eating is not followed by purging, excessive exercise, or fasting – this can ultimately lead to obesity.² Typically a binge eater eats 5,000-15,000 calories in one sitting and overeats throughout the day by snacking in addition to eating three meals a day. Binge eating can occur on its own or with another Eating Disorder, such as bulimia. The cause is unknown however, it often begins during or after strict dieting.⁴ Symptoms of Binge Eating Disorder can include:²

- Eating unusually large amounts of food in a specific amount of time
- Eating even when you're full or not hungry
- Eating fast during binge episodes
- Eating until you're uncomfortably full
- Eating alone or in secret to avoid embarrassment
- Feeling distressed, ashamed, or guilty about your eating
- Frequently dieting, possibly without weight loss

Bulimia

Bulimia is characterized by a person bingeing on food or has regular episodes of overeating which leads to a loss of control. It is more common among women than men, especially those who are adolescents and young adults. Methods such as vomiting or abusing laxatives help prevent weight gain. Many people with bulimia also have anorexia nervosa. The cause is unknown however factors such as genetics, psychological, or trauma as well as family/societal/cultural factors can also lead to bulimia.⁵

Eating binges may occur as often as several times a day for many months; this includes eating large amounts of high-calorie foods, usually in secret, and can lead to a lack of control over their eating during these episodes. Purging can bring the person a sense of relief. Those with bulimia typically have a normal weight yet believe that they are overweight. Others may not notice that someone has an Eating Disorder as their weight can appear normal and healthy. Other symptoms of bulimia can include:⁵

- Compulsive exercise
- Suddenly eating large amounts of food or buying large amounts of food that disappear right away
- Regularly going to the bathroom right after meals
- Throwing away packages of laxatives, diet pills, emetics (drugs that cause vomiting), or diuretics

Physical symptoms of bulimia can include:²

- Chronically inflamed and sore throat
- Swollen salivary glands in the neck and jaw area
- Worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acid
- Acid reflux disorder and other gastrointestinal problems
- Intestinal distress and irritation from laxative abuse
- Severe dehydration from purging of fluids
- Electrolyte imbalance (too low or too high levels of sodium, calcium, potassium and other minerals) which can lead to stroke or heart attack

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to treatment of Eating Disorders, WellCare defaults (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the APA on the topic. Highlights from their respective publications are noted below.

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

In August 2012, the APA issued a *Guideline Watch* to update the guideline for Eating Disorder published in 2006. Highlights regarding treatment outcomes and treatment settings are noted below:^{6,7}

- Full recovery rates on members with an Eating Disorder are poor, at only 33% after 2 years in the study group;
- Treatment adherence was lowest with the inpatient treatment group, at only 50% as compared with 71% for the outpatient group and 77% for the specialist outpatient group;
- First line inpatient treatment does not provide advantages over outpatient treatment;
- Patients who do not respond to outpatient treatment do poorly on transfer to inpatient facilities;
- Specialist outpatient treatment was found to be the most effective/cost-effective treatment and had the highest patient satisfaction rates; and
- There is little support for long-term inpatient (residential) care.

To access the original APA guideline or the *Guideline Watch*, click [here](#).^{6,7}

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has not published reports on this topic.

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

MARKET SPECIFIC INFORMATION

Florida

1. Member safety is always the first priority. If the member is at risk of physical bodily harm due to the medical complications of an Eating Disorder and meets inpatient criteria, WellCare will manage medical inpatient services to stabilize the member's acute physical condition and facilitate an appropriate discharge. Likewise, if the behavioral health symptoms are the most acute and the member meets inpatient criteria, WellCare will manage psychiatric inpatient services to stabilize the member's psychiatric condition and facilitate an appropriate discharge.
2. The goal of any inpatient admission is rapid stabilization and engagement with specialized outpatient services.
3. WellCare will consider the use of specialized psychiatric outpatient treatment that includes nutritional support and needed medical services the best practice for the treatment of Eating Disorders.
4. As indicated for each member based on criteria and the APA guidelines, intensive outpatient or partial hospitalization services may be an appropriate treatment response to those who need more intensive treatment than available in specialized outpatient treatment.
5. There is no evidence to support the use of long-term inpatient services in any setting (residential, crisis stabilization units, or acute inpatient facilities) and removing children from their families unless there is clear and convincing evidence of abuse or neglect is contraindicated.
6. WellCare will automatically assign a case manager to work with the integrated medical/psychiatric Utilization Management staff on treatment alternatives and discharge planning to promote the best possible outcomes.

Care Management

The potential for co-morbid conditions is high for those with Eating Disorders; this can include mental health disorders, substance use disorders and medical conditions. Cases are medically complex and can represent high acuity clinical situations. WellCare believes the following statements to be appropriate guidelines for treatment decisions and system of care interventions of an Eating Disorder:

- The treatment of an Eating Disorder is complex and requires an integrated approach to balance and manage all the co-morbid psychiatric and medical conditions present when these members access care.
- The psychogenic dynamics that contribute to the development of Eating Disorders require attention or the condition is extremely likely to continue and to escalate.
- Treating the whole person within their living environment is crucial to treatment success.
- The absence of specialty practitioners or a full spectrum of care in each community to treat these specialty conditions is a system of care deficit that needs to be considered and addressed as much as possible to facilitate best practices in the treatment of an Eating Disorder.
- Integrated Care Programs are the best paradigm to treat an Eating Disorder conditions.

MEASURABLE HEALTH OUTCOMES

- **Symptoms:** Member will have weight gain of >10% of body weight as evidenced by provider reports
- **Symptoms:** Member will have normal EKG findings as evidenced by provider report
- **Symptoms:** Member will have sodium, calcium, magnesium, liver enzymes, amylase and lipase within normal values as evidenced by provider report or labs
- **Symptoms:** Member will increase calories by >200 Kcal every 5 days for a daily total of 1900 calories a day

as evidenced by member meal logs

- **Symptoms:** Member's weight will increase by >1 lb a week until ideal body weight obtained as evidenced by provider report
- **Symptoms:** Member will have 3 or less instances in a week of restricting meals, bingeing and purging, taking laxatives, exercising excessively, counting calories and/or measuring weight per member report
- **Engagement:** Member will eat 3 main meals a day and 2 snacks as evidenced by meal diary
- **Adherence:** Member will attend >75% of outpatient therapy appointments
- **Utilization:** Member's ER admissions related to health problems due to eating disorders will decrease by >50%

CASE MANAGEMENT GOALS

- **Symptoms:** Member will verbalize at least 3 appropriate coping skills such as yoga, art, music and/or drama
- **Symptoms:** Member will verbalize at least 2 ways food is good for the body
- **Symptoms:** Member will identify at least one signal of hunger and one signal of satiety
- **Symptoms:** Member will not go more than 3 or 4 hours without eating during the day
- **Engagement:** Member will eat foods from at least 4 of the 5 food groups daily
- **Engagement:** Member will obtain a journal to record negative thoughts about food and self-image and replace them with more positive thoughts
- **Engagement:** Member will verbalize at least 2 people that are supportive and make a plan to reconnect with them
- **Engagement:** Member will engage in at least one activity such as a new hobby
- **Adherence:** Member will have a relapse prevention plan in place
- **Utilization:** Member will attend a PCP appointment to avoid health problems resulting in ER admissions

CASE MANAGEMENT OBJECTIVES

- Refer to Family Based Therapy for adolescents with Anorexia Nervosa
- Collect data such as weight, height, BMI, percentage of ideal body weight (IDBW), highest and lowest weight, and current meal plan calories
- Refer to an eating disorder support group
- Refer to a therapist with experience in eating disorders; family therapy is recommended, especially for adolescents with anorexia, CBT is recommended for anorexia, bulimia and binge eating disorder
- Ensure that a nutritionist or dietician is involved in treatment
- Ensure that member has meal plans in place and is monitored during and after meals
- Educate on the importance of engaging in distracting activities after meals
- Encourage journaling and assertive communication
- Encourage member to get rid of scales at home and get weighed only at provider appointments
- Educate on the RAVES model of eating Regularly, Adequately, a Variety of foods, Eating socially and Spontaneously
- Educate member on relaxation techniques
- Utilize Motivational Interviewing and the Stages of Change
- Educate on the physical and psychological effects of malnutrition and excessive dieting
- Educate on meal planning and shopping for healthy foods of variety and the nutrient content of foods
- Ensure member is getting treatment for common co-occurring disorders such as depression and anxiety

MEDICAL BEHAVIORAL INTEGRATION

Refeeding syndrome can occur early with refeeding a member with Anorexia. This syndrome includes cardiovascular collapse, starvation-induced hypophosphatemia and dangerous fluctuations in potassium, sodium and magnesium levels. Refeeding must be done slowly with the help of a nutritionist or dietician. Vitamin D, Calcium, Vitamin A and other vitamins should be monitored. Vitamin A levels can be elevated in early anorexia leading to dizziness, nausea, cerebral edema and mineral bone loss. Tube feedings may be initiated if member's weight is less than 85% of desired weight. Medical hospitalization to complete refeeding safely and monitor cardiovascular health and electrolytes may be needed.⁸

Psychoeducational interventions with the member and the family related to the individual/family dynamics, the nature of the ED, and the individual's emotional issues are considered to be helpful. Additionally, nutritional counseling is vital to assist the member with assuming healthy control of their intake.

Presentation for Antipsychotic or Antidepressant Drugs. The potential for co-morbid behavior is high. Psychosis can be present in the clinical picture of a member with ED- most often related to PTSD and/or major depression. Depression and Anxiety are frequent co-morbid behavioral health conditions. Additionally there is a high prevalence of borderline personality disorder. As needed psychotropic drugs can be a valuable treatment adjunct.

Evaluation for Antipsychotic Drugs. Considerations include the potential effect and side effects. Some drugs may help with weight gain in addition to controlling psychotic symptoms. Careful dosing is necessary with members whose weight or other medical conditions provide potential drug interactions or the potential for serious side effects.

PHARMACOLOGY

A database of medication guidelines has been developed by the University of South Florida (USF) and is available [here](#). Medications are searchable by childhood or adult disorders.⁹

MEMBER EDUCATIONAL RESOURCES

Currently there are no Krames/StayWell Member educational materials utilized by WellCare Case Managers.

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Anxiety Disorders: HS-1057; Child and Adolescent Behavioral Health: HS-1049; Depressive Disorders Adults, Children and Adolescents: HS-1022; Substance Use Disorders: HS-1031; and Suicidal Behavior: HS-1027.*

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

1. Eating disorders among adolescents. National Institute of Mental Health Web site. <https://www.nimh.nih.gov/health/statistics/eating-disorders.shtml>. Accessed June 27, 2018.
2. Eating disorders. National Alliance on Mental Health Web site. <https://www.nami.org/Learn-More/Mental-Health-Conditions/Eating-Disorders>. Accessed June 27, 2018.
3. Anorexia nervosa. United States Department of Health and Human Services Web site. <https://www.mentalhealth.gov/what-to-look-for/eating-disorders/anorexia/index.html>. Updated August 27, 2017. Accessed June 27, 2018.
4. Binge eating. United States Department of Health and Human Services Web site. <https://www.mentalhealth.gov/what-to-look-for/eating-disorders/binge-eating/index.html>. Updated August 27, 2017. Accessed June 27, 2018.
5. Bulimia. United States Department of Health and Human Services Web site. <https://www.mentalhealth.gov/what-to-look-for/eating-disorders/bulimia/index.html>. Updated August 27, 2017. Accessed June 27, 2018.
6. APA practice guideline: eating disorders. American Psychiatric Association Web site. <http://psychiatryonline.org/guidelines>. Published May 2006. Accessed June 27, 2018.
7. APA guideline watch: eating disorders. American Psychiatric Association Web site. <http://psychiatryonline.org/guidelines>. Published August 2012. Accessed June 27, 2018.
8. Bernstein, Bettina & Pattaki, Caroly; “Anorexia Nervosa, Treatment and Management”. <http://emedicine.medscape.com/article/912187-treatment#d11>. Updated June 7, 2018. Accessed June 27, 2018.
9. Florida Medicaid Drug Therapy Management Program for Behavioral Health. University of South Florida Web site. <http://www.medicaidmentalhealth.org/searchGuidelines.cfm>. Accessed June 27, 2018.

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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
7/12/2018	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of Pharmacology section with reference to database.
10/5/2017	<ul style="list-style-type: none"> • Approved by MPC. Updated on new template, including the Care Management section.
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