Executive Summary
Eating disorders are a significant public health problem. It is estimated that about 5 million Americans have a diagnosable eating disorder. Eating disorders can have serious, chronic effects on quality of life that result in lifelong physical and psychological problems. Despite advances in understanding and treating eating disorders, inadequate transitions in care continue to occur and patients often require costly acute hospitalizations.

Introduction
Individuals with eating disorders exhibit severe disturbances in their eating behaviors and related thoughts and emotions. They typically become obsessed with food and their body weight. Eating disorders frequently appear during the teen years or young adulthood but may also develop during childhood or later in life. In their lifetime, an estimated 0.6% of adults in the United States will suffer from anorexia, 1.0% will suffer from bulimia, and 2.8% will suffer from a binge-eating disorder. Although eating disorders primarily affect girls and women, men and boys can also be vulnerable.

In many cases, eating disorders occur together with other psychiatric disorders such as anxiety, panic, obsessive-compulsive disorder, and alcohol and drug abuse problems. Without the treatment of both the psychological and physical symptoms of these disorders, malnutrition, heart problems, and other potentially fatal conditions can result. Eating disorders may increase the risk of premature death. However, with timely and appropriate medical care, individuals with eating disorders can develop appropriate eating habits and return to improved psychological and physical health.

Major Types of Eating Disorders
The three major types of eating disorders are anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Anorexia Nervosa
People with anorexia nervosa have a distorted body image that causes them to see themselves as overweight even when they are dangerously thin. They develop unusual eating habits such as avoiding food and meals, picking out a few foods and eating them in small amounts, weighing their food, and counting the calories of everything they eat. In addition, they may exercise excessively. Some people with anorexia may also engage in binge-eating followed by extreme dieting, excessive exercise, self-induced vomiting, and/or the misuse of laxatives, diuretics, or enemas.

Anorexia can slow the heart rate and lower blood pressure, thereby increasing the chance of heart failure. Individuals who use drugs to stimulate vomiting, bowel movement, or urination are also at high risk for heart failure. Starvation can also lead to heart failure and can damage the brain. Anorexia may also cause a patient’s hair and nails to grow brittle. Skin may dry out, become yellow, and develop a covering of soft hair called lanugo. Mild anemia, swollen joints, reduced muscle mass, and light-headedness also commonly occur as a consequence of this eating disorder. Severe cases of anorexia can lead to brittle bones that break easily as a result of calcium loss.

Bulimia Nervosa
Individuals with bulimia nervosa eat an excessive amount of food in a single episode and almost immediately make themselves vomit or use laxatives, enemas, or diuretics to get rid of the food in their bodies. This behavior often is referred to as the “binge/purge” cycle. Like people with anorexia, people with bulimia have an intense fear of gaining weight.
The acid in vomit can wear down the outer layer of the teeth, inflame and damage the esophagus, and enlarge the glands near the cheeks, giving the appearance of swollen cheeks. Damage to the stomach can also occur from frequent vomiting. Irregular heartbeats, heart failure, and death can occur from chemical imbalances and the loss of important minerals such as potassium. Peptic ulcers, pancreatitis, and long-term constipation are also consequences of bulimia.

**Binge-Eating Disorder**

People with binge-eating disorder have frequent episodes of compulsive overeating, but, unlike those with bulimia, they do not purge their bodies of food. During these food binges, they often eat alone and very quickly, regardless of whether they feel hungry or full. They often feel shame or guilt over their actions.

Binge-eating disorder can cause high blood pressure and high cholesterol levels. Other effects of binge-eating disorder include fatigue, joint pain, type 2 diabetes, gallbladder disease, and heart disease.

**Determining Medical Necessity for Comprehensive Treatment of Eating Disorders Requires Thorough Assessment**

**Clinical Presentation of Eating Disorders**

Patients with eating disorders can have a wide range of symptoms. In addition to the cognitive and behavioral signs that characterize eating disorders, numerous physical signs and symptoms (Table) can occur as a consequence of nutritional deficiencies, binge-eating, and inappropriate compensatory behaviors, such as purging. However, eating disorders may also occur without any obvious physical signs or symptoms.

Patients should be evaluated for an eating disorder when they present with any of the following:

- Precipitous weight loss or gain or substantial weight fluctuations, even in individuals of normal weight.
- Weight loss or failure to thrive in a child or a developing and growing adolescent.
- Electrolyte abnormalities (with or without electrocardiographic changes), especially hypokalemia, hypochloremia, or high-normal CO₂ levels (may indicate recurrent vomit) with or without hypoglycemia.
- Bradycardia.
- Amenorrhea, menstrual irregularities, or unexplained infertility.
- Excessive exercise or participation in extreme physical training.
- Constipation in patients who are inappropriately dieting and/or are engaging in behaviors to promote weight loss.
- Type 1 diabetes and unexplained weight loss and/or poor metabolic control or diabetic ketoacidosis.
- Self-induced vomiting, dieting, fasting, or excessive exercise to lose weight after eating or perceived overeating or binge eating.
- Use or abuse of of appetite suppressants, excessive caffeine, diuretics, laxatives, enemas, ipecac, excessive hot or cold fluids, artificial sweeteners, prescription medications, psychostimulants, street drugs, or various complementary and alternative supplements.

**Clinical Presentation of Eating Disorders**

The comprehensive assessment of a patient suspected of having an eating disorder should include a complete history that determines the rate and amount of weight loss/change; nutritional status; and the methods of weight control. The history should also include a review of compensatory behaviors (vomiting, dieting, exercise, and the use of laxatives, ipecac, and diuretics); dietary intake and exercise; menstrual history in females; a comprehensive growth and development history; temperament and personality traits; family history, including the symptoms or diagnosis of eating disorders, obesity, and mood and anxiety disorders; alcohol and substance use disorders; and psychiatric history, including the symptoms of mood disorder and anxiety disorders.

The physical examination should include the patient’s supine and standing heart rate, blood pressure, respiratory rate, oral temperature, height, weight, and a determination of body mass index (BMI).

Potential laboratory and imaging studies that may be considered for the initial evaluation of a patient suspected of having an eating disorder include the following: complete blood count; comprehensive serum metabolic profile, other electrolytes and enzymes; thyroid function tests; gonadotropins and sex steroids; pregnancy test for women in their childbearing years; lipid panel; and bone mineral density test. An electrocardiogram may also be performed.
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Treatment of Eating Disorders: What is Medically Necessary?

Adequate nutrition, reducing excessive exercise, and stopping purging behaviors are the foundations of the treatment of eating disorders. Specific forms of psychotherapy (talk therapy) and medications are effective for many eating disorders. However, in more chronic cases, specific treatments have not yet been identified. Treatment plans are often tailored to individual needs and may include one or more of the following:

- Individual, group, and/or family psychotherapy
- Medical care and monitoring
- Nutritional counseling
- Medications

Some patients may also need to be hospitalized to treat problems caused by malnutrition or to ensure nutritional rehabilitation if the patient is very underweight.

Treating anorexia nervosa involves three components:

- Restoring the person to a healthy weight
- Treating the psychological issues related to the eating disorder
- Reducing or eliminating behaviors or thoughts that lead to insufficient eating and preventing relapse

Some research suggests that the use of medications, such as antidepressants, antipsychotics, or mood stabilizers, may be modestly effective in treating patients with anorexia. These medications may help resolve mood and anxiety symptoms that often occur along with anorexia.

As with anorexia, the treatment for bulimia often involves a combination of options and depends upon the needs of the individual. To reduce or eliminate binge-eating and purging behaviors, a patient may undergo nutritional counseling and psychotherapy, especially cognitive behavioral therapy (CBT) or may be prescribed medication. With CBT, the patient learns how to identify distorted or unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change their behaviors accordingly.

Some antidepressants, such as fluoxetine, may help patients who also have depression or anxiety. Fluoxetine is the only medication that is approved by the United States Food and Drug Administration (FDA) for the treatment of bulimia. It has been shown to help reduce binge-eating and purging behaviors, to reduce the chance of relapse, and to improve eating attitudes.

Like patients with bulimia, patients with binge-eating disorder may benefit from psychotherapy, especially CBT. Studies of treatments for binge-eating disorder are inherently limited by the facts that the symptoms of binge-eating disorder are highly variable and that the placebo response rates in many studies are high.
Health Plan Coverage

Many health plans have specific language that impacts the coverage of the treatment of eating disorders. Some patients may need residential care, some may need outpatient care, and others with medical problems may need treatment in a hospital. Although many plans cover the acute treatment of eating disorders under their mental health benefits, some plans do not adequately cover treatment or do not cover eating disorders at all. In addition, when insurance companies do cover treatment, they often base “wellness” solely on the patient’s BMI and not on the psychiatric care needed after the patient reaches the required BMI. Insurers can also refuse treatment coverage if the patient’s BMI is not low enough.

Health Plan Coverage

The American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Eating Disorders was updated in 2012. According to these guidelines, a comprehensive treatment plan should include nutritional rehabilitation, psychotherapy, and medication. In addition, the patient’s weight and cardiac and metabolic status determine the acuteness of the illness and the need for hospitalization. The goals of treatment are to restore the patient’s nutritional status, establish healthy eating patterns, treat medical complications, correct core dysfunctional thoughts related to the eating disorder, enlist family support, and provide family counseling.

The APA’s latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be released in May 2013. The 5th edition of the manual (DSM-5) makes a number of important changes to the criteria used in the diagnosis of eating disorders. Some of the changes include the following:

- Binge-eating disorder is added as a separate diagnosis, when it had previously been classified under the more general diagnosis of eating disorder not otherwise specified (EDNOS).
- The number of times a person binges and purges per week is no longer a central criterion for the diagnosis of bulimia; the binge/purge cycle criterion is now at least once per week for three months.
- The criterion of amenorrhea was removed for the diagnosis of anorexia. Removing this criterion allows boys and men with anorexia to receive an appropriate diagnosis, and girls and women who continue to have menstrual periods despite other symptoms associated will be eligible to receive a diagnosis.
- The criterion that a patient must be 85% or less than their recommended body weight for a diagnosis of anorexia is removed; weight is addressed by requiring “restriction of energy intake [leading to] markedly low weight.”

The Role of External Independent Medical Review in Determining Medical Necessity for Treatment of Eating Disorders

An independent medical review looks at whether or not a specific therapy or procedure is medically necessary. Determining the medical necessity of the treatment of eating disorders is complicated because it often involves medical care, mental health services, and nutritional therapy provided by a multidisciplinary team (a primary care physician, a therapist, a psychiatrist, and a dietitian). Although many health plans cover the acute treatment of eating disorders, many patients do not receive adequate treatment. Thorough clinical documentation is required not only to support the medical necessity of the treatment under review but also to ensure continuity and quality of care.

An independent review organization (IRO) provides ready access to specialists, thereby allowing for unbiased and timely determinations of whether the requested treatment falls under medical necessity guidelines. The board-certified physician specialists who work with IROs keep up-to-date with the latest medical research literature and with the latest standard of care, staying on top of continually evolving guidelines/recommendations as eating disorders and therapies are studied more extensively.

Conclusions

Eating disorders impact millions of Americans. The health consequences can be life-threatening in many cases and typically take years to overcome. Unfortunately, the diagnosis of eating disorders can be elusive. The updated diagnostic criteria in the DSM-5 represent a positive step forward in helping clinicians to make more accurate diagnoses in order to ensure that individuals suffering from eating disorders receive proper treatment.
Bibliography


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