EATING DISORDERS: Residential Level of Care

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490. ***Please verify the employer group's residential treatment benefits.***

Section I: PATIENT INFORMATION

Patient Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Patient's Home Address:	Parent/Guardian Name *(if patient under 18)*:
Patient or Parent/Guardian Phone *(if patient under 18)*: **Primary Phone: ( )** **Alternate Phone: ( )**	**Patient or Parent/Guardian Email *(if patient under 18)*:**

Section II: PROVIDER INFORMATION

Date Requested:	Facility Name:	Facility Address:

Facility NPI #:	Facility Tax ID #:	Facility Contact Person:	Phone:	Facsimile:	Email:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Admit Date:	Type of Commitment: *Please check.*
☐ Initial Admit ☐ Concurrent Review/Additional Days ☐ Retro Auth		☐ Involuntary ☐ Voluntary

Number of Initial Days Requested:	Number of Additional Days Requested:	Estimated Length of Stay:	Target Discharge Date:

Admission Source/Type: ***Please check or specify.***

☐ Direct Admit ☐ Step Down/Up from Day Treatment ☐ Transfer from Outside Hospital (*Name:* _____)
☐ Emergency Room ☐ Step Down/Up from Intensive Outpatient
☐ Step Down from Inpatient ☐ Step Up from Outpatient Therapy ☐ Other: _____

Primary Diagnosis/ICD-10 Code: ***Please check/specify.***

☐ Anorexia Nervosa/ICD-10: _____ ☐ Eating Disorder NOS/ICD-10: _____
☐ Bulimia Nervosa/ICD-10: _____ ☐ Other _____/ICD-10: _____

Secondary Diagnosis/ICD-10 Code(s):

Previous Eating Disorder Treatment: ***Please check/specify all that apply.***

☐ Day Treatment/Partial Hospitalization ☐ Intensive Outpatient Therapy ☐ Residential
☐ ECT/Electroconvulsive Therapy ☐ Outpatient Therapy ☐ TMS/Transcranial Magnetic Stimulation
☐ Inpatient ☐ Pharmacologic Agents ☐ Other: _____

Presenting/Current Eating Disorder Behaviors/Symptoms: ***Please check all that apply.***

☐ Anxiety ☐ Distorted body image ☐ Frequent body weight fluctuations ☐ Preoccupied with body weight
☐ Binge eating ☐ Diuretic use ☐ Going to bathroom after eating ☐ Purging
☐ Chewing and spitting ☐ Eating alone ☐ Hiding/hoarding food ☐ Refusing to eat
☐ Colon cleansing ☐ Enema use ☐ Laxative use ☐ Restricting food
☐ Depression ☐ Excessive exercise ☐ Makes excuses for not eating ☐ Self-induced vomiting
☐ Denial of hunger ☐ Fasting ☐ Obsession with food/nutrients ☐ Skipping meals
☐ Diet pills ☐ Feelings of shame/guilt when eating ☐ Preoccupied with body shape ☐ Strict habits/routines around food

Height:	Admit Weight:	Admit BMI:	Admit % of Ideal Body Weight (IBW):	Current Weight:	Current BMI:	Current % of Ideal Body Weight (IBW):

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ Residential Subacute Treatment Admission:			
1. Does the patient have a diagnosis of *Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified*?	☐	☐	
2. Is there clinical evidence that the patient's condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment?	☐	☐	
3. If the diagnosis is *Anorexia Nervosa* and the goal is weight restoration is the patient's weight between 75%-85% of IBW (BMI 16-17) and has no signs or symptoms of acute medical instability that would require daily physician evaluation?	☐	☐	

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(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
3. a. If body weight is ≥ 85% of IBW does the patient have any evidence of any of the following? ***Please check.*** ☐ Weight loss fluctuation of greater than 10% in the last 30 days. ☐ Patient is within 5-10 pounds of a weight at which physiologic instability occurred in the past. ☐ A child or adolescent patient rapidly losing weight and approaching 85% of IBW during a period of rapid growth.	☐	☐	
4. For patients with *Anorexia Nervosa*, does the patient's malnourished condition require 24-hour residential staff intervention to provide interruption of the food restriction, excessive exercise, purging, and/or use of laxatives/diet pills/diuretics to avoid imminent further weight loss?	☐	☐	
5. For patients with *Bulimia* or *Eating Disorder NOS*, does the patient's condition require 24-hour residential staff intervention to provide interruption of the binge and/or purge cycle to avoid imminent, serious harm due to medical consequences or to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation)?	☐	☐	
6. If present, are the patient's comorbid psychiatric disorder controlled or stable enough for the primary focus of treatment to be the eating disorder?	☐	☐	
7. Does the patient have a significant functional disruption from usual/baseline status in at least 2 two domains (school/work, family, activities, activities of daily living [ADLs]) related to the eating disorder?	☐	☐	
8. Based on past treatment history, usual level of functioning and comorbid psychiatric disorders, is there reasonable expectation that the patient will benefit from this level of care?	☐	☐	
9. Is there evidence that the patient has the need for supervision seven days per week/24 hours a day to address eating disorder behaviors which may include excessive food restricting, binging, purging, exercising, and/or use of laxatives, diet pills, and diuretics?	☐	☐	
9. a. Is the family/support system unable to provide this level of supervision along with a less-intensive level of care setting?	☐	☐	
B. ☐ <u>Residential Subacute Treatment Continued Stay:</u> 1. Despite reasonable therapeutic efforts, does the patient have clinical evidence of any of the following? ***Please check.*** ☐ Persistent problems that caused the admission to a degree that continues to meet the admission criteria, e.g., continued instability in food intake despite weight gain. ☐ Emergence of additional problems that meet the admission criteria. ☐ Discharge planning and/or attempts at therapeutic re-entry into the community have resulted in or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment.	☐	☐	
2. For adults, is there continued required collaboration and progress in their treatment?	☐	☐	
3. If low body weight was a reason for admission, has there been at least 1-2 pounds of weight gain each week?	☐	☐	
4. Is the patient making progress toward treatment goals?	☐	☐	
4. a. If "*yes*", is the patient/family adherent to treatment recommendations, including weight gain and acceptance of recommended dietary caloric intake if low body weight was a reason for admission and/or controlling binging and purging or non-purging bulimic symptoms?	☐	☐	
4. b. Has the patient met treatment goals that would allow continued treatment at a lower level of care?	☐	☐	
5. Is there weekly family therapy unless clinically contraindicated?	☐	☐	
6. Has the patient developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment?	☐	☐	
7. Has there been at least weekly family and/or support system involvement unless there is an identified valid reason why this is not clinically appropriate or feasible?	☐	☐	
8. Is the patient still unable to adhere to a meal plan?	☐	☐	
9. Is the patient still unable to maintain control over restricting food or urges to binge/purge such that continued supervision during and after meals and/or in bathrooms continues to be required?	☐	☐	

Aftercare Planning Notes:

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form, <u>CRISIS EVALUATION</u>, and medical records to 801-366-7449.