ACADEMY FOR EATING DISORDERS®

Insurance Review Guide for Clinicians

USA Version

Academy for Eating Disorders

What is this guide for?

In the United States, it is common for patients with eating disorders to have difficulty getting insurance approval to receive treatment at the level of care recommended by their mental health providers (i.e., physicians, dietitians, therapists, etc.). When treating these patients, providers may be required to engage in "insurance reviews" with a representative from the patient's insurance company. In such reviews, the provider is expected to communicate the medical and psychological necessity of the recommended and/or current level of care. **This document is meant to serve as a guide to help providers navigate this insurance review process for private insurance.** In some states, this guide may also be useful for navigating insurance reviews for Medicaid; the process for insurance reviews for Medicaid varies state-to-state, and specific guidelines for each state should be thoroughly reviewed beforehand. *This guide does not apply to patients with Medicare.*

Insurance Review Logistics

When do I need to do an insurance review?

- Reviews often occur to authorize coverage for a new (typically higher) level of care, before a patient starts treatment.
- They may also occur regularly throughout a patient's course of treatment at the same level of care, in order to get approval for continued treatment.
- If care has been denied (but is technically covered under the patient's health insurance plan), providers can request an appeal of the decision. See some suggestions here.

How are these calls scheduled/conducted?

- Calls are typically 10-15 minutes and rarely up to 1 hour. Brief, concise communication is key.
- For initial authorization, the treating provider contacts insurance by calling the regular customer service number and asks for the Authorization Department (or uses the phone tree menu). That department assigns a case manager to the patient's account. This is the person the treating provider will contact throughout care.

With whom will I speak?

- Reviewers are typically physicians from a variety of medical backgrounds. It is not uncommon to speak with a physician who is not a psychiatrist.
- Personalities and styles vary; apparent "aggression" on the part of the reviewer has nothing to do with you or your patient's need for treatment.

What information should I prepare in advance?

- Review the patient's history and previous successful/unsuccessful treatments.
- Access your record of the patient's baseline symptom severity when treatment began with you.
- Note any co-occurring medical complications (collaborate with other physicians as you are able).
- Identify current functional impairments that must be treated *at the level of care you recommend.*
- List clear treatment goals for the patient. Be able to describe why the patient cannot achieve these goals at a lower level of care. Examples include:
  - Weight restoration
  - Medication adjustment/titration
  - Situational exposures
  - Additional practice of skill implementation (i.e., consolidation of learning)
  - Improved functioning in deficit areas
- Prepare a clear and specific rationale for why your patient needs the level of care you recommend.
- Use the Appendices from this guide to support arguments for your patient's case.

What happens after the call?

- The reviewer typically gives a decision at the end of the call or soon afterward.
- If care is approved, the decision should include a fixed number of sessions covered or a final date of coverage. The provider must call the case manager on the final session/date to make the argument for an extension.
- If care is denied, the private payer is required to provide you with information about the appeal process. An appeal typically involves a "peer-to-peer" review between the treating clinician and a physician who works for the insurance company. The insurer's scheduling department will set up the call, often with short notice and limited time flexibility.
- A standard appeal asks that the insurance company reimburse for care that the patient paid out of pocket (i.e., for treatment they received after being denied further care). An expedited appeal is reserved for urgent decisions (e.g., patient is a safety/medical risk).
- Specific appeal logistics vary by insurance company. Get as many details as possible: will you call them or they call you? Is there a specific time for the call or a range during which the call is made?

Tips For a Successful Call

1. BE CONFIDENT!! You are an expert in your patient's treatment need, and you have determined your patient requires continued care. To be most effective, be firm and assertive while remaining polite and calm. Being reactive, if impassioned, rarely helps.
2. At the beginning of the call, try to get a clear understanding of why the service is being denied (e.g., length of stay, lack of acute symptoms, lack of progress, etc.). Use the clinical information you have prepared in advance to speak **specifically** to the points raised by the reviewer.
3. Ask what criteria the reviewer is using for level of care determination. Ask them to send relevant documentation. Many insurance companies publish their level of care guidelines online. Also consider reviewing the National Eating Disorder Association (NEDA) toolkit.
4. Give as much data as possible before they start asking questions.
5. Reiterate treatment goals and their relation to long-term functioning for the patient. Emphasize *why these goals cannot be met at a lower level of care or with less frequent treatment* (e.g., safety risks, need for structure/staff support, history of decompensation during treatment transition, etc.).
6. When the call is complete, give yourself a big pat on the back! Win or lose, patient advocacy is an important part of your patient's care.

Sample Basic Script

Hello, my name is Dr._____ and I am a board certified [credentials] (add other credentials like CEDS, FAACAP, etc) with ____ years of experience treating patients suffering from eating disorders and related psychiatric conditions. We are talking today to discuss the need for ongoing specialized care for my patient, _____, at a _____ level of care.

I am sure that you are committed to providing a full and fair review on behalf of this insurance member and I understand that your time is valuable. [If applicable: I have consulted with individual therapist/ family therapist/ dietician/ clinical manager and have the relevant information from their understanding of the case.] Can you please share with me the correct spelling of your name as well as your credentials and a description of your previous experience with patients with eating disorders? I am most familiar with the American Psychiatric Association's guidelines for level of care for eating disorders. Are these the criteria we will be using today for consideration of my patient's needs?

What Does the Literature Say?

Argument #1
A full course of specialized treatment is cost-effective for eating disorders.

- Specialized treatment reduces mortality in eating disorders (EDs) [1-2].
- Intensive treatment can help patients achieve recovery in a more efficient and cost-effective manner [3- 4].
- Achieving weight restoration earlier on during the illness and initiating treatment at a higher body mass index (BMI) can promote better patient outcomes [5].
- Patients who are admitted at higher body mass index (BMI) tend to have a better prognosis [6], so for patients who are losing weight, admitting earlier may improve outcome. In one study, for every unit increase in admission BMI, a 15.7% decrease in hospital cost was observed.

Argument #2
Recovery takes place over a long period of time with an uneven course and requires a full course of treatment.

- Recovery from anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) follow a common pattern in the process of change, including a long and stepwise course (despite different symptom profiles and distinct treatment needs) [7, 8]. Although patients with BN and BED tend to experience briefer illness episodes, recurrence after a period of remission is common [9], thus multiple rounds of treatment may be required.
- Physical symptoms remit before psychological symptoms. Non-purging compensatory behaviors (e.g., compulsive/driven exercise, fasting etc.) and obsession with weight and shape are the last symptoms to remit [7].
- "The course of anorexia nervosa is protracted," and recovery can take up to 6-7 years or more [10].
- Remission in BN is more likely to persist after a period of 4 months of symptom abstinence [11].

Argument #3
Treatment of eating disorders is effective and should be started early.

- According to combined evidence from over 120 high-quality studies of treatment outcome and long-term follow-up, patients with EDs who are treated earlier on in their course of illness tend to respond better to treatment and have better prognosis long-term [12].
- Treatment is often denied because a patient is deemed to have a BMI that is not considered "dangerously low," however, patients who begin treatment at a lower BMI have significantly lower BMI at discharge and are more likely to re-admit within one year [13].

Argument #4
Eating disorders are serious and lethal illnesses whose mortality rate increases with duration of illness.

- Regardless of a patient's diagnosis, EDs are lethal illnesses. Compared to the general population, mortality rates are 5.86 times higher for patients with AN, 1.93 times higher for patients with BN, and 1.92 times higher for patients with eating disorder not otherwise specified (EDNOS). One in 5 individuals with AN die by suicide [14].
- Mortality rates for EDs are estimated to be 5% at 5 years after onset. This rate increases to an estimated 20% at 20 years, suggesting that longer duration of illness could be associated with increased risk of mortality. Early treatment could save lives [14].
- Younger age and longer hospital stay at first hospitalization is associated with better outcome in AN [15].

Argument #5
Utilization of mental health benefits may offset high medical costs associated with eating disorders.

- From the **APA Practice Guidelines** — Physical consequences of eating disorders include all serious sequelae of malnutrition, especially cardiovascular compromise. Even those who "look and feel deceptively well," with normal electrocardiogram results, may have cardiac irregularities, variations with pulse and blood pressure, and are at risk for sudden death. Prolonged amenorrhea (>6 months) may result in irreversible osteopenia and high rate of fractures. Abnormal CT scans of the brain are found in >50% of patients with anorexia nervosa [16].
- Individuals with EDs have greater annual health care costs ($1,869, $p = 0.012$) and lower employment rates. Therefore, evaluations of the economic burden of EDs should also consider the wider impacts on overall psychosocial functioning [17].

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