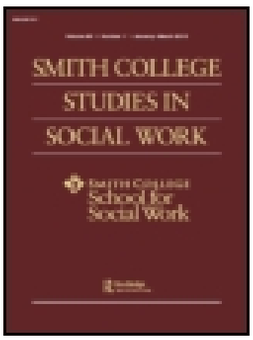

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Are Clients Being Improperly Denied Coverage for an Eating Disorder When in a Residential Treatment Center?

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ABSTRACT

Individuals struggling with eating disorder diagnoses purse higher levels of care to treat the medical, behavioral, and psychiatric aspects of their disorders. The criteria for coverage at a higher level of care often overlooks the holistic nature of treatment required for long-lasting recovery. The following piece will explore clinical information related to the true nature of an eating disorder, criteria for insurance coverage, and specific cases that show denials of care and the implication for clients seeking out support as well as an outline of necessary changes.

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Eating disorder information and history

Eating disorders have existed for centuries, cases of an ascetic and religious nature corresponding to Anorexia as early as the middle ages. Throughout the twentieth century, eating disorders have been described as relating to cultural, familial, psychiatric and medical factors (Abelli et al., 2016). Eating disorders are now understood beyond the self-deprecating and ascetic nature. This progress in seeking understanding surrounding the contributing factors have included investigating the impact of identity, age, gender – among others. This information has allowed providers and clients to have a deeper understanding regarding the various "types" of eating disorders and those who suffer from them, rather than assuming that all such individuals are homogenous.

Eating disorders are categorized according to their impact on an individual's eating patterns or habits as well as their deterioration of health and functioning (American Psychiatric Association, 2013). Eating disorders previously included two main diagnoses, Anorexia Nervosa (AN), and Bulimia Nervosa (BN), with multiple subtypes and an Other Specified diagnosis. Eating disorders now include Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder (BED), Rumination Disorder, Avoidant Restrictive Food Intake Disorder (ARFID), Other Specified Feeding or Eating Disorder (OSFED), and Unspecified Feeding or Eating Disorder. (American Psychiatric Association, 2013)

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The rise of eating disorders in recent years may not be because of a rise in the prevalence rates, but because of a rise in individuals pursuing treatment, and because of the changes made in the DSM-5, providing inclusivity to those who struggle with disorders beyond AN and BN. Moreover, eating disorders are developing at a younger age and ARFID is typically a child or adolescent diagnosis. (Fisher et al., 2014; Smink, Hoeken, & Hoek, 2012).

Individuals struggling with eating disorders include males and females and those who do not identify in a binary manner. Due to the level of secrecy and shame for males with eating disorders, males are at higher risk of mortality due to their eating disorders as they do not seek help as often, and professionals may not diagnose their eating disorders as readily as those of females. (Raevuori, Keski-Rahkonen, & Hoek, 2014). According to Hiripi et al. (2007), men comprise 25% of those struggling with AN and BN and 36% of individuals struggling with BED. Body dissatisfaction is one of the core issues experienced by transgender individuals which places individuals at risk for the development of disordered eating or an eating disorder (Arcelus et al., 2015). Trans males in particular may be at increased risk (Arcelus et al., 2015).

Seeking help

Individuals struggling with an eating disorder may be unaware of their diagnosis due to the level of inherent diet culture. The nature of restriction and then the binge-purge-restrict cycle is one that individuals may consider "normal" given the strong cultural influences dictating a thin ideal.

When an individual does decide to pursue care – whether by force from parents as an adolescent or under medical/legal guardianship – or voluntarily, they must identify treatment options and accessibility typically according to finances and geographic locations. Within the U.S. there are a plethora of options at various levels of care. In other countries with alternative health-care systems, the only support may be at a hospital or outpatient level, or one may need to travel to the only existing treatment options within an entire country.

Additionally, access to care is often extremely limited due to lack of adequate finances or health-care insurance coverage. Originally, many of the U.S. programs were only accessible through private pay at rates upward of thousands of dollars per day for a residential level of care. It may take time for many individuals to finally accept their eating disorder diagnosis, or it may take time before they are somewhat willing to seek out care. After overcoming this hurdle, they may be barred from receiving care if they don't have payment at hand or an insurance company accepted by the treatment program. The residential level of care is often necessary to implement long-lasting change and is deemed effective in changing behaviors, mood, body stability, and quality of life (Peckmezian & Paxton, 2020).

In 1996, the Mental Health Parity Act was passed. It requires insurance plans to provide the same overall limits (lifetime and annual) for mental health conditions as it does for other conditions. Eating disorders, with the second highest mortality rate of all mental health disorders, should be covered thoroughly by insurance plans under the Mental Health Parity Law. According to research on mortality rates, individuals between the ages of 15 and 24 struggling with Anorexia Nervosa are ten times more likely to die as compared with their peers. Individuals who succumb to their eating disorders may die of medical complications or suicide (which is still considered death by eating disorder rather than a separate condition).

Treatment and levels of care

Those who do have access to care via finances or insurance are faced with various levels of treatment options. Eating disorder treatment can be categorized according to levels of supervision and medical care provided. Inpatient care typically takes place in a hospital setting and includes around the clock patient monitoring. Residential care also provides 24-h care but is done so outside of the hospital and with fewer medical observations. Partial hospitalization and intensive outpatient services meet daily or multiple times per week, and endorse independence, as the client typically lives at home or in some type of transitional living facility, without constant monitoring. Outpatient care entails the client meeting with team members regularly for weekly individual and/or group sessions.

The level of care for any client is based on medical, psychiatric, and behavioral necessity. While AN may be commonly treated in hospitals and at a higher level of care, this eating disorder is less prevalent than BN and BED. This means that those who do not struggle with AN – the disorder which typically receives the most "attention" and around which programs create care may not have access to care or to feel marginalized while receiving care. Clients have reported that it feels as if treatment is geared toward AN with regard to terminology around the need for weight gain, etc. (Hiripi et al., 2007). Those who struggle with severe eating disorders (OSFED, BN, BED) are likely only being recommended to outpatient levels of care as they do not meet particular treatment guidelines created by organizations like the American Psychiatric Association for inpatient and residential settings (Yager et al., 2006). Additionally, many who struggle with AN do not necessarily meet medical criteria that would authorize the coverage at these intense levels of care.

Individuals typically are deemed as needing inpatient care when experiencing an acute medical phenomenon, or as indicated by being severely underweight. Once an individual is no longer in the "acute" phase of needing medical care and support, they are transferred to residential or a lower level of care.

While inpatient facilities and other levels of care typically review clients based on medical necessity with regard to eligibility and coverage, it is vital to note that eating disorders are not inherently medical. They are just as psychiatric and behavioral as other mental health disorders. Focusing on the medical aspect alone limits eligibility of insurance coverage and care, and posits a ranking of "severity" of the illness as related to medical dysregulation, which promotes a cycle of shame in individuals already experiencing possible shame and trauma, around "not being sick enough." For instance, if a client struggles with any of the various eating disorders, the individual may be deemed as needing or not needing care solely based on medical criteria which may be stable.

This leads to a promotion of Anorexia Nervosa above other diagnoses, as Anorexia typically has the most medical complications (Mehler & Krantz, 2003). While Bulimia Nervosa, Binge Eating Disorder, OSFED, and ARFID can cause a plethora of medical complications, they may be less obvious or deemed less important than the imbalances and potential organ failure induced by Anorexia Nervosa. It is noteworthy that many individuals struggling with severely restrictive disorders do not experience abnormal lab results. The implication that this is part of the essential criteria for coverage can lead individuals to either feel as if they do not deserve or need care. This disorder relies on measurements for validation, and yet, not everyone experiences the same bodily impact. Two individuals struggling with the same severity may experience different physical symptoms, such as one losing her menstrual cycle and the other not. It also puts an inherent value on Anorexia Nervosa that does not allow more prevalent disorders to be considered just as severe.

An individual is assessed for level of care typically by a physician or by the assessment team of a treatment program and is then recommended for a particular level of care. A client is not simply given a host of medical tests but is given verbal and often psychiatric questions/testing to determine the impact of the disorder on the individual's mental status, activities of daily living (ADLs), social functioning, and other issues.

Co-morbid diagnoses

Individuals who seek out treatment typically struggle with co-occurring medical and psychiatric conditions. According to Repic et al., 24.3% of individuals in a sample of 107 patients – the majority of whom were at a general psychiatric unit – suffered from both PTSD and an eating disorder (2014). Other studies cite high rates of anxiety disorders as well as substance abuse disorders with those at the inpatient level of care (Blinder, Cumella, & Sanathara, 2006). Many individuals struggling with an eating disorder also struggle with Borderline Personality Disorder and exhibit impulsive behavior such as self-injurious behaviors or suicide attempts.

When individuals with a co-occurring disorder enter outpatient treatment they typically do not experience the adequate containment necessary for progress. The individual is often struggling with psychiatric conditions, distorted thoughts, impacted psychosocial functioning, and behaviors such as restricting, bingeing, purging, engaging in cannabis or alcohol use, self-harm by cutting, etc. To accomplish the appropriate therapeutic work to achieve long-lasting change an individual may need to be in a residential setting, and removed from other aspects of an unhelpful home environment.

Many individuals are also able to make progress toward cessation of one behavior, but then endorse a different behavior as a means of coping. For this reason, residential or inpatient care may be recommended so that the client does not attend outpatient services for one diagnosis and experience a revolving door where they attend program after program to manage each diagnosis. Rather, all of the diagnoses can be addressed by processing the underlying issues and providing medical, psychiatric, and behavioral support.

Legal cases

Individuals pursuing coverage by insurance companies at the inpatient and residential levels of care typically are unable to financially afford the high daily cost and rely on coverage for treatment. Some insurance companies provide "no authorization required" for various levels of care – especially outpatient treatment such as PHP or IOP. Programs often provide bills at the end of a client's stay and the insurance team reviews the bills, and may request a clinician to confirm the medical necessity.

Other insurance companies require regularly scheduled reviews to note a client's progress and ongoing challenges in order to determine authorization. This may occur once per week or every few days depending on the insurance company and the clinical information being provided.

Many individuals rely on insurance coverage in order to attend a treatment program. Some individuals may be able to pay out of pocket, and some programs are, in fact, exclusively private pay. Other individuals may apply for a scholarship through the treatment facility or through a third party. The majority of individuals utilize insurance and behavioral/mental health benefits. This indicates that in order to seek out and receive care, an individual must have insurance. That is to say, they must be financially stable to privately pay for insurance, have a job that allows them insurance coverage, or be under the plan of someone, likely in their family.

Sometimes clients receive insurance denials, yet choose to remain in treatment and appeal these denials, hoping to receive retroactive reimbursement. This occurs especially when the clinical team, client, and/or family feel that it is necessary that the client not step down in their level of care, based on the client's mental status, thought process, behaviors, symptoms, vital signs, and lab results.

Three legal cases dealing with denial of coverage are presented below. Each case is followed by a brief discussion.

(1) M.K. v. Visa Cigna Network POS Plan, 628 Fed. Appx. 585 (2015):

The plaintiff in the case, M.K., was a minor who attended the residential level of care but was denied coverage for this level of care by her insurance provider, Visa Cigna, where her father was employed. M.K. believed that she met the criteria for medical necessity under her health-care plan and their coverage of Residential Treatment Center (RTC) level of care.

M.K. had an eating disorder diagnosis and struggled specifically with bingeing and purging as well as other behavioral symptoms. On June 6, 2011 these symptoms were described by the father to a customer service representative of their Point of Service (POS) insurance plan, along with including her "normal weight," lack of suicidal ideation, and lack of medical compromise. M.K.'s father pursued a particular treatment program, Avalon Hills, and was informed that the facility did not fall under their POS plan. An alternative was recommended at the outpatient level of care.

On June 7, 2011 M.K. was admitted to Avalon Hills at the RTC level of care and was given the diagnosis of "BN, Generalized Anxiety Disorder, mood disorder, moderate malnutrition, hypothyroidism, postural dizziness, back pain, problems with primary support and social issues." These medical diagnoses and symptoms indicate not only the impact of bingeing and purging but the likelihood of restriction.

While this restriction may not have impacted her weight in a manner that resulted in a low Body Mass Index, the BMI criteria has been cited as not being the most accurate measure. Body Mass Index does not take into account growth charts; if a client is subsisting on 700 calories per day but still considered at a "normal weight" many insurance companies will deny coverage for treatment. They do not consider that the number on the scale is not an accurate representation of eating disorder severity especially given that Bulimia Nervosa and Binge Eating Disorder – disorders more prevalent than Anorexia Nervosa – do not result in low body weight. Clinicians in the field of eating disorders regularly provide accounts of the severe cases they see whether under an AN, BN, BED or OSFED diagnosis not necessarily including low body weight.

M.K.'s diagnoses upon admit at Avalon Hills indicate physiological and psychosocial impairment due to her ED. According to the Visa Plan and POS clients need to meet particular medical criteria to meet standards for RTC authorization. Included in these criteria are that the client be in the least intensive setting that is appropriate to deliver needed services.

M.K. and her legal team argued these points by citing the American Psychiatric Association Guidelines as well as the report completed by an independent psychologist who argued that RTC care was appropriate. These guidelines included

but were not limited to the client's poor motivation which clinically should be treated at a symptom and given high level of containment/intensive therapy, need for meal monitoring due to purging behaviors, need for weight gain, lack of adequate support system.

Visa Cigna POS continued to deny claims that M.K. needed the RTC level of support and instead maintained that she should have pursued a lower level of care elsewhere. This denial, while on the basis of medical necessity does not take into account the varying types of medical necessity. As noted above, low weight is not present with all eating disorders and may not even be present with those struggling with AN, which M.K. was not. M.K. had a history of fleeing her home – exhibiting compulsive behaviors. She engaged in the binge/purge/restrict cycle daily and required monitoring to complete meals, a task that would likely not be possible by her parents who had six other children.

M.K. emotionally, mentally, behaviorally and psychiatrically required and would have benefited from the RTC level of care where she would have been outside the home, would not have had access to binge foods, would be supervised for meals and therefore required to complete and not able to purge, and would have experience daily, intensive therapy to target underlying issues, medication management, nutritional counseling, individual and group therapy, and behavioral change.

(2) Brigolin vs. Blue Cross Blue Shield, 516 Fed. Appx. 532 (2013):

This case includes the denial of a number of women with eating disorder diagnoses from receiving treatment at out-of-state treatment providers. The women were deemed as needing this level of care by a medical doctor.

This case also discusses the manner in which insurance providers may maintain contracts with particular in-state or out-of-state treatment facilities, providing accessibility to some clients and not others. The clients in this case argue that they were denied coverage as they did not receive the outlines of their benefits and the conditions around coverage at particular facilities and levels of care. The insurance company described, Blue Cross Blue Shield of Michigan (BCBSM), provided care without pre-certification which would then be processed by the insurance company once the client was already attending the program.

The confusing nature of seeking out treatment and understanding which programs may be in or out-of-network and the distinction between this coverage is noted in this case. While BCBSM claimed that benefits were made clear and programs could easily be distinguished as in or out of network, many times clients were informed that they could attend a program, and if deemed appropriate based on the assessment done by medical professionals it was possible that they will receive coverage given that they meet criteria. The nature of criteria being different between benefit plans and insurance programs, rather than what was deemed necessary by medical, psychiatric, and therapeutic staff left individuals confused

and without the care that they needed. Moreover, the issue of discretion within an insurance company's review process was raised; the plaintiff raised the point that they were told they could have documentation sent to appeal the denial or request coverage at an out-of-network program. They argued that the manner in doing so – by sending in documentation via fax – was a "sham." This related to these reviews not occurring in a timely manner and often not including the full picture that would indicate the necessity of the client's coverage.

In general, the manner in which clients often feel unsure of coverage both with regard to guaranteed coverage as well as where to seek out treatment cause clients to not pursue the treatment that they were being told is necessary. Many clients are resistant to pursuing treatment and do not have the finances to cover programs and when being pushed to "take the risk" may choose to focus on the necessity of treatment and worry about the coverage at a later time. Unfortunately, that time typically does come and confusion and feelings that determinations are unfair can lead to a stressor that can be unhelpful for the recovery process.

(3) Jeaneane Harlick vs. Blue Shield of California, 656 F.3d 832 (2011):

Plaintiff Jeaneane Harlick sought out residential treatment for her eating disorder seeking coverage by her insurance provider, Blue Shield of California. Blue Shield of California provided coverage for facilities listed as a Skilled Nursing Facility but did not provide coverage for the Residential Treatment Care option.

Harlick reported that she spoke with a representative from Blue Shield who informed her that RTC was not under her plan but that Partial Hospitalization Programs (PHP) or Inpatient levels of care could be covered if she was deemed as medically necessitating the program. She was given the names of particular in-network programs but she and her doctors pursued an RTC program which she and her doctor deemed as able to support her recovery unlike the options on the list provided.

This coverage of inpatient and PHP and inpatient programs can leave clients cycling back and forth due to the necessary missing level of care that typically bridges the two, as outlined above. Inpatient units are typically within a hospital and do not provide therapeutic meal support, group therapy or even individual therapy at times. A client stepping down to PHP has not yet had the practice or experience to learn to eat independently without restricting, binge-ing, purging, or engaging in exercise or compulsive rituals. These clients also have not targeted underlying issues which typically allows for therapeutic and not simply behavioral work. This therapeutic work allows for relapse prevention methods as the client does not simply learn to "eat."

Harlick appealed the denial of her coverage at RTC due to "inconsistent" reasons cited for denials as well as her pursuit as to why the California

Mental Health Parity Act does not require that this care be covered. It is also noted that a Skilled Nursing Facility is covered under Blue Shield of California but would in no way provide the care needed to target her eating disorder. This would be akin to a client seeking out treatment for an eating disorder diagnosis at a substance abuse program; it does not target the psychiatric, behavioral, medical and therapeutic issues needed when treating an eating disorder.

Conclusion

Individuals with eating disorders have complex needs. When they are in a residential treatment setting the need for collaboration with other care providers is essential if they are going to receive optimal clinical services. To reduce significant long-term health and psychosocial effects of eating disorders, a client must be given the proper coverage at whatever length of time is deemed necessary by the qualified experts. The treatment team is able to assess the client in person – unlike the insurance company – and consider all aspects of the individual's life. It is not simply the medical criteria that should be looked at, but the client's psycho-social functioning, thought patterns, co-occurring diagnoses, relationships, and engagement in the eating disorder practices. By viewing the client in a holistic manner, insurance companies can save lives and allow for re-engagement in life and recovery.

Understanding the nature of these mental illnesses and pursuing greater awareness of not only Anorexia Nervosa but also Bulimia Nervosa, Binge Eating Disorder, OSFED and the subtypes of these disorders will allow for further care and support needed at the institutional and individual levels.

Disclosure statement

No potential conflict of interest was reported by the authors.

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