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**MCG Health**  
Behavioral  
Health  
Guidelines  
27th Edition

# RMHP Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Inpatient Care

ORG\_OTG: RMHP-B-005-IP-27 (BHG)

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## Care Planning - Inpatient Admission and Alternatives

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## Clinical Indications for Admission to Inpatient Care

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- Admission to **Inpatient Level of Care for Eating Disorder for Adult** (LOCUS Level 6 - Medically Managed Residential Services, Composite Score 28 or more) is indicated due to **ALL** of the following <sup>[A]</sup> <sup>[B]</sup> <sup>[C]</sup> <sup>[D]</sup> (1)(3)(4)(13)(14)(15)(16)(17):
  - Patient risk and clinical condition are appropriate for inpatient treatment, as indicated by **1 or more** of the following:
    - Low expected body weight for height, age, and sex, and need for medical treatment of unstable physical condition and urgent refeeding are present, as indicated by **1 or more** of the following <sup>[E]</sup> (19)(20) BMI Calculator :
      - Current rapid rate of weight loss that has created an unstable physical condition(3)(4)
      - Core body temperature less than 97 degrees F (36.1 degrees C)(3)(4)
      - Dehydration that is severe or persistent
      - Heart rate less than 40 beats per minute
      - Hypotension
      - Orthostatic hypotension not responsive to appropriate outpatient treatment (eg, hydration)
      - Prolonged corrected QT interval <sup>[F]</sup>
      - Severe muscle weakness <sup>[G]</sup>
      - Serum phosphorus less than 1.5 mg/dL (0.48 mmol/L) <sup>[H]</sup>
      - Electrolyte abnormality that cannot be corrected (to near normal) in emergency department or other ambulatory setting (eg, serum potassium less than 2.5 mEq/L (mmol/L), serum sodium less than 130 mEq/L (mmol/L))
      - Significant injury due to purging (eg, mucosal (Mallory-Weiss) tear, hematemesis due to ongoing frequent vomiting, colonic injury due to enema misuse)
      - Malnutrition-related severe organ dysfunction or damage findings (eg, heart failure, arrhythmia, altered mental status)
    - Imminent risk of developing significant medical instability (eg, marked vital sign abnormalities, malnourishment requiring refeeding) due to rapid rate of weight loss(3)(4)(18)
    - Supervisory needs, motivation to recover, weight-related behaviors, and comorbidities are appropriate for inpatient treatment, as indicated by **ALL** of the following:
      - Strict staff supervision of meals (may include monitoring of specialized feeding modality, such as nasogastric tube) and bathroom use (direct monitoring in bathroom) is necessary.(3)(4)(23)
      - Motivation to recover is very poor to poor (patient condition requires involuntary treatment, or if voluntary patient, highly structured, inpatient setting is necessary for adherence to care). <sup>[I]</sup> (3)(4)(23)
    - Behaviors or clinical findings (eg, weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care, as indicated by **1 or more** of the following <sup>[J]</sup> (3)(4)(23):
      - There has been sustained inability to achieve or maintain clinically appropriate weight goals.
      - There has been continued or renewed compensatory weight-loss behavior (eg, food refusal, self-induced vomiting, or excessive exercise). <sup>[K]</sup> <sup>[L]</sup>
      - There has been continued or renewed use of pharmaceuticals with intent to control weight (eg,

laxatives, diuretics, stimulants, or over-the-counter weight loss preparations). <sup>[K]</sup>

- Treatment services available at proposed level of care are necessary to meet patient needs and **1 or more** of the following <sup>[M]</sup> (16)(17):
  - Specific condition related to admission diagnosis is present and judged likely to further improve at proposed level of care.
  - Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
  - Patient is receiving continuing care (eg, transition of care from less intensive level of care).
  
- Situation and expectations are appropriate for inpatient care for adult, as indicated by **1 or more** of the following (2)(7)(24)(25)(26):
  - Patient is unwilling to participate in treatment voluntarily and requires treatment (eg, legal commitment) in an involuntary unit.
  - Voluntary treatment at lower level of care is not feasible (eg, very short-term crisis intervention or residential care unavailable or insufficient for patient condition).
  - Need for physical restraint, seclusion, or other involuntary treatment intervention is present (eg, actively violent patient for whom treatment in an involuntary unit is deemed necessary in accord with applicable medical and legal criteria).
  - Around-the-clock medical and nursing care to address symptoms and initiate intervention is required; specific need is identified. <sup>[N]</sup>
  - Patient management/treatment at lower level of care is not feasible or is inappropriate (eg, less intensive level of care is unavailable or not suitable for patient condition or treatment history).
  - Biopsychosocial stressors <sup>[O]</sup> potentially contributing to clinical presentation (eg, comorbidities, <sup>[P]</sup><sup>[Q]</sup> illness history, environment, <sup>[R]</sup> social network, ability to cope, and level of engagement <sup>[S]</sup> ) have been assessed and are absent or manageable at proposed level of care. (2)(5)(6)(7)(8)(9)(10)(12)(30)(31)

## Alternatives to Admission

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- Alternatives include:
  - Outpatient care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Outpatient Care.
  - Intensive outpatient program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Intensive Outpatient Program.
  - Partial hospital program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Partial Hospital Program.
  - Residential care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Residential Care.
  - Crisis intervention. See Crisis Intervention Behavioral Health Level of Care.
  - Observation behavioral health level of care. See Observation Behavioral Health Level of Care.

See Behavioral Health Levels of Care for further information.

## Alternative Care Planning

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- Care planning needs for patient not requiring admission may include (32):
  - Treatment planning and referrals:
    - Prompt visit to psychiatrist and possible medication management for:
      - Bulimia nervosa
      - Binge-eating disorder
      - Other specified feeding or eating disorders

- Referral for structured psychotherapy
  - Bulimia nervosa
  - Binge-eating disorder
  - Other specified feeding or eating disorders
- Prompt medical care visit (eg, primary care) to assess physical health and set weight goal(3)(4)
- Referral to registered dietitian for dietary planning and nutritional counseling(33)
- [Telehealth services](#) if indicated [I] (34)
- Discharge Planning as appropriate
- Patient, family, and caregiver education as appropriate. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Patient Education for Clinicians.

## Hospitalization

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## Optimal Recovery Course

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Day	Clinical Status	Interventions	Medications	Evaluation
1	<ul style="list-style-type: none"> <li>• <b>Clinical Indications met</b> [U]</li> <li>• <a href="#">Social Determinants of Health Assessment</a></li> <li>• Begin <a href="#">Discharge planning</a></li> </ul>	<ul style="list-style-type: none"> <li>• Dietary plan developed [V]</li> <li>• Monitored meals [W]</li> <li>• Continual observation [X]</li> <li>• Supervision of bathroom use [Y]</li> </ul>	<ul style="list-style-type: none"> <li>• Possible medication</li> </ul>	<ul style="list-style-type: none"> <li>• Exploration of admission precipitants [Z]</li> <li>• Psychiatric, social, medical, dietary, and substance use histories, as well as assessment of food-related or eating-disorder behaviors [AA] [BB]</li> <li>• Mental status and physical examinations [CC]</li> <li>• Laboratory tests [DD]</li> <li>• ECG, if clinically indicated [EE]</li> <li>• Evaluation of fall risk</li> <li>• Symptoms assessed multiple times per shift</li> <li>• Self-efficacy evaluation</li> </ul>
2	<ul style="list-style-type: none"> <li>• <a href="#">Social Determinants of Health Assessment</a></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Close observation</b></li> <li>• Monitored meals [W]</li> </ul>	<ul style="list-style-type: none"> <li>• Medication review if prescribed</li> </ul>	<ul style="list-style-type: none"> <li>• <b><a href="#">Evaluation completed and reviewed</a></b></li> <li>• Weight goal set</li> <li>• Weight [GG]</li> </ul>

Day	Clinical Status	Interventions	Medications	Evaluation
		<ul style="list-style-type: none"> <li>Supervision of bathroom use [X]</li> </ul>		<ul style="list-style-type: none"> <li>Symptoms assessed multiple times per shift</li> </ul>
3	<ul style="list-style-type: none"> <li>Adherent to dietary plan for at least 24 hours</li> <li>No purging (eg, self-induced vomiting), bingeing, or other problem behaviors (eg, excessive physical activity) for at least 24 hours</li> <li><a href="#">Social Determinants of Health Assessment</a></li> </ul>	<ul style="list-style-type: none"> <li>Close observation at reduced intensity</li> <li>Monitored meals [W]</li> <li>Possible supervision of bathroom use [X]</li> </ul>	<ul style="list-style-type: none"> <li>Medication review if prescribed</li> </ul>	<ul style="list-style-type: none"> <li>Weight [GG]</li> <li>Transition to patient check-in with staff</li> </ul>
4	<ul style="list-style-type: none"> <li><a href="#">Social Determinants of Health Assessment</a></li> </ul>	<ul style="list-style-type: none"> <li>Close observation at reduced intensity</li> <li>Dietary plan reviewed and revised as necessary</li> <li>Possible supervision of bathroom use [X]</li> </ul>	<ul style="list-style-type: none"> <li>Medication review if prescribed</li> </ul>	<ul style="list-style-type: none"> <li>Weight [GG]</li> <li>Patient check-in only</li> </ul>
5	<ul style="list-style-type: none"> <li>Adequate adherence to dietary plan for next level of care</li> <li><a href="#">Purging, bingeing, and other problem behavior absent or manageable/treatable at available lower level of care</a></li> <li>Weight stable, increasing, or weight issues manageable/treatable at available lower level of care</li> <li>Physical status acceptable [U]</li> </ul>	<ul style="list-style-type: none"> <li>No close observation</li> <li>Review follow-up treatment and crisis plan with patient and supports [JJ]</li> </ul>	<ul style="list-style-type: none"> <li>Medication review if prescribed</li> </ul>	<ul style="list-style-type: none"> <li>Weight [GG]</li> </ul>

Day	Clinical Status	Interventions	Medications	Evaluation
	<ul style="list-style-type: none"> <li>• <b>Thoughts of suicide or Harm</b> absent or manageable/treatable at available lower level of care</li> <li>• <b>Patient and supports understand follow-up treatment and crisis plan</b></li> <li>• <b>Provider and supports sufficiently available at lower level of care</b></li> <li>• <b>Patient can participate (eg, verify absence of plan for harm) in needed monitoring</b></li> <li>• <b>Medical comorbidities, adverse medication events, and substance use absent or manageable/treatable at available lower level of care</b></li> <li>• <a href="#">Social Determinants of Health Assessment</a></li> <li>• Complete <a href="#">Discharge planning</a></li> <li>• Discharge</li> </ul>			
<a href="#">(3)</a> <a href="#">(4)</a> <a href="#">(7)</a> <a href="#">(13)</a> <a href="#">(35)</a> <a href="#">(39)</a> <a href="#">(40)</a> <a href="#">(41)</a> <a href="#">(42)</a> <a href="#">(43)</a>				

Recovery Milestones are indicated in **bold**.

### Goal Length of Stay: 4 days

### Extended Stay

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Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be needed for [\(3\)](#)[\(4\)](#)[\(41\)](#):
  - Persistent self-induced vomiting to purge food and/or continued bingeing or other problem eating behaviors
    - Expect prompt reassessment steps, including:
      - Identification of precipitants of purging, bingeing, or other problem eating behaviors, including:
        - Concerns about edema or other bodily changes
        - Dissatisfaction with food choices
        - Psychosocial conflict

- Review of dietary plan with patient's input
  - Review of plan for monitoring patient during and after meals
  - Review of behavioral management plan if applicable [\[KK\]](#)
  - Repeat serum electrolytes
- Anticipate treatment measures, including as appropriate:
  - Interventions to address psychosocial precipitants of purging, bingeing, or other problem eating behaviors
  - Supervision of bathroom use
  - Initiation or modification of behavioral management plan [\[KK\]](#)
- Expect brief to moderate stay extension.
- [Current plan](#) for suicide or serious [Harm](#) to self(2)(44)
  - Expect prompt reassessment steps, including:
    - Identification of precipitants of thoughts of suicide or self-harm
    - Assessment for comorbid mood disorder
  - Anticipate treatment measures, including as appropriate:
    - Psychosocial interventions to relieve precipitants
    - Appropriate treatment of mood disorder if diagnosed
  - Expect brief to moderate stay extension.
- Cardiac arrhythmia (eg, supraventricular tachycardia, conduction disorder)(45)
  - Anticipate diagnostic (eg, ECG) and therapeutic (eg, medication) measures.
  - Expect brief to moderate stay extension.
- Major depressive disorder
  - Anticipate close observation (eg, for suicidality) and treatment measures (eg, pharmacotherapy, psychotherapy).
  - Expect brief to moderate stay extension.
- Malnutrition (eg, protein-calorie malnutrition, nutritional marasmus)
  - Anticipate refeeding program, nutritional assessments, and careful observation.
  - Expect brief to moderate stay extension.

## Hospital Care Planning

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- Evaluation and care needs may include(3)(4)(13):
  - Diagnostic test scheduling and completion, including:
    - Urine drug screening. See Urine Toxicology Testing.
    - Pregnancy test
    - Laboratory tests [\[DD\]](#)
    - ECG [\[EE\]](#)
  - Treatment and procedure scheduling and completion, including:
    - Psychosocial interventions emphasizing admission precipitants and barriers to discharge [\[FF\]](#)
    - Clinical management and psychoeducation [\[HH\]](#)
    - Psychological testing to evaluate cognitive function and personality dynamics [\[LL\]](#)
    - Dietary planning and nutritional counseling(33)
    - Structured psychotherapy
    - Possible medication
    - Potassium repletion, using oral potassium chloride, for marked hypokalemia
    - Upper gastrointestinal endoscopy
  - Consultation, assessment, and other services scheduling and completion, including:
    - Substance use disorder assessment
    - Social services consultation for placement or housing
    - [Telehealth services](#) if indicated [\[ \] \(34\)](#)
  - Monitoring patient's status for deterioration and comorbid conditions, including:
    - Dental erosion due to self-induced vomiting
    - Gastroesophageal injury due to self-induced vomiting
    - Electrolyte disturbance due to vomiting or misuse of laxatives or diuretics
    - Peripheral edema due to withdrawal from laxatives or diuretics
    - Constipation due to laxative misuse or withdrawal

- Identification and treatment of psychiatric comorbidity (eg, depression, anxiety disorders)
- See Inpatient Monitoring and Assessment Tool, as appropriate.

## Discharge

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### Discharge Planning

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- Discharge planning includes [\[MM\]](#) :
  - Assessment of needs and planning for care, including [\(48\)](#):
    - Develop treatment plan (involving multiple providers as needed).
    - Evaluate and address preadmission functioning as needed.
    - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment for further information.
    - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool for further information. [\(47\)](#)[\(49\)](#)
    - Evaluate and address patient or caregiver preferences as indicated.
    - Identify skilled services needed at next level of care, with specific attention to [\(50\)](#):
      - Medication management, adherence instruction, and side effects assessment [\(51\)](#)[\(52\)](#)
      - Nutrition and hydration management
      - Psychosocial assessment, management, and referrals
  - Early identification of anticipated discharge destination; options include [\(53\)](#)[\(54\)](#):
    - Home, considerations include:
      - Access to follow-up care
      - Home safety assessment. See Home Safety Assessment for further information.
      - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment for further information.
      - Caregiver need, ability, and availability
    - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool for further information.
  - Transitions of care plan complete, including [\(54\)](#):
    - Patient and caregiver education complete. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Patient Education for Clinicians for further information.
      - See Teach Back Tool for further information.
    - Medication reconciliation complete
    - Plan communicated to patient, caregiver, and all members of care team, including [\(58\)](#)[\(59\)](#):
      - Inpatient care and service providers
      - Primary care provider
      - All post-discharge care and service providers
    - Appointments planned or scheduled, which may include [\(50\)](#):
      - Primary care provider
      - Behavioral health provider
      - Dietitian
      - Psychiatrist
      - Other
    - Outpatient testing and procedure plans made, which may include:
      - Laboratory testing [\(60\)](#)
      - Other



- Referrals made for assistance or support, which may include:
  - Alcohol and other drug abuse or dependence treatment([61](#))
  - Behavioral health services (eg, counseling)([50](#))([60](#))
  - Community services
  - Financial, for follow-up care, medication, and transportation
  - Self-help or support groups
  - Tobacco use treatment
  - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
  - Nutritional supplements
  - Other

## Discharge Destination

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### Usual

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- Outpatient care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Outpatient Care.

### Alternate

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- Intensive outpatient program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Intensive Outpatient Program.
- Partial hospital program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Partial Hospital Program.
- Residential care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Residential Care.

See Behavioral Health Levels of Care for further information.

## Evidence Summary

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### Background

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Bulimia nervosa generally begins in late adolescence or early adulthood and has a variable, often chronic course that may be complicated by psychiatric comorbidities, such as anxiety, depression, substance use, and personality disorders, as well as an increased risk of suicidal ideation.([1](#))([3](#))([4](#))([13](#))([14](#))([62](#))([63](#)) (**EG 2**) Binge-eating disorder differs from bulimia nervosa in that patients do not engage in inappropriate compensatory behaviors to avoid weight gain (eg, self-induced vomiting, misuse of laxatives).(14)(64)(65) (**EG 2**) Other eating disorders include pica and rumination disorder and avoidant/restrictive food intake disorder.(14) (**EG 2**)

### Length of Stay

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Analysis of national hospital discharge data shows 32% of hospitalized adult patients (18 years of age or older) with the principal diagnosis of bulimia nervosa or a related disorder discharged in 4 days or fewer.(41) (**EG 3**)

### Treatment

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**Psychosocial therapy - Bulimia nervosa:** Cognitive behavioral therapy (CBT) has been shown in systematic reviews and meta-analyses of randomized controlled trials to reduce bingeing and purging in adults.(3)(4)(13)(66)(67) (EG 1) A systematic review and meta-analysis of the efficacy of psychological therapies in reducing weight and binge eating in adults with bulimia nervosa and binge-eating disorder (19 articles included) found that while CBT was superior in terms of reducing short-term binge eating as compared with behavioral weight loss therapy, there were no differences between groups in terms of binge-eating remission, reduction of binge-eating frequency, and weight loss. The authors recommended additional research on long-term outcomes.(68) (EG 1) A randomized controlled trial of 70 adults with bulimia nervosa found that CBT (20 sessions over 5 months) was more effective in relieving bingeing and purging than psychoanalytic psychotherapy (2 years of weekly sessions), and alleviated eating disorder symptoms and general psychopathology more quickly.(69) (EG 1) A systematic review and expert consensus support a trial of interpersonal psychotherapy for adults with bulimia nervosa who do not respond to CBT or an antidepressant.(1)(13)(70) (EG 1)

**Psychosocial therapy - Binge-eating disorder:** A systematic review and meta-analysis of treatment of binge-eating disorder that addressed trials comparing cognitive behavioral therapy (CBT) and no or limited intervention concluded that there was high-strength evidence to support therapist-led CBT for binge abstinence, binge frequency, and eating-related psychopathology.(65) (EG 1) A meta-analysis of treatments for binge-eating disorder (81 heterogeneous randomized controlled trials with 1 study including adolescents) found psychotherapy (CBT was most commonly studied) to have a large effect size in significantly reducing binge-eating episodes.(32) (EG 1) A randomized controlled trial of 139 adults with binge-eating disorder found that treatment with an internet-delivered CBT (iCBT) program led to a significant reduction in number of observed binge-eating episodes and a significant, but small, reduction in body weight as compared with waitlist controls; improvement persisted at 1-year follow-up.(71) (EG 1) A systematic review and meta-analysis of mindfulness-based interventions for adults with binge-eating disorder (19 studies) reported that most of the included trials showed a large-magnitude benefit, though significant statistical heterogeneity among studies was described.(72) (EG 1) A systematic review and meta-analysis of the efficacy of psychological therapies in reducing weight and binge eating in adults with bulimia nervosa and binge-eating disorder (19 articles included) found that while CBT was superior in terms of reducing short-term binge eating as compared with behavioral weight loss therapy, there were no differences between groups in terms of binge-eating remission, reduction of binge-eating frequency, and weight loss. The authors recommended additional research on long-term outcomes.(68) (EG 1)

**Psychosocial therapy - Other specified eating disorders:** For patients diagnosed with a type of eating disorder other than anorexia, bulimia nervosa, or binge-eating disorder, expert consensus guidelines recommend using treatments shown to be effective for the full syndrome disorder that most closely resembles the patient's presentation.(3)(4)(13) (EG 2) Reviews of treatments for rumination disorder emphasize the role of behavioral interventions, including training patients in diaphragmatic breathing exercises.(73)(74)(75) (EG 2)

**Pharmacotherapy - Bulimia nervosa:** Meta-analyses and practice guidelines examining the role of psychotropic agents indicate that antidepressants, in particular fluoxetine, are effective in the treatment of bulimia nervosa in adults by decreasing urges to binge and purge, and also may benefit comorbid psychiatric conditions.(13)(76)(77)(78) (EG 1) When antidepressant treatment is administered without additional specialized eating-disorder program components, dropout rates tend to be high, and therapeutic benefit is minimized.(13)(76) (EG 2)

**Pharmacotherapy - Binge-eating disorder:** A systematic review and meta-analysis that included 3 randomized placebo-controlled trials reported high-strength evidence for lisdexamfetamine in promoting binge abstinence, reducing binge episodes per week, decreasing eating-related obsessions and compulsions, and promoting weight loss. This meta-analysis also included 8 placebo-controlled trials of antidepressants (6 studying selective serotonin reuptake inhibitors, 1 studying a norepinephrine-dopamine reuptake inhibitor, and 1 studying a selective serotonin-norepinephrine reuptake inhibitor) and reported high-strength evidence for promoting binge abstinence and reducing frequency of binge episodes per week, as well as moderate-strength evidence for reducing binge days per week.(65) (EG 1) A meta-analysis of treatments for binge-eating disorder (81 randomized controlled trials described as heterogeneous with 1 study including adolescents) found that pharmacotherapy (mainly lisdexamfetamine and second-

generation antidepressants) had a positive small effect size in decreasing episodes of binge eating and increasing abstinence from binge eating, though the reviewers rated the quality of evidence as low or very low.(32) (EG 1) It is unclear if the benefits reported for the use of antidepressants in the treatment of binge-eating disorder are related to a direct effect on this condition, or are due to amelioration of comorbid mood or anxiety symptoms.(79) (EG 2) A systematic review identified 2 randomized placebo-controlled trials of topiramate for treatment of binge-eating disorder and found moderate-strength evidence for improving binge abstinence and weight loss, as well as reducing binge eating, and the obsessions and compulsions related to binge eating.(65) (EG 1)

**Pharmacotherapy - Other specified feeding or eating disorders:** For patients diagnosed with a type of eating disorder other than anorexia, bulimia nervosa, or binge-eating disorder, expert consensus guidelines recommend using treatments shown to be effective for the full syndrome disorder that most closely resembles the patient's presentation.(3)(4)(13) (EG 2) Behavioral therapy is the cornerstone of treatment for rumination syndrome; baclofen and tricyclic antidepressants have been evaluated in small studies and are considered as potential adjunctive therapies.(73)(74)(75)(80) (EG 2) A randomized double-blind, placebo-controlled cross-over trial of 20 adults with rumination syndrome found a significant decrease in the number of rumination events in adults after a 2-week trial of baclofen.(81) (EG 2) There is insufficient evidence to determine if there is any role for pharmacotherapy in the treatment of pica.(82)(83) (EG 2)

## Level of Care

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Patients with bulimia nervosa or related disorders can nearly always be treated in outpatient settings; however, patients with these conditions occasionally require inpatient care because of malnutrition, physical complications of self-induced vomiting, laxative or diuretic misuse (eg, severe hypokalemia, esophageal injury), inability to curtail dangerous behaviors in lower levels of care, or imminent risk of suicide or serious self-harm.(3)(4)(13) (EG 2)

Residential care facilities may provide an effective, less restrictive alternative to inpatient care for patients who need around-the-clock behavioral care to manage severe purging or risk of suicide, but do not require continuous medical or nursing attention.(3)(4)(84) (EG 2) Partial hospital programs (also known as day hospitals) provide multidisciplinary behavioral care for 6 to 8 hours per day, 5 to 7 days per week, and are staffed similarly to the day shift of an inpatient unit.(12) (EG 2) A randomized trial of patients with bulimia nervosa comparing inpatient treatment to an 8-hour day clinic program 5 days a week demonstrated similar outcomes between the 2 settings.(85) (EG 1) While partial hospital programs occasionally may be indicated for patients with bulimic or bulimic subtype disorders refractory to standard outpatient care, intensive outpatient or outpatient care programs may be equally effective, as the relatively short periods of meal supervision and observation provided in partial hospital programs generally are inadequate to address purging behaviors.(3)(4)(13) (EG 2) Intensive outpatient programs typically provide 3 to 4 hours of psychosocial treatment, 1 to 4 days a week (usually 6 to 12 hours of treatment per week), mostly by using a group format, and are intended for circumstances when a patient needs a type or frequency of treatment that is not available in a standard outpatient setting.(12) (EG 2) An intensive outpatient program may be appropriate for a patient with bulimia nervosa if it can provide a therapy such as cognitive behavioral therapy with demonstrated efficacy for bulimia nervosa, when that therapy is not available in a standard outpatient setting.(13) (EG 2) A retrospective study including admission and discharge data from 773 patients (age 11 to 68 years with over half diagnosed with other specified feeding and eating disorder) admitted to partial hospital and intensive outpatient levels of care found that 54.9% of patients showed statistically significant improvements in eating disorder severity by discharge.(86) (EG 2)

## Remission and Relapse

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Adults with bulimia nervosa who are treated with cognitive behavioral therapy (CBT) are reported to have remission rates from 30% to 45% by the end of treatment. These rates drop to 25% at 1-year follow-up, suggesting that patients in remission have a significant risk of relapse.(1)(13) (EG 2) Most studies of the use of antidepressant medications to treat bulimia have not reported follow-up remission rates, but the evidence suggests that less than 25% of patients achieve lasting remission. Patients who receive fluoxetine

during acute treatment and experience a significant reduction in vomiting may have lower relapse rates in the following year if the medication is continued.(13)(76) (EG 2) Studies in adults with binge-eating disorder have been conducted on a variety of therapies, including CBT, interpersonal psychotherapy, and pharmacotherapy, and these studies have reported a wide range of remission rates, from 40% to 80%, after 2 to 5 months of treatment.(13)(65)(32)(76) (EG 1) A meta-analysis of psychological or behavioral treatments for binge-eating disorder (including 39 randomized controlled trials with 65 treatment conditions (mostly CBT)) found that 45.1% of patients achieved abstinence from binge eating at the post-treatment visit, and 42.3% showed abstinence from binge eating at the most recent follow-up visit.(87) (EG 1) A randomized placebo-controlled trial in which adults with binge-eating disorder were treated with CBT, fluoxetine, or both, found that at 12 months post-treatment outcomes were better in patients treated with CBT (with or without fluoxetine) as compared with those treated with fluoxetine alone.(88) (EG 1) A double-blind, placebo-controlled, randomized study of 418 adults with moderate to severe binge-eating disorder identified 275 responders to lisdexamfetamine; in the withdrawal phase of the study, the risk of relapse over 6 months was significantly lower in participants who continued on lisdexamfetamine as compared with placebo (3.7% vs 32.1%, respectively).(89) (EG 1) A study examining the long-term efficacy of short-term CBT for adults with binge-eating disorder (41 patients) found that symptoms improved significantly during the treatment phase, and symptoms remained stable or improved over a 4-year follow-up period.(90) (EG 2)

## Policy History

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7/13/2023 - Modified 25th edition MCG guideline by removing BMI from clinical indications as required by new legislation Colorado Revised Statute CRS 10-16-166 and Senate Bill 23-176, effective date 7/1/2023.

11/5/2023 - Upgraded to 27th edition MCG with BMI removed from clinical indications.

## References

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Colorado Revised Statute CRS 10-16-166 and Senate Bill 23-176.

## References

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1. Call CC, Attia E, Walsh BT. Feeding and eating disorders. In: Sadock BJ, Sadock VA, Ruiz P, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2017:2065-2082. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#) ]
2. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: <https://www.communitypsychiatry.org/keystone-programs/locus>. [accessed 2022 Sep 09] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#), [11](#), [12](#), [13](#), [14](#), [15](#), [16](#) ]
3. American Psychiatric Association. Treatment of patients with eating disorders, third edition. American Journal of Psychiatry 2006;163(7 Suppl):4-54. (Reaffirmed 2022 May) [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#), [11](#), [12](#), [13](#), [14](#), [15](#), [16](#), [17](#), [18](#), [19](#), [20](#), [21](#), [22](#), [23](#), [24](#), [25](#), [26](#), [27](#), [28](#), [29](#), [30](#), [31](#), [32](#), [33](#), [34](#), [35](#), [36](#), [37](#), [38](#), [39](#), [40](#), [41](#), [42](#), [43](#), [44](#) ]
4. Yager J, et al. Guidelines Watch (August 2012): Practice Guideline for the Treatment of Patients with Eating Disorders, 3rd edition. [Internet] American Psychiatric Association. 2012 Aug Accessed at: <https://psychiatryonline.org/>. [accessed 2022 Sep 26] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#), [11](#), [12](#), [13](#), [14](#), [15](#), [16](#), [17](#), [18](#), [19](#), [20](#), [21](#), [22](#), [23](#), [24](#), [25](#), [26](#), [27](#), [28](#), [29](#), [30](#), [31](#), [32](#), [33](#), [34](#), [35](#), [36](#), [37](#), [38](#), [39](#), [40](#) ]

5. American Association of Community Psychiatrists. CALOCUS/CASII: Child and Adolescent Level of Care Utilization System. Child and Adolescent Version 20 [Internet] American Association of Community Psychiatrists. 2019 Jul Accessed at: <https://www.communitypsychiatry.org/resources/locus>. [accessed 2022 Mar 10] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#) ]
6. Level of care placement. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provence SM, editors. ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013:174-306. [ Context Link [1](#), [2](#), [3](#), [4](#) ]
7. APA Work Group on Psychiatric Evaluation. The American Psychiatric Association practice Guidelines for the Psychiatric Evaluation of Adults. 3rd edition [Internet] American Psychiatric Association. 2016 Accessed at: <https://psychiatryonline.org/>. [accessed 2022 Sep 26] DOI: 10.1176/appi.books.9780890426760. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#), [11](#), [12](#), [13](#), [14](#) ]
8. CASII. Child and Adolescent Service Intensity Instrument [Internet] American Academy of Child and Adolescent Psychiatry. Accessed at: [https://www.aacap.org/aacap/Member\\_Resources/Practice\\_Information/CASII.aspx](https://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx). [accessed 2022 Sep 28] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#) ]
9. Child & Adolescent Service Intensity Instrument (CASII) User's Manual version 4.0. American Academy of Child and Adolescent Psychiatry 2014 Oct. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#) ]
10. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep. [ Context Link [1](#), [2](#), [3](#), [4](#) ]
11. Assessment measures. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:841-857. [ Context Link [1](#) ]
12. Rosser J, Michael S. Partial Hospitalization Programs and Intensive Outpatient Programs. 2021 AABH Standards and Guidelines [Internet] Association for Ambulatory Behavioral Healthcare. 2021 Accessed at: <https://aabh.org/>. [accessed 2022 Sep] [ Context Link [1](#), [2](#), [3](#), [4](#) ]
13. Eating Disorders: Recognition and Treatment. NICE Guidance NG69 [Internet] National Institute for Health and Care Excellence. 2020 Dec Accessed at: <https://www.nice.org.uk/guidance>. [accessed 2022 Oct 21] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#), [10](#), [11](#), [12](#), [13](#), [14](#), [15](#), [16](#), [17](#), [18](#), [19](#), [20](#) ]
14. Feeding and eating disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:371-397. [ Context Link [1](#), [2](#), [3](#), [4](#) ]
15. Suarez-Pinilla P, et al. Inpatient treatment for anorexia nervosa: a systematic review of randomized controlled trials. Journal of Psychiatric Practice 2015;21(1):49-59. DOI: 10.1097/01.pra.0000460621.95181.e2. [ Context Link [1](#) ]
16. Madden S, Hay P, Touyz S. Systematic review of evidence for different treatment settings in anorexia nervosa. World Journal of Psychiatry 2015;5(1):147-153. DOI: 10.5498/wjp.v5.i1.147. [ Context Link [1](#), [2](#) ]
17. Clausen L, Jones A. A systematic review of the frequency, duration, type and effect of involuntary treatment for people with anorexia nervosa, and an analysis of patient characteristics. Journal of Eating Disorders 2014;2(1):29. DOI: 10.1186/s40337-014-0029-8. [ Context Link [1](#), [2](#) ]
18. Hilbert A, Hoek HW, Schmidt R. Evidence-based clinical guidelines for eating disorders: international comparison. Current Opinion in Psychiatry 2017;30(6):423-437. DOI: 10.1097/YCO.0000000000000360. [ Context Link [1](#), [2](#) ]
19. Mehler PS, Brown C. Anorexia nervosa - medical complications. Journal of Eating Disorders 2015;3:11. DOI: 10.1186/s40337-015-0040-8. [ Context Link [1](#) ]
20. Sachs KV, Harnke B, Mehler PS, Krantz MJ. Cardiovascular complications of anorexia nervosa: A systematic review. International Journal of Eating Disorders 2016;49(3):238-48. DOI: 10.1002/eat.22481. [ Context Link [1](#) ]

21. Sachs K, Andersen D, Sommer J, Winkelman A, Mehler PS. Avoiding medical complications during the refeeding of patients with anorexia nervosa. *Eating Disorders* 2015;1-11. DOI: 10.1080/10640266.2014.1000111. [ Context Link [1](#) ]
22. Levels of Care. [Internet] National Eating Disorders Association (NEDA). Accessed at: <https://www.nationaleatingdisorders.org/types-treatment>. Updated 2022 [accessed 2022 Apr 04] [ Context Link [1](#), [2](#), [3](#) ]
23. Matorin AA, Shah AA, Ruiz P. Clinical manifestations of psychiatric disorders. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2017:1114-1150. [ Context Link [1](#) ]
24. Baron DA, Cobb RT, Juarez GM. Other psychiatric emergencies. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2017:2622-2637. [ Context Link [1](#) ]
25. Winkler D, et al. Intensive care in psychiatry. *European Psychiatry* 2011;26(4):260-264. DOI: 10.1016/j.eurpsy.2010.10.008. [ Context Link [1](#) ]
26. Criteria for Short-Term Treatment of Acute Psychiatric Illness [Article] *American Academy of Child and Adolescent Psychiatry and American Psychiatric Association* 1997; 29. [ Context Link [1](#), [2](#), [3](#) ]
27. Matching multidimensional severity and level of function with type and intensity of service. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provenance SM, editors. *ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013:69-104. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#) ]
28. Service planning and placement. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provenance SM, editors. *ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013:105-126. [ Context Link [1](#) ]
29. Fong T. Assessment. In: Brady KT, Levin FR, Galanter M, Kleber HD, editors. *Textbook of Substance Use Disorder Treatment*. 6th ed. American Psychiatric Association Publishing; 2021:63-76. [ Context Link [1](#) ]
30. Kober D, Martin A. Inpatient psychiatric, partial hospital, and residential treatment for children and adolescents. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2017:3797-3803. [ Context Link [1](#) ]
31. Hilbert A, et al. Meta-analysis of the efficacy of psychological and medical treatments for binge-eating disorder. *Journal of Consulting and Clinical Psychology* 2019;87(1):91-105. DOI: 10.1037/ccp0000358. [ Context Link [1](#), [2](#), [3](#), [4](#) ]
32. Ozier AD, Henry BW, American Dietetic Association. Position of the American Dietetic Association: nutrition intervention in the treatment of eating disorders. *Journal of the American Dietetic Association* 2011;111(8):1236-1241. DOI: 10.1016/j.jada.2011.06.016. [ Context Link [1](#), [2](#), [3](#) ]
33. Deslich S, Stec B, Tomblin S, Coustasse A. Telepsychiatry in the 21(st) century: transforming healthcare with technology. *Perspectives in Health Information Management* 2013;10:1f. [ Context Link [1](#), [2](#), [3](#), [4](#) ]
34. Approved: New requirements for residential and outpatient eating disorders programs. Effective July 1, 2016, for Behavioral Health Care Accreditation Program. *Joint Commission Perspectives* 2016;36(1):4-9. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#), [6](#), [7](#), [8](#), [9](#) ]
35. Attia E. Eating disorders. *Annals of Internal Medicine* 2012;156(7):ITC41. DOI: 10.1059/0003-4819-156-7-201204030-01004. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#) ]
36. Sudak HS. Suicide treatment. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2017:2618-2622. [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#) ]
37. Bryan CJ, et al. Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders* 2017;212:64-72. DOI: 10.1016/j.jad.2017.01.028. [ Context Link [1](#) ]

38. Berkman ND, et al. Management of eating disorders. Evidence Report/Technology Assessment 2006;(135):1-166. (Reaffirmed 2022 May) [ Context Link [1](#) ]
39. McElroy SL, Guerdjikova AI, Martens B, Keck PE, Pope HG, Hudson JI. Role of antiepileptic drugs in the management of eating disorders. *CNS Drugs* 2009;23(2):139-56. [ Context Link [1](#) ]
40. Premier PINC AI™ Healthcare Database (PHD), 01/01/2020-12/31/2021. Premier, Inc. [ Context Link [1](#), [2](#), [3](#) ]
41. Jacobs DG, Baldessarini RJ, Conwell Y, et al. Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. [Internet] American Psychiatric Association. 2010 Accessed at: <https://psychiatryonline.org/>. [created 2003; accessed 2022 Sep 26] [ Context Link [1](#) ]
42. Society for Adolescent Health and Medicine. Medical management of restrictive eating disorders in adolescents and young adults. *Journal of Adolescent Health* 2022;71(5):648-654. DOI: 10.1016/j.jadohealth.2022.08.006. [ Context Link [1](#) ]
43. Cliffe C, Shetty H, Himmerich H, Schmidt U, Stewart R, Dutta R. Suicide attempts requiring hospitalization in patients with eating disorders: A retrospective cohort study. *International Journal of Eating Disorders* 2020;53(5):458-465. DOI: 10.1002/eat.23240. [ Context Link [1](#) ]
44. Tith RM, et al. Association of bulimia nervosa with long-term risk of cardiovascular disease and mortality among women. *JAMA Psychiatry* 2020;77(1):44-51. DOI: 10.1001/jamapsychiatry.2019.2914. [ Context Link [1](#) ]
45. Meyer GJ, et al. Psychological testing and psychological assessment. A review of evidence and issues. *American Psychologist* 2001;56(2):128-65. [ Context Link [1](#) ]
46. Hudson T. The role of social determinates of health in discharge practices. *Nursing Clinics of North America* 2021;56(3):369-378. DOI: 10.1016/j.cnur.2021.04.004. [ Context Link [1](#), [2](#) ]
47. Mayer RS, Noles A, Vinh D. Determination of postacute hospitalization level of care. *Medical Clinics of North America* 2020;104(2):345-357. DOI: 10.1016/j.mcna.2019.10.011. [ Context Link [1](#) ]
48. Hazzard VM, Loth KA, Hooper L, Becker CB. Food insecurity and eating disorders: a review of emerging evidence. *Current Psychiatry Reports* 2020;22(12):Online. DOI: 10.1007/s11920-020-01200-0. [ Context Link [1](#) ]
49. Eating disorders. In: Videbeck SL, editor. *Psychiatric-Mental Health Nursing*. 8th ed. Philadelphia, PA: Lippincott Williams and Wilkins; 2020:380-401. [ Context Link [1](#), [2](#), [3](#) ]
50. Adverse drug reactions and medication errors. In: Burchum JR, Rosenthal LD, editors. *Lehne's Pharmacology for Nursing Care*. 11th ed. Elsevier; 2022:63-73. [ Context Link [1](#) ]
51. Medication adherence. In: Perez R, Rogers S, Prince M, Fraser K, editors. *Case Management Adherence Guidelines*. 2020 ed. Case Management Society of America; 2022:57-74. [ Context Link [1](#) ]
52. Roles, functions, and preparation of case management team members. In: Powell SK, Tahan H, editors. *Case Management a Practical Guide for Education and Practice*. 4th ed. Philadelphia, PA: Wolters Kluwer, Lippincott, Williams & Wilkins; 2019:35-60. [ Context Link [1](#) ]
53. Saleeby J. Communication and collaboration. In: Perry AG, Potter PA, Ostendorf WR, editors. *Nursing Interventions and Clinical Skills*. 7th ed. Elsevier; 2020:9-21. [ Context Link [1](#), [2](#) ]
54. National Patient Safety Goals. 2022 National Patient Safety Goals [Internet] Joint Commission on Accreditation of Healthcare Organizations. Accessed at: [https://www.jointcommission.org/standards\\_information/npsgs.aspx](https://www.jointcommission.org/standards_information/npsgs.aspx). Updated 2022 [accessed 2022 Oct 18] [ Context Link [1](#) ]
55. The nursing process in drug therapy and patient safety. In: Karch AM, Tucker RG, editors. *Focus on Nursing Pharmacology*. 8th ed. Philadelphia, PA: Wolters Kluwer; 2020:45-55. [ Context Link [1](#) ]

56. Ostendorf WR. Preparation for safe medication administration. In: Perry AG, Potter PA, Ostendorf WR, editors. *Nursing Interventions and Clinical Skills*. 7th ed. Elsevier; 2020:551-567. [ Context Link [1](#) ]
57. Transitional planning: understanding levels and transitions of care. In: Powell SK, Tahan H, editors. *Case Management a Practical Guide for Education and Practice*. 4th ed. Philadelphia, PA: Wolters Kluwer, Lippincott, Williams & Wilkins; 2019:156-211. [ Context Link [1](#) ]
58. Case management standards and professional organizations. In: Powell SK, Tahan H, editors. *Case Management a Practical Guide for Education and Practice*. 4th ed. Philadelphia, PA: Wolters Kluwer, Lippincott, Williams & Wilkins; 2019:314-354. [ Context Link [1](#) ]
59. Nitsch A, Dlugosz H, Gibson D, Mehler PS. Medical complications of bulimia nervosa. *Cleveland Clinic Journal of Medicine* 2021;88(6):333-343. DOI: 10.3949/ccjm.88a.20168. [ Context Link [1](#), [2](#) ]
60. Eating disorders. In: Morgan KI, Townsend MC, editors. *Davis Advantage for Psychiatric Mental Health Nursing*. 10th ed. Philadelphia, PA: F.A. Davis; 2021:630-653. [ Context Link [1](#) ]
61. Crow SJ, Swanson SA, le Grange D, Feig EH, Merikangas KR. Suicidal behavior in adolescents and adults with bulimia nervosa. *Comprehensive Psychiatry* 2014;55(7):1534-9. DOI: 10.1016/j.comppsy.2014.05.021. [ Context Link [1](#) ]
62. Treasure J, Duarte TA, Schmidt U. Eating disorders. *Lancet* 2020;395(10227):899-911. DOI: 10.1016/S0140-6736(20)30059-3. [ Context Link [1](#) ]
63. Herpertz-Dahlmann B. Adolescent eating disorders: update on definitions, symptomatology, epidemiology, and comorbidity. *Child and Adolescent Psychiatric Clinics of North America* 2015;24(1):177-96. DOI: 10.1016/j.chc.2014.08.003. [ Context Link [1](#) ]
64. Berkman ND, et al. Management and Outcomes of Binge-Eating Disorder. Comparative Effectiveness Review #160 AHRQ Publication No. 15(16)-EHC030-EF [Internet] Agency for Healthcare Research and Quality (AHRQ). 2015 Dec Accessed at: <https://www.effectivehealthcare.ahrq.gov/>. [accessed 2022 Mar 16] [ Context Link [1](#), [2](#), [3](#), [4](#), [5](#) ]
65. McIntosh VV, Carter FA, Bulik CM, Frampton CM, Joyce PR. Five-year outcome of cognitive behavioral therapy and exposure with response prevention for bulimia nervosa. *Psychological Medicine* 2011;41(5):1061-71. DOI: 10.1017/S0033291710001583. [ Context Link [1](#) ]
66. Polnay A, James VA, Hodges L, Murray GD, Munro C, Lawrie SM. Group therapy for people with bulimia nervosa: systematic review and meta-analysis. *Psychological Medicine* 2013;1-14. DOI: 10.1017/S0033291713002791. [ Context Link [1](#) ]
67. Palavras MA, Hay P, Filho CA, Claudino A. The efficacy of psychological therapies in reducing weight and binge eating in people with bulimia nervosa and binge eating disorder who are overweight or obese-a critical synthesis and meta-analyses. *Nutrients* 2017;9(3):E299. DOI: 10.3390/nu9030299. [ Context Link [1](#), [2](#) ]
68. Poulsen S, et al. A randomized controlled trial of psychoanalytic psychotherapy or cognitive-behavioral therapy for bulimia nervosa. *American Journal of Psychiatry* 2014;171(1):109-16. DOI: 10.1176/appi.ajp.2013.12121511. [ Context Link [1](#) ]
69. Hay PP, Bacaltchuk J, Stefano S, Kashyap P. Psychological treatments for bulimia nervosa and bingeing. *Cochrane Database of Systematic Reviews* 2009, Issue 4. Art. No.: CD000562. DOI: 10.1002/14651858.CD000562.pub3. [ Context Link [1](#) ]
70. Wagner B, et al. Randomized controlled trial of an internet-based cognitive-behavioral treatment program for binge-eating disorder. *Behavior Therapy* 2016;47(4):500-14. DOI: 10.1016/j.beth.2016.01.006. [ Context Link [1](#) ]
71. Godfrey KM, Gallo LC, Afari N. Mindfulness-based interventions for binge eating: a systematic review and meta-analysis. *Journal of Behavioral Medicine* 2015;38(2):348-62. DOI: 10.1007/s10865-014-9610-5. [ Context Link [1](#) ]
72. Murray HB, Juarascio AS, Di Lorenzo C, Drossman DA, Thomas JJ. Diagnosis and treatment of rumination syndrome: a critical review. *American Journal of Gastroenterology* 2019;114(4):562-578. DOI: 10.14309/ajg.0000000000000060. [ Context Link [1](#), [2](#) ]



73. Hejazi RA, McCallum RW. Ruminationsyndrome: a review of current concepts and treatments. *American Journal of the Medical Sciences* 2014;348(4):324-9. DOI: 10.1097/MAJ.0000000000000229. [ Context Link [1](#), [2](#) ]
74. Kessing BF, Smout AJ, Bredenoord AJ. Current diagnosis and management of the rumination syndrome. *Journal of Clinical Gastroenterology* 2014;48(6):478-83. DOI: 10.1097/MCG.0000000000000142. [ Context Link [1](#), [2](#) ]
75. Aigner M, Treasure J, Kaye W, Kasper S, WFSBP Task Force On Eating Disorders. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the pharmacological treatment of eating disorders. *World Journal of Biological Psychiatry* 2011;12(6):400-443. DOI: 10.3109/15622975.2011.602720. (Reaffirmed 2022 May) [ Context Link [1](#), [2](#), [3](#), [4](#) ]
76. Flament MF, Bissada H, Spettigue W. Evidence-based pharmacotherapy of eating disorders. *International Journal of Neuropsychopharmacology* 2012;15(2):189-207. DOI: 10.1017/S1461145711000381. [ Context Link [1](#) ]
77. Lock J, La Via MC, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with eating disorders. *Journal of the American Academy of Child and Adolescent Psychiatry* 2015;54(5):412-425. DOI: 10.1016/j.jaac.2015.01.018. (Reaffirmed 2022 Jul) [ Context Link [1](#) ]
78. Goracci A, di Volo S, Casamassima F, Bolognesi S, Benbow J, Fagiolini A. Pharmacotherapy of binge-eating disorder: a review. *Journal of Addiction Medicine* 2015;9(1):1-19. DOI: 10.1097/ADM.0000000000000089. [ Context Link [1](#) ]
79. Zeevenhooven J, Koppen IJ, Benninga MA. The new Rome IV criteria for functional gastrointestinal disorders in infants and toddlers. *Pediatric Gastroenterology, Hepatology & Nutrition* 2017;20(1):1-13. DOI: 10.5223/pghn.2017.20.1.1. [ Context Link [1](#) ]
80. Pauwels A, Broers C, Van Houtte B, Rommel N, Vanuytsel T, Tack J. A randomized double-blind, placebo-controlled, cross-over study using baclofen in the treatment of rumination syndrome. *American Journal of Gastroenterology* 2018;113(1):97-104. DOI: 10.1038/ajg.2017.441. [ Context Link [1](#) ]
81. Williams DE, McAdam D. Assessment, behavioral treatment, and prevention of pica: clinical guidelines and recommendations for practitioners. *Research in Developmental Disabilities* 2012 Nov-Dec;33(6):2050-2057. DOI: 10.1016/j.ridd.2012.04.001. [ Context Link [1](#) ]
82. Matson JL, Hattier MA, Belva B, Matson ML. Pica in persons with developmental disabilities: approaches to treatment. *Research in Developmental Disabilities* 2013;34(9):2564-71. DOI: 10.1016/j.ridd.2013.05.018. [ Context Link [1](#) ]
83. Brewerton TD, Costin C. Long-term outcome of residential treatment for anorexia nervosa and bulimia nervosa. *Eating Disorders* 2011;19(2):132-44. DOI: 10.1080/10640266.2011.551632. [ Context Link [1](#) ]
84. Zeeck A, Weber S, Sandholz A, Wetzler-Burmeister E, Wirsching M, Hartmann A. Inpatient versus day clinic treatment for bulimia nervosa: a randomized trial. *Psychotherapy and Psychosomatics* 2009;78(3):152-60. DOI: 10.1159/000206869. [ Context Link [1](#) ]
85. Hayes NA, Welty LJ, Slesinger N, Washburn JJ. Moderators of treatment outcomes in a partial hospitalization and intensive outpatient program for eating disorders. *Eating Disorders* 2019;27(3):305-320. DOI: 10.1080/10640266.2018.1512302. [ Context Link [1](#) ]
86. Linardon J. Rates of abstinence following psychological or behavioral treatments for binge-eating disorder: Meta-analysis. *International Journal of Eating Disorders* 2018;51(8):785-797. DOI: 10.1002/eat.22897. [ Context Link [1](#) ]
87. Grilo CM, Crosby RD, Wilson GT, Masheb RM. 12-month follow-up of fluoxetine and cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology* 2012;80(6):1108-13. DOI: 10.1037/a0030061. [ Context Link [1](#) ]
88. Hudson JI, McElroy SL, Ferreira-Cornwell MC, Radewonuk J, Gasior M. Efficacy of lisdexamfetamine in adults with moderate to severe binge-eating disorder: a randomized clinical trial. *JAMA Psychiatry* 2017;74(9):903-910. DOI: 10.1001/jamapsychiatry.2017.1889. [ Context Link [1](#) ]

89. Fischer S, Meyer AH, Dremmel D, Schlup B, Munsch S. Short-term cognitive-behavioral therapy for binge eating disorder: long-term efficacy and predictors of long-term treatment success. *Behaviour Research and Therapy* 2014;58:36-42. DOI: 10.1016/j.brat.2014.04.007. [ [Context Link 1](#) ]

## Footnotes

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[A] Inpatient psychiatric units generally are locked, equipped to restrain or seclude patients for safety if necessary, and staffed by nurses around the clock. Attending physicians typically round at least 5 days per week, and a covering physician always is available to see a patient on site.(1)(2) [ [A in Context Link 1](#) ]

[B] Whether or not a patient with an eating disorder should be hospitalized on a psychiatric vs a general medical unit depends on a variety of factors, including medical and psychiatric status, skills and abilities of staff in the proposed admitting institution, and the availability of suitable programs to address medical and psychiatric needs. There is some evidence to suggest that when hospital admission is necessary, admission to inpatient units specializing in eating disorder treatment may be associated with better outcomes.(3)(4) [ [B in Context Link 1](#) ]

[C] The purpose of the care guidelines is to promote evidence-based care across the continuum of care to enhance the delivery of quality healthcare. Indications are presented for different levels of care. These indications help define the optimal level of care and can assist in developing alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. Relevant professional society guidelines are foundational content for evaluation and treatment of behavioral health disorders at different levels of care and are complemented by the best available published evidence.(2)(5)(6)(7)(8)(9)(10)(11)(12) [ [C in Context Link 1](#) ]

[D] Composite score does not replace clinical judgment and is meant as a guide to assist in determining needed level of care. Extreme risk of harm, severe functional impairment, or severe comorbidity may independently necessitate placement at inpatient level of care.(2) [ [D in Context Link 1](#) ]

[E] Practice guidelines for the treatment of patients with eating disorders indicate that the decision for hospitalization of a patient with an eating disorder should be made on an individualized basis, utilizing a patient's personal weight status and risk of developing medical complications, instead of using standardized cutoff levels for BMI, rate of weight change, or percentage of healthy body weight.(18) [ [E in Context Link 1](#) ]

[F] QT-interval prolongation is a possible complication of anorexia nervosa and a suspected contributor to the increased incidence of sudden death observed in patients with this disorder.(21) [ [F in Context Link 1](#) ]

[G] Muscle weakness is considered severe if it prevents the patient from rising from a seated position without use of the arms, or rising from a supine position even with use of the arms, or from being able to sit up at all.(13) [ [G in Context Link 1](#) ]

[H] Total body phosphorus depletion, a possible consequence of malnutrition, increases the risk (during nutritional rehabilitation) of refeeding syndrome, a condition involving severe alterations in fluid and electrolyte balances that can lead to potentially life-threatening cardiac and neuromuscular complications.(22) [ [H in Context Link 1](#) ]

[I] A practice guideline for the treatment of patients with eating disorders indicates that an assessment of motivation to recover is indicated in the initial admission assessment to assist in determining the appropriate level of care to treat the eating disorder.(3)(4) [ [I in Context Link 1](#) ]

[J] Patients appropriate for inpatient eating disorder treatment may be preoccupied with intrusive or repetitive thoughts for more than 6 hours a day.(3)(4) [ J in Context Link [1](#) ]

[K] A practice guideline for the treatment of patients with eating disorders indicates that patients engaged in and unable to control multiple daily episodes of purging behaviors that are severe, persistent, and disabling, and who have been unable to regulate these behaviors despite appropriate trials of outpatient care may be considered for inpatient management. This is the case even in the absence of metabolic abnormalities, provided that they otherwise meet inpatient admission criteria related to supervisory needs, motivation, and comorbidities.(3)(4) [ K in Context Link [1](#), [2](#) ]

[L] A practice guideline for the treatment of patients with eating disorders indicates that compulsive exercising rarely is a sole indication for increasing level of care.(3)(4) [ L in Context Link [1](#) ]

[M] Assessment of the likelihood of benefit at the proposed level of care may help identify subgroups of patients more likely to respond to particular treatments and help optimize the care plan to increase the likelihood of successful recovery. It may also help determine if a specialized treatment setting (eg, dual-diagnosis program) or a different level of service intensity would be more appropriate to address the patient's needs.(2)(3)(4)(6) [ M in Context Link [1](#) ]

[N] Examples of medical conditions appropriate for inpatient care include conditions that require intensive, around-the-clock medical monitoring and daily nursing interventions, or patients with significant metabolic or ECG abnormalities related to vomiting.(2) [ N in Context Link [1](#) ]

[O] Biopsychosocial stressors may impact the level of care necessary to manage a psychiatric or behavioral condition, including the ability of the program to meet comprehensive patient needs, ensure treatment adherence, enhance motivation, or prevent relapse (ie, comorbidities, environmental factors, or other barriers may prevent effective treatment at a less intensive level of care than might otherwise be appropriate to the patient's condition). Biopsychosocial assessment factors should be incorporated into care planning, including planned treatment goals, and intensity and duration of interventions. Any identified deficits should be manageable by the program directly or through alternative arrangements.(2)(5)(8)(9) [ O in Context Link [1](#) ]

[P] Comorbid conditions may directly impact the experience of psychiatric symptoms (eg, COPD and anxiety), or may indirectly impact determination of the appropriate venue for care (eg, routine blood sugar and insulin management in people with diabetes). If clinically appropriate, testing related to diagnosis or management (eg, screening for liver and kidney function, hepatitis, HIV, syphilis, tuberculosis) may be performed off-site.(2)(5)(8)(9) Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(2)(5)(7)(8)(9)(10)(27) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(2)(5)(8)(9)(28) [ P in Context Link [1](#) ]

[Q] Evaluation/assessment and treatment of co-occurring substance use disorders through services and treatment settings capable of rendering integrated care is recommended.(2)(5)(7)(8)(9)(27) The level that comorbid substance use disorders contribute to the primary presenting condition may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care or specialty dual-diagnosis program).(2)(5)(8)(9)(28) [ Q in Context Link [1](#) ]

[R] The degree of environmental stressors and amount of support in the patient recovery environment should be considered in the context of the clinical presentation in determining the appropriate level of care for treatment. The level of environmental stressors may be low, mild, moderate, high, or extreme. The level of support in the environment may range from absent or minimal to limited to supportive or highly supportive.(2)(5)(7)(8)(9)(10)(27)(28) [ R in Context Link [1](#) ]

[S] Participation motivated by a wish to avoid negative consequences rather than accept the need to work toward recovery may require more intense monitoring and follow-up.(6)(28)(29) The patient's level of engagement may be described on a continuum: optimal, positive, limited, minimal, or unengaged. Readiness to change may range from actively and willingly engaged to unable to follow treatment recommendations due to clinical condition.(2)(5)(8)(9)(28) [ S in Context Link 1 ]

[T] Telehealth may improve access to and coordination of mental health care. Patients with behavioral health diagnoses may use telehealth or telepsychiatry to access mental health support or care (eg, to get assistance with problem -solving techniques or ask about presenting symptoms or medication use).(34) [ T in Context Link 1, 2 ]

[U] See [Clinical Indications for Admission to Inpatient Care](#) in this guideline. [ U in Context Link 1 ]

[V] A registered dietitian should develop a dietary plan, taking into consideration the patient's healthy weight goal and caloric and nutrient needs.(3)(4)(33) [ V in Context Link 1 ]

[W] Monitored meals means meals and snacks are given under the supervision of trained staff members who demonstrate empathy and understanding, while setting firm limits about what must be consumed.(3)(4) [ W in Context Link 1, 2, 3 ]

[X] Continual observation may be necessary to prevent a patient from exercising more than is appropriate, given the patient's caloric intake and physical condition.(3)(4) [ X in Context Link 1 ]

[Y] Patients with a history of self-induced vomiting may need to be supervised while using the bathroom, especially during the hour after each meal.(3) [ Y in Context Link 1, 2, 3, 4 ]

[Z] Precipitants explain why the admission occurred at the specific point in time.(7) [ Z in Context Link 1 ]

[AA] Medical history should include documentation of last menstrual period.(35) [ AA in Context Link 1 ]

[BB] Assessment of food-related or eating-disorder behaviors should include weight history and attitudes, beliefs, and perceptions regarding food, weight, and body shape.(3)(4)(35) When available, outside observations (eg, by family members) should be included in the assessment.(35) [ BB in Context Link 1 ]

[CC] History and examination should include determination of BMI as well as date of last menstrual period.(35) [ CC in Context Link 1 ]

[DD] Laboratory tests that are generally indicated as part of the initial assessment of patients with eating disorders include CBC , urinalysis, complete metabolic profile (including phosphorus and magnesium), creatinine, thyroid function testing, and (fasting) glucose.(35) [ DD in Context Link 1, 2 ]

[EE] Examples of possible indications for ECG include electrolyte abnormalities or hypotension.(35) [ EE in Context Link 1, 2 ]

[FF] Psychosocial interventions should be individualized, address all admission precipitants and barriers to discharge, and involve family and other supports as necessary.(7)(36)(37) [ FF in Context Link 1, 2, 3, 4, 5 ]

[GG] The patient should be weighed at the same time each day, wearing the same type of garment, immediately after voiding.(3)(4) [ GG in Context Link 1, 2, 3, 4 ]

[HH] Clinical management should include discussion of the psychological and physical consequences of attempting to normalize diet and eating patterns and the beneficial and adverse effects of any medication that is prescribed.(3)(4)(13) [ HH in Context Link 1, 2 ]

[II] Physical status is acceptable if any physiologic instability, electrolyte abnormality, dehydration, or physical complication (eg, esophageal damage) is absent or can be safely managed/treated at an available lower level of care.(3)(4)(13) [ II in Context Link [1](#) ]

[JJ] A crisis or safety plan establishes what actions the patient and supports are to take if food refusal, purging, or dangerous ideation or behavior develops or worsens.(38) [ JJ in Context Link [1](#) ]

[KK] A behavioral management plan uses positive reinforcements (eg, privileges) and negative reinforcements (eg, monitored use of bathroom) to encourage restraint from purging.(3)(4) [ KK in Context Link [1](#), [2](#) ]

[LL] Routine assessment upon admission is not indicated.(7) Testing that would not affect or contribute substantially to a diagnosis or treatment plan is inappropriate.(46) [ LL in Context Link [1](#) ]

[MM] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(47) [ MM in Context Link [1](#) ]

## Codes

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**ICD-10 Diagnosis: F50.2, F50.81, F50.82, F50.89, F50.9, R63.4, R63.6**

**DSM-5: F50.2, F50.81, F50.82, F50.89, F50.9**

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