

# MEDICAL POLICY



MEDICAL POLICY DETAILS	
Medical Policy Title	STANDARD DIALECTICAL BEHAVIOR THERAPY
Policy Number	3.01.10
Category	Behavioral Health
Effective Date	04/28/11
Revised Date	04/26/12, 04/25/13, 04/24/14, 06/25/15, 06/22/16, 06/22/17, 10/25/18, 08/22/19
Product Disclaimer	<ul style="list-style-type: none"> <li>• If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.</li> <li>• If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.</li> <li>• If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.</li> </ul>

## POLICY STATEMENT

- I. Based upon our criteria and assessment of peer-reviewed literature, full dialectical behavior therapy (DBT) skills training groups have been medically proven to be effective and therefore are considered a **medically appropriate** treatment for adults who meet the following criteria:
- A. The patient must have a principal diagnosis of mental illness as specified in the current edition of the Diagnostic and Statistical Manual (DSM) or ICD-10-CM equivalent of one of the following conditions:
1. Borderline Personality Disorder (BPD);
  2. Eating disorder;
  3. Post-traumatic stress disorder (PTSD);
  4. Substance use disorder; or
  5. Depression in older adults.
- AND ONE of the following;
- B. History of self-harm or suicidal ideation in the last six months;
- C. Recurrent suicidal behaviors; OR
- D. High risk symptom/clinical acuity.
- II. Based upon our criteria and assessment of peer-reviewed literature, full dialectical behavior therapy (DBT) skills training groups have been medically proven to be effective and therefore are considered a **medically appropriate** treatment for adolescents who meet the following criteria:
- A. The patient must have a principal diagnosis of mental illness as specified in the current edition of the Diagnostic and Statistical Manual (DSM) or ICD-10-CM equivalent of one of the following conditions:
1. Borderline Personality Disorder (BPD);
  2. BPD traits of (with patient meeting three symptoms for BPD as outlined in the DSM);
  3. Eating disorder;
  4. Substance use disorder; or
  5. Mood disorder.
- AND ONE of the following;
- B. History of recurrent suicidal behavior, gestures or threats; OR
- C. Self-mutilating behavior.
- III. Standard Dialectical Behavior Therapy Programs **must** meet the following requirements:
- A. Adult DBT skills training groups consist of one cycle which includes the following four modules. The standard treatment for adults typically includes the completion of two cycles. One cycle typically lasts 24-26 weeks.
1. Mindfulness;
  2. Interpersonal effectiveness;
  3. Emotional regulation; and

## Medical Policy: STANDARD DIALECTICAL BEHAVIOR THERAPY

Policy Number: 3.01.10

Page: 2 of 6

4. Distress tolerance.
- B. *Adolescent* DBT Skills Training Groups consist of one cycle which includes the following five modules. The standard treatment for adolescents typically includes the completion of one cycle which typically lasts 24-26 weeks. Parenting DBT Skills Groups are included in the treatment for Adolescents.
  1. Mindfulness
  2. Interpersonal effectiveness;
  3. Emotional regulation;
  4. Distress tolerance; and
  5. Walking the Middle Path (specific for parents and adolescents).
- C. Standard DBT programs must include weekly individual therapy.
- D. All DBT providers must receive specialized training in DBT.
  1. Standard DBT programs must include a consult therapy team for DBT trained providers.
  2. Standard DBT programs must offer phone coaching.
  3. Standard DBT programs are expected to maintain clear written descriptions of the treatment goals and objectives, as well as admission and discharge criteria.
- IV. Based upon our criteria and assessment of peer-reviewed literature, standard DBT does not improve patient outcomes and is considered **not medically necessary** for diagnoses other than those listed in I and II above.
- V. Based upon our criteria and assessment of peer-reviewed literature, full DBT skills training groups are considered **investigational** for all other diagnoses.
- VI. Stand-Alone Dialectical Behavior Therapy Group Programs must meet the following requirements:
  - A. Adults diagnosed with mood disorders, substance use disorders, eating disorders, and PTSD.
  - B. Adolescents diagnosed with mood disorders, anxiety disorders, oppositional defiant disorders, disruptive mood dysregulation disorder, substance use disorders, and eating disorders.
  - C. All DBT therapists must receive specialized training in DBT treatment (not intensively DBT trained, but must have documentation of some training to run individuals components).
  - D. Groups must be limited to no more than ten to twelve (10-12) members and meet for duration of 60 - 90 minutes per session. Groups for children and/or adolescents may meet for a minimum of sixty (60) minutes. The group must be limited to no more than ten to twelve (10-12) sessions.
  - E. Stand-alone DBT groups are expected to maintain clear written descriptions of the treatment goals and objectives, as well as admission and discharge criteria per individual member.
  - F. Mindfulness groups are typically shorter, and four per cycle as opposed to the Jon Kabat Zinn practice, which is eight (8) sessions in length.
- VII. Based upon our criteria and assessment of peer-reviewed literature, stand-alone DBT Groups is considered **investigational** for all other diagnoses.
- VIII. Based upon our criteria and assessment of peer-reviewed literature, stand-alone DBT groups for interpersonal effectiveness, distress tolerance, and Walking the Middle Path is considered **investigational**.

*For a clearer understanding of our policies relating to outpatient mental health group psychotherapy, please refer to Corporate Medical Policy # 3.01.08, Group Therapy for Mental Health and Substance Use Disorder.*

### **POLICY GUIDELINES**

- I. It is expected that patients will be seen for medication management and support by a psychiatrist as necessary while in either a full DBT program or stand-alone DBT groups.
- II. The Federal Employee Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

## **Medical Policy: STANDARD DIALECTICAL BEHAVIOR THERAPY**

**Policy Number: 3.01.10**

**Page: 3 of 6**

### **DESCRIPTION**

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment that was originally created for chronically suicidal patients but has been modified to treat individuals with Borderline Personality Disorder. DBT is empirically supported and is a standardized treatment with a specific model incorporating skills training group, individual therapy, phone coaching and therapist consultation.

Borderline Personality Disorder (BPD) is a personality disorder characterized by unstable and intense interpersonal relationships, inappropriate and uncontrolled anger, unstable self-image, and recurrent suicidal ideation, gestures, threats and other self-mutilating behaviors (Diagnostic and Statistical Manual). 69% to 80% of individuals diagnosed with BPD engage in suicidal behavior with a suicide rate up to 9%. Individuals diagnosed with BPD use more services than those with major depression and other personality disorders. These services include frequent visits to emergency departments, psychiatric inpatient hospitalizations and high utilization of outpatient treatment. Clinicians are reluctant to diagnose personality disorders in individuals less than 18 years of age and therefore adolescents are rarely diagnosed with personality disorders. The goals of the comprehensive DBT program are intended to reduce suicidal ideation and gestures, unstable self-image, emotional instability and interpersonal difficulties.

### **RATIONALE**

Studies have been performed assessing DBT for the treatment of BPD and BPD's with co-existing substance use, eating disorders and mood disorders. The majority of studies find statistically significant findings for DBT as the treatment for BPD versus 'Treatment As Usual'.

In one (1) randomized controlled trial, Linehan, et al (1991) studied the comprehensive DBT program (with individual psychotherapy) compared to 'Treatment As Usual' (TAU) with chronically suicidal women diagnosed with Borderline Personality Disorder. The findings showed reductions in para suicidal behavior and statistically significant likelihood of starting and completing treatment for the comprehensive DBT program. Further, in this study, inpatient hospital days for those engaged in the DBT program were significantly fewer than 'Treatment As Usual' and at one year after treatment ended, these findings were maintained. In 2006, Linehan et al. completed a two (2) year randomized controlled trial studying treatment outcomes of individuals receiving DBT versus individuals receiving treatment rendered by non-behavioral psychotherapy experts. This study included one year of DBT or one year of community treatment followed by one year of post treatment follow-up. This intent of this study was to measure assessment outcomes of suicidal behavior, use of emergency services and general psychological functioning for subjects in the DBT group versus subjects in the treatment offered by community psychotherapy clinicians. In this study, DBT showed better outcomes than those in community treatment. Subjects receiving DBT were half as likely to make a suicide attempt, required less hospitalization for suicidal ideation and were less likely to drop out of treatment with fewer psychiatric emergency department visits.

Linehan, Heard and Armstrong (1993) also studied the efficacy of DBT skills group as an additional treatment for members already engaged in individual psychotherapy with a community therapist. This study intended to question the outcome of exposing members to DBT skills only while in treatment with an individual psychotherapist. The results of this study did not show strong results of adding only DBT skills group to ongoing individual psychotherapy.

Verheul, et al (2003) also studied the effectiveness of twelve months of DBT compared to twelve months in 'Treatment As Usual' in a randomized controlled study to compare treatment retention, suicidal, self-mutilating and impulsive behaviors. This study showed statistically significant results with reductions in self-mutilating; self-damaging behaviors and treatment dropout rates for individuals receiving DBT compared to those individuals receiving 'Treatment As Usual.'

Linehan et al. (1999) conducted a randomized controlled trial to evaluate DBT for individuals diagnosed with borderline personality disorder and co-morbid chemical dependency compared to 'Treatment As Usual' in the community. The results showed statistically significant reduction in substance abuse for subjects engaged in DBT versus subjects engaged in 'Treatment As Usual' and further, DBT showed greater treatment retention, increased social and global functioning.

Safer, et al (2001) completed a randomized controlled trial to evaluate DBT for women with binge eating disorder. The results showed that DBT decreased bingeing and purging behaviors when DBT was adapted specifically for bulimia nervosa. The DBT group showed 0% drop out rate and was statistically significant results for decreasing bingeing and purging.

**Medical Policy: STANDARD DIALECTICAL BEHAVIOR THERAPY**

**Policy Number: 3.01.10**

**Page: 4 of 6**

Sinnaeve, et al. (2018) compared standard 12-month outpatient DBT to a step-down DBT program which consisted of three (3) months of residential DBT treatment and six (6) months of outpatient DBT treatment for a total of nine(9) months of step down DBT. A total of 84 participants with high levels of BPD symptoms were randomly assigned to step down DBT versus standard DBT with the primary aim to determine the clinical efficacy and cost-effectiveness of step-down DBT treatment. Only 45% of participants started the outpatient DBT program compared to 95% starting the step down program. The authors attribute this to the waitlist for outpatient DBT. In the step-down DBT, 53% of the participants completed the entire nine (9) month program compared to 63% completing the outpatient DBT program. Results showed the probability of suicidal behavior did not change significantly over 12 months, the probability of non-suicidal self-injurious behaviors decreased significantly in step-down DBT but not outpatient DBT, and the severity of borderline symptoms decreased significantly in both groups with improvement leveling off at the end of treatment. The authors concluded step down DBT was not more clinically effective or cost-effective than 12 months of outpatient DBT. Findings should be considered tentative because of high noncompliance and the need to evaluate long term outcomes.

The National Institute for Health and Care Excellence (NICE) published clinical guidelines for the recognition and management of borderline personality disorder in January 2009, which states “women with borderline personality disorder for whom reducing self-harm is a priority, consider a comprehensive dialectical behavior therapy programme”.

The United States Preventive Services Task Force (USPSTF) states in the Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: Clinical Summary (2014) most effective treatments to reduce suicide risk include psychotherapy which includes cognitive behavioral therapy, dialectical behavior therapy, problem-solving therapy, and developmental group therapy.

**CODES**

- *Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

**CPT Codes**

<b>Code</b>	<b>Description</b>
90853	Group psychotherapy
90785	Interactive complexity, add on code for 90791-90792, 90832-90838

*Copyright © 2019 American Medical Association, Chicago, IL*

**Revenue Codes**

<b>Code</b>	<b>Description</b>
915	Psychiatric/psychological services- group therapy

**ICD10 Codes**

<b>Code</b>	<b>Description</b>
F31.0-F31.9	Bipolar disorder (code range)
F32.0-F32.9	Major depressive disorder, single episode (code range)
F33.0-F33.9	Major depressive disorder, recurrent (code range)
F34.81	Disruptive mood dysregulation disorder
F41.0-F41.9	Other anxiety disorders (code range)
F43.10-F43.12	Post-traumatic stress disorder (code range)
F50.00-F50.9	Eating disorders (code range)
F60.3	Borderline personality disorder
F91.3	Oppositional defiant disorder



**Medical Policy: STANDARD DIALECTICAL BEHAVIOR THERAPY**

**Policy Number: 3.01.10**

**Page: 6 of 6**

[7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&Keyword=psychiatry&KeyWordLookUp=Title&KeywordSearchType=Exact&kq=true&bc=IAAACABAAA&](#)