Medical Policy

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***Current Policy Effective Date: 1/1/24**
(See policy history boxes for previous effective dates)

Title: Dialectical Behavior Therapy

Description/Background

Dialectical behavior therapy provides a safe space, with a trained professional, for individuals to discuss intense emotions. Through reflection and guidance, DBT helps the subject understand who they are while focusing on recognizing unhealthy patterns of thoughts and behaviors. Once the challenges are identified, participants can explore solutions for positive life changes. The 6 main points of DBT are to develop skills related to (1) accepting circumstances and making changes, (2) analyzing behaviors and learning healthier patterns of responding, (3) changing unhelpful, maladaptive, or negative thoughts, (4) developing collaboration skills, (5) learning new skills, and (6) receiving support.

According to guidelines published by the American Psychiatric Association (APA), DBT consists of approximately 1 year of manual-guided therapy, which includes 1 hour of weekly individual therapy for 1 year and 2.5 hours of group skills training per week for 6 to 12 months. There is also a requirement for all therapists to meet weekly for team consultation (APA, 2001).

Clients in standard DBT treatment receive 3 main modes of treatment: individual therapy, skills group and phone coaching. In individual therapy, clients receive weekly individual sessions that are typically an hour to an hour-and-a half in length. Clients also must attend a 2-hour weekly skills group for at least 1 year. Unlike regular group psychotherapy, these skills groups emerge as classes during which clients learn the 4 sets of important skills – mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. Clients are also asked to call their individual therapists for skills coaching *prior* to hurting themselves. The therapist then guides them through alternatives to self-harm or suicidal behaviors.

Medical Policy Statement

The effectiveness of dialectical behavior therapy (DBT) has been established. It may be a useful therapeutic option for the treatment of individuals who meet DSM criteria for borderline personality disorder.

Inclusionary and Exclusionary Guidelines

Inclusions: (Must meet all)

- Patients ≥ 16 years of age with a primary diagnosis of borderline personality disorder documented by mental health treatment provider(s) in the preceding 2 years.
- *Severe* behaviors and symptoms, due to borderline personality disorder, occurring over the previous 6 months (e.g., self-injury, chronic suicidal ideation, suicide attempts or other para-suicidal behavior)
- An initial assessment completed by the DBT provider should show that the member is in the contemplation or action phase of readiness to change and can commit to the DBT treatment plan.
- Treatment must be provided by a participating provider who has, to the satisfaction of BCBSM/BCN, completed intensive training in DBT. DBT treatment is limited to individual and group psychotherapy (also known as skills group) treatment.

In addition to the above, the member must meet at least **one** of the following criteria:

- Repeated attempts and failures in traditional outpatient mental health treatment.
- At least 2 inpatient or partial hospitalizations for psychiatric symptoms in the preceding 12 months.

Exclusions:

- DBT for any other primary indication, including but not limited to:
  - Depression
  - Bipolar Disorder
  - Eating disorders
  - Trauma-related disorders
  - Obsessive-compulsive disorder
- DBT of greater than 1 years duration
- DBT for borderline personality disorder in the absence of severe behaviors and symptoms due to borderline personality disorder, occurring over the previous 6 months (e.g., self-injury, chronic suicidal ideation, suicide attempts or other para-suicidal behavior)
- Telephone coaching is considered an integral part of dialectical behavior therapy and not separately reimbursable.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

90785	90832	90833	90834	90836	90837
90838	90846	90847	90853	90899	99354
99355					

Other codes (investigational, not medically necessary, etc.):

N/A

Rationale

Dialectical behavior therapy (DBT) is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "a cognitive-behavioral treatment approach with 2 key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies and an emphasis on dialectical processes." The therapy was originally developed for the treatment of individuals with borderline personality disorder who exhibited self-harm behaviors. Later, it was proposed as a treatment for other indications, including depression, post-traumatic stress disorder, substance abuse and eating disorders.

Criteria for borderline personality disorder (DSM-5 code 301.83, F60.3) is defined in *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition, (DSM-5) as:

"A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by 5 (or more) of the following:

- Frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least 2 areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- Recurrent suicidal behavior, gestures and/or threats or self-mutilating behavior.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms excluding suicidal or self-mutilating behavior.

DBT serves 5 functions (SAMHSA, 2006):

- Capability enhancement (skills training)
- Motivational enhancement (individual behavioral treatment plans)
- Generalization (access to therapist outside clinical setting, homework and inclusion of family in treatment)
- Structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors)
- Capability and motivational enhancement of therapists (therapist team consultation group)

Skills-training is taught in a series of 4 modules:

- Mindfulness
- Distress tolerance
- Emotional regulation
- Interpersonal effectiveness

Bipolar Disorder

According to practice guidelines published by the American Psychiatric Association (APA, 2001) for treatment of individuals with bipolar disorder, DBT has been shown in randomized controlled trials to have clinical efficacy. However, the guidelines note that substantial improvement may not occur until after approximately 1 year of treatment, and some individuals may require treatment of a longer duration to achieve outcomes. In 2005, the APA published a guideline watch, which provided continued support of the recommendations in the 2001 guideline.

In a Cochrane review by Binks et al (2006) the effects of psychological interventions for individuals with borderline personality disorder were evaluated. DBT was found to offer a small benefit over treatment as usual in preventing individuals from engaging in self-harm behaviors. Although this finding was consistent across studies, in small trials, it was not always statistically significant. In 1 larger study, however, this finding did reach statistical significance at 12 months. Additional findings were that individuals participating in DBT reported less hopelessness and anxiety and DBT may also help to keep people in treatment, thus reducing the rate of drop-out. The authors noted that “DBT seemed to be helpful on a wide range of outcomes, such as admission to hospital or incarceration in prison, but the small size of included studies limit confidence in their results.”

Kliem et al (2010) reported on the results of a meta-analysis examining the efficacy and long-term effectiveness of DBT for individuals with borderline personality disorder. Included in the analysis were 8 randomized controlled studies, 1 non-randomized controlled study and 7 non-randomized, non-controlled studies. Moderators were used to control for potential confounding factors. Global effect sizes, from pre- to post-treatment interventions, were calculated based upon 8 randomized controlled trials and 8 non-randomized, non-controlled studies. A moderate global effect and moderate effect size was found for suicidal and self-injurious behaviors. The authors noted that the findings of this meta-analytic review support the efficacy of DBT for borderline personality disorder. However, a significant difference in the rate of treatment drop-out for DBT versus the control condition was not found. At follow-up, a decrease in the moderated global effect of DBT was also observed. The authors concluded that additional research is needed to assist individuals with applying the skills learned in treatment to daily life.

Adrian et al (2019) compared dialectical behavior therapy with individual/group supportive therapy (IGST) in borderline personality adolescents with extensive self-harm histories. One hundred seventy-three adolescents were included in the intent-to-treat sample and randomized to receive 6 months of DBT or IGST. Potential baseline predictors and moderators were identified within 4 categories: demographics, severity markers, parental psychopathology, and psychosocial variables. Primary outcomes were suicide attempts and non-suicidal self-injury evaluated at baseline, mid-treatment (3 months), and end of treatment (6 months) via the Suicide Attempt and Self-Injury Interview (Psychological Assessment, 18, 2006, 303). DBT was associated with better rates of improvement compared to IGST for adolescents with higher baseline emotion dysregulation and those whose parents reported greater psychopathology and emotion dysregulation. Authors concluded that adolescents who have high levels of family conflict, externalizing problems, and increased level of severity markers demonstrated the most change in self-harm behaviors over the course of treatment and benefit from both treatment interventions. Those with higher levels of emotion dysregulation and parent psychopathology may benefit more from the DBT.

Walton et al (2020) reported on the outcomes of a randomized trial comparing dialectical behavior therapy and conversational model for treatment of borderline personality disorder in a routine clinical setting. Participants had a diagnosis of borderline personality disorder and a minimum of 3 suicidal and/or non-suicidal self-injurious episodes in the previous 12 months. Consenting individuals were randomized to either dialectical behavior therapy or conversational model and contracted for 14 months of treatment (n = 162 commenced therapy). Dialectical behavior therapy involved participants attending weekly individual therapy, weekly group skills training and having access to after-hours phone coaching. Conversational model involved twice weekly individual therapy. Assessments occurred at baseline, mid-treatment (7 months) and post-treatment (14 months). Assessments were conducted by a research assistant blind to treatment condition. Primary outcomes were change in suicidal and non-suicidal self-injurious episodes and severity of depression. We hypothesized that dialectical behavior therapy would be more effective in reducing suicidal and non-suicidal self-injurious behavior and that conversational model would be more effective in reducing depression. Both treatments showed significant improvement over time across the 14 months duration of therapy in suicidal and non-suicidal self-injury and depression scores. There were no significant differences between treatment models in reduction of suicidal and non-suicidal self-injury. However, dialectical behavior therapy was associated with significantly greater reductions in depression scores compared to conversational model. Authors concluded that this research adds to the accumulating body of knowledge of psychotherapeutic treatment of borderline personality disorder and supports the use of both dialectical behavior therapy and conversational model as effective treatments in routine clinical settings, with some additional benefits for dialectical behavior therapy for persons with co-morbid depression.

Eating Disorders

Based upon positive outcomes observed with borderline personality disorder, there has been interest in the use of DBT for the treatment of eating disorders. More specifically, DBT has been proposed as a viable treatment for binge-eating behaviors with the emphasis directed towards teaching the individual skills to regulate his/her mood thus reducing the need to binge eat.

The APA published practice guidelines in 2006 for the treatment of individuals with eating disorders indicating that DBT may be a possible treatment alternative to address behavioral and psychological symptoms associated with binge eating.

Telch et al (2001) reported on the results of a small randomized controlled trial (n=44) evaluating dialectical behavior therapy adapted for binge eating disorder versus a wait-list control condition. Compared to the wait-list control group, individuals in the DBT group exhibited significant improvement with respect to binge eating. Eighty-nine percent of individuals in the DBT group had stopped binge eating for at least 4 weeks prior to the end of treatment compared to 12.5 percent of individuals in the wait-list control group. However, at 6 months, abstinence from binge eating in the DBT group was reduced to 56 percent. Furthermore, there were no significant differences found between the groups on measures of weight, mood and affect regulation.

Lenz et al (2014) reported on a meta-analysis evaluating the effectiveness of DBT in patients with eating disorders and comorbid depression. Large effect sizes were found in both between-groups and single-group study samples suggesting that DBT may be helpful to decrease the frequency of eating disorder episodes in this population. Furthermore, medium to large effect sizes were observed in both between-groups and single-group study samples suggesting that DBT was effective in decreasing the severity of depressive symptoms in patients with an eating disorder. The authors noted that while these findings are encouraging, this analysis consisted of only 9 studies. However, when synthesizing the data for this analysis, variable and smaller sample sizes were accounted for through weighting and inverse variance procedures. Due to the limited number of available studies, additional research is needed to confirm the effectiveness of DBT protocols for the treatment of eating disorders.

Intellectual Disabilities

McNair et al (2016) reported on a systematic review examining the evidence for DBT in subjects with intellectual disabilities. Seven studies were included in the review and reported adaptations and outcomes of DBT for people with intellectual and development disabilities. Four studies had full DBT programs and 3 had DBT skills groups. The reviewers concluded that DBT and DBT skills groups can be adapted for individuals with intellectual disabilities however, further high-quality studies are needed to determine the effectiveness of DBT for this clinical indication.

Summary

The effectiveness of DBT for the treatment of borderline personality disorder has been demonstrated in multiple studies. There are a number of small studies in the medical literature evaluating DBT or adapted forms of DBT for other indications, including, but not limited to, depressive disorders, comorbid substance abuse, eating disorders and trauma-related disorders. However, at this time, the research is preliminary. The evidence is insufficient to determine the efficacy of DBT for indications other than borderline personality disorder.

Government Regulations
National/ Local:

There is no national or local coverage determination for dialectical behavior therapy.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 8/5/23, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/12	2/21/12	3/26/12	Joint policy established
7/1/13	4/16/13	4/22/13	New codes 90875 and 90832-90838 added for 2013; 90806 deleted; no change in policy status.
1/1/15	10/24/14	11/3/14	Routine maintenance
1/1/16	10/13/15	10/27/15	Routine maintenance
1/1/17	10/11/16	10/11/16	Routine maintenance
1/1/18	10/19/17	10/19/17	Routine maintenance
1/1/19	10/16/18	10/16/18	Routine maintenance
1/1/20	10/15/19		Routine maintenance
1/1/21	10/20/20		Routine maintenance Addition of 99354 and 99355 to EST
1/1/22	10/19/21		Routine maintenance
1/1/23	10/18/22		Routine maintenance
1/1/24	10/17/23		Routine maintenance (slp) Vendor Managed: N/A

Next Review Date: 4th Qtr, 2024

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: N/A	Revised: N/A
BCBSM: N/A	Revised: N/A

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: DIALECTICAL BEHAVIOR THERAPY

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member’s certificate and is not guaranteed. Please consult the individual member’s certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.