United Behavioral Health

Behavioral Clinical Policy: Extended Outpatient Psychotherapy Sessions

Policy Number: BH803OPSBCP_062018 **Effective Date**: June 13, 2018

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INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®[1]. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

[1] Optum is a brand used by United Behavioral Health and its affiliates.

COVERAGE RATIONALE

Extended outpatient psychotherapy sessions are proven and medically necessary in the following non-routine circumstances:

- The member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and psychotherapy for crisis is appropriate for providing rapid and time-limited assessment and stabilization.
    - o
    - o

OR

- An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or an acute worsening of the member's condition that would likely require a more intensive level of care if the outpatient session is not extended.

OR

- There is periodic involvement of a child, adolescent, or geriatric member's family in a psychotherapy session, and such involvement is essential to the member's progress (e.g., psychoeducation or parent management skills are being provided).
    - o This is not synonymous with marital or family therapy.

OR

- An extended psychotherapy session is otherwise needed to address new symptoms or the re-emergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without this session, the new or re-emerging symptoms are likely to worsen and require a more intensive level of care.

Extended outpatient psychotherapy sessions are proven and medically necessary in the following circumstances as indicated by the member's condition and specific treatment needs:

- The member has been diagnosed with posttraumatic stress disorder, panic disorder, obsessive compulsive disorder, or specific phobia, and is being treated with prolonged exposure therapy;

OR

- The member has been diagnosed with posttraumatic stress disorder and is being treated with eye movement desensitization and reprocessing (EMDR) or traumatic incident reduction (TIR);

OR

- The member's borderline personality disorder diagnosis is a covered condition, and the member is being treated with dialectical behavior therapy (DBT).

Extended outpatient psychotherapy sessions are unproven and not medically necessary outside of the above circumstances and conditions.

- There is limited evidence regarding the use of extended outpatient psychotherapy sessions outside of those specific circumstances and conditions described above.
- The efficacy of extended outpatient psychotherapy sessions outside of the above indications has not been verified in well-designed controlled trials.

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with Level of Care Guidelines and/or evidence-based clinical guidelines.

All services must be provided by or under the direction of a properly qualified behavioral health provider.

DESCRIPTION OF SERVICES

Prolonged exposure therapy is the most common form of exposure therapy, usually comprising 8-15 weekly or biweekly individual sessions of approximately 60-90 minutes each (United States Department of Veterans Affairs, 2016a; Jonal et al, 2013; VA/DOD 2010). Prolonged exposure therapy is evidence-based for treating posttraumatic stress disorder, and asks clients to directly describe and explore trauma-related memories, objects, emotions, or places (United States Department of Veterans Affairs, 2016a; Substance Abuse and Mental Health Services Administration, 2014). Cognitive-behavioral therapy involving exposure and response prevention is an empirically supported psychological treatment for obsessive-compulsive disorder, and entails systematic, repeated and prolonged confrontation with stimuli that provoke anxiety and the urge to perform compulsive rituals (Abramowitz et al 2009). Exposure therapy focuses on confronting the fears underlying an anxiety disorder in order to help people engage in activities they have been avoiding (National Institue of Mental Health, 2016). Exposure-based cognitive behavioral therapy (CBT) has received the most empirical support for the treatment of anxiety disorders in youths (AACAP 2007).

Eye movement desensitization and reprocessing (EMDR) is an evidence-based treatment for posttraumatic stress disorder, and helps to process trauma by thinking about the upsetting memory while paying attention to a back-and-forth movement or sound (United States Department of Veterans Affairs, 2016b). The number of EMDR sessions may vary with the complexity of the trauma being treated. Generally, current standards for EMDR consist of 5-15 individual weekly sessions of 50-90 minutes each, with many indivdiuals noticing improvement after a few sessions (United States Department of Veterans Affairs, 2016b; Agency for Healthcare Research and Quality, 2013).

Traumatic incident reduction (TIR) is a brief, memory-based, therapeutic intervention for children, adolescents, and adults who have experienced crime-related and/or interpersonal violence, war, disasters, torture, childhood abuse, neglect, emotional abuse, traumatic bereavement, or other severe or shocking events (Substance Abuse and Mental Health Services Adminstration 2011). Through sessions typically lasting 90-120 minutes, the practitioner facilitates the client's examination and resolution of a past trauma. Depending on the incident and symptoms experienced by the client, resoution may be achieved in one or two sessions, or it may take repeated sessions for clients experiencing residual distress (Substance Abuse and Mental Health Services Administration 2011).

Dialectical behavior therapy (DBT) is considered an evidence-based and empirically supported treatment for borderline personality disorder (Rizvi, et al 2013); randomized controlled trials indicate DBT is associated with improvements in problem behaviors, including suicidal ideation/behavior, non-suicidal self-injury, and hospitalization (MacPherson, et al 2013). DBT has five functions: enhancing behavioral capabilities; improving motivation; assuring generalization of gains to the natural environment; structuring the environment so that it reinforces functional behaviors; and enhancing therapist capabilities and motivation (MacPherson, et al 2013). Standard DBT consists of weekly individual therapy (approximately 1 hour/week) and group skills training sessions (2-2.5 hours/week) (MacPherson, et al 2013; Linehan, et al 2006; Chapman, 2006). The majority of research on DBT consists of delivery over a 12 month period; some studies have also found evidence of efficacy for a shorter, 6-month course of DBT (Rizvi, et al 2013).

CLINICAL EVIDENCE

Clinical Trials

Linehan and colleagues (2015) conducted a randomized controlled trial (RCT) to evaluate the importance of the skills training component of dialectical behavior therapy (DBT) for high suicide risk in individuals with borderline personality disorder (BPD). The study was a single-blind trials involving 1 year of treatment and 1 year of follow-up. The study compared skills training plus case management (DBT-S; n = 33), DBT individual therapy plus activities (DBT-I; n = 33), and standard DBT (n = 33; which included skills training and individual therapy). All participants were females with BPD who had at least 2 suicide attempts and/or nonsuicidal self-injury (NSSI) acts in the last 5 years, an NSSI act or suicide attempt in the 8 weeks before screening, and a suicide attempt in the past year. Outcomes were evaluated quarterly by blinded assessors. All providers used the DBT suicide risk assessment and management protocol. Results found that all treatment conditions had similar improvement in frequency and severity of suicidal attempts, suicidal ideation, use of crisis services, and reasons for living. Interventions that included skills training resulted in greater improvements in frequency of NSSI acts and depression during the treatment year. The authors conclude that a variety of DBT interventions are effective for reducing suicide attempts and NSSI episodes. They further note that interventions including DBT skills training are more effective than those without.

McLean and colleagues (2015) conducted a crossover trial to evaluate the effectiveness of exposure and response prevention (EX/RP) among individuals with obsessive-compulsive disorder (OCD) who were nonresponders to serotonin reuptake inhibitor (SRI) augmentation with 8 weeks of risperidone or placebo. Eligible participants had a principal diagnosis of OCD and had received an SRI at a therapeutic dose for at least 12 weeks yet remained moderately symptomatic, and had been randomized to 8-weeks of SRI augmentation and were classified as non-responders. Non-responders could crossover from their randomized condition to either EX/RP (for those randomized to

risperidone or pill placebo) or risperidone (for those randomized to pill placebo). EX/RP consisted of 17 twice-weekly, 90-minute sessions. Primary outcome was OCD severity as measured by the Yale-Brown Obsessive-Compulsive Scale (YBOCS), and associated impairment was also assessed. These assessments occurred at crossover baseline (week 8), post EX/RP treatment (week 16), and follow-up (weeks 20, 24, 28, and 32). Results found that between crossover baseline and follow-up, non-responders to SRI augmentation who then received EX/RP showed significant reductions in COD symptoms and significant increases in insight, quality of life, and social functioning. The authors conclude that EX/RP is an effective treatment for OCD patients failing to respond to SRI augmentation. They note limitations in the open trial and naturalistic design of the study, and that a controlled augmentation would provide stronger evidence of the efficacy of EX/RP with this population.

Mehlum and colleagues (2014) conducted a randomized trial to examine whether a shortened form of dialectical behavior therapy (DBT) is more effective than enhanced usual care (EUC) in reducing self-harm among adolescents. A total of 77 adolescents with recent and repetitive self-harm were randomly allocated to either DBT (n = 39) or EUC (n = 38). DBT consisted of 19 weeks of 1 weekly session of individual therapy (60 minutes), 1 weekly session of multifamily skills training (120 minutes), and family therapy sessions and telephone coaching outside of therapy sessions as needed. The EUC group received 19 weeks of standard care (no less than 1 weekly treatment session). Assessment of self-harm, suicidal ideation, depression, hopelessness, and symptoms of borderline personality disorder were made at baseline and after 9, 15, and 19 weeks. Frequency of hospitalizations and emergency department visits over the trials period were also recorded. Results found good retention in both treatment groups, and an overall low use of emergency services. DBT was superior in reducing self-harm, suicidal ideation, and depressive symptoms. The authors conclude that CBT may be an effective intervention to reduce self-harm, suicidal ideation, and depression in adolescents with repetitive self-harming behavior.

Eftekhari and colleagues (2013) evaluated the effectiveness of prolonged exposure (PE) therapy implemented with veterans with posttraumatic stress disorder (PTSD) in a large healthcare system. The evaluation included 1931 veteran patients, treated by a total of 804 clinicians who participated in the Department of Veterans Affairs (VA) PE Training Program. After the clinicians completed the 4-day PE training, they implemented PE (with consultation) for a minimum of 2 patients with a primary diagnosis of PTSD. Primary outcome was changes in PTSD and depression symptoms, measured at baseline and at final treatment session using the PTSD Checklist and Beck Depression Inventory II. Results of the evaluation indicated that PE is effective in reducing symptoms of PTSD, with the proportion of patients screening positive for PTSD decreasing from 87.6% to 46.2% over the course of study. The authors conclude that clinically significant reductions in PTSD symptoms were achieved among veterans with both combat-related and non-combat-related PTSD.

Foa and colleagues (2013) conducted a six-month follow-up of a randomized controlled trial (RCT) that augmented serotonin reuptake inhibitor (SRI) treatment with exposure and ritual prevention (ERP) for patients with obsessive-compulsive disorder (OCD). In the RCT, 111 OCD patients with partial response to SRIs were randomized to added ERP or stress management training. This additional therapy was delivered twice weekly (90 to 120 minutes per session) for 8 weeks. Responders (38 of 52 in the ERP condition and 11 of 52 in the stress management condition) entered a 24-week maintenance phase (monthly 45-minute session). Results found that after the 24 week period, patients randomized to and receiving ERP had significantly better outcomes and higher response rates (measured by YBOCS score), compared to stress management training. The authors conclude that augmenting SRI treatment with ERP leads to better outcome after both acute treatment and 24-week follow-up, when compared to stress management training.

Linehan and colleagues (2006) conducted a randomized controlled trial (RCT) and two-year follow-up of dialectical behavior therapy (DBT) compared to community treatment, for treatment of borderline personality disorder (BPD). All participants were females meeting criteria for BPD and had current or past suicidal behavior, defined by at least 2 suicidal attempts or self-injuries in the past 5 years. Primary outcome measures were suicidal behaviors, emergency services use, and general psychological functioning, and assessed at trimester intervals. DBT consisted of weekly individual psychotherapy (1 hr/wk) and group skills training (2.5 hr/week). Both DBT and community treatment groups were treated for 1-year, followed by 1 year of post-treatment follow-up. DBT was found to be associated with better outcomes than community treatment in most target areas during the 2-year period. Subjects receiving DBT were half as likely to make a suicide attempt, required less hospitalization for suicidal ideation, and had lower medical risks. They were also less likely to drop out of treatment, had fewer psychiatric hospitalizations, and fewer psychiatric emergency department visits. They authors conclude that DBT appears to be uniquely effective in reducing suicide attempts, and that their findings replicate those of previous studies of DBT.

Systematic Reviews and Meta-Analyses

Ost and colleagues (2016) conducted a systematic review and meta-analysis to provide an update on the efficacy of cognitive behavioral therapy (CBT) and serotonin reuptake inhibitors (SRIs) in the treatment of childhood OCD. CBT in the treatment of OCD entailed exposure and response prevention (ERP), cognitive therapy (CT), or a combination of the two. The clinician-administered C-YBOCS was used to calculate effect size for each study, and served as the

primary outcome measure. A total of 34 studies were included in the analysis (n = 1990). Only 24 studies (71%) reported data on response and 16 (47%) on remission. The mean effect sizes for CBT, SRI, and combined treatment all reach statistical significance in the treatment of pediatric OCD. The CBT group had significantly lower attrition (13%) than SRI (24%) and placebo (25%). Combination treatment was not found to be more effective than CBT alone, regardless of initial severity. The authors conclude that CBT treatment option led to better treatment effects than SRIs and should be the first-line treatment for youth with OCD. Treatment effects were found to be maintained at follow-up. The authors note that RCTs not using the interview of the CY-BOCS were excluded, and that none of the SRI studies provided data on remission rates.

Ost and colleagues (2015) conducted a systematic review and meta-analysis of studies ranging from 1993-2014 focusing on the efficacy of cognitive-behavioral therapy for obsessive-compulsive disorder (OCD). The study mentions that the recommended treatment of choice for OCD is CBT which refers to exposure and response prevention (ERP) with or without the inclusion of cognitive therapy strategies. The analysis included 37 randomized controlled trials that used the interview-based Yale-Brown Obsessive Compulsive Scale (Y-BOCS). The effect size of CBT compared with waiting-list and placebo condition was very large. CBT was also found to be significantly better than antidepressant medication, and combination of CBT and medication was not significantly better than CBT plus placebo. The authors conclude that there is no added gain to combining ERP and CT, as each leads to good effects on their own, and that CBT leads to better effects than antidepressant medication in this population. They note that the analysis excluded RCTs not using the interview version of the Y-BOCS.

Jonas and colleagues (2013) conducted a comparative effectiveness review to assess efficacy, comparative effectiveness, and harms of psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). The review included 92 trials of patients, generally with severe PTSD. Strength of evidence (SOE) was graded based on established guidance. The review found a high SOE to support the efficacy of exposure therapy for improving PTSD symptoms. This is based on consistent, direct, and precise evidence from trials that used common comparators and found large effect sizes. Evidence also supported (with moderate SOE) cognitive processing therapy, cognitive therapy, cognitive behavioral therapy, eye movement desensitization and reprocessing, and narrative exposure therapy for improving PTSD symptoms and/or achieving loss of diagnosis. The review found insufficient head-to-head evidence comparing efficacious treatments.

Watts and colleagues (2013) conducted a meta-analysis to examine the efficacy of all treatments for posttraumatic stress disorder (PTSD). Articles in which all subjects were adults with a diagnosis of PTSD and a valid PTSD symptoms measure was reported were selected for the meta-analysis. A total of 112 studies were included, consisting of 137 treatment comparisons. Results from the analysis found effective psychotherapies to include cognitive therapy, exposure therapy, and eye movement desensitization and reprocessing. The authors conclude that because of substantial differences in study design and participant characteristics, identification of a single best treatment is not possible.

Ponniah and colleagues (2013) conducted a systematic review to provide an update on the efficacy of psychological treatments for obsessive compulsive disorder (OCD). A total of 45 randomized controlled trials were included in the review. Exposure and response prevention (ERP; n = 31) and cognitive behavioral therapy (CBT; n = 18) were the two most frequently evaluated therapies. Results of the review found ERP and CBT to be efficacious and specific for OCD. More purely cognitive interventions (without ERP), including eye movement desensitization and reprocessing (EMDR) were found to be probably efficacious. Little support was found for stress management or psychodynamic therapy. The authors recommend that although ERP and CBT are the best established psychosocial treatments for this population, further research is necessary to determine which treatments are most effective for differing OCD presentations.

Powers and colleagues (2010) conducted a meta-analysis to estimate the overall efficacy of prolonged exposure (PE) therapy for posttraumatic stress disorder (PTSD). The analysis included all published randomized controlled trials of PE vs. control for the treatment of PTSD in adolescents or adults. A total of thirteen studies met final inclusion criteria (n = 675). The primary analyses showed a large effect for PE on both primary and secondary outcome measures, relative to control. Also demonstrated were medium to large effect sizes for PE at follow-up. The analysis found PE-treated patients to fare, on average, better than 86% of patients in control conditions at post-treatment (on PTSD measures). The authors conclude that PE is a highly effective treatment for PTSD, and results in substantial treatment gains that are maintained over time.

Kliem and colleagues (2010) conducted a meta-analysis to examine the efficacy and long-term effectiveness of dialectical behavior therapy (DBT) in patients with borderline personality disorder (BPD). Studies were excluded if patients were treated for diagnoses other than BPD, the treatment did not comprise all components specified in the BT manual, or the intervention group contained fewer than 10 patients. A total of 16 studies were included in the analysis; 8 were randomized controlled trials, and 8 were neither randomized nor controlled. Results of the analysis found a moderate effect size for DBT in the treatment of BPD patients. They note that the overall methodological

quality of the studies can be considered adequate. They recommend future research compare DBT with other active borderline-specific treatments that have also demonstrated efficacy.

Professional Societies

American Academy of Child & Adolescent Psychiatry (AACAP): In 2012, the AACAP published a practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder (OCD). The parameter recommends a cognitive-behavioral therapy (CBT) approach as first line treatment for mild to moderate cases of OCD in children. A specific protocol noted consists of 14 visits over 12 weeks, spread scross five phases: psychoeducation, cognitive training, mapping OCD, exposure and response prevention (E/RP), and relapse prevention, and generalization training. Except for weeks 1 and 2, these visits occur once per week, and last 1 hour. The parameter further notes that repeated exposure is associated with decreased anxiety across exposure trials.

In 2007, the AACAP published a practice parameter for the assessment and treatment of children and adolescents with anxiety disorder. The parameter notes that among the psychotherapies, exposure-based CBT has received the most empirical support for the treatment of anxiety disorders in youths. Specific components suggested for panic disorder include interoceptive exposure and education about the physiological processes leading to these physical sensations.

American Psychiatric Association (APA): In 2009, the APA published a practice guideline for the treatment of patients with panic disorder. The guideline notes that cognitive behavior therapy (CBT) is a time-limited treatment with durable effects. When delivered for panic disorder, CBT generally includes exposure to fear cues. Additionally, the guidelines notes that exposure therapy, which focuses almost exclusively on systematic exposure to fear cues, is also effective for treating panic disorder.

In 2007, the APA published a practice guideline for the treatment of patients with obsessive-compulsive disorder. The guideline notes that cognitive behavior therapy (CBT) alone, consisting of exposure and response prevention, is recommended as the initial treatment for patients who are not too depressed, anxious, or otherwise severely ill to cooperate with this modailty, or who prefer not to take medications. The guideline further notes that CBT primarily relying on behavioral techniques such as exposure and response prevention is recommended because it has the best evidentiary support.

In 2004, the APA published a practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. The guideline notes that patients with acute stress disorder may be helped by cognitive behavior therapy and other exposure-based therapy, and that these are also effective treatments for the core symtoms of acute and chronic posttraumatic stress disorder (PTSD). The guidelines further note that eye movement desensitization and reprocessing (EMDR) is also effective for PTSD, and that prolonged exposure techniques may be indicated for treatment of PTSD and its associated symptoms, such as anxiety and avoidance.

In 2001, the APA published a practice guideline for the treatment of patients with borderline personality disorder (BPD). The guideline notes that dialectical behavior therapy has been shown in randomized controlled trials to have efficacy for treatment of BPD. Dialectical behavior therapy consists of approximately 1 year of manual-guided therapy (including 1 hour/week of individual therapy for 1 year, and 2.5 hours/week of group skills training for 6 months to 1 year). Results from studies noted by the guideline indicate that those receiving dialectical behavior therapy had less parasuicidal behavior, reduced medical risk due to parasuicidal acts, and fewer hospital admissions and psychiatric hospital days.

United States Department of Veterans Affairs / Department of Defense (VA/DOD): In 2010, the VA/DOD published a clinical practice guideline for the management of posttraumatic stress. The guideline defines exposure-based therapies as those which emphasize in-vivo, imaginal, and narrative exposure, but also generally include elements of cognitive restructuring, relaxation techniques, and self-monitoring of anxiety. The most commonly used protocol is Prolonged Exposure Therapy. The guideline describes eye movement desensitization and reprocessing (EMDR) as closely resembling other cognitive behavior therapy (CBT) modalities in that there is an exposure component combined with a cognitive component. For treatment options, the guideline strongly recommends that patients who are diagnosed with PTSD be offered one of the evidence-based trauma-focused psychotherapeutic interventions, with choice based on severity of symtoms, cliician expertise, and patient preference. Options may include exposure-based therapy (e.g., Prolonged Exposure), a cognitive-based therapy, stress management therapy, or EMDR.

U.S. FOOD AND DRUG ADMINISTRATION

Extended outpatient sessions are not applicable to US FDA review.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

No relevant National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) were located for extended outpatient sessions.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary procedure)

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HISTORY/REVISION INFORMATION

Date	Action/Description
04/11/2017	• Version 1
4/11/2018	• Annual Update: Updated formatting. Approved by UMC.
6/13/2018	• Updated title, prior auth will only be required for OON providers.