POLICY STATEMENT:

I. Based upon our criteria and assessment of peer-reviewed literature, sex offender treatment programs have been medically proven to be effective and therefore are considered a medically appropriate treatment for adults and adolescents.

II. Adults must meet the following criteria. The patient must have a principal diagnosis of mental illness as specified in the current edition of Diagnostic and Statistical Manual (DSM) or ICD-9-CM or ICD-10 which includes:
   A. Paraphilic disorders;
   B. Pedophilic disorders;
   C. Co-morbid substance abuse disorder;
   D. History of legal charges related to sexual offenses with high risk of re-offending.

III. Adolescents must meet the following criteria. The patient must have a principal diagnosis of mental illness as specified in the current edition of Diagnostic and Statistical Manual (DSM) or ICD-9-CM or ICD-10 which includes:
   A. Paraphilic disorders;
   B. Pedophilia disorder;
   C. Impulse control disorder;
   D. Co-morbid substance abuse disorder;
   E. History of legal charges related to sexual offenses with high risk of re-offending.

IV. The diagnosis must be consistent with nationally recognized, evidenced based tier (different levels of evidenced based) Behavioral Health standards.

V. Sex offender treatment programs must meet the following requirements:
   Adult and Adolescent sex offender treatment programs consist on average of 2 years or 104 weekly group visits for completion of the program; per the peer reviewed literature.
   A. Individual therapy may be encompassed with the group therapy.
   B. Substance abuse referrals for treatment should also be made when required.
   C. Ongoing and regular collateral contacts with the legal systems, medical systems, behavioral health systems, Child Protective Services, and other sources should continue throughout treatment.
   D. The sex offender treatment program should administer polygraph testing and/or plethysmographic testing (when available) at least annually and this should be noted in the treatment plan.
   E. Sex offender therapy programs should abide by the Association for the Treatment of Sexual Abusers (ATSA) standards.
   F. All sex offender treatment program providers must receive specialized training in sex offender treatment.
   G. Two co-therapists should be used at all times during the group process and the group should not exceed eight offenders.

VI. Based upon our criteria and assessment of peer-reviewed literature, sex offender treatment programs for adults do not improve patient outcomes and are not medically necessary for diagnoses other than paraphilic disorders and/or pedophilic disorders.
VII. Based upon our criteria and assessment of peer-reviewed literature, sex offender treatment programs for adolescents do not improve patient outcomes and are not medically necessary for diagnoses other than paraphilic disorders, pedophilia disorder and/or impulse control disorder.

VIII. Based upon our criteria and assessment of peer-reviewed literature, sex offender therapy programs are considered investigational for all other diagnoses.

POLICY GUIDELINES:

I. Sex offender treatment programs are expected to maintain clear written descriptions of the treatment goals and objectives, as well as admission and discharge criteria.

II. Medical necessity reviews are required for any requests which will extend beyond two years.

III. It is expected that patients will be seen for medication management and support by a psychiatrist as necessary while in sex offender treatment program.

IV. The Federal Employee Health Benefits 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.

DESCRIPTION:

Please refer to Corporate Medical Policy # 11.01.15 Medically Necessary Services for classification as to the criteria utilized by the Health Plan in determining when services are medically necessary.

Sex Offender Treatment Program (SOTP) is a cognitive-behavioral treatment (CBT) approach. SOTP originated in the mid-1980s as a relapse prevention model; by the late 80s most states were trained and utilizing this method as the treatment for sex offenders. Current treatment consists primarily of CBT with relapse prevention, pharmacological options, and other behavioral techniques as an addition.

The goal of CBT is to empower the patient(s) so they can experience clearer thinking, eliminate thinking errors, and live an overall more optimistic life. These goals are attained by increasing self-control, learning to be empathetic for others, and increasing positive problem solving skills through the group process, a cohesive group is also an important part of the process.

RATIONALE:

Studies have been performed assessing methods of treatment (CBT, group treatment, interpersonal therapy, behavioral therapy, etc.) for Sex Offender Treatment Program (SOTP) as the treatment(s) for sexual offenders including methods for treatment, length of treatment, and outcomes associated with treatment.

Maletzky and Steinhauser (2002) conducted a mixed longitudinal study over a 25 year period to show how CBT lowered recidivism and risk to the community across different diagnoses and crimes related to sexual crimes. Due to the longevity of this study follow up for the sexual offenders was limited and made for a small number of participants engaging in the overall study. The study suggested an average duration for a sexual offender group is 1 ¾ years in length, and the treatment modality of the group should be CBT while augmenting aversive conditioning primarily olfactory stimuli and relapse prevention (Jennings & Deming, 2013; Yates, 2003). When assessed at 5 year and 25-year spans CBT for most offenders appeared effective. However, as time passed, recidivism increased, it appeared low at 6 months and 1-year, doubling at 5-years, but then remaining steady. Male rapists in this study were an exception; they continued to rise until close to 10 years. Jennings & Sawyer (2003) also added to the literature that CBT and group are the most effective and common format to treat sexual offenders.

Beech & Hamilton-Giachritsis (2005) also studied CBT as a primary method of sexual offender group treatment effective hours needed to lower the rate of recidivism associated with sexual offending. The study was six different medium security U.K. prison systems and 12 different treatment groups across these prison systems totaling 100 participants. The researchers found no significant relationship between length of treatment and amount of treatment change. Meaning, there was no change in outcome for recidivism between 80 hours of group treatment vs. 160 hours of...
group treatment. Instead, the authors indicated the change they noticed were in the groups where cohesiveness was noted. Those groups where clear cohesive relationships were reported as well as an extent to which freedom of action and expressions of feelings were encouraged showed lower reductions in co-offending attitudes. Levenson and Macgowan (2004) completed a qualitative study utilizing an outpatient sex offender program. They found group cohesiveness was important for free expression, for instilling hope, and that a non-confrontational approach worked better with offenders.

Dennis, et al. (2012) studied CBT focused sexual offender groups ranging from 8-weeks to 4-years. The study indicated most completed the program in 3-years including a 1-year aftercare program. However the research did suggest those whose attendance was at least 20 sessions showed effective change and was no different from those who attended 40 visits. Groups were 90 minutes in length. As with other studies, those who dropped out of the study were more likely to reoffend. Recidivism was measured by reconviction, or self-report.

Reitzel and Carbonell (2006) completed a meta-analysis to better understand and add to the limited research on adolescent sex offending. The study contributed to the evidence that adolescent sex offending rates are lower than non-sexual recidivism rates as well as adult sex offending rates. For those sex offending adolescents who received treatment vs. those who did not receive treatment recidivism rates there were significant statistical differences. For those in treatment recidivism averaged 7.37%, while those who were not in treatment averaged 18.93% recidivism. This study suggested that CBT might not be the treatment modality of choice for adolescents, however more research was needed in this area to further assess as the majority of the studies the authors researched had multiple models utilized. The outcomes of this study were very similar to a study completed 10-years previous indicating treatment for adolescent sex offender has been effective as it has not continued to rise and recidivism has continued to reduce.

**CODES:**

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<td>CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.</td>
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Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

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REFERENCES:


Dennis JA, et al. Psychological interventions for adults who have sexually offended or are at risk of offending. Cochrane Database of Systematic Reviews 2012;12:CD007507.


KEY WORDS:

Sex Offender Treatment Programs (SOTP)

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**CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS**

There is currently a Local Coverage Determination (LCD) for Psychiatry and Psychological Services. Please refer to the following LCD website for Medicare Members: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33632&ContrId=298&ver=29&ContrVer=1&CntnctrSelected=298*1&Cntrctr=298&name=National+Government+Services%2c+Inc.+(13201%2c+A+and+B+and+HHH+MAC%2c+J++K)&s=All&DocType=Active&bc=AggAAAQAAAAAA%3d%3d&