MEDICAL POLICY

Excellus

SUBJECT: SEX OFFENDER TREATMENT PROGRAM	EFFECTIVE DATE: 06/22/16 REVISED DATE: 06/22/17, 10/25/18
POLICY NUMBER: 3.01.17 CATEGORY: Behavioral Health	PAGE: 1 OF: 4

- ***If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.***
- ***If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.***
- ***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.***

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 history of legal charges related to sexual offenses with high risk of re-offending AND a principal diagnosis of mental illness as specified in the current edition of Diagnostic and Statistical Manual (DSM) or ICD-10-CM which includes:
   A. Paraphilic disorders; or
   B. Pedophilic disorders.

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

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 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.

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.

Kim, B, et al. (2016) completed a systematic review of meta-analyses to examine the effectiveness of sex offender treatment programs across different age populations and sizes. A final set of 11 meta-analyses were included in this review examining research as late as 2009. The authors found that sex offender treatments for adults produced an overall 5% reduction in recidivism while sex offender treatments for adolescents produced an overall 24% reduction in recidivism. Sex offender treatments occurring in the community produced an overall 17% reduction in recidivism while institutional treatments produced about a 10% reduction. Surgical castration and hormonal medication have significantly larger effects compared to psychological treatments. However the authors suggest cautious interpretation of these results due to the need for more rigorous studies. Cognitive behavioral treatment (CBT) is the most prevalent treatment approach even though it might not be as effective as hormonal medications. Multi-systemic therapy (MST) which is provided at home and focuses on interrupting the sexual assault cycle by working with the offender and their family was also found to be effective in reducing recidivism. The authors conclude sex offender treatments can be considered as proven or at least promising with a greater reduction in recidivism in adolescents than adults. Additional research is needed to evaluate which target groups respond to specific techniques and which are more effective.

CODES: Number Description

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.

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

CPT:	90853	Group psychotherapy
	90785	Interactive complexity (add on code for 90853)
REVENUE:	915	Psychiatric/psychological services-group therapy
ICD10:	F65.2	Exhibitionism
	F65.3	Voyeurism
	F65.4	Pedophilia
	F65.89	Other paraphilias
	F65.9	Unspecified paraphilia
	F63.9	Impulse control disorder

REFERENCES:

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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.

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*Levenson J and Macgowan M. Engagement, denial, and treatment progress among sex offenders in group therapy. Sexual Abuse: A Journal of Research and Treatment 2004;16(1):49-63.

*Prentky R and Schwartz B. Treatment of adult sex offenders. Harrisburg PA: VAWnet, a project of national resource center on domestic violence/Pennsylvania coalition against domestic violence. 2006 [http://www.vawnet.org] accessed 8/22/18.

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KEY WORDS:

Sex Offender Treatment Programs (SOTP)

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&ver=42&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=psychological&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&