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Subject **Dialectical Behavior Therapy (DBT)**

Effective Date **7/15/2011**
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Coverage Policy Number **0388**

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Coverage Policy

Services provided by a psychiatrist, psychologist or other behavioral health professional are subject to the provisions of the applicable behavioral health benefit.

CIGNA covers dialectical behavior therapy (DBT) as medically necessary when BOTH of the following criteria are met:

- The individual meets the criteria for the diagnosis of borderline personality disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, text revision (DSM-IV-TR).
- DBT is rendered by a qualified behavioral-health provider.

CIGNA does not cover DBT for any other indication because it is considered experimental, investigational or unproven.

General Background

Dialectical behavior therapy (DBT) is a cognitive-behavioral treatment approach that was initially developed in the late 1980s as an intervention for chronically suicidal individuals. This therapy has since evolved into treatment for individuals who meet criteria for borderline personality disorder (BPD), a personality disorder that is characterized by pervasive instability in mood, interpersonal relationships, self-image and behavior. DBT

combines basic behavioral procedures of skills training, exposure-based procedures; cognitive modification; contingency management; and problem solving with validation, mindfulness practices, reciprocity, and a focus on the patient-therapist relationship. As a treatment, it has been noted that DBT serves five functions (Koerner and Linehan, 2000; Lieb, et al., 2004):

- to increase behavioral capabilities by teaching specific skills to regulate emotions, tolerate emotional distress when change is slow or unlikely, be more effective in interpersonal conflicts; and control attention in order to skillfully participate in the moment
- to improve motivation to change by intensive behavioral analyses, application of exposure-based treatment procedures, and management of reinforcement contingencies
- to ensure that new capabilities are useful for day-to-day life by various strategies (e.g., use of the telephone)
- to structure the environment, in particular, the treatment network, to reinforce skillful behaviors
- to enhance the therapist capabilities and motivation with a weekly meeting of therapists for support and consultation

The American Psychiatric Association (APA) guidelines for treatment of patients with BPD note that DBT consists of approximately one year of manual-guided therapy (involving one year of weekly individual therapy for one year and 2.5 hours of group skills training per week for either six or 12 months) along with a requirement for all therapists in a study or program to meet weekly as a group (APA, 2001/2005). DBT is a therapy that is based on standardized delivery methods outlined in the published DBT treatment manual. It was designed specifically to treat the self-harm behaviors associated with BPD.

Borderline Personality Disorder

Borderline personality disorder (BPD) is a personality disorder characterized by pervasive instability in mood, interpersonal relationships, self-image and behavior. Individuals with BPD suffer from a disorder of emotion. Each person develops their own personality as they move from adolescence to adulthood. Their personality defines the way in which they characteristically go through experiences and relationships in their life. An individual's personality is stable over time, though it may appear more pronounced during times of stress. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) defines a personality disorder as when those experiences, relationships and resultant behaviors that are enduring and deviate markedly from an individual's cultural and familial expectations are noted to be pervasive, inflexible and cause substantive functional impairment or subjective distress (American Psychiatric Association [APA], 2000).

Further, the DSM-IV-TR indicates that the marked deviation must be manifest in at least two of the following areas: cognition, emotional response, interpersonal function, and impulse control. Personality disorders are not typically diagnosed prior to the age of 18, as the adolescent years are marked by normal developmental variation, experimentation and fluidity. It is toward the end of adolescence that core elements of personality truly begin to emerge and consolidate. Nevertheless, it is not uncommon that certain cognitive, emotional and behavioral manifestations of personality begin to exert themselves as dominant within the adolescent years, and become antecedents of future true personality. The instability of BPD often disrupts family and work life, long-term planning, and the individual's sense of self-identity.

Originally thought to be on the “borderline” of psychosis, some persons with BPD may experience intermittent breaks with reality. BPD affects approximately 2% of adults. The disorder occurs more commonly in women. There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases (National Institute of Mental Health [NIMH], 2001/2010). BPD often occurs with other psychiatric disorders. Common comorbid conditions include major depression, bipolar disorder, anxiety disorder, substance abuse, eating disorders and other maladaptive personality traits. According to the DSM-IV-TR, the essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity that begins by early adulthood and is present in a variety of contexts (APA, 2000).

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Diagnostic Criteria for Borderline Personality Disorder (DSM-IV-TR code 301.83) from: Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, Text Revision (DSM-IV-TR)
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 five (or more) of the following: (1) frantic efforts to avoid real or imagined abandonment * (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (3) identity disturbance: markedly and persistently unstable self-image or sense of self (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) * (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (6) 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) (7) chronic feelings of emptiness (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) (9) transient, stress-related paranoid ideation or severe dissociative symptoms *excluding suicidal or self-mutilating behavior covered in criterion (5)

Literature Review—Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD)

Studies: Harned, et al. (2008) reported on a study that evaluated whether DBT was more efficacious than treatment by nonbehavioral psychotherapy experts in reducing co-occurring Axis I disorders among suicidal individuals with BPD. Women with BPD and recent and repeated suicidal and/or self-injurious behavior (n=101) were randomly assigned to 1 year of DBT (n=52) or community treatment by experts (n=49), plus 1 year of follow-up assessment. For substance dependence disorders, the patients treated with DBT were more likely to achieve full remission, spend more time in partial remission, spend less time meeting full criteria, and reported more drug- and alcohol-abstinent days than did patients treated with community treatment by experts. These findings suggest that improvements in co-occurring substance dependence disorders among suicidal BPD patients are specific to DBT and cannot be attributed to general factors associated with nonbehavioral expert psychotherapy. In addition, group differences in substance dependence disorders remission were not explained by either psychotropic medication usage or changes in BPD criterion behaviors. It was also reported that both the DBT and community treatment by experts groups did not significantly differ in the reduction of anxiety disorders, eating disorders, or major depressive disorder.

Linehan et al. (2006) conducted a one-year randomized controlled trial with one year of post-treatment follow-up. The objective was to evaluate the hypothesis that unique aspects of DBT are more efficacious compared to treatment offered by non-behavioral psychotherapy experts. The study included 101 female participants with recent suicidal and self-injurious behaviors that met DSM-IV criteria. Fifty-two patients were randomly assigned to the DBT group and received 2.5 hours of group skills training each week, in addition to phone consultations. The DBT focused on improving patients' coping skills and motivation by assisting them in reducing interfering emotions and thinking and reinforcing functional behaviors. Forty-nine patients received treatment by experts in the community, which included one weekly therapy session plus additional treatment as needed at therapist discretion. Outcome measures included trimester assessment of suicidal behaviors, emergency services use,

and general psychological functioning. The results indicated that DBT was associated with better outcomes in the intent-to-treat analysis than patients treated by experts in most target areas during the two-year period. The subjects who received DBT were half as likely to make a suicide attempt (p=.005), required less hospitalization for suicide ideation (p=.004) and lower medical risk (p=.04) across all suicide attempts and self-injurious acts combined. In addition, it was noted that subjects who received DBT were less likely to drop out of treatment (p<.001) and had fewer psychiatric hospitalizations (p=.007 and emergency department visits (p=.04). The authors concluded that the "findings replicated previous studies of DBT and suggest that the effectiveness of DBT cannot reasonably be attributed to general factors associated with expert psychotherapy. Dialectical behavior therapy appears to be uniquely effective in reducing suicide attempts."

Verheul et al. (2003) conducted a randomized controlled study for the purpose of comparing the effectiveness of DBT with TAU for patients with BPD and to examine the impact of baseline severity on effectiveness. The study included 58 women who were randomized to either DBT or TAU and who received treatment over one year. The results included: DBT had a substantially lower 12-month attrition rate (37%) compared with TAU (77%); treatment with DBT resulted in greater reduction of self-mutilating and self-damaging impulsive acts than TAU; and the impact on frequency of self-mutilating behaviors was far more pronounced in participants who reported a higher baseline frequency. Van den Bosch et al. (2005) published a follow-up review of this study that examined whether the treatment results in the Verheul study were sustained over six-month follow-up or up to week 78. It was noted that in the six months after treatment discontinuation, the benefits of DBT over TAU in terms of lower levels of impulsive and self-mutilating behaviors were sustained. At 18 months, there was no relapse observed for the DBT group to the former level of problem behavior. Also, it was noted that the DBT group showed significantly larger reduction in alcohol use than the TAU group, both at 52 and 78 weeks. The review notes that, "The conclusion of the 12-months study, that DBT is superior to TAU can now be extended to at least 6 months follow-up without treatment, but overly optimistic expectations about the longer-term effects of a single one-year treatment episode with DBT should be avoided." The authors concluded that DBT seems to have a sustained effect on some of the core symptoms of BPD and on alcohol problems in a mixed population of patients with and without substance abuse problems.

Linehan et al. (2002) conducted a randomized controlled trial for the purpose of evaluating whether DBT would be more effective for opiate-dependent women with BPD than treatment with comprehensive validation therapy (CVT) with 12-step (CVT+12S). Substance use disorders often coexist with BPD. The study indicates that substance use disorder among clients with BPD may range from approximately 25–50%. CVT+12S is a manualized approach that provides the major acceptance-based strategies employed in DBT in combination with participation in the 12-step program. There were 23 individuals in the study, with 11 in the DBT group and 12 in the CVT+12S group. All subjects were also treated with an opiate agonist medication for approximately one year. The authors note that results of this comparison included: 1) that both treatments were effective in reducing opiate use and in maintaining this reduction in the four-month follow-up period; 2) there was a lower dropout rate with CVT+12S; 100% stayed for the entire year compared to a dropout rate of 36% with DBT; and 3) subjects in both treatment conditions demonstrated significant overall reductions in level of psychopathology relative to baseline. Improvements were noted on measures of global adjustment for both treatments.

Rathus et al. (2002) conducted a study with a group of suicidal adolescents with borderline personality features. Participants included 111 outpatient admissions. Eighty-two participants were assigned to TAU and 29 were assigned to DBT. The groups were not randomized, but it was noted that there was more severe pretreatment symptomatology in the DBT group than the TAU group. The group treated with DBT had significantly fewer inpatient psychiatric hospitalizations during the 12 weeks of treatment. The groups did not differ significantly in number of suicide attempts made during treatment. There was a slightly higher rate of treatment completion in the DBT group.

Koons et al. (2001) conducted a randomized controlled study of DBT compared to TAU. It was noted that TAU was somewhat more standardized in this study than in other randomized controlled trials of psychodynamic or cognitive behavioral treatments for BPD, or for recurrent suicidal or self-injurious behavior, for the following reasons: all patients received their treatment in the same system (local veterans' hospital), and efforts were successfully made to ensure that all patients who were referred to TAU actually began treatment. Twenty female veterans who met criteria for BPD were randomly assigned to either DBT or TAU for six months. The authors concluded the results generally support the efficacy of DBT. It was noted that DBT treatment was associated with clinically significant changes in the symptoms and functioning of patients with BPD, and these changes were significantly greater than changes in symptoms in the TAU group. Specifically, patients in DBT changed

significantly more than patients in TAU on four variables: suicidal ideation, hopelessness, Beck depression, and anger expression. Limitations of the study include the small sample size and the lack of follow-up data to address the issue of durability of effects.

A randomized clinical trial was conducted by Linehan et al. (1991) with 44 subjects to evaluate the effectiveness of DBT for the treatment of chronically parasuicidal women who met criteria for BPD. Patients who received DBT had an average of 8.46 inpatient days per year compared to 38.86 days for the control group. It was also noted that it did not appear that there were differences between the two groups on measures of depression, hopelessness, suicide ideation, or reasons for living. Linehan et al. (1993) conducted a naturalistic follow-up review of 39 of these subjects to determine whether the effects of DBT were maintained over one year post-treatment. In the 12- to 18-month period, subjects completing DBT had fewer parasuicidal episodes and fewer medically treated episodes. In the 18- to 24-month period, there were no significant between-group differences on parasuicide measurements, although psychiatric inpatient days during this time were lower for subjects in the DBT group. In 1999, Linehan et al. conducted a randomized controlled study of 28 women to evaluate whether DBT would be effective for drug-dependent women with BPD when compared to TAU in the community. There was a significant reduction in substance abuse among subjects in the DBT group. The retention rate for the DBT group was 64%—higher than that for the TAU group, which was 27%. Improvements were noted in social and global adjustment in the DBT group.

Systematic Reviews: Binks et al. (2006) conducted a Cochrane review to evaluate the effects of psychological interventions for people with BPD. Seven studies were identified involving 262 people and five separate comparisons. The review noted that, in comparison, DBT appears to offer a small benefit over TAU in preventing people from engaging in acts of self-harm or parasuicide. It was a consistent finding, although it was not always statistically significant in the small trials. In the one larger study (n=63), the finding did appear to reach conventional levels of statistical significance at 12 months. Other findings included that with DBT there seems to be less hopelessness, and DBT may help keep people in care and does not seem to put people off continuing in treatment. It was 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."

Brazier et al. (2006) published a systematic review regarding psychological therapies, including DBT for borderline personality disorder. Ten studies met inclusion criteria. Nine of them were randomized controlled trials and one was a nonrandomized comparative study. Four studies involved DBT. The quality of the studies was noted to be moderate to poor. The findings regarding DBT included:

- There is some evidence that DBT is more effective than treatment as usual for treatment of chronically parasuicidal and drug-dependent borderline women.
- There is some evidence that DBT-orientated therapy is more effective than client-centered therapy for the treatment of BPD.
- There is some evidence that DBT is as effective as comprehensive validation therapy with 12-step for treatment of opioid-dependent borderline women.

It was also noted that the findings should be interpreted with caution since not all studies were primarily targeted to borderline symptoms, and there were considerable differences in patient characteristics, comparison groups and outcomes among the studies.

Professional Societies/Organizations—Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD)

The American Psychiatric Association (APA) has published Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder (2001). In the guidelines it states that "two psychotherapeutic approaches have been shown in randomized controlled trials to have efficacy: psychoanalytic/psychodynamic therapy and DBT. The treatment provided in these trials has three key features: weekly meetings with an individual therapist, one or more weekly group sessions, and meetings of therapists for consultation/supervision. No results are available from direct comparisons of these two approaches to suggest which patients may respond better to which type of treatment." The guidelines indicate that substantial improvement may not occur until after approximately one year of psychotherapeutic intervention, and many patients may require longer treatment time. Pharmacotherapy may be used for diminution of targeted symptoms such as affective instability, impulsivity, psychotic-like symptoms and self-destructive behavior. In 2005, the APA published a guideline watch for the

practice guideline for the treatment of patients with borderline personality disorder. This document noted that the evidence and opinion continue to support the recommendation of 2001 guideline.

Dialectical Behavior Therapy for Eating Disorders
DBT has been proposed as a treatment for eating disorders, in particular binge eating disorders and bulimia. According to the Diagnostic and Statistical Manual (DSM) of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), bulimia nervosa is characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise (APA, 2000). A disturbance of perception of body shape and weight is also an essential feature. The DSM also notes that binge-eating behavior is included in the impulsive behavior criterion that is part of the definition of BPD. If the full criteria for both disorders are met, then the manual notes both diagnoses can be given. DBT is proposed based on the theory that binge eating serves to regulate affect and that the new skills taught in DBT are aimed at enhancing adaptive affect regulation, and thus reduce the need to binge eat.

Literature Review—Dialectical Behavior Therapy (DBT) for Eating Disorders:
Courbasson et al. (2011) conducted a matched randomized controlled trial of 25 patients that examined the preliminary efficacy of dialectical behavior therapy (DBT) adapted for concurrent eating disorders (EDs) and substance use disorders (SUDs). Participants randomized to either received DBT or control group and received treatment as usual (TAU), both for a period of 1 year. A series of measures related to disordered eating, substance use and depression were administered at the beginning of treatment and at 3, 6, 9 and 12months into treatment, followed by 30 and 60 month follow-up assessments. Participants randomized to the DBT condition evidenced a superior retention rate relative at various study time points, including post-treatment (80% versus 20%) and follow-up (60% versus 20%). Due to an unexpected elevated dropout rate and the worsening of ED–SUD symptomatology in the TAU condition, recruitment efforts were terminated early. Results from the DBT condition revealed that the intervention had a significant positive effect on behavioral and attitudinal features of disordered eating, substance use severity and use, negative mood regulation and depressive symptoms. Increases in participants' perceived ability to regulate and cope with negative emotional states were significantly associated with decreases in emotional eating and increases in levels of confidence in ability to resist urges for substance use. Limitations include small study size, heterogeneity of the ED and SUD group, and loss of control group.

Safer et al. (2010) conducted a study that compared Dialectical Behavior Therapy for Binge Eating Disorder (DBT-BED) to an active comparison group therapy (ACGT). The study included men and women that were randomly assigned to 20 group sessions of DBT-BED (n=50) or ACGT (n=51). The DBT-BED group had a lower dropout rate (4%) than ACGT (33.3%). Linear Mixed Models revealed that post-treatment binge abstinence and reductions in binge frequency were achieved more quickly for DBT-BED than for ACGT (post-treatment abstinence rate=64% for DBT-BED vs. 36% for ACGT) although these differences did not persist over the three, six and 12-month follow-up assessments. The secondary outcome measures revealed no sustained impact on emotion regulation. The lack of differential findings over follow-up suggests that the hypothesized specific effects of DBT-BED do not show long-term impact beyond those attributable to nonspecific common therapeutic factors.

Safer et al. (2001) conducted a study of 31 women who averaged at least one binge/purge episode per week over the previous three months. The mean age was 34 years. The mean age when beginning bulimic behaviors was 22.3 years with the behaviors continuing for an average of 12.2 years. The patients were randomly assigned to 20 weeks of DBT or 20 weeks of waiting-list comparison condition. The DBT involved 20 sessions of weekly 50-minute individual psychotherapy specifically aimed at teaching emotional regulations skills to reduce rates of binge eating and purging. Three patients did not complete the study. One dropped out from the waiting–list group and two were withdrawn from treatment. Primary outcome measure was eating behavior in preceding four weeks, including the number of binge and purge episodes. Secondary outcome measures included measures with the Eating Disorder Examination, the Negative Mood Regulation Scale and the Beck Depression Inventory, the Emotional Eating Scale, the Multidimensional Personality Scale, the Positive and Negative Affect Schedule, and the Rosenberg Self-Esteem Scale. The study found significant treatment effects for the frequency of both binge eating and purging behaviors. There were no significant differences between the groups for the secondary measures. One limitation of this study was the small sample size. The authors note that without comparisons that involve other conditions besides the waiting-list condition, they cannot confidently conclude that DBT had an effect on bulimic symptoms beyond the nonspecific effects of psychotherapy. They

concluded that further studies with a greater number of participants and more than one comparison group appear to be warranted.

Telch et al. (2001) conducted a study involving 44 patients with binge eating disorder. The mean age of the participants was 50 years. The women were randomly assigned to group DBT or to a wait-list control condition. They were administered the Eating Disorder Examination in addition to measures of weight, mood and affect regulation at baseline and post-treatment. The patients were randomly assigned to either DBT skills training treatment (n=22) or a wait-list control condition (n=22). Ten participants dropped from the study following randomization (four in treatment group and six in the wait-list group). Two of the women assigned to treatment dropped before treatment began, and two women dropped before the third treatment session. The study noted that at the end of treatment, significant effects were found for both binge days and episodes. Of the DBT group, 89% were abstinent (i.e., no binge eating in the past four weeks) compared with 12.5% of the control group. Those receiving treatment were noted to have significantly lower scores on subsets of the Eating Disorder Examination subscales: Weight Concerns, Shape Concerns, and Eating Concerns. There were no significant differences noted between the two groups on dietary restraint. The treatment group was also assessed at three months and six-month follow-up. At three months, 67% were abstinent, and at six months 56% were abstinent. A primary limitation of the study is that due to the wait list design, it can only be concluded that DBT skills treatment is better than no treatment. Other limitations include a small sample size and the brevity of the follow-up interval, particularly given the chronicity of the disorders. The authors concluded that the results support further research into DBT as a treatment for binge eating disorder.

Professional Societies/Organizations—Dialectical Behavior Therapy (DBT) for Eating Disorders: The American Psychiatric Association has published practice guidelines for the treatment of patients with eating disorders (APA, 2006). The guidelines note that DBT has been shown to be effective for behavioral and psychological symptoms of binge eating disorders and may be considered as an alternative treatment.

The National Institute for Clinical Excellence (NICE) clinical guideline for eating disorders notes that for atypical eating disorders, including binge eating disorder, other psychological treatments including modified DBT may be offered to adults with persistent binge eating disorder (2004).

The American Dietetic Association (ADA) in 2006 published a position paper regarding nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. In the paper, regarding DBT, the ADA notes that, “Although much newer, dialectical behavior therapy, which is a form of psychotherapy that teaches mindful eating and targets emotion regulation, has shown preliminary efficacy in reducing binge eating.”

It appears that research regarding treatment with DBT for eating disorders, specifically binge eating disorder, is preliminary. Two published studies involve a small number of patients with limited follow-up and involved wait-list as the control condition. Further well-designed clinical trials are needed to support the use of DBT as a treatment for eating disorders.

Summary

There are multiple studies published that suggest the efficacy of dialectical behavior therapy (DBT) for treatment of borderline personality disorder (BPD). While questions remain regarding some aspects of treatment with DBT, the literature indicates that DBT is effective for treatment of BPD, and in the practicing behavioral health community, DBT is considered an accepted treatment for BPD.

DBT has also been proposed as a treatment for other disorders including depression, eating disorders, and trauma-related disorders. At this time, there is insufficient evidence in the literature to demonstrate the efficacy of this treatment for indications other than BPD.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary for the treatment of borderline personality disorder when the coverage criteria are met:

CPT®* Codes	Description
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90853	Group psychotherapy (other than of a multiple-family group)

HCPCS Codes	Description
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem

ICD-9-CM Diagnosis Codes	Description
301.83	Borderline personality disorder

***Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.**

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	7/15/2007	0388	Dialectical Behavior Therapy (DBT)

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