CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

Subject **Eye Movement Desensitization and Reprocessing (EMDR)**

Effective Date 12/15/2008
Next Review Date……..6/15/2010
Coverage Policy Number 0374

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Hyperlink to Related Coverage Policies

INSTRUCTIONS FOR USE
*Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2008 CIGNA*

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 eye movement desensitization and reprocessing (EMDR) as medically necessary when BOTH of the following criteria are met:

- The individual meets the criteria of the Diagnostic and Statistical Manual of Mental disorders, Fourth edition, Text Revision (DSM-IV-TR) for the diagnosis of posttraumatic stress disorder (PTSD) or acute stress disorder (ASD).
- EMDR is provided by a qualified behavioral-health provider.

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

General Background

Posttraumatic stress disorder (PTSD) and Acute Stress Disorder (ASD) are anxiety disorders that may develop following exposure to a potentially life-threatening event. Typically, examples of traumatic events sufficient in intensity and threat that can trigger PTSD and or ASD include violent personal assaults, natural disasters, man-

made atrocities such as genocide and political torture, motor vehicle, recreational or other traumatic accidents and/or military combat. These conditions can be extremely disabling. ASD is distinguished from PTSD by its temporal relationship to the trauma. ASD develops within two days of the event and is resolved in less than one month. If it persists beyond one month, it is reclassified as PTSD. It is also possible for PTSD to evolve without the precursor development of ASD and may occur at any time subsequent to the trauma.

Both disorders are characterized by the presence of the trauma and a response to the trauma that is portrayed by intense horror or fear. In addition, the disorders include the development of three groups of symptoms to varying degrees, after the experience of the trauma has occurred. These include: 1) persistent re-experiencing of the trauma in one form or another; 2) emotional avoidance and withdrawal; and 3) physical symptoms of anxiety and arousal. Examples of re-experiencing the trauma may occur in the form of flashback episodes, intrusive memories, or nightmares, intense psychological distress and/or a high level of physical arousal caused by emotional reminders of the event. Examples of emotional avoidance and withdrawal may include loss of memory for aspects of the trauma, attempts to avoid reminders of the trauma, a sense of isolation and lack of emotional expressiveness, as well as loss of interest in life and concerns about a foreshortened future. Symptoms that are common examples of physiological anxiety and arousal include: sleep disturbances, irritability, outbursts of anger, trouble concentrating and hypervigilance. Other symptoms that may accompany these disorders, although not specifically part of the criteria set, may include: depression, generalized fear, guilt and shame, or even psychosis, in vulnerable individuals. Comorbid conditions may require additional treatment. (*Refer to the table below for diagnostic criteria.)

***Diagnostic criteria for Posttraumatic Stress Disorder (DSM-IV-TR code 309.81) from: Diagnostic and Statistical Manual of Mental disorders, Fourth edition, Text Revision (DSM-IV-TR)**

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed
2. recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. feeling of detachment or estrangement from others
6. restricted range of affect (e.g., unable to have loving feelings)
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than three months
Chronic: if duration of symptoms is three months or more

Specify if:
With Delayed Onset: if onset of symptoms is at least six months after the stressor.

****Diagnostic criteria for Acute Stress Disorder (DSM-IV-TR code 308.3) from: Diagnostic and Statistical Manual of Mental disorders, Fourth edition, Text Revision (DSM-IV-TR)**

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1. a subjective sense of numbing, detachment, or absence of emotional responsiveness
2. a reduction in awareness of his or her surroundings (e.g., "being in a daze")
3. derealization
4. depersonalization
5. dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of two days and a maximum of four weeks and occurs within four

weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

The goals of treatment of PTSD listed in the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder include (APA, 2004):

- reduce severity of symptoms
- prevent or reduce trauma-related comorbid conditions
- improve adaptive functioning and restore or promote normal developmental progression
- protect against relapse
- integrate the danger experienced as a result of the traumatic situation into a constructive schema of risk, safety, prevention and protection

The APA guidelines note that treatment of ASD and PTSD includes three approaches either alone or in combination: psychopharmacology, psychotherapeutic interventions, and educational supportive measures. Psychotherapeutic interventions include cognitive behavior treatments, such as cognition therapy, exposure therapy, and stress inoculation training (Gringage, 2003). It is thought that these therapies focus on ways for patients to confront fear and develop anxiety-management tools.

Eye movement desensitization and reprocessing (EMDR) has been proposed as a treatment for PTSD. This treatment was developed in the late 1980s by Francine Shapiro, PhD. It is theorized that EMDR facilitates the accessing and processing of traumatic memories to bring these to an adaptive resolution (Shapiro, 2002). EMDR is thought to combine elements of cognitive behavior therapy, exposure therapy, along with attention to eye movements (APA, 2004). During EMDR, the patient is asked to identify a disturbing image that represents the traumatic event, the associated emotions and body sensation and a negative self-referring cognition. The patient is then asked to identify a preferred belief about the self. Then while holding these images and thoughts, the patient will track the clinician's moving finger back and forth in front of their visual field for approximately 20 seconds (Veterans Health Administration/Department of Defense [VADoD], 2003; EMDR International Association [EMDRIA]).

Literature Review

Studies: Devilly et al. (1999) performed a randomized clinical trial for the purpose of comparing EMDR with a cognitive behavior variant (Trauma Treatment Protocol [TTP]) for treatment of PTSD. Data was collected at pretreatment, post-treatment, two-week and three-month follow-up. The inclusion criteria incorporated the following: had undergone a traumatic incident and fulfilled DSM-IV criteria for PTSD; the trauma occurred greater than four weeks prior to assessment; were over age 18; were currently receiving no psychotherapy for PTSD; there was no current psychosis or organic mental dysfunction; and had not previously received cognitive behavior therapy (CBT) for their symptoms nor EMDR. Twenty-three participants completed treatment, while nine participants dropped out of treatment before completion; of these nine, three were in the TTP group and six were in the EMDR group. The authors concluded that the results indicated the TTP approach was both statistically and clinically more effective than the EMDR approach, both in the short- and long-term. This study had a small number of participants, and a large percentage was lost to follow-up.

Ironson et al. (2002) conducted a randomized clinical trial to compare EMDR with prolonged exposure (PE) for PTSD. The study included 22 participants ranging in age from 16–62 years. The participants included five rape victims, two attempted rapes, seven molestation victims, five physical assault victims, one accident victim, one person whose brother had been killed, and one person whose wife had been raped. Seventeen of the participants were women and five were men, and they ranged in age from 16 to 62 years of age. The patients were randomly assigned to PE or EMDR and were assessed at baseline, after six sessions, and at three-month follow-up. The authors concluded that both PE and EMDR appeared to work well to reduce PTSD symptoms and to generate treatment gains that were maintained at three-month follow-up. It was also noted by the authors that EMDR appeared to be better tolerated, as indicated by a lower dropout rate and lower Subjective Units of Distress Scores (SUDS) during the initial session.

Chemtob et al. (2002) conducted a randomized clinical trial to evaluate the usefulness of brief psychosocial treatment for children with disaster-related PTSD. Participants were children who had not responded to previous treatment following two years after Hurricane Iniki. After the hurricane, elementary school children with the most trauma symptoms were selected for treatment. At one-year follow-up, there were children still exhibiting significant trauma symptoms. These children were referred to in the study as treatment nonresponders. Participants from the study were selected from this group of nonresponders and met criteria for disaster-related PTSD. Three sessions of EMDR were provided to 32 children who met clinical criteria for PTSD. The main purpose of this study was not to establish the efficacy of EMDR. EMDR was utilized because a treatment manual could be easily developed; treatment could be provided in a few sessions; and efficacy data using EMDR with single-event trauma seemed promising. Group 1 was assessed at pretreatment, provided treatment and then reassessed at post-treatment. Group 2 consisted of wait-listed participants who were assessed at baseline, then again following Group 1 treatment (approximately one month later), reassessed at pretreatment, and then provided treatment and reassessed post-treatment. Both groups were reassessed at six months. The authors noted that, although these children had failed to respond to prior effective treatment, in this study they showed large reductions in levels of symptoms of PTSD following three sessions of treatment. They also appeared to have decreased levels of associated symptoms of PTSD, specifically anxiety and depression. The wait-listed group, once treated, also demonstrated change commensurate with effects of the first treated group.

Lee et al. (2002) conducted a randomized clinical trial to determine the effectiveness of EMDR as compared to Stress Inoculation Training with Prolonged Exposure (SITPE). The study involved 24 patients who had a diagnosis of PTSD. Practitioners had referred patients who appeared to have been traumatized by a recent event. Participants were then interviewed about the nature of trauma to ensure it satisfied DSM-IV criteria. After six weeks on a wait-list, the patients were randomly assigned to one of the treatments. The patients were assessed immediately after treatment and at a three-month follow-up. The authors concluded that both the EMDR and SITPE procedures produced significant improvement on self-report. It was also noted that EMDR resulted in greater reduction in intrusive symptoms than SITPE, particularly at the follow-up assessment. It was also noted that “EMDR appears to be a more efficient treatment than SITPE” and that patients may prefer EMDR.

Servan-Schreiber et al. (2006) conducted a study to investigate the mechanism of action of EMDR. Twenty-one patients were included in the study. The patients had single event PTSD and received three consecutive sessions of EMDR with three different types of auditory and kinesthetic stimulation (i.e., tones and vibrations); intermittent alternating right-left which is commonly used with standard EMDR; intermittent simultaneous bilateral and continuous bilateral. The therapists were blinded to the type of stimulation they delivered and the assignment of stimulation type was randomized and counterbalanced. All three stimulation types resulted in clinically significant reductions of subjective units of distress. The authors concluded that there are clinically significant effects of the EMDR that appear to be independent of the nature of the kinesthetic stimulation used and alternating rhythmic sensory stimulation may confer additional benefit to EMDR procedures and warrants further study.

van der Kolk et al. (2007) conducted a study to compare the efficacy of a psychopharmocologic agent, a selective serotonin reuptake inhibitor (SSRI), fluoxetine, with a psychotherapeutic treatment, EMDR and pill placebo. The study included eighty-eight patients diagnosed with PTSD who were randomly assigned EMDR, fluoxetine or pill placebo. They received eight weeks of treatment and were assessed by blind raters post-treatment and at six-month follow-up. The primary outcome measure was the Clinician-Administered PTSD Scale (CAPS), DSM-IV version. Secondary outcome measurement was the Beck Depression Inventory-II. All three groups were sustained considerable improvement. Eighty-eight percent of EMDR, 81% of fluoxetine and 12% of placebo patients became asymptomatic. Over six months following the end of treatment, the EMDR group continued to mildly improve, while the fluoxetine group appeared to lose some of it is gains. The results indicated that the psychotherapy intervention was more successful than the pharmacotherapy in reaching sustained reductions in PTSD and depression symptoms. This benefit appeared to accrue primarily for adult-onset trauma survivors. At six-month follow-up, 75% of adult-onset versus 33.3% of child-onset trauma subjects receiving EMDR achieved asymptomatic end-state functioning compared with none in the fluoxetine group. The authors concluded that that the study supports the efficacy of brief EMDR treatment to produce substantial and sustained reduction of PTSD and depression in most victims of adult-onset trauma. They also noted that, “future research should assess the impact of lengthier intervention, combination treatments, and treatment sequencing on the resolution of PTSD in adults with childhood-onset trauma.”

Ahmad and Sundelin-Wahlsten (2008) reported on a randomized-controlled study that examined treatment with EMDR on children with PTSD. Thirty-three children, aged 6–16, were involved in the study. The children were randomized to treatment with EMDR or wait-list for eight weeks followed by EMDR. All the participating children attended at least one EMDR session, while 21 (63.6%) completed all eight sessions. The post-traumatic stress symptom scale for children (PTSS-C scale) was used to estimate the study outcome. The average treatment effect sized on the total PTSS scores, PTSD-related, PTSD-non-related, re-experiencing, avoidance and hyperarousal scales was reported to be: 0.16, 0.22, 0.06, 0.40, 0.21 and -0.01 respectively. The authors note that the re-experiencing symptoms were mostly improved by EMDR treatment.

Hogberg et al. (2008) reported on an observational, longitudinal study of 20 patients, part of a larger study of PTSD among the employees of the Stockholm public transportation system. Patients were treated with five sessions of EMDR. They were assessed with psychometric scales and diagnostic interviews before treatment, directly after the treatment, at eight months and 35 months after the end of therapy. A full diagnosis of PTSD was the primary outcome variable. Secondary outcome variables included results from interview-based and self-evaluation psychometric scales. Three patients withdrew during the follow-up period. After receiving treatment, patients were classified as remitters or non-remitters—those who no longer fulfilled criteria of PTSD were classified as remitters (n=12) and those who still met the diagnostic criteria of PTSD after treatment were classified as non-remitters (n=8). It was found that the initial results were sustained at the 35-month follow-up. Regarding secondary outcome variable, a significant immediate change towards normality that was stable in the long-term follow-up was noted. After three years of follow-up, it was noted that 83% of the initial remitters were found to have full working capacity.

Systematic reviews: Van Etten et al. (1998) conducted a meta-analysis of the literature regarding treatments for PTSD. The purpose of the study was to evaluate the relative efficacy of various treatments for PTSD. A total of 41 studies were included, that yielded sixty-one treatment outcome trials. Eleven studies were included that examined EMDR. The authors report that behavior therapy and EMDR were the most effective psychological therapies for PTSD, with the two being generally equally efficacious. The review noted that behavior therapy was significantly more effective than all treatments, on observer-rated total PTSD symptoms and no differences in comparative treatment efficacy were discernable between behavior therapy and EMDR across the specific symptom domains of PTSD. It was noted that effect sizes for these therapies were large relative to control conditions, indicating good treatment acceptance. It was also noted, however, that “despite its apparent efficacy, what works in EMDR and the mechanism for how it works remains unclear. That is, we know little about the active ingredients in EMDR and the mechanisms by which these ingredients result in decreased PTSD symptoms.” The literature is not conclusive regarding the role of eye-movement in this treatment.

Davidson et al. (2001) conducted a meta-analysis to evaluate EMDR with a variety of populations and measures. The meta-analysis included 34 published studies, of which all reported group comparisons and except for one used randomized assignment. The results of the meta-analysis indicate that EMDR appears to be better than no treatment. In addition, EMDR appears to be better than non-specific treatments. It was noted that it did not appear that EMDR was more effective than other exposure techniques. It was also noted that the eye movements that are integral to the treatment may be unnecessary.

In 2002, Maxfield et al. performed a review of EMDR studies for the purpose of determining what methodological factors might have produced variability in the EMDR efficacy results, and to come to a conclusion with regard to the evidence of EMDR for treatment of PTSD. Twelve controlled studies were reviewed to identify methodological strengths, weaknesses, and empirical findings. The authors noted that studies that examined the efficacy of EMDR for treatment of PTSD have yielded a range of results, with the efficacy of EMDR varying across studies. This study sought to investigate whether the differences in outcome were related to methodological factors. The authors concluded that the findings indicate a significant correlation between methodology and outcome and that, as methodology became more rigorous, the treatment effect became larger. It was noted by the review that the more rigorous methodological studies achieved large effect size and indicated that EMDR was more efficacious than the control condition.

Perkins et al. (2002) performed a review of the literature regarding EMDR for the purpose reducing the confusion surrounding EMDR. The authors note in the article that they have successfully utilized EMDR in treatment of patients for several years. It is noted in the article that, although the research regarding the

necessity of the eye movement component is currently inconclusive, EMDR has received considerable empirical validation as a psychological treatment for PTSD.

McCabe (2004) performed a review of evidence-based research findings, published case and anecdotal reports and primary source documents on EMDR for the purpose of examining the available evidence-base for EMDR treatment in psychiatric nursing practice. The author concluded that:

- The use of EMDR remains controversial.
- Although it appears to be a safe treatment, little is know regarding the mechanism of action of any therapeutic effect.
- More rigorous empirical establishment of efficacy is needed.

Bradley et al. (2005) performed a multidimensional meta-analysis of studies on psychotherapy for PTSD. In addition to effect size, indices included in the review included recovery rate and improvement rate, and sustained efficacy over time. Twenty-six studies were included, with 10 of these studies involving EMDR. The treatment conditions included: 13 exposure-based therapies, five cognitive behavior therapy treatment other than exposure, nine combined cognitive behavior therapy and exposure, 10 EMDR and seven other. Twenty-three of the studies included control conditions. The control conditions included: wait-list (n=15) and supportive control (N=8). The length of treatment raged from three to 52 hours with the average length of 15.64 hours. The total number of patients reported in the studies including both treatment and control conditions was 1535, with 966 receiving active treatment, 317 assigned to wait-list control conditions and 252 receiving placebo treatment. The results of this meta-analysis "suggest that psychotherapy (used in this meta-analysis) for PTSD leads to a large initial improvement from baseline. More that half of patients who complete treatment with various forms of cognitive behavior therapy or eye movement desensitization and reprocessing improve." It is noted that "reviews and meta-analyses have supported the efficacy of psychotherapy for PTSD, particularly cognitive behavior therapy and, more recently, eye movement desensitization and reprocessing." The reviewers recommend that future research should "avoid exclusion criteria other than those a sensible clinician would impose in practice [e.g., schizophrenia], should avoid wait-list and other relatively inert control conditions, and should follow patients through at least two years."

Seidler and Wagner (2006) conducted a meta-analytic study comparing the efficacy of EMDR and trauma-focused CBT in treatment of PTSD. The study included seven randomized studies that compared EMDR and CBT. The review found that the superiority of treatment over the other could not be determined. Both treatments appeared to be equally efficacious. In their conclusion, the authors note, "We suggest that future research should not restrict its focus to the efficacy, effectiveness and efficiency of these therapy methods but should also attempt to establish which trauma patients are more likely to benefit from one method or the other. What remains unclear is the contribution of the eye movement component in EMDR to treatment outcome."

Bisson and Andrew (2008) reported on a Cochrane systematic review of the psychological treatment of PTSD. Thirty-three studies were included in the review, of which 12 studies considered EMDR. Findings included that there is evidence that EMDR was better than wait list/usual care in reducing traumatic stress symptoms and additionally associated symptoms of depression and anxiety. It was noted that the studies included small sample sizes and two lacked randomization concealment. The authors note that, "EMDR appeared to have similar effectiveness to TFCBT [treatment focused cognitive behavior therapy] in the studies that compared them directly. There was some evidence that EMDR was a more effective treatment than stress management therapies and other therapies." Among the conclusions of the review, it is noted that, "TFCBT and EMDR have the best evidence for efficacy at present and should be made available to PTSD sufferers." Among the implications for research it is noted that large EMDR trials are required.

Professional Societies/Organizations
Based on a review of the available literature regarding EMDR, the American Psychiatric Association (APA) in their Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, note that "In summary, EMDR belongs within a continuum of exposure-related and cognitive behavior treatments. EMDR employs techniques that may give the patient more control over the exposure experience (since EMDR is less reliant on a verbal account) and provides techniques to regulate anxiety in the apprehensive circumstance of exposure treatment." It was also noted that "EMDR is better than no treatment or supportive counseling and may be as effective as cognitive behavior therapy and other exposure-based techniques." The guidelines also suggest that there are still questions regarding the theoretical rationale of the

treatment and that similar to other therapies, the extent to which gains are maintained over long term requires further evaluation.

The Veterans Health Administration, Department of Veteran's Affairs, and Department of Defense (VA/DoD) have developed Clinical Practice Guidelines for Management of Post-traumatic Stress (2004). After reviewing the available literature on EMDR, the guidelines conclude that "Overall, argument can reasonably be made that there are sufficient controlled studies that have sufficient methodological integrity to judge EMDR as effective treatment for PTSD."

National Institute for Clinical Excellence (NICE) (United Kingdom) has developed clinical practice guidelines for PTSD. The guidelines include the recommendation that patients with PTSD should be offered a course of trauma-focused psychological treatment, trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing.

Summary
Although there are studies suggesting the efficacy of eye movement desensitization and reprocessing (EMDR) for treatment of posttraumatic stress disorder (PTSD) and acute stress disorder (ASD), many of the studies have involved small numbers of participants and control conditions such as wait-list, relaxation therapy and supportive therapy, rather than psychotherapeutic interventions or medications. While questions remain regarding some aspects of EMDR, such as the theoretical basis and the role of eye movements, the literature appears to indicate that EMDR is as effective as other established treatments for PTSD and ASD, and in the practicing behavioral health community EMDR is an accepted treatment for PTSD and ASD.

EMDR has also been proposed as a treatment for other disorders including substance abuse, personality disorder, dissociative disorders, and anxiety disorders such as panic disorder, claustrophobia, blood and injection phobias and spider phobias. There is insufficient literature to demonstrate the efficacy of this treatment for indications other than PTSD and ASD.

Coding/Billing Information

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

Covered when medically necessary:

CPT®* Codes	Description
	No specific codes

HCPCS Codes	Description
	No specific codes

ICD-9-CM Diagnosis Codes	Description
309.81	Posttraumatic stress disorder

***Current Procedural Terminology (CPT®) ©2007 American Medical Association: Chicago, IL.**

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	6/15/2008	0374	Eye Movement Desensitization and Reprocessing (EMDR)