



CIGNA MEDICAL COVERAGE POLICY

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

Subject Eye Movement Desensitization and Reprocessing (EMDR)

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Coverage Policy Number 0374

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INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer'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 customer'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 customer'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 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 ©2011 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

Eye movement desensitization and reprocessing (EMDR) has been proposed as a treatment for posttraumatic stress disorder (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]).

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.

Literature Review

Several published studies have investigated the efficacy of EMDR. Several randomized trials compared the efficacy of EMDR with various other treatments for PTSD including psychotherapeutic treatments (e.g., cognitive behavior treatment, prolonged exposure treatment) and psychopharmacologic treatment (Devilley, et al., 1999; Ironson, et al., 2002; Lee, et al., 2002; and, van der Kolk, et al., 2007). Although most of the studies are small in size, they indicate that EMDR is an effective treatment for PTSD. A longitudinal, observational study of 20 patients reported on effects of treatment with EMDR before treatment, directly after the treatment, at eight months and 35 months after the end of therapy (Hogberg, et al., 2008). The study found that the initial results were sustained at the 35-month follow-up. There are fewer trials that examined EMDR therapy on children however, these studies indicate that treatment with EMDR improved symptoms of PTSD (Chemtob, et al., 2002; and Ahmad, et al., 2008; Kemp, et al., 2009). However these indicate that treatment with EMDR improved symptoms of PTSD.

Systematic reviews: Several meta-analysis and systematic reviews have been published regarding treatment for PTSD including EMDR. Overall, the reviews indicate that EMDR is better than no treatment and as effective as other psychological treatments for PTSD. The studies also suggest that it is still unknown what contributions the eye movements make to the treatment.

Van Etten et al. (1998) conducted a meta-analysis of the literature regarding treatments for PTSD. The review included 41 studies with 11 studies involving EMDR. The authors report that behavior therapy and EMDR were the most effective psychological therapies for PTSD, with the two being generally equally efficacious.

Davidson et al. (2001) conducted a meta-analysis to evaluate EMDR with a variety of populations and measures. The review 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.

A review of 12 controlled EMDR was conducted (Maxfield, et al., 2002). 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. 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.

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.

Bradley et al. (2005) performed a multidimensional meta-analysis of studies on psychotherapy for PTSD. Twenty-six studies were included, with 10 of these studies involving EMDR and 23 or the studies including control conditions. The treatment conditions included: exposure-based therapies, cognitive behavior therapy treatment other than exposure, combined cognitive behavior therapy and exposure, EMDR and seven other. 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 than 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."

ECRI published an evidence report regarding EMDR for treatment of PTSD (ECRI, 2007). The review included 12 randomized controlled trials. The report included the following findings:

- When comparing EMDR to a waitlist control (no treatment) for adults, weak evidence was found to support that EMDR is more effective than no treatment in reducing symptoms of depression and anxiety.
- Regarding other outcomes, including overall change in PTSD status, overall reduction in PTSD symptoms, dissociation, and quality of life, it was found that the size and quality of the evidence was too low to determine the impact of EMDR on these outcomes.
- There were too few studies available to determine the efficacy of EMDR for children under 15 years of age or when compared to a nonassigned treatment control group.
- Overall, the evidence is inconclusive (no indication of statistical or clinically significant between-group difference) to determine whether EMDR was more or less effective than ET in changing overall PTSD status, overall symptoms of PTSD, depression, or anxiety. In comparison to other types of nondrug treatments, the size and quality of the evidence was too low to reach a determination of whether EMDR was more or less effective.

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.

A meta-analysis of studies that examined the efficacy of EMDR in children with PTSD was conducted by Rodenburg, et al., 2009. The review included seven randomized, controlled studies that reported on 109 children treated with EMDR and 100 in control groups. The overall post-treatment effect size for EMDR was found to be medium and significant. The review indicated that EMDR is efficacious in treating children with PTSD. The study noted that further study with increased multi-center research, randomized designs and larger sample sizes is needed.

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, chronic phantom limb pain, eating disorders, 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®*	Description
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Codes	
90899†	Unlisted psychiatric service or procedure

†**Note: Covered when medically necessary when used to report Eye Movement Desensitization and Reprocessing (EMDR)**

ICD-9-CM Diagnosis Codes	Description
308.3	Other acute reactions to stress
309.81	Posttraumatic stress disorder

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

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Policy History

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

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