

WellCare Health Plans, Inc.
The WellCare Group of Companies

Clinical Coverage Guideline



WellCare Prescription Insurance, Inc.

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WellCare of Ohio, Inc.

Eye Movement Desensitization Therapy

Guideline Number: HS-071

Original Effective Date: 12/18/2008

Revision Date: 12/22/2009

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

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DISCLAIMER

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APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

CLINICAL COVERAGE GUIDELINE

Eye Movement Sensitization and Reprocessing (EMDR) for the treatment of acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) is considered medically necessary if ALL of the following criteria are met:

- Member meets diagnostic criteria for ASD or PTSD as set forth in the DSM-IV(TR); **AND**,
- Therapy is performed by a behavioral-health provider specifically trained and licensed in EMDR.

EMDR is considered experimental and investigational and NOT a covered benefit in the following circumstances:

- Used as a treatment option for psychological disorder other than ASD or PTSD; **OR**,
- Used for the prevention of ASD or PTSD; **OR**,
- For all other medical and psychological disorders not listed above.

NOTE: EMDR may be used as a stand-alone therapy, within a standard "talking" therapy, or as an adjunctive therapy with a separate therapist for ASD or PTSD. Three ninety-minute sessions of EMDR has resulted in the best results in a clinical trial setting.

BACKGROUND

Post-traumatic stress disorder (PTSD) is an anxiety disorder that may develop in people who experience a terrifying event in which serious physical or emotional harm or the threat thereof occurs to them or others, or who learn about a terrifying event, including actual or threatened death or serious physical or emotional harm of a loved one. The diagnosis of PTSD is given when, for a period longer than a month after such an event, the patient experiences the following symptoms: persistent re-experiencing of the event or portions thereof, avoidance of factors associated with the event and a diminished general responsiveness (numbing), and persistent symptoms of increased arousal. Traumatic events that may result in PTSD include combat trauma, rape, physical or sexual abuse or assault, transportation accidents, torture, acts of terrorism, and natural or human-made disasters. PTSD is a debilitating disorder that can dominate a person's life and is associated with an increased risk of other mental health problems (e.g., drug abuse, depression, personality disorder).

Treatment of PTSD is similar to that of other anxiety disorders, and includes medication and psychotherapy. The psychotherapies used for PTSD are typically cognitive-behavioral therapies (CBT) and include stress management training, in which the patient is taught to manage anxiety through relaxation; cognitive restructuring, in which the therapist helps the patient change distorted thoughts and beliefs; and systematic desensitization, in which the patient is gradually exposed to aspects of the traumatic event under the guidance of a therapist. The underlying principle of desensitization is that prolonged exposure to a fear-inducing stimulus gradually reduces the cognitive and physiological symptoms of anxiety. The therapist provides reassurance and/or instructs the patient to use techniques that reduce anxiety (e.g., relaxation, coping techniques) during exposure to the event. The patient's negative emotional responses to memories of the trauma are thus reduced, resulting in reduction or elimination of the symptoms of PTSD.

EMDR was developed as a method to treat PTSD using exposure and cognitive restructuring, in a relatively short time and without exposing the patient to prolonged anxiety. Patients are instructed to identify a target traumatic memory, articulate a negative statement that is associated with the memory (e.g., "I am helpless"), and formulate a positive statement to replace the negative one (e.g., "I am in control"). The patient engages a series of saccadic bilateral eye movements by following the therapist's fingers that move rapidly across the patient's field of vision. After each set of 10 to 20 eye movements, the patient is instructed to mentally "remove" the traumatic image, and rate distress and belief in the negative and positive cognition. In addition to general principles of cognitive behavioral therapies, several mechanisms of action have been proposed for EMDR, specifically, including a conditioning process in which the eye movements serve an accelerating function, and activation of a neurobiological substrate that modulates emotional responses, resulting in a homeostatic process.

Ten relatively small randomized studies and two meta-analyses were identified. Subjects were adults with a full or partial diagnosis of PTSD. The trauma that resulted in PTSD included combat trauma, rape, traffic accident, life-threatening injury, earthquake, battery and assault, physical or sexual abuse during childhood, exposure to sudden death, and witnessing the death of a loved one. Outcome measures included observer or subjective reports of symptoms of PTSD, depression, anxiety, and overall functioning, and consisted of standardized and some nonstandardized tests, questionnaires, and interviews. EMDR was compared with wait list only in one study and to at least one active treatment in all others. Comparison treatments included prolonged exposure therapies, relaxation training, fluoxetine, standard counseling, and Rogerian-based active listening (a non-directive "talk" therapy).

EMDR was superior to no treatment (wait list) in all six studies that included a wait list condition. When compared with routine counseling and a specific counseling technique (Rogerian-based active listening), three studies showed that both counseling and EMDR reduced symptoms of PTSD, depression, and anxiety, and that EMDR did so to a greater extent. EMDR was compared with relaxation training in three studies, and both treatments were reported to reduce symptoms of PTSD, depression and anxiety, with superior effects reported for EMDR in two studies, and no differences observed in the third. In one study, EMDR was compared with fluoxetine, and EMDR resulted in longer-lasting improvements in PTSD symptoms and depression than fluoxetine. Four studies compared EMDR with exposure therapies, and the results were mixed. Both EMDR and exposure therapy reduced PTSD symptoms, anxiety, and depression in all four studies, and two reported somewhat superior or more rapid effects for EMDR, one suggested no differences, and one suggested that exposure therapy was somewhat superior. The effects of EMDR were maintained at follow-up (3 to 15 months) in all studies.

Two meta-analyses reported similar findings: one analyzed results from 34 studies and reported that EMDR was superior to no treatment and to treatments that do not include exposure, and comparable in efficacy to exposure therapies; the other included seven studies that compared EMDR to exposure therapies and reported comparable efficacy. No complications directly attributable to EMDR were reported in the reviewed literature. However, one case report described a patient developing suicidal ideation after EMDR treatment, suggesting that, as with any other psychotherapy, caution is warranted regarding suicide risk.

Definitive patient selection criteria for EMDR have not been established. However, there is sufficient evidence to support the use of EMDR in adult men and women with a diagnosis of PTSD or with complaints of intrusive memories resulting from a traumatic experience.

Results of the randomized studies reviewed for this report suggest that EMDR is safe and efficacious for adults with PTSD

or complaints of intrusive memories. EMDR was more efficacious than no treatment, short-term pharmacological treatment, and several other therapies that do not include exposure (from Hayes, 2007).

CODING

Covered CPT® Codes

- 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, 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, with medical evaluation and management services

ICD-9-CM Procedure Codes

Not applicable

HCPCS Codes

Not applicable

Covered ICD-9-CM Diagnosis Codes

- 308.3 Acute Stress Disorder (ASD)
309.81 Posttraumatic stress disorder (PTSD)

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

REFERENCES

1. Hayes Directory. Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder. April 16, 2007.
2. American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. 2004.