Eye Movement Desensitization Therapy for Treatment of Post-Traumatic Stress Disorder

Policy Number: HS-071

Original Effective Date: 12/18/2008


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.
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 non-standardized 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 (Hayes, 2007).

2009 Update to American Psychiatric Association Guideline

EMDR continues to be examined as a treatment for victims of trauma; however, many of the studies published since 2004 include participants without a formal PTSD diagnosis.

POSITION STATEMENT

Applicable To:
- Medicaid
- Medicare

Eye Movement Sensitization and Reprocessing (EMDR) for the treatment of acute stress disorder (ASD) and posttraumatic stress disorder (PSTD) 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 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.

CODING

Covered CPT® Codes
Effective January 1, 2013 CPT codes 90804, 90805, 90806, 90807, 90808, 90809 have been deleted. To report, see psychotherapy codes 90832, 90834, 90837 or psychotherapy add-on codes when performed with an E&M service.

90785+ Interactive complexity (list separately in addition to the code for the primary procedure)
90832 Psychotherapy, 30 minutes with patient and/or family member
90833+ Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service
90834 Psychotherapy, 45 minutes with patient and/or family member
90836+ Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service
90837 Psychotherapy, 60 minutes with patient and/or family member
90838+  Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service
90899  Unlisted psychiatric service or procedure
99354+  Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour
99355+  Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes
99356+  Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour
99357+  Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes
90785  Interactive complexity (list separately in addition to the code for primary procedure)

+ List separately in addition to the code for primary procedure.
  Use Add-on code in conjunction with E&M Codes 99201-99255, 99304-99337, 99341-99350.
  Use the appropriate prolonged service code 99354–99355 for psychotherapy services 68 minutes or longer.

Covered ICD-9-CM Procedure Codes
94.33  Behavior Therapy

Covered ICD-10-PCS Codes
GZ51ZZZ  Individual psychotherapy, behavioral
GZ58ZZZ  Individual psychotherapy, cognitive-behavioral

HCPCS Code – No applicable codes.

Covered ICD-9-CM Diagnosis Codes
308.3  Acute Stress Disorder (ASD)
309.81  Posttraumatic stress disorder (PTSD)

Covered ICD-10-CM Diagnosis Codes
F43.0  Acute stress reaction
F43.10-F43.12  Post-traumatic stress disorder (PTSD)


REFERENCES

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<tr>
<td>12/3/2015</td>
<td>Approved by MPC. Coding changes only.</td>
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<tr>
<td>12/4/2014, 12/5/2013</td>
<td>Approved by MPC. No changes.</td>
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<tr>
<td>12/6/2012</td>
<td>Approved by MPC. Name changed to reflect purpose for EMD therapy – now includes “for Treatment of Post-Traumatic Stress Disorder”.</td>
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<tr>
<td>1/5/2012</td>
<td>Approved by MPC. Reformatted references. Added 2009 Update to American Psychiatric Association Guideline.</td>
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<tr>
<td>12/1/2011</td>
<td>New template design approved by MPC.</td>
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