

Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Policy MP-065

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.

Description:

Eye movement desensitization and reprocessing (EMDR) therapy is a complex method of psychotherapy that combines a range of therapeutic approaches with eye movements or other forms of rhythmical stimulation (e.g., sound and touch) in ways that stimulate the brain's information processing system. Eye movement desensitization and reprocessing was introduced in 1989 as a treatment for post-traumatic stress disorder (PTSD). Since then, it has been proposed as a treatment of various psychiatric and behavioral disorders including phobias, panic and anxiety disorders, as well as eating disorders.

Policy Statement and Criteria

1. Commercial Plans

U of U Health Plans covers Eye Movement Desensitization and Reprocessing (EMDR) to a maximum of 15 sessions during a 12 month period for the treatment of Post-Traumatic Stress Disorder (PTSD).

U of U Health Plans does NOT cover Eye Movement Desensitization and Reprocessing (EMDR) for any other indications including the prevention of PTSD as it is considered investigational/experimental.

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U

Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at:

<http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

3. Medicare Plans

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicare policies and coverage, please visit their search website at:

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Clinical Rationale

Guidelines on PTSD from the National Institute for Clinical Excellence (NICE, 2005) state that all people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioral therapy (CBT) or EMDR). National Institute for Clinical Excellence guidelines note that these treatments should normally be provided on an individual outpatient basis.

Guidelines on PTSD from the American Psychiatric Association (APA, 2004) stated that CBT and EMDR have been shown to be effective for core symptoms of acute and chronic PTSD. These guidelines note, however, that no controlled studies of EMDR have been conducted that would establish data-based evidence of its efficacy as an early preventive intervention for PTSD. The APA guidelines state that stress inoculation, imagery rehearsal, and prolonged exposure techniques may also be indicated for treatment of PTSD and PTSD-associated symptoms such as anxiety and avoidance. The APA guidelines observe that the shared element of controlled exposure of some kind may be the critical intervention.

In reviewing the evidence supporting EMDR, the APA found that, like many of the studies of other cognitive behavior and exposure therapies, most of the well-designed EMDR studies have been small, but several meta-analyses have demonstrated efficacy similar to that of other forms of cognitive and behavior therapy. The APA noted that studies also suggest that the “eye movements are neither necessary nor sufficient to the outcome, but these findings remain controversial.” “Although it appears that efficacy may be related to the components of the technique common to other exposure- based cognitive therapies, as in the previously described cognitive behavior therapies, further study is necessary to clearly identify the effective subcomponents of combined techniques. Follow-up studies are also needed to determine whether observed improvements are maintained over time”

The American Psychiatric Association’s Guideline for EMDR continues to be examined as a treatment for victims of trauma through their guideline watch (2009); however, many of the studies published since 2004 include participants without a formal PTSD diagnosis.

In 2007, Hayes reported on EMDR and reprocessing for PTSD. They found ten relatively small randomized studies and two meta-analyses have been 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).

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. EMDR appears similar in efficacy to exposure therapy. Additional studies are required to further evaluate the durability of treatment effect, establish optimal protocols for therapy, and define the contribution of the different components of EMDR therapy. The authors found that 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.

Furuta and colleagues (2018) noted that approximately 3% of women in community samples develop PTSD following childbirth. Higher prevalence rates are reported for high risk samples. Post-partum PTSD can adversely affect women's well-being, mother-infant relationships and child development. These researchers examined the effectiveness of trauma-focused psychological interventions (TFPT), for post-natal women. They conducted a systematic review and meta-analysis including all clinical trials that reported post-traumatic stress symptoms for intervention and control groups or at least 2 time-points, pre- and post-intervention. A total of 11 studies, reported in 12 papers, involving 2,677 post-natal women were included. All were RCTs, bar 1 case series. Interventions varied in modality, duration and intensity, and included exposure therapy, trauma-focused cognitive behavioral therapy, EMDR and other psychological approaches. Participants had experienced uncomplicated births, emergency cesarean sections and/or pre-term births. Results suggested that TFPT were effective for reducing PTSD symptoms in the short-term (up to 3 months post-partum [4 RCTs, $n = 301$, standardized mean difference [SMD] = -0.50, 95% CI: -0.73 to -0.27]), and medium-term (i.e., 3 to 6 months post-partum [2 RCTs, $n = 174$, SMD = -1.87, 95% CI: -2.60 to -1.13]). However, there was no robust evidence to suggest whether TFPT could also improve women's recovery from clinically significant PTSD symptoms. The authors concluded that further larger studies, distinguishing between low- and high-risk groups, and with longer-term follow-up, are needed to establish which TFPT are most effective and acceptable for treating post-partum PTSD.

In 2020, Cuijpers and associates stated that there is no comprehensive meta-analysis of randomized trials examining the effects of EMDR on PTSD and no systematic review at all of the effects of EMDR on other mental health problems. These investigators carried out a systematic review and meta-analysis of 76 trials. Most trials examined the effects on PTSD (62%). The effect size of EMDR compared to control conditions was $g = 0.93$ (95% CI: 0.67 to 0.18), with high heterogeneity ($I^2 = 72\%$). Only 4 of 27 studies had low risk of bias, and there were indications for publication bias. EMDR was more effective than other therapies ($g = 0.36$; 95% CI: 0.14 to 0.57), but not in studies with low risk of bias. Significant results were also found for EMDR in phobias and test anxiety, but the number of studies was small and risk of bias was high. EMDR was examined in several other mental health problems, but for none of these problems, sufficient studies were available to pool outcomes. The authors concluded that EMDR may be effective in the treatment of PTSD in the short-term, however, the quality of studies was too low to draw definite conclusions. They stated that there is currently inadequate evidence to advise it for the use in other mental health problems. The authors stated that they conducted a meta-analysis according

to the current standards for such studies. However, the results of a meta-analysis could never be better than the set of selected studies. This was clearly an issue here because the included studies had several limitations. These investigators already mentioned the small number of studies with low risk of bias, the high heterogeneity in most comparisons, and the lack of studies examining longer-term effects. Especially the risk for selective outcome reporting and the small number of registered trials was striking. Another limitation was that most trials had small sample sizes, with several having less than 10 subjects in each condition. They stated that future research should focus on high-quality, sufficiently powered, randomized trials with long-term effects. Without such studies, the effects of EMDR will remain as uncertain as they are now. Despite these limitations, the results of this meta-analysis aid the authors in concluding that EMDR may be effective in the treatment of PTSD in the short-term and possibly have comparable effects as other treatments. However, the quality of studies was too low to draw definite conclusions. Furthermore, it was evident that the long-term effects of EMDR are unclear and that there is certainly inadequate evidence to advise its use in patients with mental health problems other than PTSD.

Applicable Coding

CPT Codes

- 90832** Psychotherapy, 30 minutes with patient
- 90833** Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90834** Psychotherapy, 45 minutes with patient
- 90836** Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90837** Psychotherapy, 60 minutes with patient
- 90838** Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90899** Unlisted psychiatric service or procedure

HCPCS Codes

No applicable codes

ICD-10 Codes

- F43.10** Post-traumatic stress disorder, unspecified
- F43.11** Post-traumatic stress disorder, acute
- F43.12** Post-traumatic stress disorder, chronic
- Z86.51** Personal history of combat and operational stress reaction

References:

1. American Psychiatric Association (APA). "Guideline Watch: Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder." March 2009. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf
2. American Psychiatric Association (APA). Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington, VA: APA; November 2004.
3. Cuijpers P, van Veen SC, Sijbrandij M, et al. Eye movement desensitization and reprocessing for mental health problems: A systematic review and meta-analysis. *Cogn Behav Ther.* 2020;49(3):165-180.
4. Furuta M, Horsch A, Ng ESW, et al. Effectiveness of trauma-focused psychological therapies for treating post-traumatic stress disorder symptoms in women following childbirth: A systematic review and meta-analysis. *Front Psychiatry.* 2018;9:591.
5. Hayes, Inc. (April 16, 2007). Health Technology Assessment. "Eye Movement Desensitization and Reprocessing For Post-Traumatic Stress Disorder." Available at: <https://evidence.hayesinc.com/report/dir.eyem0001/executive.html> Archived May, 15 2012.
6. National Institute for Clinical Excellence (NICE). Post-traumatic stress disorder (PTSD). The management of PTSD in adults and children in primary and secondary care. Clinical Guideline 26. London, UK: NICE; March 2005.
7. Shapiro F. EMDR 12 years after its introduction: Past and future research. *J Clin Psychol.* 2002;58(1):1-22.

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