Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 1/1/25**
(See policy history boxes for previous effective dates)

Title: Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder (PTSD)

Description/Background

According to the National Institute of Mental Health, post-traumatic stress disorder (PTSD) is "an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat". Individuals who develop PTSD as a result of experiencing traumatic events are sometimes unable to process or integrate these experiences within the central nervous system, which can result in impaired emotional and cognitive functioning.

Eye movement desensitization and reprocessing (EMDR) therapy is a multifaceted treatment that incorporates various elements of psychotherapy. EMDR was introduced in 1989 as a treatment for PTSD, and over the last 2 decades it has been proposed as a treatment of other psychiatric and behavioral disorders, including panic and anxiety disorders, phobias and eating disorders.

EMDR is an information processing technique that assists the patient in accessing traumatic memories in order to effectively examine and resolve them. EMDR is unique to other forms of treatment in that it utilizes bilateral stimulation of the brain, such as eye movement or other forms of rhythmical stimulation (e.g., sound and touch) to stimulate the brain's information processing system. EMDR also utilizes a technique called dual attention awareness, which allows the individual to alternate between the memory of the traumatic event and the safety of the present moment.

EMDR is a process that involves 8 phases:

- Phase I, Client History Phase – the patient's history and treatment plan are discussed. The client and the therapist identify possible targets, or traumatic memories, for EMDR. These include distressing events, circumstances that elicit emotional disturbance, related

historical incidents and the development of skills and behavioral techniques that the individual will need in future situations once formal therapy is completed.

- Phase II, Preparation Phase – the therapist confirms that the participant understands the purpose and goals of EMDR. Informed consent is obtained and the therapist assesses whether the participant can adequately manage emotional distress, has good coping skills and is overall stable enough to proceed with the next phase of treatment.
- Phases III-VI, Assessment, Desensitization, Installation and Body Scan phases – a negative memory or thought is targeted; this involves the subject identifying the most vivid visual image related to the traumatic experience. The participant also identifies a positive thought for use later in the session. The individual is instructed to focus on the negative image or thought and body sensations while simultaneously following an object as it moves side to side across their field of vision for approximately 20-30 seconds. After performing a set of eye movements, the participant is asked to discuss what has surfaced; this may be a thought, a feeling, a physical sensation, an image or a memory. Next, the therapist instructs the participant to let his/her mind go blank and to notice whatever thought, feeling, image, memory or sensation comes to mind. This is repeated several times throughout the session, and with each phase of therapy the participant is asked about his/her level of distress. Desensitization ends when the Subjective Units of Disturbance Scale (SUDS) level reaches 0 or 1, which indicates minimal to no distress at all. When the participant reports no distress related to the targeted memory, the therapist will ask him/her to think of the positive thought that was identified at the beginning of the session and to focus on the incident, while again simultaneously engaging in the eye movements.
- Phase VII, Closure Phase – the therapist and participant may use a variety of techniques to facilitate participant stability at the completion of the EMDR session and between sessions. The participant may be asked to keep a journal to document any new or related information that may arise.
- Phase VIII, Reevaluation Phase – the therapist and participant assess the effects of previous processing of targets. They may evaluate the progress since the previous treatment, identifying any residual disturbances, new information which may have emerged, current triggers and barriers to achieving goals that were established at the onset of treatment.

Overall, the goal of EMDR therapy is to assist the individual to process and resolve negative experiences and to provide the participant with cognitive and emotional tools that will enable him/her to effectuate healthy behaviors.

EMDR is a specialized area of behavioral health treatment, and providers choosing to perform EMDR may obtain certification, training and continuing education via the EMDR International Society (EMDRIA).

Medical Policy Statement

Eye movement desensitization and reprocessing (EMDR) is an established therapy for adult-onset post-traumatic stress disorder (PTSD).

Inclusionary and Exclusionary Guidelines

Inclusions:
EMDR therapy is established for the following indications only:

- The individual (18 years of age and older) meets the criteria of the Diagnostic and Statistical Manual of Mental disorders, Fifth edition (DSM-V) for the diagnosis of post-traumatic stress disorder (PTSD).
- EMDR therapy is provided by a psychiatrist, psychologist or other licensed behavioral health professional.

Exclusions:

- EMDR for the treatment of other psychiatric and behavioral disorders (e.g., panic and anxiety disorders, anger, depression, dissociative disorders, eating disorders, guilt and phobias) is not established.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

90832	90833	90834	90836	90837	90838
90846	90847				

Other codes (investigational, not medically necessary, etc.):

N/A

Note: The above code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

Rationale

According to guidelines published by the American Psychiatric Association (APA), EMDR is an effective therapy for PTSD and “may prove advantageous for individuals who cannot tolerate prolonged exposure as well as for those who have difficulty verbalizing their traumatic experiences.” The APA guidelines note that further research is needed to determine the sustainability of improvements from EMDR therapy over time.

In its 2010 Clinical Practice Guidelines for the management of PTSD, the U.S. Department of Veterans Affairs identifies EMDR as one of the recommended “evidence-based trauma-focused psychotherapeutic interventions”.

van der Kolk et al (2007) published a randomized clinical trial comparing the efficacy of EMDR with a psychopharmacologic agent, Fluoxetine, and a pill placebo for individuals with PTSD. Researchers concluded that brief EMDR treatment was more successful than

pharmacotherapy in achieving sustained reductions in PTSD and depression symptoms primarily of adult-onset trauma victims. At 6-month follow-up, 75.0 percent of adult-onset versus 33.3 percent of child-onset trauma achieved asymptomatic end-state functioning compared with none in the Fluoxetine group.

Bisson et al (2007) performed a meta-analysis of 38 randomized controlled trials in an effort to determine the efficacy of specific psychological treatments for PTSD. The review showed that Trauma-Focused Cognitive Behavioral Therapy (TFCBT), EMDR, stress management and group cognitive behavioral therapies resulted in improvement in all PTSD symptom measures that were superior to waiting-list control groups or standard treatments. There was inconclusive evidence regarding other therapies. TFCBT and EMDR were not shown to yield significant differences in outcomes; however, there was evidence that TFCBT and EMDR were more effective treatments compared to stress management and other therapies.

Chen et al (2014) published a meta-analysis of 26 randomized controlled trials assessing EMDR for PTSD. The analysis found EMDR significantly reduced the symptoms of PTSD, depression, anxiety and subjective distress in those with PTSD. This analysis also found sessions lasting more than 60 minutes were a major contributing factor in reducing anxiety and depression and participants had greater reductions in PTSD symptoms when they received EMDR therapy from therapists who were experienced in this type of treatment.

Pharmacotherapy versus Psychotherapy
Schrader et al (2021) states that prior to 2013 there was little evidence to suggest that there was differentiation in treatment of PTSD using pharmacotherapy versus psychotherapy. After over a decade of research, Veterans Affairs (VA) and the Department of Defense (DoD) released updated recommendations for strategies to control trauma-associated symptoms of post-traumatic stress disorder. Evaluation of 2 large meta-analysis which compared existing pharmacotherapy and manualized psychotherapy determined that manualized, trauma-focused therapies (e.g., EMDR) have shown consistent reduction of symptoms of PTSD with completion of 12-16, 60 minute weekly sessions. VA and the DoD reports that there is strong evidence for manualized psychotherapy (e.g., eye movement desensitization and restructuring).

Children and Adolescents
Cohen (Up-to-Date; 2023) discussed the use of trauma-focused psychotherapy for the management of PTSD in children and adolescents. Preferences for the types of therapies varied by patient age and presentation. EMDR therapy was used only when the subject was able and preferred to verbally describe the traumatic experience. Although EMDR has been found to have a shorter duration of treatment than trauma-focused cognitive behavioral therapy (8 sessions versus 8 to 16 sessions) both treatments had equivalent efficacy. Other RCTs of EMDR in children showed mixed results and methods differed, including small sample sizes.

There are few studies that examine EMDR therapy in children. According to the American Academy of Child *&* Adolescent Psychiatry (2010), EMDR is an effective treatment for adult PTSD; however, most randomized controlled trials for child-modified EMDR “have had serious methodologic shortcomings”. It was noted that there were dissimilarities among the adult and child EMDR methods and components and that EMDR for children was more aligned with cognitive behavioral therapy principles.

Depression and Eating Disorders
The application of EMDR for the treatment of depression and eating disorders is not clearly established by the medical literature. Case studies are small and target populations are not well defined.

Government Regulations

National:

Medicare has no National Coverage Determination on this topic.

Local:

No local coverage determination was found.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

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2. Bisson, Jonathan I., et al., "Psychological treatments for chronic post-traumatic stress disorder," *British Journal of Psychiatry,* Vol. 190, 2007, pp 97-104.
3. Chen, Y.R. et al., "Efficacy of eye-movement desensitization and reprocessing for patients with posttraumatic-stress disorder: A meta-analysis of randomized controlled trials," *PLoS One*, 2014, Volume 9, Issue 8, e103676. doi: 10.1371/journal.pone.0103676. eCollection 2014.
4. Cohen, J.A. "Posttraumatic stress disorder in children and adolescents: Management with trauma-focused psychotherapy." 2023. https://www.uptodate.com/contents/posttraumatic-stress-disorder-in-children-and-adolescents-management-with-trauma-focused-psychotherapy?search=ehye%20movement%20desensitization%20and%20post%20traumatic%20stress%20disorder&topicRef=111729&source=see_link. Accessed August 8, 2023.
5. *HAYES Directory*, "Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder," Lansdale, PA, HAYES, Inc., April 6, 2007.
6. *HAYES Medical Technology Update Search*, "Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder," Lansdale, PA, HAYES, Inc., April 6, 2011.

7. Schrader C, Ross A. A Review of PTSD and Current Treatment Strategies. *Mo Med.* 2021 Nov-Dec;118(6):546-551. PMID: 34924624
8. U.S. Department of Health and Human Services, "Post-Traumatic Stress Disorder (PTSD)," *National Institute of Mental Health*; http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. Accessed August 26, 2022.
9. Ursano, R.J., et al., APA Practice Guidelines, Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder, 2010; http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf. Accessed August 26, 2022.
10. U.S. Department of Veterans Affairs, "Management of Post-Traumatic Stress: Guideline Summary," *VA DoD Clinical Practice Guideline*, October 2010; http://www.healthquality.va.gov/ptsd/ptsd-sum_2010a.pdf. Accessed August 26, 2022.
11. van der Kolk, Bessel A., MD, et al., "A Randomized Clinical Trial of Eye Movement Desensitizati*on and Reprocessing (EMDR), Fluoxe*tine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance," *Journal psychiatry*, Vol. 68, No. 1, January 2007, pp. 37-46.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 8/14/24, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
9/1/11	6/21/11	6/21/11	Joint policy established
1/1/13	10/16/12	10/16/12	Routine maintenance
7/1/13	4/16/13	4/22/13	Code 90806 deleted and replaced with codes 90832-90838.
1/1/15	10/24/14	11/3/14	Routine maintenance
1/1/16	10/13/15	10/27/15	Routine maintenance
1/1/17	10/11/16	10/11/16	Routine maintenance
1/1/18	10/19/17	10/19/17	• Routine maintenance • Added codes: 90846 and 90847
1/1/19	10/16/18	10/16/18	Routine maintenance
1/1/20	10/15/19		Routine maintenance
1/1/21	10/20/20		• Routine maintenance • Added 99354 and 99355 to EST
1/1/22	10/19/21		Routine maintenance
1/1/23	10/18/22		Routine maintenance (slp)
1/1/24	10/17/23		• Routine maintenance (slp) • Vendor Managed: N/A • Per encoder 99354 and 99355 have been combined to 99417
1/1/25	10/15/24		• Routine maintenance (slp) • Vendor managed: N/A • 99417 removed from policy

Next Review Date: 4th Qtr, 2025

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: EYE MOVEMENT DESENSITIZATION AND REPROCESSING FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered, criteria apply
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.