Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Number: 0583

Policy

*I* Please see amendment for Pennsylvania Medicaid at the end of this CPB.

I. Aetna considers eye movement desensitization and reprocessing (EMDR) therapy medically necessary for the treatment of post-traumatic stress disorder (PTSD).

II. Aetna considers EMDR therapy experimental and investigational for all other indications (including those listed below) because its effectiveness for indications other than PTSD has not been established:

- Prevention of PTSD
- Treatment of addiction
- Treatment of chronic pain including chronic back pain and chronic phantom limb pain
- Treatment of panic and anxiety disorders including generalized anxiety disorder, panic disorder, dental phobia and social phobia (other than PTSD)
- Treatment of post-operative pain
Treatment of other psychiatric and behavioral disorders (e.g., anger, bipolar disorder, de-personalization de-realization disorder, depression, dissociative disorders, eating disorders, guilt, phobias, psychogenic non-epileptic seizures, and psychotic disorders)

Background
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.

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 AAP 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” (APA, 2004).

Advocates of EMDR therapy state that it is a specialized approach and method that requires supervised training for full therapeutic effectiveness and client safety. Training is considered mandatory for appropriate use. However, a meta-analysis of the literature on EMDR by Davidson and Parker (2001) found that the effectiveness of EMDR was not affected by whether the therapist providing the treatment was trained by the EMDR Institute.

There are insufficient data to support the use of EMDR in the treatment of other psychiatric and behavioral disorders including anger, guilt, phobias, dissociative disorders, eating disorders, and panic and anxiety disorders other than PTSD. In a randomized study on the effectiveness of EMDR treatment on negative body image in eating disorder inpatients, Bloomgarden and Calogero (2008) concluded that further research is needed to determine whether or not EMDR is effective for treating the variety of eating pathology presented by eating disorder inpatients.

In a case series, Schneider et al (2008) assessed EMDR therapy for patients with chronic phantom limb pain (PLP). A total of 5 subjects with PLP ranging from 1 to 16 years were included in
this study. All patients were on extensive medication regimens prior to EMDR therapy; 3 to 15 sessions of EMDR were used to treat the pain and the psychological ramifications. Patients were measured for continued use of medications, pain intensity/frequency, psychological trauma, and depression. Treatment with EMDR resulted in a significant decrease or elimination of PLP, reduction in depression and PTSD symptoms to sub-clinical levels, and significant reduction or elimination of medications related to the PLP and nociceptive pain at long-term follow-up. The authors concluded that the overview and long-term follow-up indicate that EMDR therapy was successful in the treatment of both PLP and the psychological consequences of amputation. The latter include issues of personal loss, grief, self-image, and social adjustment. These results suggest that (i) a significant aspect of PLP is the physiological memory storage of the nociceptive pain sensations experienced at the time of the event, and (ii) these memories can be successfully reprocessed. They stated that further research is needed to explore the theoretical and treatment implications of this information-processing approach.

de Roos et al (2010) examined if a psychological treatment directed at processing the emotional and somatosensory memories associated with amputation reduces PLP. A total of 10 consecutive participants (6 men and 4 women) with chronic PLP after leg amputation were treated with EMDR. Pain intensity was assessed during a 2-week period before and after treatment (mean number of sessions = 5.9), and at short-term (3 months) and long-term (mean of 2.8 years) follow-up. Multivariate ANOVA for repeated measures revealed an overall time effect ($F[2, 8] = 6.7; p < 0.02$) for pain intensity. Pair-wise comparison showed a significant decrease in mean pain score before and after treatment ($p = 0.00$), which was maintained 3 months later. All but 2 subjects improved and 4 were considered to be completely pain-free at 3 months follow-up. Of the 6 subjects available at long-term follow-up (mean of 2.8 years), 3 were pain-free and 2 had reduced pain intensity. The authors concluded that these preliminary results suggested that, following a psychological intervention focused on trauma
or pain-related memories, substantial long-term reduction of chronic PLP can be achieved. However, they stated that larger outcome studies are needed.

In a pilot study, Sandstrom and colleagues (2008) examined the effects of EMDR in women with post-traumatic stress after childbirth. This study consisted of a "before and after" treatment design combined with follow-up measurements 1 to 3 years after EMDR treatment. Quantitative data from questionnaires (Traumatic Event Scale [TES]) were collected. In addition, qualitative data from individual interviews with the participants were collected as well as data from the psychotherapist's treatment notes of the EMDR treatment sessions. A total of 4 women with post-traumatic stress following childbirth (1 pregnant and 3 non-pregnant) were included in this study. All participants reported reduction of post-traumatic stress after treatment. After 1 to 3 years, the beneficial effects of EMDR treatment remained for 3 of the 4 women. Symptoms of intrusive thoughts and avoidance seemed most sensitive for treatment. The authors concluded that EMDR might be a useful tool in the treatment of non-pregnant women severely traumatized by childbirth; however, they stated that further research is needed.

Bae et al (2008) stated that while CBT is considered to be the first-line therapy for adolescent depression, there are limited data on whether other psychotherapeutic techniques are also effective in treating adolescents with depression. This report suggested the potential application of EMDR for treatment of depressive disorder related, not to trauma, but to stressful life events. At present, EMDR has only been empirically validated for only trauma-related disorders such as PTSD. These researchers reported the findings of 2 teenagers with major depressive disorder (MDD) who underwent 3 and 7 sessions of EMDR aimed at memories of stressful life events. After treatment, their depressive symptoms decreased to the level of full remission, and the therapeutic gains were maintained after 2 and 3 months of follow-up. The effectiveness of EMDR for depression is explained by the model of adaptive
information processing. Given the powerful effects observed within a brief period of time, the authors suggested that further investigation of EMDR for depressive disorders is warranted.

Torun (2010) noted that vaginismus is a type of sexual dysfunction in which spasm of the vaginal musculature prevents penetrative intercourse. The main diagnostic criterion is the presence of recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. In many cases, associated pain or the fear of pain may contribute to its persistence. These researchers reported 2 patients who presented with vaginismus that developed secondary to childhood sexual trauma, which was treated with the EMDR. Randomized controlled trials with PTSD patients and with victims of sexual abuse have shown that EMDR is effective. The standard 8-phase EMDR protocol was used in both of the presented cases. Following 3 sessions of EMDR, the patients exhibited a substantial reduction in self-reported and clinician-rated anxiety, and a reduction in the credibility of dysfunctional beliefs concerning sexual intercourse. The authors concluded that these findings support the notion that EMDR could be an effective treatment alternative for patients with vaginismus of traumatic etiology. These preliminary results need to be validated with well-designed studies.

Landin-Romero et al (2013) noted that some functional imaging abnormalities found in bipolar disorder are state-related, whereas others persist into euthymia. It is uncertain to what extent these latter changes may reflect continuing sub-syndromal affective fluctuations and whether those can be modulated by therapeutic interventions. These researchers reported functional magnetic resonance imaging (fMRI) findings during performance of the n-back working memory task in a bipolar patient who showed a marked improvement in sub-syndromal affective symptoms after receiving EMDR therapy in the context of a clinical trial. The patient's clinical improvement was accompanied by marked changes in functional imaging, as compared to 30 healthy subjects.
Changes in fMRI were noted particularly in de-activation, with failure of de-activation in the medial frontal cortex partially normalizing after treatment. The authors concluded that this case supports the potential therapeutic overall benefit of EMDR in traumatized bipolar patients and suggests a possible neurobiological mechanism of action: normalization of default mode network dysfunction.

de Bont and colleagues (2013) stated that trauma contributes to psychosis and in psychotic disorders PTSD is often a co-morbid disorder. A problem is that PTSD is under-diagnosed and under-treated in people with psychotic disorders. This study’s primary goal is to examine the safety and effectiveness of prolonged exposure and EMDR for PTSD in patients with both psychotic disorders and PTSD, as compared to a waiting list. Secondly, the effects of both treatments are determined on (a) symptoms of psychosis, in particular verbal hallucinations, (b) depression and social performance, and (c) economic costs. Thirdly, goals concern links between trauma exposure and psychotic symptomatology and the prevalence of exposure to traumatic events, and of PTSD. Fourthly predictors, moderators, and mediators for treatment success will be explored. These include cognitions and experiences concerning treatment harm, credibility and burden in both participants and therapists. A short PTSD-screener assesses the possible presence of PTSD in adult patients (21 to 65 years of age) with psychotic disorders, while the Clinician Administered PTSD Scale interview will be used for the diagnosis of current PTSD. The M.I.N.I. Plus interview will be used for diagnosing lifetime psychotic disorders and mood disorders with psychotic features. The purpose is to include consenting participants (n = 240) in a multi-site single-blind randomized clinical trial. Patients will be allocated to 1 of 3 treatment conditions (n = 80 each): prolonged exposure or EMDR (both consisting of 8 weekly sessions of 90 minutes each) or a 6-month waiting list. All participants are subjected to blind assessments at pre-treatment, 2 months post-treatment, and 6 months post-treatment. In addition, participants in the experimental conditions will have assessments at mid treatment and at
12-month follow-up.

Baslet (2012) noted that psychogenic non-epileptic seizures (PNES) can significantly affect an individual's quality of life, the health care system, and even society. The first decade of the new millennium has seen renewed interest in this condition, but etiological understanding and evidence-based treatment availability remain limited. After the diagnosis of PNES is established, the first therapeutic step includes a presentation of the diagnosis that facilitates engagement in treatment. These investigators presented the current evidence of treatments for PNES published since the year 2000 and discussed further needs for clinical treatment implementation and research. They reviewed clinical trials that have evaluated the effectiveness of structured, standardized psychotherapeutic and psychopharmacological interventions. The primary outcome measure in clinical trials for PNES is event frequency, although it is questionable whether this is the most accurate indicator of functional recovery. Cognitive behavioral therapy has evidence of efficacy, including 1 pilot randomized controlled trial where cognitive behavioral therapy was compared with standard medical care. The anti-depressant sertraline did not show a significant difference in event frequency change when compared to placebo in a pilot randomized, double-blind, controlled trial, but it did show a significant pre- versus post-treatment decrease in the active arm. Other interventions that have shown efficacy in uncontrolled trials included augmented psychodynamic interpersonal psychotherapy, group psychodynamic psychotherapy, group psychoeducation, and the anti-depressant venlafaxine. Larger clinical trials of these promising treatments are necessary, while other psychotherapeutic interventions such as hypnotherapy, mindfulness-based therapies, and EMDR may deserve exploration.

Tesarz and associates (2013) examined if a standardized, short-term EMDR intervention added to treatment as usual (TAU) reduces pain intensity in non-specific chronic back pain (CBP) patients with psychological trauma versus TAU alone. The
study will recruit 40 non-specific CBP patients who have experienced psychological trauma. After a baseline assessment, the patients will be randomized to either an intervention group (n = 20) or a control group (n = 20). Individuals in the EMDR group will receive ten 90-min sessions of EMDR fortnightly in addition to TAU. The control group will receive TAU alone. The post-treatment assessments will take place 2 weeks after the last EMDR session and 6 months later. The primary outcome will be the change in the intensity of CBP within the last 4 weeks (numeric rating scale 0 to 10) from the pre-treatment assessment to the post-treatment assessment 2 weeks after the completion of treatment. In addition, the patients will undergo a thorough assessment of the change in the experience of pain, disability, trauma-associated distress, mental co-morbidities, resilience, and quality of life to explore distinct treatment effects. To explore the mechanisms of action that are involved, changes in pain perception and pain processing (quantitative sensory testing, conditioned pain modulation) will also be assessed. The statistical analysis of the primary outcome will be performed on an intention-to-treat basis. The secondary outcomes will be analyzed in an explorative, descriptive manner. The authors concluded that this study adapts the standard EMDR treatment for traumatized patients to patients with CBP who have experienced psychological trauma. This specific, mechanism-based approach might benefit patients.

Tesarz and colleagues (2014) systematically reviewed the evidence regarding the effects of EMDR therapy for treating chronic pain. These researchers screened MEDLINE, EMBASE, the Cochrane Library, CINHAL Plus, Web of Science, PsycINFO, PSYNDEX, the Francine Shapiro Library, and citations of original studies and reviews. All studies using EMDR for treating chronic pain were eligible for inclusion in the present study. The main outcomes were pain intensity, disability, and negative mood (depression and anxiety). The effects were described as standardized mean differences. A total of 2 controlled trials with a total of 80 subjects and 10 observational studies with 116 subjects met the inclusion criteria. All of these studies
assessed pain intensity. In addition, 5 studies measured disability, 8 studies depression, and 5 studies anxiety. Controlled trials demonstrated significant improvements in pain intensity with high effect sizes (Hedges' g: -6.87 [95% confidence interval (CI95): -8.51 to -5.23] and -1.12 [CI95: -1.82 to -0.42]). The pre-treatment/post-treatment effect size calculations of the observational studies revealed that the effect sizes varied considerably, ranging from Hedges' g values of -0.24 (CI95: -0.88 to 0.40) to -5.86 (CI95: -10.12 to -1.60) for reductions in pain intensity, -0.34 (CI95: -1.27 to 0.59) to -3.69 (CI95: -24.66 to 17.28) for improvements in disability, -0.57 (CI95: -1.47 to 0.32) to -1.47 (CI95: -3.18 to 0.25) for improvements in depressive symptoms, and -0.59 (CI95: -1.05 to 0.13) to -1.10 (CI95: -2.68 to 0.48) for anxiety. Follow-up assessments showed maintained improvements; no adverse events were reported. The authors concluded that although these findings suggested that EMDR may be a safe and promising treatment option in chronic pain conditions, the small number of high-quality studies led to insufficient evidence for definite treatment recommendations.

An UpToDate review on “Treatment of depersonalization derealization disorder” (Simeon, 2015) states that “Eye movement desensitization and reprocessing (EMDR), a form of CBT that incorporates saccadic eye movements during exposure, has also been proposed for use in the treatment of DDPD in conjunction with hypnosis”. Its effectiveness need to be ascertained in well-designed studies.

An UpToDate review on “Treatment of myofascial pelvic pain syndrome in women” (Moynihan and Elkadry, 2015) states that “Eye movement desensitization and reprocessing -- Eye movement desensitization and reprocessing (EMDR) is a psychotherapy technique that was initially developed to treat people with post-traumatic stress disorder. Over time, it has been used to treat people with other trauma-related conditions, including chronic pain. The goal of EMDR is to guide patients to process memories or experiences that are contributing to pain and to use these past experiences to create
positive experiences in the future. EMDR is conducted one-on-one by a therapist who has specific training in the process. Clinical studies of EMDR in women with MPPS are lacking”.

An UpToDate review on “Psychotherapy for specific phobia in adults” (McCabe and Swinson, 2015) states that “Eye movement desensitization and reprocessing -- Eye movement desensitization and reprocessing (EMDR) is a psychotherapeutic approach initially developed to treat post-traumatic stress disorder. EMDR is a variation of exposure that incorporates exposure to traumatic memories with simultaneous focus on external stimuli such as therapist-directed bilateral eye movements, hand-tapping, or audio stimulation. A trial comparing EMDR to a waitlist control condition in 31 patients with dental phobia found that EMDR focused on processing traumatic dental memories reduced dental anxiety and avoidance behavior compared to the control group after one year. Additional research is needed to confirm these findings and to determine whether EMDR offers incremental benefit over imaginal or in vivo exposure”.

Bandelow et al (2015) stated that no previous meta-analysis has attempted to compare the efficacy of pharmacological, psychological and combined treatments for the 3 main anxiety disorders (panic disorder, generalized anxiety disorder and social phobia). Pre-post and treated versus control effect sizes (ES) were calculated for all evaluable randomized-controlled studies (n = 234), involving 37,333 patients. Medications were associated with a significantly higher average pre-post ES [Cohen's d = 2.02 (1.90 to 2.15); 28,051 patients] than psychotherapies [1.22 (1.14 to 1.30); 6,992 patients; p < 0.0001]. Effect sizes were 2.25 for serotonin-noradrenaline reuptake inhibitors (n = 23 study arms), 2.15 for benzodiazepines (n = 42), 2.09 for selective serotonin reuptake inhibitors (n = 62) and 1.83 for tricyclic anti-depressants (n = 15). Effect sizes for psychotherapies were mindfulness therapies, 1.56 (n = 4); relaxation, 1.36 (n = 17); individual cognitive behavioral/exposure therapy (CBT), 1.30 (n = 93);
group CBT, 1.22 (n = 18); psychodynamic therapy 1.17 (n = 5); therapies without face-to-face contact (e.g., Internet therapies), 1.11 (n = 34); EMDR, 1.03 (n = 3); and inter-personal therapy 0.78 (n = 4). The ES was 2.12 (n = 16) for CBT/drug combinations. Exercise had an ES of 1.23 (n = 3). For control groups, ES were 1.29 for placebo pills (n = 111), 0.83 for psychological placebos (n = 16) and 0.20 for wait-lists (n = 50). In direct comparisons with control groups, all investigated drugs, except for citalopram, opipramol and moclobemide, were significantly more effective than placebo. Individual CBT was more effective than waiting list, psychological placebo and pill placebo. When looking at the average pre-post ES, medications were more effective than psychotherapies. Pre-post ES for psychotherapies did not differ from pill placebos; this finding cannot be explained by heterogeneity, publication bias or allegiance effects. However, the decision on whether to choose psychotherapy, medications or a combination of the two should be left to the patient as drugs may have side effects, interactions and contraindications.

Addiction:

Little et al (2016) conducted 2 proof-of-principle studies to examine if EMDR can reduce the sensory richness of substance-related mental representations and accompanying craving levels. These researchers investigated the effects of EMDR on (i) vividness of food-related mental imagery and food craving in dieting and non-dieting students, and (ii) vividness of recent smoking-related memories and cigarette craving in daily smokers. In both experiments, participants recalled the images while making EM or keeping eyes stationary. Image vividness and emotionality, image-specific craving and general craving were measured before and after the intervention. As a behavioral outcome measure, participants in study 1 were offered a snack choice at the end of the experiment. Results of both experiments showed that image vividness and craving increased in the control condition but remained stable or decreased after the EMDR; EMDR additionally reduced image emotionality (experiment 2) and affected behavior (experiment...
1): participants in the EMDR group were more inclined to choose healthy over unhealthy snack options. The authors concluded that these data suggested that EMDR can be used to reduce intensity of substance-related imagery and craving. Moreover, they stated that although long-term effects are yet to be demonstrated, the current studies suggested that EMDR might be a useful technique in addiction treatment.

Post-Operative Pain:

In a randomized controlled trial (RCT), Maroufi et al (2016) examined the effectiveness of EMDR for post-operative pain management in adolescents. A total of 56 adolescent surgical patients aged between 12 to 18 years were allocated to gender-balanced EMDR (treatment) or non-EMDR (control) groups. Pain was measured using the Wong-Baker FACES Pain Rating Scale (WBFS) before and after the intervention (or non-intervention for the control group). A Wilcoxon signed-rank test demonstrated that the EMDR group experienced a significant reduction in pain intensity after treatment intervention, whereas the control group did not. Additionally, a Mann-Whitney U-test showed that, while there was no significant difference between the 2 groups at time 1, there was a significant difference in pain intensity between the 2 groups at time 2, with the EMDR group experiencing lower levels of pain. The authors concluded that these findings suggested that EMDR may be an effective treatment modality for post-operative pain. These preliminary findings need to be validated by well-designed studies.

CPT Codes / HCPCS Codes / ICD-10 Codes

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<th>Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by &quot;+&quot;:</th>
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<td>ICD-10 codes will become effective as of October 1, 2015:</td>
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<tr>
<td>There is no specific CPT code for eye movement desensitization and reprocessing:</td>
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Other CPT codes related to the CPB:

<table>
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<tr>
<th>Codes</th>
<th>Description</th>
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<tr>
<td>90832 - 90899</td>
<td>Psychotherapy, other psychotherapy, and other psychiatric services or procedures [not covered for eye movement desensitization and reprocessing therapy]</td>
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ICD-10 codes covered if selection criteria are met:

<table>
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<tr>
<th>Codes</th>
<th>Description</th>
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<tr>
<td>F43.10 - F43.12</td>
<td>Posttraumatic stress disorder</td>
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<tr>
<td>Z86.51</td>
<td>Personal history of combat and operational stress reaction</td>
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ICD-10 codes not covered for indications listed in the CPB:

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<th>Codes</th>
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<tr>
<td>F01.50 - F43.0</td>
<td>Mental disorders (other than posttraumatic stress disorder)</td>
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<tr>
<td>F43.20 - F99</td>
<td>Phantom limb (syndrome)</td>
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<tr>
<td>G54.6 - G54.7</td>
<td>Chronic pain, not elsewhere classified</td>
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<tr>
<td>G89.21 - G89.29</td>
<td>Chronic pain syndrome</td>
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<td>G89.4</td>
<td>Chronic pain syndrome</td>
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<td>M54.5</td>
<td>Low back pain [chronic back pain]</td>
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<tr>
<td>M54.9</td>
<td>Dorsalgia, unspecified [chronic back pain]</td>
</tr>
<tr>
<td>R56.00 - R56.9</td>
<td>Convulsions [psychogenic non-epileptic seizures]</td>
</tr>
</tbody>
</table>

The above policy is based on the following references:

3. Lohr JM, Tolin DF, Lilienfeld SO. Efficacy of eye movement desensitization and reprocessing: Implications for


46. de Bont PA, van den Berg DP, van der Vleugel BM, et al. A
multi-site single blind clinical study to compare the effects of prolonged exposure, eye movement desensitization and reprocessing and waiting list on patients with a current diagnosis of psychosis and comorbid post traumatic stress disorder: Study protocol for the randomized controlled trial Treating Trauma in Psychosis. Trials. 2013;14:151.

47. Baslet G. Psychogenic nonepileptic seizures: A treatment review. What have we learned since the beginning of the millennium? Neuropsychiatr Dis Treat. 2012;8:585-598.


50. Simeon D. Treatment of depersonalization derealization disorder. UpToDate Inc., Waltham, MA. Last reviewed April 2015.


55. Staring AB, van den Berg DP, Cath DC, et al. Self-esteem treatment in anxiety: A randomized controlled crossover trial of eye movement desensitization and reprocessing (EMDR) versus competitive memory training (COMET) in


Amendment to
Aetna Clinical Policy Bulletin Number: 0583
Eye Movement Desensitization and Reprocessing (EMDR) Therapy

There are no amendments for Medicaid.