ACCELERATED RESOLUTION THERAPY

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BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

COVERAGE RATIONALE

Accelerated Resolution Therapy (ART) is unproven and not medically necessary for the treatment of behavioral disorders including, but not limited to, Post-Traumatic Stress Disorders (PTSD).

A review of the clinical literature does not support ART as a significant intervention in treating behavioral disorders, such as PTSD. A number of substantial limitations exist in the reviewed studies, such as wide variation of treatment protocols, small sample sizes, and inadequacies in study design. The studies available for review are limited to two randomized, controlled trials and small cohort studies of similar populations.

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with Level of Care Guidelines and/or evidence-based clinical guidelines.

All services must be provided by or under the direction of a properly qualified behavioral health provider.

DESCRIPTION OF SERVICES

Accelerated Resolution Therapy (ART) is a type of psychological therapy designed to treat the physiological and cognitive aspects of depression, anxiety, panic attacks, post-traumatic stress disorder (PTSD). ART is delivered in 1 to 5 sessions over an approximate 2-week timeframe.

ART incorporates aspects of Exposure Therapy, Gestalt Therapy, Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Imagery Re-scripting, Guided Imagery, and Brief Psychodynamic Therapy.
**Summary of Clinical Evidence**

A review of the current literature does not support Accelerated Resolution Therapy as a significant intervention in treating Post-Traumatic Stress Disorders.

The studies available for review are limited to two randomized, controlled trials and small cohort studies of similar populations. Though short-term benefits have been seen, long-term efficacy of ART has not been determined. ART is considered unproven until additional studies are available.

**Clinical Trials**

Kip and colleagues (2012) conducted a prospective cohort study to examine the use of Accelerated Resolution Therapy (ART), with the use of eye movements, for the treatment of adults with Post-Traumatic Stress Disorder (PTSD). Eighty adults (aged 21-60) with PTSD were recruited for a median of three ART sessions. 66 of 80 completed the treatment and 54 of 80 provided data at 2-months post-treatment. Results indicate that there was a significant treatment effect across a range of symptoms. The mean score on the PCL-C was 54.5 ± 12.2 before ART versus 31.2 ± 11.4 after ART (mean difference = 22.8 ± 13.5; effect size = 1.72; p < 0.0001). No serious adverse events were reported. The authors conclude that ART is a safe and effective treatment for the symptoms of PTSD.

Kip and colleagues (2013) conducted an uncontrolled prospective cohort study to evaluate the use of ART in the treatment of PTSD and comorbid major depressive disorder. 28 subjects were recruited and participated in a mean of 3.7 ART sessions. Follow-up was recorded at both 2- and 4-months post-ART. Follow-up data suggest that there is a statistically significant treatment effect observed for symptoms of PTSD and depression following ART. For the PCL-C, the pre-ART mean was 62.5 with mean reductions of -29.6, -30.1, and -31.4 at post-ART, 2-month, and 4-month follow-up, respectively (p <0.0001). For the CES-D, the pre-ART mean was 35.1 with mean reductions of -20.6, -18.1, and -15.6 at post-ART, 2-month, and 4-month follow-up, respectively (p <0.0001). Adverse events included feeling depressed, lightheadedness and balance issues, and participant adverse health events not directly related to ART. The authors conclude that ART is a brief, safe, and effective treatment for adults with PTSD and comorbid depression.

Kip and colleagues (2013) conducted a randomized controlled trial to evaluate the effectiveness of ART for combat-related psychological trauma. 57 U.S. service members/veterans were randomly assigned to either receive ART or an Attention Control (AC) regimen, with those in the AC group offered crossover to ART. Data were collected after a mean of 3.7 ART sessions (with a 94% completion rate) via self-report after 3 months. Mean reductions in symptoms of PTSD, depression, anxiety, and trauma-related guilt were significantly greater (p < 0.001) with ART compared to AC. Favorable results for those treated with ART persisted at 3 months, including reduction in aggression (p < 0.0001). No adverse events were reported. The authors conclude ART appears to be a brief, effective, and safe method of exposure therapy for veterans with symptoms of combat-related PTSD.

Kip and colleagues (2014) conducted a randomized controlled trial to assess ART versus attention control (AC) in 45 U.S. service members/veterans with symptoms of PTSD. The study also examined the treatment of pain experienced by veterans with PTSD. Treatment in the ART group included Imaginal Exposure (IE), Imagery Re-scripting (IR), and the use of bilateral eye movements, with a mean of 3.7 sessions. The mean pre-/post-change on the POQ was -16.9 +/-16.6 in the ART group versus -0.7 +/- 14.2 in the AC group (effect size p=0.0006). The study also showed that there were significant decreases in pain with ART versus AC treatment. No significant adverse events were reported. The authors conclude that ART can significantly reduce the symptoms of both PTSD and pain in service members/veterans.

Kip and colleagues (2015) examined the effect of ART between a civilian and a military population. Individual data were pooled from two studies of ART. The first study examined 80 civilians in an uncontrolled prospective cohort. The second study examined military personnel in a 2-group randomized controlled trial. Both studies involved ART intervention in 1 to 5 sessions, and included imaginal exposure (IE), imagery re-scripting, and bilateral eye movements. Results found that mean PCL scores before/after treatment with ART were 53.2/30.2 among civilians compared with 56.0/40.5 among military participants (adjusted p = 0.25). The authors conclude that there are meaningful reductions in PTSD symptoms in both civilian and military populations with ART treatment.

**Systematic Reviews and Meta-Analyses**

Finnegan and colleagues (2015) conducted a review of ART. The authors indicate that ART can achieve a positive result in one to five sessions over a short period of time. ART can also significantly reduce PTSD symptoms in both military and civilian populations. ART may also be a useful treatment for other conditions including depression, anxiety, pain, alcohol and drug abuse, etc.
Steenkamp and colleagues (2016) conducted a review of ART. The authors indicate that ART is considered a second-line intervention, along with other cognitive-behavioral therapies. The authors conclude that there is a need for improvement in PTSD treatments, and for novel treatment approaches to be studied.

**Professional Societies**

**Substance Abuse and Mental Health Services Administration (SAMHSA):**
Accelerated Resolution Therapy is listed in SAMHSA’s National Registry of Evidence-based Programs and Practices.

**U.S. FOOD AND DRUG ADMINISTRATION**

Accelerated Resolution Therapy is not subject to Food and Drug Administration (FDA) regulations.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**

Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) for Accelerated Resolution Therapy could not be identified.

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90899</td>
<td>Unlisted psychiatric service or procedure</td>
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**REFERENCES**


### HISTORY/REVISION INFORMATION

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<th>Action/Description</th>
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<td>04/11/2018</td>
<td>• Version 1 approved by UMC. New policy, previously approved by CTAC.</td>
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<tr>
<td>10/21/2019</td>
<td>• Approval to retire policy</td>
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