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Cognitive Rehabilitation
Corporate Medical Policy

File Name: Cognitive Rehabilitation
File Code: UM.REHAB.10
Origination: New Policy (Separated from Speech Language Pathology Medical Policy)
Last Review: 06/2020
Next Review: 06/2021
Effective Date: 10/01/2020

Description/Summary

Cognitive rehabilitation is a therapeutic approach designed to improve cognitive functioning after central nervous system insult. It includes an assembly of therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, problem-solving, and executive functions. Cognitive rehabilitation comprises tasks to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems. Cognitive rehabilitation may be performed by a physician, psychologist, or a physical, occupational, or speech therapist.

For individuals who have cognitive deficits due to traumatic brain injury who receive cognitive rehabilitation delivered by a qualified professional, the evidence includes randomized controlled trials (RCTs), nonrandomized comparison studies, case series, and systematic reviews. Relevant outcomes are functional outcomes and quality of life. The cognitive rehabilitation trials have methodologic limitations and have reported mixed results, indicating there is no uniform or consistent evidence base supporting the efficacy of this technique. Systematic reviews have generally concluded that efficacy of cognitive rehabilitation is uncertain. The evidence is insufficient to determine the effects of the technology on health outcomes. Clinical input obtained in 2010 provided the strongest support for the use of cognitive rehabilitation as part of the treatment of traumatic brain injuries. Cognitive rehabilitation may be considered medically necessary for traumatic brain injury based on this input.

For individuals who have cognitive deficits due to dementia who receive cognitive rehabilitation delivered by a qualified professional, the evidence includes RCTs, nonrandomized comparison studies, case series, and systematic reviews. Relevant outcomes are functional outcomes and quality of life. Systematic reviews of RCTs have generally shown no benefit of cognitive rehabilitation or effects of clinical importance. One large RCT evaluating a goal-oriented cognitive rehabilitation program reported a significantly less functional decline in 1 of 2 functional scales and lower rates of institutionalization in the cognitive rehabilitation group compared with usual care at 24 months. These results need replication. The evidence is insufficient to determine the effect of the technology on health outcomes.

For individuals who have cognitive deficits due to stroke who receive cognitive rehabilitation delivered by a qualified professional, the evidence includes RCTs and systematic reviews. Relevant outcomes are functional outcomes and quality of life. Four systematic reviews evaluating 3 separate domains of cognitive function have shown no benefit of cognitive rehabilitation or effects of clinical importance. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have cognitive deficits due to multiple sclerosis who receive cognitive rehabilitation delivered by a qualified professional, the evidence includes RCTs and systematic reviews. Relevant outcomes are functional outcomes and quality of life. Systematic reviews of RCTs have shown no significant effects of cognitive rehabilitation on cognitive outcomes. Although numerous RCTs have investigated cognitive rehabilitation for multiple sclerosis, high quality trials are lacking. The ability to draw conclusions based on the overall body of evidence is limited by the heterogeneity of patient samples, interventions, and outcome measures. Further, results of the available RCTs have been mixed, with positive studies mostly reporting short-term benefits. Evidence for clinically significant, durable improvements in cognition is currently lacking. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have cognitive deficits due to epilepsy, autism spectrum disorder, postencephalopathy, or cancer who receive cognitive rehabilitation delivered by a qualified professional, the evidence includes RCTs, nonrandomized comparison studies, and case series. Relevant outcomes are functional outcomes and quality of life. The quantity of studies for these conditions is much less than that for the other cognitive rehabilitation indications. Systematic reviews generally have not supported the efficacy of cognitive rehabilitation for these conditions. Relevant RCTs have had methodologic limitations, most often very short lengths of follow-up, which do not permit strong conclusions about efficacy. The evidence is insufficient to determine the effects of the technology on health outcome

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I - CPT® Code Table
Attachment II - ICD-10-CM Code Table

When a service may be considered medically necessary

Cognitive rehabilitation (as a distinct and definable component of the rehabilitation process) may be considered **medically necessary** in the rehabilitation of patients with traumatic brain injury or brain injury due to cerebrovascular accident (stroke) , intracranial aneurysm, anoxia, encephalitis, brain tumors, or brain toxins when **ALL** of the following conditions are met:

- For services to be considered medically necessary, they must be provided by a qualified licensed professional and must be prescribed by the attending physician as part of the written care plan (e.g. an occupational therapist, physical therapist, speech/language pathologist, neuropsychologist, psychiatrist, psychologist or a physician). In addition, there must be a potential for improvement (based on preinjury function), and patients

must be able to actively participate in the program. (Active participation requires sufficient cognitive function to understand and participate in the program, as well as adequate language expression and comprehension, i.e., participants should not have severe aphasia.) Ongoing services are considered necessary only when there is demonstrated continued objective improvement in function.

When a service is considered investigational

Cognitive rehabilitation is **investigational** for all other applications, including but not limited to, concussion/post-concussion syndrome, attention deficit disorder, attention deficit hyperactivity disorder, developmental delay, learning disabilities, prematurity, Parkinson's disease, multiple sclerosis, seizure disorder, cerebral palsy, schizophrenia, pervasive developmental disorders/autism spectrum disorders, and the aging population, including individuals with Alzheimer's disease and other dementias. There is insufficient evidence in the published peer-reviewed literature to validate the effectiveness of cognitive rehabilitation as either an isolated component or one component of a multimodal rehabilitation program for these conditions.

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Related Policies

Speech Language Pathology Services

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

06/2017	Input received from external provider. New policy (new policy created from speech language pathology services to address cognitive rehabilitation services individually. Updated position statement from Speech Language Pathology Services medical policy to include: brain injury due to cerebrovascular accident (stroke), intracranial aneurysm, anoxia, encephalitis, brain tumors, or brain toxins. Updated ICD-10 tables
01/2018	97127 was added. This code can only be reported once per day. Code 97532 was deleted Added HCPCS CodeG0515.Added code 99483 code can only be reported every 180 days.
06/2018	Reviewed no changes to policy statement.
01/2019	Summary updated to reflect BCBS MPRM 8.03.10. No change to policy statement. Updated references.
01/2020	Adaptive Maintenance Updates: Deleted 97127 and replaced with 97129 & 97130 effective 01/01/2020. Code 96125 added to table as requiring prior approval if over 8 hours.
03/2020	Reviewed at MPT removed PA requirement for code 96125.
06/2020	Policy reviewed no changes to policy statement. References updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

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Attachment I
CPT® Code Table

The following code will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Brief Description**	**Policy Instructions**
CPT®	96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	.
CPT®	97129	Therapeutic interventions that focus on cognitive function and compensatory strategies; initial 15 minutes	
CPT®	97130	Therapeutic interventions that focus on cognitive function and compensatory strategies; each additional 15 minutes	
CPT®	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care	The code can only be reported every 180 days.

		Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	
HCPCS	G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	

Attachment II
ICD-10-CM Code Table

ICD-10 Code	Description
The following diagnoses are considered medically necessary when applicable criteria is met.	
S06.0-S06.9X9-	Traumatic brain injury, code range
I63.9	Cerebral infarction (Stroke)
I67.1	Cerebral aneurysm (Intracranial)
G93.1	Anoxic brain damage, not elsewhere specified
G04.00-G04.02	Encephalitis, code range
G92	Toxic encephalopathy
C71.0-C71.9 D33.0-D33.2 D43.0-D43.2 D49.6	Brain Tumor(s) code ranges