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: 06/2018
Next Review: 06/2019
Effective Date: 08/01/2018

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 consists of tasks designed to reinforce or re-establish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems.

Policy

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I
Attachment II

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.

**Reference Resources**

Canadian best practice recommendations for stroke care. Ottawa (ON): Canadian Stroke
Network; 2010 Dec 8.
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rehabilitation (CACR) for patients with acquired brain injury. Cincinnati Children's Hospital
Medical Center; 2011 Sep 13.
rehabilitation in adults. A national clinical guideline. Scottish Intercollegiate Guidelines
Network (SIGN); 2013 Mar.
Health and Care Excellence (NICE); 2013 Jun.
Caltagirone C, Costa A. A pilot study on the effect of cognitive training on BDNF serum
15. Blue Cross Blue Shield Association Medical Policy Reference Manual. 8.03.10 Cognitive
Rehabilitation, (March 2017).
16. Blue Cross Blue Shield Association Technology Evaluation Center (TEC). Cognitive
Rehabilitation for Traumatic Brain Injury in Adults. TEC Assessments 2002, Volume 17, No.
20.
17. Blue Cross Blue Shield Association Technology Evaluation Center (TEC). Cognitive
05/27/14).
18. Blue Cross and Blue Shield of Florida. Medical Coverage Guidelines (medical policy) 01-
DOI: 10.1002/14651858.CD003586. (Updated 07/04/05).
Rehabilitation; European Federation of Neurological Societies. EFNS guidelines on cognitive
21. Ceravolo MG. Cognitive rehabilitation of attention deficit after brain damage: from
role of plasticity. Front Neurol. 2015 Apr 2;6:67.
23. Cicerone KD et al. Evidence-based cognitive rehabilitation: updated review of the
(Accessed 06/22/14)
24. Cicerone KD, et. al. Evidence-Based Cognitive Rehabilitation: Updated Review of the
06/22/14)
26. Clare L, Woods RT, Moniz Cook ED, Orrell M, Spector A. Cognitive rehabilitation and
cognitive training for early-stage Alzheimer’s disease and vascular dementia. The Cochrane
Database of Systematic Reviews 2003, Issue 4. Art. No.: CD003260. DOI:
10.1002/14651858.CD003260. (Updated 09/04/06).
27. ClinicalTrials.gov. NCT00166348. Does Cognitive Rehabilitation Demonstrate Benefits in the
Group Setting With People Whom Have Experienced Brain Injury? Mayo Clinic. Last updated
01/19/10.
28. ClinicalTrials.gov. NCT01207856. Randomised Controlled Clinical Trial of Cognitive Rehabilitation in Multiple Sclerosis (REACTIV). University Hospital, Bordeaux. Last updated 05/05/11.
38. Florida Medicare Part B Local Coverage Determination. L6196 THERSVCS Therapy and Rehabilitation Services, 01/16/07.
39. Florida Medicare Part B Local Coverage Determination. LCD for Therapy and Rehabilitation Services (L29289) (02/02/09); last updated 01/07/14.
61. Samenienė J, Kriščiūnas A, Endzelytė E. The evaluation of the rehabilitation effects on cognitive dysfunction and changes in psychomotor reactions in stroke patients. Medicina (Kaunas) 2008; 44(11).

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>06/2017</td>
<td>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</td>
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<tr>
<td>01/2018</td>
<td>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.</td>
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<tr>
<td>06/2018</td>
<td>Reviewed no changes to policy statement.</td>
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Eligible providers

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

Approved by BCBSVT Medical Directors       Date Approved

Gabrielle Bercy-Roberson, MD, MPH, MBA
Senior Medical Director  
Chair, Health Policy Committee

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I
CPT® Code Table

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Brief Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>97127</td>
<td>Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>The code can only be reported one time per day</td>
<td></td>
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<tr>
<td>CPT®</td>
<td>99483</td>
<td>initiating, organizing and sequencing tasks, direct (one-on-one) patient contact</td>
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<td></td>
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<td>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 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.</td>
<td>The code can only be reported every 180 days.</td>
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</table>
Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

| HCPCS | G0515 |

Attachment II
ICD-10-CM Code Table

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