

## Clinical Policy: Cognitive Rehabilitation Therapy

Reference Number: TX.CP.MP.553

Last Review Date: 07/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

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### Description

An acquired brain injury (ABI) is a non-congenital injury to the brain that occurs after birth that disrupts the normal function of the brain. Traumatic brain injury (TBI) is a subset of ABI and may be caused by external blows or jolts to the head, falls, concussions, or skull fractures, industrial accidents, domestic violence, and combat. The broader ABI includes TBI and other brain injuries resulting from stroke, heart attack, brain tumors, poisoning, infection, choking, near-drowning, or other anoxic conditions.

Cognitive rehabilitation therapy (CRT) “attempts to enhance functioning and independence in patients with cognitive impairments as a result of brain damage or disease” (IOM, 2011, p. 76). The goal of CRT is to help an individual with a brain injury enhance his or her ability to function in daily life by recovering or compensating for damaged cognitive functions. A restorative approach helps the member reestablish cognitive function, while compensatory approaches help the individual to adapt to an ongoing impairment. These two techniques can be used in combination and can be components of a comprehensive multidisciplinary rehabilitation program that involves other forms of remediation and psychosocial therapy (Hayes, 2015).

Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. It is provided in accordance with the plan of care developed by the assessor and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

This policy provides guidelines in processing pre-authorization requests for CRT for STAR+PLUS Waiver and STAR+PLUS Dual Waiver members.

### Policy/Criteria

- I. It is the policy of Superior HealthPlan that CRT is **medically necessary** when all the following criteria are met:
  - A. The member must qualify and be eligible for the STAR+PLUS Home and Community Based Services (HCBS) program.
  - B. The member has cognitive deficits that have been acquired as a result of neurologic impairment due to **one** of the following:
    1. Traumatic brain injury
    2. Brain surgery
    3. Stroke
    4. Encephalitis and other infectious disorders
    5. Brain tumors
    6. Hypoxic-hypotensive injury

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- C. A Neurobehavioral Assessment must be completed by a physician, nurse practitioner or physician assistant or a neuropsychological assessment must be performed by a psychiatrist, psychologist, neuropsychologist or licensed psychological associate. These tests should document the member's need for CRT services. If a neurobehavioral assessment is used, it must be accompanied by a separate plan of care.
- D. The treatment conforms to the submitted plan of care specific to the member's diagnosed impairment or condition.
- E. The service must be provided by a qualified provider, which would include one of the following:
  - 1. Psychologists
  - 2. Speech and language pathologists

*Note: If services are being provided by a speech and language pathologist or an occupational therapist, treatment should be overseen by physician.*

- F. Services are rendered either in an outpatient setting or in the member's residence.
- G. Services costs do not exceed the member's individualized service plan (ISP).

## II. Initial authorization for CRT treatment must include **all** of the following to complete **medical necessity** review:

- A. An order for CRT with appropriate frequency and duration, signed and dated by the prescribing provider, and no older than three months before the actual date of service.
- B. A copy of the neurobehavioral assessment or neuropsychological assessment.
- C. A plan of care, signed and dated by the prescribing provider that includes the CRT frequency and duration.
- D. The written plan of care must include **all** of the following:
  - 1. Cognitive therapy evaluation
  - 2. Diagnosis with date of onset or exacerbation
  - 3. Short and long term functional treatment goals that are specific and measurable
  - 4. Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve measurable goals
  - 5. Education of the member and primary caregiver, if applicable
  - 6. Summary of results achieved during previous periods of therapy, if applicable
  - 7. Potential for improvement in the member's cognitive function
- E. The member's diagnosis that qualifies him/her for CRT

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**III. Continued authorization** for CRT treatment must include **all** of the following to complete the **medical necessity** review.:

- A. Treatment progress must be clearly documented in an updated plan of care/current progress summary. This must be signed by the therapist at the end of each authorization period or when additional visits are being requested.
- B. Treatment orders specifying the frequency and duration of the requested service and signed by the prescribing provider, cannot be older than three months before the actual date of service.  
Documentation must include the following:
  - 1. A description of the member's current level of functioning or impairment
  - 2. Objective demonstration of the member's progress toward each prior treatment goal
  - 3. Summary of member's response to therapy, with documentation of any issues which have limited progress
  - 4. Documentation of member's or caregiver's participation in and adherence to treatment
  - 5. Brief prognosis statement with clearly established discharge criteria
  - 6. An explanation of any changes to the member's plan of care, and the clinical rationale for revising the plan
  - 7. Prescribed treatment modalities and their anticipated frequency and duration
- C. Treatment progress must be clearly documented in an updated plan of care/current progress summary signed by the therapist, as submitted by the requesting provider at the end of each authorization period and/or when additional visits are being requested.
- D. The member must be re-evaluated on a routine basis by a qualified provider (e.g. every 30 days to 10 visits) and a follow-up neuropsychological or neurobehavioral assessment must be conducted at 12 to 18 months.

*Note: Please refer to TX.UM.26 Electronic and Verbal Signature Policy for other acceptable alternative orders.*

### IV. Additional Information

- A. Cognitive rehabilitation therapy for visuo-spatial deficits generally entails 20 one hour sessions delivered over the course of four weeks (Ciceron et al, 2000). For language and communication deficits, members usually receive therapy one to three times per week but it may be as often as five times per week in the initial phase of treatment. A CRT treatment course substantially longer than above frequency and/or duration may be considered for medical necessity based on a member's individual needs, injury, and response to treatment by sending it for secondary review.
- B. Cognitive rehabilitation therapy for all other indications, such as the treatment of mental retardation, cerebral palsy, dementia (e.g., from Alzheimer's disease, HIV-infection\*, or

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Parkinson's disease), a cognitive decline in multiple sclerosis or chronic obstructive pulmonary disease, Wernicke encephalopathy, or behavioral/psychiatric disorders such as attention-deficit/hyperactivity disorder, schizophrenia, and pervasive developmental disorders including autism are considered experimental and investigational because its effectiveness has not been proven through empirical scientific research in treating the condition or illness (*CP.MP.36 Experimental Technologies*).

*Note: CRT is considered medically necessary for encephalopathy due to HIV when medical necessity criteria in section I above are met.*

- C. Cognitive rehabilitation therapy for coma stimulation, also known as the "responsiveness program" (cognitive remediation of comatose persons), is considered experimental and investigational for the treatment of coma and persistent vegetative state because its effectiveness has not been proven through empirical scientific research in treating the condition or illness (*CP.MP.36 Experimental Technologies*).
- D. For STAR+PLUS Dual Waiver members receiving acute care services through Medicare, Superior HealthPlan will determine the medical necessity for CRT services. The service coordinator team will work with the member and family to find the appropriate Medicare provider to perform the neurobehavioral or neuropsychological assessment.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
97129	Therapeutic interventions that focus on cognitive function & compensatory strategies, direct patient contact; 1 <sup>st</sup> 15minutes
97130	Therapeutic interventions that focus on cognitive function & compensatory strategies, direct patient contact; each additional 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

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HCP Codes	Description
N/A	

### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Removed work process and imbedded under attachment. Updated authorization protocol to include work process for initial assessment and re-assessment request. Updated SC group queues to include queues for MRSA Central and MRSA West. Updated References and Signatories.	02/15	02/15
Updated references and signatories. Removed work processes imbedded under attachment. Removed initial and continued authorization for 96116 and 96118. Grammatical changes.	01/16	01/16
Updated references and signatories. Renaming of Cenpatico to Envolv People Care.	01/17	01/17
Updated review date, references, and signatories. Removed work process and corrected minor grammatical errors.	02/18	02/18
Updated approval criteria and documentation requirements. Deleted Revision history prior to 2014.	08/18	08/18
Updated to new template from TX.UM.10.53 (TX.CP.MP.553 nomenclature implementation 09/14/19). Codes entered into CPT chart.	09/19	09/19
Annual Review. Updated References.	07/20	07/20
Annual review. Updated references. Updated and removed CPT code 97532 replaced with 97129 and 97139.	07/21	07/21
Annual Review. Updated references. Section I H-J were moved to new section IV labeled <i>Additional Information</i> .	07/22	07/22

### References

1. Cicerone KD, Dahlberg C, Kalmar K, et al. Evidence-based cognitive rehabilitation: Recommendations for clinical practice. *Arch Phys Med Rehabil*. 2000; 81(12):1596-1615
2. Cicerone, K., Langerbahn, D., et al. Evidence-Based Cognitive Rehabilitation: Updated Review of the Literature From 2003 Through 2008. *Archives of Physical Medicine and Rehabilitation*, Vol 92, Apr 2011, 519-527. .
3. Cognitive Rehabilitation Therapy for Traumatic Brain Injury: Evaluating the Evidence. Report at A Glance. Institute of Medicine of National Academies. 2011. Available at: <http://www.iom.edu/Reports/2011/Cognitive-Rehabilitation-Therapy-for-Traumatic-Brain-Injury-Evaluating-the-Evidence/Report-Brief.aspx?page=1>. Accessed last 1/8/14.
4. CP.MP.36 Experimental Technologies

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5. Hayes, Inc. Medical Technology Directory. Cognitive Rehabilitation for Traumatic Brain Injury. Hayes, Inc; Lansdale, PA: June 23, 2011. Last updated July 2015.
6. Institute of Medicine. Cognitive Rehabilitation Therapy for Traumatic Brain Injury: Evaluating the Evidence. 2011. The National Academies Press.
7. Rohling, Faust, et al. Effectiveness of cognitive rehabilitation following acquired brain injury: A meta-analytic re- examination of Cicerone et al.'s (2000, 2005) systematic reviews. Neuropsychology, Vol 23(1), Jan 2009, 20-39. doi: 10.1037/a0013659
8. Sohlberg, M.M., Mateer, C.A. Cognitive Rehabilitation: An Integrative Neuropsychological Approach. 2001. Guilford Press.
9. TX.UM.26 Electronic and Verbal Signature Policy

### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

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recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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