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Original Effective Date: 05/15/01

Reviewed: 01/25/24

Revised: 02/15/24

Subject: Cognitive Rehabilitation

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

DESCRIPTION:

Cognitive rehabilitation is a structured set of therapeutic activities designed to retrain an individual's ability to think, use judgment, and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term cognitive rehabilitation is applied to various intervention strategies or techniques that attempt to help reduce, manage, or cope with cognitive deficits caused by brain injury. The desired outcomes are improved quality of life and function in home and community life. The term rehabilitation broadly encompasses reentry into familial, social, educational, and working environments, the reduction of dependence on assistive devices or services, and general enrichment of quality of life.

POSITION STATEMENT:

Cognitive rehabilitation as a distinct and definable component of the rehabilitation process **meets the definition of medical necessity** in the rehabilitation of individuals 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:

- Cognitive rehabilitation is prescribed by the attending physician as part of a written treatment plan
- Member is able to actively participate in the program (e.g. is not in a vegetative or comatose state)
- Cognitive rehabilitation is provided by a qualified licensed healthcare professional (e.g. an occupational therapist, physical therapist, speech/language pathologist, neuropsychologist, psychiatrist, psychologist or a physician)
- Member is expected to make significant improvement (based on the pre-injury function)
- Member demonstrates continued objective improvement in function, once rehabilitation is begun.

When one or more of the above conditions is not met, then cognitive rehabilitation is considered **experimental or investigational,** as there is insufficient evidence to support conclusions regarding effects on net health outcomes.

Cognitive rehabilitation is **experimental or 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, 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.

Summary and Analysis of Evidence: Cisneros et al (2021) states "Post-TBI cognitive, affective, behavioral and psychosocial disorders are known to increase memory difficulties already present in normal aging, such as those involving short-term episodic memory, working memory, and attention and memory processes related to cognitive regulation. Cognitive rehabilitation in healthy older adults has been shown to improve attention and memory performance, among other positive cognitive impacts. This is also true with mild cognitive impairment (MCI). Belleville and collaborators (2006) developed a comprehensive memory program (Méthode d'Entraînement pour Mémoire Optimale [MEMO]) for older adults with MCI that focuses on attention and encoding self-initiated strategies based on visual imagery for face-name associations and word lists and on semantic analysis and synthesis of texts. MEMO training significantly improved delayed recall of word lists, face-name associations, as well as self-reported memory functioning and psychological well-being, with the effect persisting for 6 months." Mulhern (2023) states "Given the high incidence of stroke and resultant significant impacts of cognitive impairment, there is a substantial need for evidence-based interventions and multidisciplinary efforts to facilitate return to independence, work, and participation in functional aspects of daily living. Cognitive rehabilitation addresses skills in the cognitive domains of attention, memory, and executive functioning and how they impact functionality and safety. In a course of cognitive rehabilitation, rehabilitative therapists commonly refer to more advanced activities of daily living that require increased cognitive demands as Instrumental Activities of Daily Living (IADLs). Examples of IADLs may include meal preparation, managing medications, housekeeping, managing financial responsibilities, time management for appointments, and self-care. Individuals and their support systems can benefit from cognitive rehabilitation throughout the stages of stroke recovery if there are functional, task-specific goals related to activities of daily living along with motivation.

BILLING/CODING INFORMATION:

CPT Coding

97129	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, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	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, initiating, organizing, and sequencing tasks), direct (one-on-one) patient

	contact; each additional 15 minutes (List separately in addition to code for primary procedure)

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, treatment plan, radiology studies, and operative report (if applicable).

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician visit note	18733-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Radiology report	18726-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Surgical report	28573-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

REIMBURSEMENT INFORMATION:

Refer to sections entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request

DEFINITIONS:

No guideline specific definitions apply.

RELATED GUIDELINES:

None applicable.

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 01/25/24.

GUIDELINE UPDATE INFORMATION:

04/25/02	Annual review of investigational status; no change.
05/15/03	Medical Coverage Guideline Reviewed; no change (investigational).

05/15/04	Review and revision of guideline consisting of updated references, no change to investigational status.
05/15/05	Review and revision of guideline consisting of updated references.
05/15/06	Review and revision of guideline consisting of updated references.
05/15/07	Review and revision of guideline consisting of updated references and reformatted guideline.
05/15/08	Scheduled review; no change in position statement. Update references.
06/15/09	Scheduled review; no change in position statement. Update references.
06/15/10	Biennial review; position statement revised to include indication for traumatic brain injury, and Medicare exception statement revised. Reference section updated.
09/15/10	Position Statement revised for clarification, and formatting changes.
09/15/11	Revision; formatting changes.
07/15/12	Scheduled review. Revised description and position statement. Updated references. Reformatted guideline.
01/01/13	Annual CPT coding update. Revised code descriptor for 97532.
07/15/13	Scheduled review. Revised description section, position statement and program exceptions section. Updated references and reformatted guideline.
08/15/14	Scheduled review. Revised position statement. Updated references and reformatted guideline.
07/15/15	Scheduled review. Position statement maintained. Updated references and reformatted guideline.
01/01/18	Annual CPT/HCPCS coding update: added 97127, G0515; deleted 97532. Revised program exceptions section. Reformatted guideline.
01/01/20	Annual CPT/HCPCS coding update. Added 97129, 97130. Deleted 97127, G0515.
02/15/20	Scheduled review. Revised description, maintained position statement, and updated references.
02/15/22	Scheduled review. Maintained position statement and updated references.
05/22/23	Update to Program Exceptions section.
02/15/24	Scheduled review. Revised description, maintained position statements and updated references.