

**WellCare Health Plans, Inc.**  
*The WellCare Group of Companies*

# *Clinical Coverage Guideline*



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## **Cognitive Rehabilitation**

**Guideline Number: HS-095**

**Original Effective Date: 4/2/2009**

**Revision Date: n/a**

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

# Clinical Coverage Guideline HS-095

## Cognitive Rehabilitation

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Revised Date(s): n/a

### DISCLAIMER

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### APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

### CLINICAL COVERAGE GUIDELINE

**Cognitive rehabilitation is considered medically necessary as adjunctive treatment of cognitive deficits (e.g., attention, language, memory, reasoning, executive functions, problem solving, and visual processing) when ALL of the following are met:**

- The cognitive deficits have been acquired as a result of neurologic impairment due to traumatic brain injury, stroke, or encephalopathy; **AND**,
- The member has been seen and evaluated by a neuropsychiatrist or neuropsychologist; **AND**,
- Neuropsychological testing has been performed and neuropsychological results will be used in treatment-planning and directing rehabilitation strategies; **AND**,
- The member is expected to make significant cognitive improvement, e.g., is not in a vegetative or custodial state.

**NOTE:** Cognitive rehabilitation is considered medically necessary for encephalopathy due to HIV when medical necessity criteria in guideline section 1 above are met.

**NOTE:** Rehabilitation for visuospatial deficits generally entails 20 1-hour sessions delivered over the course of 4 weeks. For language and communication deficits, patients usually receive 8 hours of weekly therapy, beginning at 4 weeks post-onset. For continuation of service beyond the initial course of rehabilitation, up to 48 weeks, proof of improvement must be given. Courses of cognitive rehabilitation substantially longer than the stated durations must be reviewed for medical necessity.

**Cognitive rehabilitation is considered experimental and investigational for the following indications:**

- dementia (e.g., from Alzheimer's disease, Parkinson's disease),
- cognitive decline in multiple sclerosis,
- or following brain surgery (e.g., frontal lobectomy),

- and behavioral/psychiatric disorders such as attention-deficit/hyperactivity disorder (ADHD), schizophrenia,
- Pervasive developmental disorders including autism
- Mental retardation
- Cerebral palsy
- Any indication not listed in the medically necessary section above

**Cognitive rehabilitation is considered experimental and investigational for the treatment of children and adolescents with cognitive deficits of any etiology.**

### **Background**

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

Individualized, structured cognitive rehabilitation programs are effective in facilitating recovery in selected patients with traumatic head injury, acute brain insult or stroke. There is insufficient evidence, however, to support the use of cognitive rehabilitation for the treatment of mild traumatic brain injury. Cognitive rehabilitation has also been proposed for numerous other conditions that cause impaired cognitive function, including dementia, cerebral palsy, attention deficit disorder, schizophrenia, pervasive developmental disorders, learning disabilities and developmental delay. There is insufficient evidence in the published medical literature to support the use of cognitive rehabilitation for these conditions.

### **CODING**

#### **Covered CPT® Codes**

**97532** Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

#### **Covered ICD-9 Procedure Code**

**93.89** Rehabilitation, not elsewhere classified

#### **HCPCS® Codes**

No applicable codes

#### **Covered ICD-9 Diagnosis Codes when the above criteria have been met.**

<b>310.2</b>	Post concussion syndrome
<b>348.1</b>	Anoxic brain damage
<b>348.30 - 348.39</b>	Encephalopathy
<b>349.82</b>	Toxic encephalopathy
<b>430 - 434.91</b>	Subarachnoid hemorrhage, intracerebral hemorrhage, other and unspecified intracranial hemorrhage, occlusion and stenosis of precerebral arteries, and occlusion of cerebral arteries
<b>436</b>	Acute, but ill-defined cerebrovascular disease
<b>437.0 - 437.9</b>	Other and Ill-Defined Cerebrovascular diseases
<b>438.0 - 438.19</b>	Late effects of Cerebrovascular Disease, i.e. Speech and Language deficits
<b>800.10 - 800.49</b>	Fracture of vault of skull, closed with intracranial injury
<b>800.60 - 800.99</b>	Fracture of vault of skull, open with intracranial injury
<b>801.10 - 801.49</b>	Fracture of base of skull, closed with intracranial injury

<b>801.60 - 801.99</b>	Fracture of base of skull, open with intracranial injury
<b>851.00 - 854.99</b>	Cerebral lacerations and contusions
<b>852.00 - 852.59</b>	Subarachnoid, subdural and extradural hemorrhage following injury
<b>853.00 - 853.19</b>	Intracranial Hemorrhage following injury
<b>854.00 - 854.19</b>	Intracranial Injury of other and specified nature
<b>905.0</b>	Late effect of fracture of skull and face bones
<b>907.0</b>	Late effect of intracranial injury without mention of skull fracture
<b>994.1</b>	Drowning and nonfatal submersion
<b>997.01</b>	Central nervous system complication (anoxic brain damage)

**Cognitive rehabilitation is considered experimental and investigational for the following indications:**

**Non-Covered ICD-9 Diagnosis – This list may not be all inclusive**

<b>290.0 - 290.43</b>	Dementia
<b>294.10 - 294.9</b>	Dementia in conditions classified elsewhere
<b>285,99 - 295.9</b>	Schizophrenic Disorders
<b>299.00 - 299.91</b>	Pervasive Developmental Disorders, including Autism
<b>314.00 - 314.93</b>	Attention Deficit Disorders
<b>317 - 319</b>	Mental Retardation
<b>331.0</b>	Alzheimer's disease
<b>332.0</b>	Paralysis agitans (Parkinson's disease)
<b>343.0 – 343.9</b>	Cerebral Palsy

\*Current Procedural Terminology (CPT®) ©2009 American Medical Association: Chicago, IL.

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