



Harmony Behavioral Health, Inc.

Harmony Behavioral Health of Florida, Inc.

Harmony Health Plan of Illinois, Inc.

HealthEase of Florida, Inc.

*'Ohana Health Plan, a plan offered by
WellCare Health Insurance of Arizona, Inc.*

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

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WellCare Prescription Insurance, Inc.

Cognitive Rehabilitation

Policy Number: HS-095

Original Effective Date: 4/2/2009

Revised Date(s): 4/30/2010; 4/30/2011

DISCLAIMER

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.

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.

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.

POSITION STATEMENT

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; **OR**
- 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.

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.

310.2 Post-concussion syndrome
348.1 Anoxic brain damage
348.30 - 348.39 Encephalopathy
349.82 Toxic encephalopathy
430 - 434.91 Subarachnoid hemorrhage, intracerebral hemorrhage, other and unspecified intracranial hemorrhage, occlusion and stenosis of precerebral arteries, and occlusion of cerebral arteries
436 Acute, but ill-defined cerebrovascular disease
437.0 - 437.9 Other and Ill-Defined Cerebrovascular diseases
438.0 - 438.19 Late effects of Cerebrovascular Disease, i.e. Speech and Language deficits
800.10 - 800.49 Fracture of vault of skull, closed with intracranial injury
800.60 - 800.99 Fracture of vault of skull, open with intracranial injury
801.10 - 801.49 Fracture of base of skull, closed with intracranial injury
801.60 - 801.99 Fracture of base of skull, open with intracranial injury
851.00 - 854.99 Cerebral lacerations and contusions
852.00 - 852.59 Subarachnoid, subdural and extradural hemorrhage following injury
853.00 - 853.19 Intracranial Hemorrhage following injury
854.00 - 854.19 Intracranial Injury of other and specified nature
905.0 Late effect of fracture of skull and face bones
907.0 Late effect of intracranial injury without mention of skull fracture
994.1 Drowning and nonfatal submersion
997.01 Central nervous system complication (anoxic brain damage)

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

290.0 - 290.43 Dementia
294.10 - 294.9 Dementia in conditions classified elsewhere
285.99 - 295.9 Schizophrenic Disorders
299.00 - 299.91 Pervasive Developmental Disorders, including Autism
314.00 - 314.93 Attention Deficit Disorders
317 - 319 Mental Retardation
331.0 Alzheimer's disease
332.0 Paralysis agitans (Parkinson's disease)
343.0 - 343.9 Cerebral Palsy

*Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.

REFERENCES

Peer Reviewed

1. Hayes, Cognitive Rehabilitation for Traumatic Brain Injury. April 2, 2008.

Government Agencies, Professional and Medical Organizations

1. Agency for Healthcare Policy and Research (AHCPR). Rehabilitation for traumatic brain injury. AHCPR Evidence Report/Technology Assessment No.2. AHCPR Pub No. 99-E005. Rockville, MD: AHCPR; February 1999.
2. Brain Injury Association of America, Cognitive Rehabilitation: The Evidence, Funding and Case for Advocacy in Brain Injury. A Position Paper of the Brain Injury Association of America, November 2006. National Academy of Neuropsychology (NAN). Cognitive rehabilitation. Official Statement of the National Academy of Neuropsychology. NAN Position Papers. Denver, CO: NAN; May 2002.
3. National Institute of Neurological Disorders and Stroke (NINDS). Cognitive Rehabilitation Interventions: Moving From Bench To Bedside. September, 2004.
4. National Institutes of Health (NIH), National Institute of Child Health and Human Development. Report of the Consensus Development Conference on the Rehabilitation of Persons with Traumatic Brain Injury. Bethesda, MD: NIH; September 1999. Available at: <http://www.nichd.nih.gov/publications/pubs/traumatic/default.htm>

Other

1. BlueCross BlueShield Association (BCBSA), Technology Evaluation Center (TEC). Cognitive rehabilitation for traumatic brain injury in adults. TEC Assessment Program. Chicago IL: BCBSA; 2002;17(20). Available at: http://www.bcbs.com/tec/vol17/17_20.html

HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
4/30/2011	<ul style="list-style-type: none">• Approved by MPC.