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Cognitive Rehabilitation Corporate Medical Policy

File Name: Cognitive Rehabilitation
File Code: 8.03.VT10
Origination: 06/2017
Last Review: 05/2024
Next Review: 05/2025
Effective Date: 06/01/2024

Description/Summary

Cognitive rehabilitation is a structured set of therapeutic activities designed to retrain an individual's ability to think, use judgment, and make decisions following a central nervous system insult. 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. Cognitive rehabilitation comprises tasks to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems. The desired outcomes are improved quality of life and function in home and community life. Cognitive rehabilitation may be performed by a physician, psychologist, or a physical, occupational, or speech therapist.

While there is insufficient evidence to determine the efficacy of cognitive rehabilitation in individuals manifesting with cognitive deficits due to any medical condition, cognitive rehabilitation may meet the definition of medical necessity, when certain conditions are met, in the rehabilitation of individuals with *moderate to severe* traumatic brain injury, brain injury due to cerebrovascular accident (stroke), intracranial aneurysm, anoxia, encephalitis, brain tumors, or brain toxins.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I - CPT® Code Table](#)

[Attachment II - ICD-10-CM Code Table](#)

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

moderate to severe 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 provided by a qualified licensed healthcare professional (e.g., an occupational therapist, physical therapist, speech/language pathologist, neuropsychologist, psychologist, psychiatrist or other physician);
- Cognitive rehabilitation is prescribed by the attending physician as part of a written treatment plan;
- The member is 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., member is not in a vegetative or comatose state and does not have severe aphasia);
- Cognitive rehabilitation is expected to provide the potential for improvement (based on the pre-injury function);
- The member demonstrates continued objective improvement in function once rehabilitation has commenced.

When a service is considered investigational

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

Cognitive rehabilitation is considered **investigational** for all other applications, including but not limited to, *mild* traumatic brain injury/concussion/post-concussion syndrome, attention deficit disorder, 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 individuals with Alzheimer's disease or 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

1. Therapy Association (AOTA); 2009.
2. Blue Cross and Blue Shield of Florida. Medical Coverage Guidelines (medical policy) 01- 97000-04 - Cognitive Rehabilitation. Last reviewed 01/2024. Accessed 04/2024.
3. Blue Cross and Blue Shield Association Medical Policy Reference Manual 8.03.10 - Cognitive Rehabilitation. Last reviewed 01/2024. Accessed 04/2024.
4. UpToDate - Mild cognitive impairment: Prognosis and treatment. Literature review current through 03/2024. Accessed 04/2024.

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

06/2017	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
01/2018	97127 was added. This code can only be reported once per day. Code 97532 was deleted Added HCPCS Code G0515. Added code 99483 code can only be reported every 180 days.
06/2018	Reviewed no changes to policy statement.
01/2019	Summary updated to reflect BCBS MPRM 8.03.10. No change to policy statement. Updated references.
01/2020	Adaptive Maintenance Updates: Deleted 97127 and replaced with 97129 & 97130 effective 01/01/2020. Code 96125 added to table as requiring prior approval if over 8 hours.
03/2020	Reviewed at MPT removed PA requirement for code 96125.
06/2020	Policy reviewed no changes to policy statement. References updated.
07/2021	Policy reviewed. Clarified policy statements regarding medically necessary and investigational. Code G0515 removed from coding table code deleted. Coding diagnosis table updated.
05/2022	Policy Reviewed. Abridged description/summary and removed superfluous language. Added clarifying language and separated out conditions for medical necessity criteria in policy. Minor grammatical fixes. References updated.
05/2023	Policy reviewed. Minor grammatical edits. References updated. No change to policy intent/statement.
05/2024	Policy reviewed. No change to policy statement. References updated. Minor formatting changes.

Eligible providers

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

Approved by BCBSVT Medical Directors

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Vice President

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
CPT® Code Table

The following code will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	Number	Brief Description	Policy Instructions
CPT®	96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	
CPT®	97129	Therapeutic interventions that focus on cognitive function and compensatory strategies; initial 15 minutes	
CPT®	97130	Therapeutic interventions that focus on cognitive function and compensatory strategies; each additional 15 minutes	
CPT®	99483	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	The code can only be reported every 180 days.

		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. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	
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Attachment II
ICD-10-CM Code Table

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