

Cognitive Rehabilitation

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[Instructions for Use](#)

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|--|------|
| Table of Contents | Page |
| Coverage Rationale | 1 |
| Definitions | 1 |
| Applicable Codes | 2 |
| Description of Services | 2 |
| Clinical Evidence | 3 |
| U.S. Food and Drug Administration | 7 |
| Centers for Medicare and Medicaid Services | 7 |
| References | 7 |
| Policy History/Revision Information | 9 |
| Instructions for Use | 9 |

| Related Commercial Policies |
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| <ul style="list-style-type: none"> Habilitative Services and Outpatient Rehabilitation Therapy Sensory Integration Therapy and Auditory Integration Training |
| Community Plan Policy |
| <ul style="list-style-type: none"> Cognitive Rehabilitation |

Coverage Rationale

Cognitive rehabilitation (CR) is proven and medically necessary when treating individuals following a traumatic brain injury (TBI) or stroke when ALL of the following criteria are met:

- Individual has the ability to actively participate, and
- Treatment regimen includes:
 - Specific interventions for functional communication deficits, including pragmatic conversational skills, or
 - Compensatory memory strategy training

The following are unproven and not medically necessary due to insufficient evidence of efficacy:

- Cognitive rehabilitation for any other condition or diagnosis
- Coma stimulation (also known as coma arousal, coma responsiveness, multisensory stimulation, and coma care therapy/programs) for any indication, including individuals who are comatose, in a vegetative or minimally conscious state

Definitions

Cognitive Rehabilitation: Is a multidisciplinary treatment program designed to improve cognitive function and retrain an individual’s ability to think, use judgment and make decisions. The focus of these therapeutic activities is to improve deficits in memory, attention, perception, visual processing, language, reasoning, learning, planning, judgment, and problem-solving. Cognitive rehabilitation comprises tasks to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems. The goal of cognitive rehab is to maximize functional independence with minimal interference from cognitive limitations (Hayes, 2019).

Coma: A state of unconsciousness from which one cannot be aroused. Coma is the most severe of the alterations of consciousness. It differs from sleep in that comatose patients will not awaken with stimulation. It differs from lethargy, drowsiness, or stupor (states in which patients are slow to respond) in that comatose patients are completely unresponsive. Finally, it differs from delirium, confusion, or hallucinosis (states in which patients' sense of reality is distorted and expressions are bizarre) in that comatose patients cannot express themselves at all (Taber’s, 2014).

Coma Stimulation: This treatment may include a variety of stimulation techniques designed to awaken the comatose individual. Techniques may include visual activities (i.e., presenting the comatose individual with objects to look at), auditory (i.e., playing music or speaking), tactile (i.e., touching the individual), taste and smell (i.e., offering things for the individual to taste or smell) stimulation. Mobility stimulation may also be included in stable individuals. A stimulus is considered successful if the individual grimaces or moves. Therapists, nurses, physicians, or family members can perform these services in the hospital, the individual's home, or in a nursing home.

Minimally Conscious State: A severe alteration in consciousness that does not meet the diagnostic criteria for either Coma or a Persistent Vegetative State, in which patients respond to some sounds and unpleasant stimuli and have a sleep-wake cycle but do not attend to their environment consistently (Taber's, 2014).

Persistent Vegetative State: A continuing and unremitting clinical condition of complete unawareness of the environment accompanied by sleep-wake cycles with either complete or partial preservation of hypothalamic and brainstem autonomic functions. The diagnosis is established if the condition is present for 1 month after acute or nontraumatic brain injury or has lasted for 1 month in patients with degenerative or metabolic disorders or developmental malformations (Taber's, 2014).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|----------|---|
| 97129 | Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., 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 (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., 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) |

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| HCPCS Code | Description |
|------------|---------------------------|
| S9056 | Coma stimulation per diem |

Description of Services

According to the Centers for Disease Control and Prevention (CDC), "a TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain" (2017).

Brain injury is defined as damage to the brain caused by externally inflicted trauma or damage due to stroke, aneurysm, anoxia, encephalitis, brain tumors, and brain toxins. Either type of injury may result in significant physical, cognitive, and psychosocial impairment in functioning and consciousness.

CR targets such functions as attention, memory and learning, affect and expression, problem solving, and executive functions. Two basic approaches to CR are used: (1) restorative (remedial) CR, where intellectual deficits are bolstered by various repetitive exercises; and (2) compensatory (adaptive) CR, where adaptive devices and strategies and modification of the environment are used to restore functioning despite ongoing deficits. These 2 techniques can be used in combination and can

also be components of a comprehensive rehabilitation program that involves other forms of remediation and psychosocial therapy (Hayes, 2018).

Coma (or sensory) stimulation is proposed to promote awakening of brain-injured patients from a Coma or Vegetative State. This may involve stimulation of any or all of the senses with various stimuli for each sense. There is not an established protocol for completing this type of stimulation or definitive patient selection criteria.

Clinical Evidence

Most published evidence evaluates cognitive rehabilitation for treatment of cognitive deficits resulting from moderate or severe traumatic brain injury (TBI) and stroke/cerebral infarction. The evidence in the published medical literature is difficult to assess due to variability in study design, low power to detect difference or variation in treatment. Variation in treatment is related to the heterogeneous nature of the treated population; specific CR interventions are typically targeted to the specific deficit. Given these limitations, the published data provides the most support for effectiveness of CR in individuals with TBI.

Brain Injury

A Hayes report explored CR for TBI. A search of the published peer reviewed medical literature returned 14 randomized controlled trials (RCTs) with sample sizes ranging from 50-366 participants. Regarding attention, memory, or executive functioning, it was concluded that the moderate quality evidence suggests that CR may improve neuropsychological outcomes. However, specific weaknesses around study design, outcome selection, small sample size, and differences in intervention strategies impede the generalizability of evidence on this topic. Additionally, some important patient groups—such as children or those with milder TBI—are less well represented in the published literature and require further evaluation (2018).

In a systematic review, Cicerone et al. (2011) evaluated 112 studies to update clinical recommendations for CR in individuals with TBI and stroke. Of the 112 studies, 14 were rated as class I, 5 as class IA, 11 as class II, and 82 as class III. Evidence within each area of intervention was synthesized and recommendations for Practice Standards, Practice Guidelines, and Practice Options were made. The authors concluded that there is substantial evidence to support interventions for attention, memory, social communication skills, executive function, and for comprehensive-holistic neuropsychologic rehabilitation after TBI. Evidence supports visuospatial rehabilitation after right hemisphere stroke, and interventions for aphasia and apraxia after left hemisphere stroke. According to the authors, there is sufficient information to support evidence-based protocols and implement empirically-supported treatments for cognitive disability after TBI and stroke.

Turner-Stokes et al. (2015) investigated multi-disciplinary rehabilitation for acquired brain injury in adults of working age in a Cochrane review. Authors identified 19 studies (3480 people). Twelve studies were of good methodological quality and seven were of lower quality. Within the subgroup of predominantly mild brain injury, 'strong evidence' suggested that most individuals made a good recovery when appropriate information was provided, without the need for additional specific interventions. For moderate to severe injury, 'strong evidence' showed benefit from formal intervention, and 'limited evidence' indicated that commencing rehabilitation early after injury results in better outcomes. For participants with moderate to severe ABI already in rehabilitation, 'strong evidence' revealed that more intensive programs are associated with earlier functional gains, and 'moderate evidence' suggested that continued outpatient therapy could help to sustain gains made in early post-acute rehabilitation. The context of multi-disciplinary rehabilitation appears to influence outcomes. 'Strong evidence' supports comprehensive cognitive rehabilitation in a therapeutic environment that involves a peer group of patients. 'Limited evidence' shows that specialist in-patient rehabilitation and specialist multi-disciplinary community rehabilitation may provide additional functional gains. In conclusion, for mild brain injury, information and advice were usually more appropriate than intensive rehabilitation. Patients with moderate to severe brain injury who received more intensive rehabilitation showed earlier improvement and earlier rehabilitation was better than delayed. It also supports that cognitive rehabilitation be provided in an environment where patients receive group-based therapy with peers facing the same challenges.

In other Cochrane reviews, analyses by Loetscher and Lincoln (2013) and Bowen et al. (2013) concluded that the long term efficacy of CR remains unconfirmed after examining studies involving 223 and 628 participants, respectively. The reviewers concur that further high quality clinical trials are required.

Position and Practice Statements

The Institute of Medicine released a report on Cognitive Rehabilitation Therapy (CRT) for TBI at the request of the U.S. Department of Defense. The report, which reviewed 90 studies published from 1991 to 2011, states that current evidence provides limited support for the efficacy of CRT for TBI. The report states that there is some evidence about the potential value of CRT for treating TBI, but overall it is not sufficient to develop definitive guidelines on how to apply these therapies and to determine which type of CRT will work best for a particular patient. Despite the methodological shortcomings of the evidence, the authors of the report support the ongoing clinical application of CRT interventions for individuals with cognitive and behavioral deficits due to TBI (2011).

The Agency for Healthcare Research and Quality (AHRQ) issued a comparative effectiveness review on multidisciplinary CR for moderate to severe TBI in adults. The goal of the review was to identify the most effective multidisciplinary postacute rehabilitation interventions for this demographic. The report evaluated 16 studies assessing prespecified primary outcomes or secondary patient-centered outcomes. The authors concluded that the body of evidence is not informative regarding effectiveness or comparative effectiveness of multidisciplinary postacute rehabilitation, stating that failure to draw broad conclusions must not be misunderstood to be evidence of ineffectiveness. According to the authors, the limited evidence on this topic stems from the complexity of the condition and treatments resulting in limited available research and from limitations within that research to answer salient research questions about what works for which patients. Further research should address methodological flaws common in these studies as well as questions regarding efficacy (Brasure et al. 2012; updated 2016).

Stroke

Cochrane Reviews

In a 2016 updated Cochrane review first published in 2000 and subsequently updated in 2007. The objective was to determine whether participants who have received CR for memory problems after a stroke had better outcomes in relation to memory function, functional ability, mood, and quality of life (QOL), than those given no treatment or a placebo control. The review included 13 trials involving 514 participants. The reviewers concluded that no significant effects of treatment were found in subjective reports in the long term or on performance on objective memory measures, mood, functional abilities, or QOL. Benefits were reported in the short term on subjective measures of memory; however, these did not persist. In addition, no benefits were reported in objective memory measures, mood, or daily functioning. There was insufficient evidence to support or refute the effectiveness of memory rehabilitation after stroke. This may be because of poor methodological quality of the included studies, inconsistencies in the choice of outcome measures, and small sample sizes. Furthermore, more robust trials of memory rehabilitation that use standardized activity or participatory level outcome measures are required. (das Nair et al., 2016).

Position and Practice Statements

Guidance from the National Institute for Health and Care Excellence (NICE) on stroke rehabilitation in adults recommends CR with interventions for memory and cognitive functions that focus on the relevant functional tasks, taking into account the underlying impairment. Interventions could include increasing awareness of the memory deficit, enhancing learning using errorless learning and elaborative techniques (making associations, use of mnemonics, internal strategies related to encoding information such as 'preview, question, read, state, test'), external aids (e.g., diaries, lists, calendars and alarms), or environmental strategies (routines and environmental prompts) (2013).

Schizophrenia

Iwata et al. (2017) conducted a multicenter RCT examining whether cognitive remediation is effective in improving both cognitive and social functions in schizophrenia in outpatient settings that provide learning-based psychiatric rehabilitation. Participants were randomly assigned either a cognitive remediation program (n=29) or treatment as usual (n=31). The cognitive remediation intervention included cognitive training using computer software (CogPack) administered twice a week, while the control group met weekly over 12 weeks and was based on the Thinking Skills for Work program. Most participants were attending day treatment services where social skills training, psychoeducation for knowledge about schizophrenia, group activities and other psychosocial treatment were offered. Cognitive and social functioning were assessed using the Brief Assessment of Cognition in Schizophrenia (BACS) and Life Assessment Scale for Mentally Ill (LASMI) at pre- and postintervention. Processing speed, executive function, and the composite score of the BACS, as well as significant improvement in interpersonal relationships and work skills on the LASMI, showed greater improvement for the cognitive remediation group than the control group. The researchers concluded that cognitive remediation in addition to psychiatric

rehabilitation contributed to greater improvement in both cognitive and social functioning than psychiatric rehabilitation alone. Cognitive remediation may enhance the efficacy of psychiatric rehabilitation improving social functioning. Limitations to this study include but were not limited to small study size and absence of long term follow up.

A systematic review by Isaac and Januel assessed the effect of cognitive remediation programs on neural processes. 15 reports included 19 randomized controlled studies on 455 adult patients suffering from a schizophrenia spectrum disorder. Overall, the reviewers concluded that studies provided interesting conclusions on a possible neuroplastic effect of cognitive remediation in schizophrenia through functional reorganization of neural networks, superior to other interventions or usual care. Specifically, cognitive remediation can improve various cortical and subcortical activations, including frontal activation associated with high-level cognitive and social-cognitive functions. Further randomized controlled studies are needed to confirm or clarify existing results, in order to provide stronger evidence for a neurobiological effect of cognitive remediation programs in schizophrenia spectrum disorders (2016).

Barlati et al. (2012) reviewed the available literature on cognitive remediation in the early course of schizophrenia. According to the authors, few studies on the effects of cognitive training programs have been conducted in first episode or in early schizophrenia and only one study has been conducted in the prodromal phase (period of decreased functioning that may correlate with the onset of psychotic symptoms of the disease). The authors state that although preliminary positive results have been achieved, more research is needed to confirm the efficacy of cognitive remediation in the early course of schizophrenia.

A RCT by Eack et al. (2010) compare CR (n=31) to supportive therapy (n=27) in patients with either early schizophrenia (n=35) or schizoaffective disorder (n=18). All patients were stable on anti-psychotic medication. The CR group received 60 hours of weekly computer-based neurocognitive training coupled with 45 weekly social-cognitive group sessions. The supportive therapy group only received individual psychotherapy. Fifty-three patients (30 CR and 23 supportive therapy subjects) underwent MRI to evaluate gray matter in the brain. The supportive therapy group showed greater loss of gray matter on MRI compared to the CR group. The authors found that the CR group had a decrease in loss of, and, in some cases, an increase in gray matter compared with the supportive therapy group. The area with less loss was related to improved neurocognitive function. The authors concluded that CR can protect against gray matter loss and may therefore decrease cognitive impact in this group of patients. Further studies must compare CR to a treatment of known and predictable effectiveness, e.g., pharmacotherapy with anti-psychotic agents.

Other Disorders

CR has also been investigated for disorders such as cerebral palsy, Down syndrome, Alzheimer's Disease (AD), attention deficit hyperactivity disorder (ADHD), multiple sclerosis, developmental disorders such as autism, and Parkinson's disease. Based on the peer reviewed literature there is insufficient evidence to support the use of cognitive rehabilitation in all other conditions except for traumatic brain injury and stroke as indicated above, medical literature is limited and available studies include small study samples and lack of comparison groups and long term follow up.

In 3 separate RCTs, analyses by Hanssen et al. (2016), Campbell et al. (2016), and Rilo et al. (2018) concluded that individuals with multiple sclerosis receiving multicomponent or computerized CR during research periods that ranged from 12 weeks to 7 months demonstrated improvements in several cognitive domains for 120, 38, and 42 participants, respectively. Additional research is needed to further explore the benefits of CR in this patient population.

Díez-Cirarda and colleagues assessed structural and functional cerebral changes in 44 PD patients, after attending a three-month integrative cognitive rehabilitation program (REHACOP) as part of a RCT. Participants were randomly divided into REHACOP group (cognitive rehabilitation) and a control group (occupational therapy). T1-weighted, diffusion weighted and functional magnetic resonance images (fMRI) during resting-state and during a memory paradigm were obtained both pre- and post-treatment. Cerebral changes were assessed with repeated measures ANOVA 2 × 2 for group x time interaction. Results demonstrated that the REHACOP group showed significantly increased brain connectivity and activation in both the resting state and recognition fMRIs compared to the control group. The study group showed increased brain activation in the learning fMRI when comparing the post- to the pre-treatment, as well as showing significant and positive correlations between the brain connectivity and activation and the cognitive performance at post-treatment. Researchers concluded that an integrative CR program can produce significant functional cerebral changes in PD patients. Acknowledging the small sample size, future studies with larger samples are needed to replicate these findings (2017).

In 2013, Reichow et al. reported a systematic review of psychosocial interventions administered by nonspecialists for children and adolescents with intellectual disability or lower-functioning autism-spectrum disorders. Five comparative trials in patients with autism-spectrum disorders (total N=255) who received CR, training, and support were included. Improvements in school performance and developmental outcomes were inconsistent across trials.

A Cochrane review evaluated the efficacy of cognitive training and CR for mild to moderate AD and vascular dementia. The evidence reviewed included 11 trials of cognitive training and a single trial of CR. The authors found no evidence for the efficacy of cognitive training to improve cognitive functioning, mood or activities of daily living (ADL) in individuals with mild to moderate AD or vascular dementia. The single trial of CR provided preliminary indications of the potential benefits of individual CR to improve ADLs in individuals with mild AD. The authors recommend that more high-quality trials of both cognitive training and CR are needed in order to establish the efficacy of cognitive training and CR for individuals with early-stage dementia (Bahar-Fuchs, 2013).

Kurz, et al. (2011) conducted a multicenter RCT on 201 patients with mild dementia in AD. The intervention comprised 12 individual weekly sessions of CR and combined 4 established strategies adopted from neurorehabilitation and psychotherapy. ADLs were chosen as the primary outcome. The results showed no effect of the intervention on everyday functioning. There were improvements favoring the intervention on QOL and treatment satisfaction and a significant antidepressant effect in female participants. The findings of this study may be helpful for designing further studies that are needed to determine the potential of CR in older adults with dementia.

Sonuga-Barke et al. (2013) conducted a meta-analysis on the efficacy of ADHD treatments that included cognitive training. The authors concluded that better evidence for efficacy from blinded assessments is required for behavioral interventions and cognitive training before they can be supported as treatments for core ADHD symptoms.

Riccio and French (2004) evaluated available empirical support regarding the efficacy of treatments for treatment of attention deficits across disorders and age levels. The search of the major databases yielded 83 studies that included treatment of attentional deficits. A review of the studies indicated that, regardless of the treatment program or population, the existing research does not provide sufficient evidence to reach any conclusions about the efficacy of programs designed to address attention deficits. Before any conclusions can be drawn, there is a need for more rigorous study of available treatment programs across age levels and disorders, with sufficient baseline and outcome data as well as control or alternative treatment conditions.

Wade et al. (2003) evaluated whether a program of multidisciplinary rehabilitation and group support achieves sustained benefit for people with Parkinson's disease. The study was a crossover RCT comparing 144 patients and caregivers who had received rehabilitation four months before assessment with those who had not. Analysis comparing patients, before and six months after treatment showed worsening in disability, QOL, and caregiver strain. The investigators concluded that patients with Parkinson's disease decline significantly over 6 months, but a short spell of multidisciplinary rehabilitation may improve mobility.

Coma Stimulation

Controlled trials comparing care with and without coma stimulation programs are limited in current literature that effectively demonstrates a consistent, reproducible and positive impact on health outcomes.

In 2016, Padilla and colleagues conducted a systematic review to assess the effectiveness of sensory stimulation to improve arousal and alertness of people in a coma or persistent vegetative state following a traumatic brain injury. A total of 9 studies published from 2008 through 2013 were included for analysis. The authors concluded that there is strong evidence for the effectiveness of multimodal sensory stimulation in improving the clinical outcomes after a traumatic brain injury-induced coma or persistent vegetative state. In addition, "Moderate evidence was also provided for auditory stimulation, limited evidence was provided for complex stimuli, and insufficient evidence was provided for median nerve stimulation." This systematic review grouped widely heterogeneous studies in terms of design, outcomes and populations. Furthermore, the clinical significance of the studies chosen for inclusion is not clear. Given the lack of rigorous, clinically meaningful studies for inclusion and the qualitative methodological approach that was used in analysis, more research is needed to confirm the conclusions the authors have made from this review.

Megha (2013) conducted a randomized controlled trial (RCT) to evaluate the effectiveness of multimodal coma stimulation in comatose individuals with traumatic brain injury. Study participants were randomly assigned to one of three groups (group A

received 20-minute multimodal coma stimulation sessions, 5 times a day,; group B received 50-minute stimulation twice a day,; group C acted as the control group and received conventional physiotherapy twice a day). Duration of treatment was 2 weeks in all three groups. Prior to coma stimulation, participants' levels of consciousness were assessed using the Western Neuro Sensory Stimulation profile (WNSSP) and the Glasgow Coma Scale (GCS). Final results showed significant improvement in measures of consciousness levels in the respective treatment groups, A and B, when each was compared with the control group C. Specifically, there was a statistically significant difference observed between group A and C in favor of group A for GCS. Similarly, there was a statistically significant difference observed between groups B and C in favor of group B for WNSSP. Despite these early positive findings, the study was characterized by several limitations, including its small size, lack of blinded assessments and lack of follow-up. Without an adequate follow-up period, it is not clear if the improvements in consciousness levels were durable beyond the 2-week treatment duration. Despite the statistically significant findings between groups, the study was also limited by the lack of generalizability and clinical heterogeneity in the baseline characteristics of study participants.

A Cochrane systematic review was completed evaluating sensory stimulation of brain-injured patients in coma or vegetative state. This study included RCTs and non-RCTs. Three studies were identified with 68 patients in total. The overall methodological quality was poor and studies differed widely in terms of outcomes measures, study design and conduct. The conclusion was that there is no reliable evidence which supports or rules out the effectiveness of multisensory programs in patients in coma or vegetative state (Lombardi, 2002).

Professional Societies

American Academy of Neurology (AAN)

In their "Practice Parameters: Assessment and Management of Patients in the Persistent Vegetative State," the AAN makes no reference to sensory stimulation as a treatment modality (2006, Updated 2016).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Cognitive Rehabilitation is not subject to U.S. Food and Drug Administration (FDA) regulation.

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for cognitive rehabilitation. Local Coverage Determinations (LCDs) exist. Refer to the following LCDs at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>:

- Home Health Occupational Therapy
- Home Health Speech-Language Pathology
- Outpatient Occupational Therapy
- Outpatient Physical and Occupational Therapy Services
- Outpatient Speech Language Pathology
- Speech-Language Pathology
- Speech Language Pathology (SLP) Services: Communication Disorders
- Therapy and Rehabilitation Services (PT, OT)

Medicare does not have an NCD for coma stimulation. LCDs do not exist at this time.
(Accessed February 6, 2020)

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Policy History/Revision Information

| Date | Summary of Changes |
|------------|---|
| 08/01/2020 | <p>Template Update</p> <ul style="list-style-type: none"> Reformatted policy; transferred content to new template |
| 04/01/2020 | <p>Related Policies</p> <ul style="list-style-type: none"> Added reference link to the Coverage Determination Guideline titled <i>Habilitative Services and Outpatient Rehabilitation Therapy</i> <p>Coverage Rationale</p> <ul style="list-style-type: none"> Modified language to clarify Coma Stimulation (<i>also known as coma arousal, coma responsiveness, multisensory stimulation, and coma care therapy/programs</i>) is unproven and not medically necessary <i>for any indication</i>, including individuals who are comatose or in a Vegetative or Minimally Conscious State <p>Definitions</p> <ul style="list-style-type: none"> Added definition of: <ul style="list-style-type: none"> Cognitive Rehabilitation Coma Stimulation <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i>, <i>CMS</i>, and <i>References</i> sections to reflect the most current information Archived previous policy version 2020T0144U |

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.