

# Cognitive Rehabilitation

**Policy Number:** BIP142.M  
**Effective Date:** June 1, 2025

[Instructions for Use](#)

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## Related Benefit Interpretation Policies

- [Autism Spectrum Disorder](#)
- [Habilitative Services](#)
- [Inpatient and Outpatient Mental Health](#)
- [Rehabilitation Services Physical, Occupational, and Speech Therapy](#)
- [Skilled Nursing Facility \(SNF\): Skilled Nursing Facility \(SNF\) Care](#)

## Related Medical Policies

- [Cognitive Rehabilitation](#)
- [Neuropsychological Testing Under the Medical Benefit](#)

## Federal/State Mandated Regulations

None

## State Market Plan Enhancements

None

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

**Note:** Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

### Outpatient Cognitive Habilitation and Rehabilitation Therapy

Neuropsychological testing by a provider acting within the scope of his or her license or as authorized under California law and the medically necessary treatment of functional deficits due to a traumatic brain injury or cerebral vascular insult or when provided as part of an authorized autism behavioral health treatment plan. Refer to the following Medical Policies titled:

- [Cognitive Rehabilitation](#)
- [Habilitation and Rehabilitation Therapy \(Occupational, Physical, and Speech\)](#)
- [Neuropsychological Testing Under the Medical Benefit](#)

### Inpatient Cognitive Habilitative and Rehabilitation Therapy

Coverage for inpatient cognitive habilitative and rehabilitative therapy will be covered when a member also meets criteria for inpatient medical rehabilitation services.

- Refer to the following Medical Policies titled:
  - [Cognitive Rehabilitation](#)
  - [Habilitation and Rehabilitation Therapy \(Occupational, Physical, and Speech\)](#)
- Refer to the following Benefit Interpretation Policy titled:
  - [Rehabilitation Services \(Physical, Occupational, and Speech Therapy\)](#)

## Habilitative Services

- Habilitative services may or may not be covered; Refer to member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.
- Habilitative services shall be covered under the same terms and conditions applied to rehabilitative and habilitative services under the plan contract.
- If request is for physical therapy, speech therapy, or occupational therapy services that are habilitative in nature refer to the Benefit Interpretation Policy titled [Rehabilitation Services \(Physical, Occupational, and Speech Therapy\)](#) or [Habilitative Services](#).

### Notes:

- Cognitive habilitative and rehabilitation therapy can be performed by licensed providers within the scope of their licensure, e.g., occupational, physical, and speech therapists/pathologist, neuropsychologist, or a physician.
- Refer to the Benefit Interpretation Policy titled [Skilled Nursing Facility \(SNF\): Skilled Nursing Facility \(SNF\) Care](#).

## Not Covered

- Cognitive behavioral therapy unless medically necessary and provided by a provider acting within the scope of his or her license or as authorized under California law also known as cognitive therapy.
  - Cognitive habilitative and rehabilitation therapy for any condition other than listed in *Covered Benefits* section.
  - In-home cognitive rehabilitation therapy unless documented to be medically necessary and is prior authorized by the member's primary medical group or UnitedHealthcare.
- Note:** In-home cognitive rehabilitation is considered home health and is subject to the applicable home health visit co-payment/coinsurance, deductibles, and benefit limitations, if any. Refer to the member's EOC/SOB.

## Policy History/Revision Information

Date	Summary of Changes
06/01/2025	<ul style="list-style-type: none"> <li>• Routine review; no change to coverage guidelines</li> <li>• Archived previous policy version BIP142.L</li> </ul>

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.