UnitedHealthcare®

MEDICAL POLICY

COGNITIVE REHABILITATION

Policy Number: 2014T0144M
Effective Date: May 1, 2014

Table of Contents

	Page
BENEFIT CONSIDERATIONS	1
COVERAGE RATIONALE	2
APPLICABLE CODES	2
DESCRIPTION OF SERVICES	2
CLINICAL EVIDENCE	3
U.S. FOOD AND DRUG ADMINISTRATION	8
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	8
REFERENCES	9
POLICY HISTORY/REVISION INFORMATION	11

Related Policies:
Sensory Integration Therapy and Auditory Integration Training

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD) and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this Medical Policy is based. In the event of a conflict, the enrollee's specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the enrollee specific plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

BENEFIT CONSIDERATIONS

Essential Health Benefits for Individual and Small Group:
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage.

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COVERAGE RATIONALE

Cognitive rehabilitation is proven and medically necessary for the treatment of traumatic brain injury (TBI) and brain injury due to stroke, aneurysm, anoxia, encephalitis, brain tumors, and brain toxins when the patient can actively participate in the program (e.g., is not comatose or at a level of consciousness that would preclude such active engagement).

The treatment regimen usually includes one of the following modalities:

- **Specific interventions for functional communication deficits, including pragmatic conversational skills, or**
- **Compensatory memory strategy training**

Cognitive rehabilitation is unproven and not medically necessary for the treatment of cerebral palsy, Down syndrome, Alzheimer's disease, attention deficit hyperactivity disorder, developmental disorders such as autism, schizophrenia and Parkinson's disease.
Evidence in the published, peer-reviewed, medical literature to support the use of cognitive rehabilitation for these conditions is limited and conflicting. Available studies also contain design flaws including small study samples, lack of comparison groups and lack of long-term follow-up.

Coma stimulation is unproven and not medically necessary for the treatment of comatose or minimally responsive patients who have sustained a brain injury due to limited evidence with overall poor quality in methodology and design, and diversity in reporting outcome measures.

APPLICABLE CODES

The Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this policy are for reference purposes only. Listing of a service code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit 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 claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

CPT® Code	Description
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

CPT® is a registered trademark of the American Medical Association.

HCPCS Code	Description
S9056	Coma stimulation per diem

DESCRIPTION OF SERVICES

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.

Cognitive rehabilitation involves therapies that are designed to improve damaged intellectual, perceptual, psychomotor, and behavioral skills, and to increase levels of self-management and independence following damage to the central nervous system. Cognitive rehabilitation involves

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therapies designed to help improve damaged cognitive functions such as attention, memory and learning, affect and expression, problem-solving, and executive function. There are two basic approaches to cognitive rehabilitation: restorative (where intellectual deficits are bolstered by various repetitive exercises) and compensatory (where adaptive devices and strategies and modification of the environment are used to restore functioning despite ongoing deficits) cognitive rehabilitation. These two techniques can be used in combination, and can be components of a comprehensive multidisciplinary rehabilitation program that involves other forms of remediation and psychosocial therapy (Hayes, 2008). The goals of cognitive rehabilitation are to enhance the person's capacity to process and interpret information and to improve the person's ability to function in all aspects of family and community life.

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

Brain Injury

The clinical evidence was reviewed on January 28, 2014 with no additional information identified that would change the proven and medically necessary conclusions.

In a systematic review, Cicerone et al. (2011) evaluated 112 studies to update clinical recommendations for cognitive rehabilitation in individuals with traumatic brain injury (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.

Early research by Ruff and Neiman (1990), Neistadt (1992), Novak et al. (1996), and Salazar (2000) indicated that there was not a significant difference between the control and treatment groups who had completed cognitive rehabilitation. Ruff and Neiman (1990) did find that that there was less depression in the treatment group. Neistadt (1992) noted there was no significant difference between the restorative and compensatory types of cognitive rehabilitation. Cicerone (2000) concluded in a meta-analysis of literature that the evidence supported the effectiveness of several forms of cognitive rehabilitation.

Levine et al. (2000) completed a small randomized trial comparing a structured protocol for goal management training with motor skill training. Although the sample size was small (n=30), in all six outcome measures, the group treated with goal management training showed more improvement and less decline that the motor skills group. Four of the 6 comparisons were statistically significant.

A larger (n=110) randomized controlled trial was completed by Powell et al. (2002) that compared community based cognitive rehabilitation with a group that had limited support. Outcome measures included ability to engage in ADL, level of activity participation and overall psychological functioning. The treatment group had greater improvement in most functional areas and less depression and anxiety than did the limited support group.

Westerberg et al. (2007) conducted a randomized pilot study of 18 stroke patients who were randomized to a treatment group (computerized training on working memory tasks) and passive

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control group. More than 1 year after stroke, working memory training improved working memory and attention.

Cicerone et al. (2004) completed a nonrandomized prospective study of a comprehensive program versus standard rehabilitation. Outcome measures included the level of community integration and functioning. The treatment group had greater community integration and independent functioning than did the standard rehabilitation group.

Cochrane Reviews: There is some indication that training improves alertness and sustained attention but no evidence to support or refute the use of cognitive rehabilitation for attention deficits to improve functional independence following stroke (Lincoln et al., 2000). There is insufficient evidence to support or refute the effectiveness of cognitive rehabilitation for memory problems after stroke. There is a need for better-designed trials of memory rehabilitation using common standardized outcome measures (Nair and Lincoln, 2007). Several types of neglect specific approaches are described but there is insufficient evidence to support or refute their effectiveness at reducing disability and improving independence. They can alter test performance and warrant further investigation in randomized trial (Bowen and Lincoln, 2007).

A 1999 **National Institutes of Health (NIH)** Consensus Statement on the rehabilitation of persons with traumatic brain injury noted that the available evidence, although limited, supports the use of certain cognitive and behavioral rehabilitation strategies for individuals with brain damage. This document also states that rehabilitation services should be matched to the needs of individual, and that community-based non-medical services are required to optimize outcomes over the course of recovery (NIH, 1999b).

In 2011, the **Institute of Medicine** released a report on Cognitive Rehabilitation Therapy for Traumatic Brain Injury. The report, which reviews 90 studies published from 1991 to 2011, states that current evidence provides limited support for the efficacy of cognitive rehabilitation therapy for traumatic brain injury. The report states that there is some evidence about the potential value of cognitive rehabilitation therapy (CRT) for treating traumatic brain injury (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.

In 2012, the **Agency for Healthcare Research and Quality (AHRQ)** issued a comparative effectiveness review on cognitive rehabilitation for multidisciplinary postacute rehabilitation for moderate to severe traumatic brain injury (TBI) in adults. The goal of the review was to identify the most effective multidisciplinary postacute rehabilitation interventions for impairments from moderate to severe TBI in adults. 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. The authors state 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 and further address effectiveness research questions (Brasure et al. 2012).

In an archived evidence report on cognitive rehabilitation for TBI, the Agency for Healthcare Research and Quality (AHRQ) noted that there was no evidence from comparative studies either for or against early rehabilitation in patients with mild and moderate injury. The report went on to state that the evidence was insufficient to define appropriate treatment protocols or to establish the value of memory aid devices. In addition, there was limited evidence that employment can improve the vocational outcomes of TBI survivors. The efficacy of case management in the

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treatment of TBI patients was also evaluated, with the conclusion that there is evidence that case management can lead to functional improvements, although some study results were conflicting. A subsequent evidence report that focused specifically on cognitive rehabilitation in children and adolescents concluded that clinical studies with designs capable of providing evidence for the effectiveness of interventions for children and adolescents with TBI were lacking (Carney, 1999~~b~~; Chestnut, 1999).

BlueCross BlueShield Association Technology Evaluation: Technology Evaluation Center (TEC) Association Cognitive Rehabilitation for Traumatic Brain Injury in Adults (2008) The 2008 update of the technology assessment concluded that the number of clinical trials is relatively small. Many of the studies suffer from small sample sizes, insufficient follow-up, and lack of assessment of health outcomes. Only the nonrandomized study shows benefits of cognitive rehabilitation in terms of health outcomes. Most of the randomized studies do not show an improvement in health outcomes after a program of cognitive rehabilitation. Based on the above, cognitive rehabilitation for traumatic brain injury in adults does not meet the TEC criteria.

Professional Societies
National Academy of Neuropsychology (NAN): In a 2002 position statement, NAN expressed support for empirically and rationally based cognitive rehabilitation techniques that are designed to improve the quality of life and functional outcomes for patients with acquired brain injury. This statement also outlined the need for more evidence-based research to define cost-effective cognitive rehabilitation interventions (NAN, 2002).

Schizophrenia
The clinical evidence was reviewed on January 28, 2014 with no additional information identified that would change the unproven and not medically necessary conclusions.

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.

McGurk et al. (2007) conducted a meta-analysis of 26 randomized controlled trials (1,151 subjects). The study evaluated the effects of cognitive remediation on cognitive performance, symptoms and psychosocial functioning. The mean duration of cognitive remediation programs was 12.8 weeks. Programs targeted for training an average of 2.9 cognitive domains, whereas changes in cognitive functioning were assessed on an average of 3.1 cognitive domains. The results showed that the overall effect size on improving cognitive performance averaged 0.41, symptoms were 0.28 and psychosocial functioning was 35. The authors found that the impact of cognitive remediation on functioning was influenced by several factors, including the addition of adjunctive psychiatric rehabilitation, cognitive training methods, and patient age. They also noted that long term effects on the maintenance of treatment could not be evaluated because only 6 studies conducted follow-up assessments at an average of 8 months after completion of the program. The authors concluded that cognitive remediation has a positive impact on patients with schizophrenia. Functional outcomes were greater when combined with psychiatric rehabilitation. The study is limited by multiple confounding variables and short term follow-up.

A randomized controlled trial by Eack et al. (2010) compare cognitive rehabilitation (n=31) with 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 cognitive rehabilitation 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 cognitive rehab and 23 supportive therapy subjects)

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underwent MRI to evaluate gray matter in the brain. The supportive therapy group showed greater loss of gray matter on MRI compared to the cognitive rehabilitation group. The authors found that the cognitive rehabilitation 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 cognitive rehabilitation can protect against gray matter loss and may therefore decrease cognitive impact in this group of patients. Further studies must compare cognitive rehabilitation to a treatment of known and predicable effectiveness, e.g., pharmacotherapy with anti-psychotic agents.

Matsui et al. (2009) conducted a randomized controlled trial to compare the addition of cognitive rehabilitation (CR) to medication alone for patients with schizophrenia. Eleven patients received cognitive rehabilitation plus medication and 9 patients received medication only. Patients were followed for 6 months. Five patients (3 CR and 2 control group) were lost to follow-up. All participants completed a neuropsychological test battery assessing executive functioning, verbal memory, and social knowledge. Patients in both group showed improvement in neuropsychological test scores with the CR group showing slightly better results. The authors concluded that adding cognitive rehabilitation to antipsychotic medication may improve social cognitive abilities in the schizophrenic patient. The study is limited by extremely small sample size and high dropout rate of 25% of participants.

A review by Velligan et al. (2006) examined the research findings from 8 evidence-based approaches to cognitive remediation. The eight approaches included: attention process training, integrated psychological therapy, cognitive enhancement therapy, neurocognitive enhancement therapy, cognitive remediation therapy, the neuropsychological educational approach to remediation, errorless learning approaches, and attention shaping. The studies included in the review did not include sample sizes and varied considerably for criteria, conceptual organization, and interpretation of findings. The authors noted that there were no established guidelines for levels of intensity or duration of training. Improvements in attention, memory, and executive functioning were reported. However, many persons with schizophrenia are more impaired in real-world functioning than one would expect given the magnitude of their cognitive deficits. Based upon the review, the authors concluded that additional research is needed to look beyond cognition to other targets such as motivation to identify the reasons that many persons with schizophrenia demonstrate such marked levels of disability.

Other Disorders

The clinical evidence was reviewed on January 28, 2014 with no additional information identified that would change the unproven and not medically necessary conclusions.

Cognitive rehabilitation has also been investigated for disorders such as cerebral palsy, Down syndrome, Alzheimer's disease, attention deficit hyperactivity disorder, developmental disorders such as autism, and Parkinson's disease. There is little evidence that cognitive rehabilitation is beneficial for these conditions.

A 2008 Cochrane review by Clare and Woods evaluated the effectiveness and impact of cognitive training and cognitive rehabilitation interventions aimed at improving memory and other aspects of cognitive functioning for people in the early stages of Alzheimer’s disease or vascular dementia. Nine randomized controlled trials (RCTs) were identified for cognitive training, with no RCTs identified for cognitive rehabilitation. No positive or negative effects of cognitive training were observed. The authors concluded that the available evidence remains limited with no indication of any significant benefits from cognitive training. Further, well-designed studies of cognitive training and cognitive rehabilitation are required to provide more definitive evidence.

Kurz. Et al. (2011) conducted a multicenter, randomized, controlled trial on 201 patients with mild dementia in Alzheimer’s disease. The intervention comprised 12 individual weekly sessions of Cognitive Rehabilitation (CR), and combined 4 established strategies adopted from neurorehabilitation and psychotherapy. Activities of daily living were chosen as the primary

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outcome. The results showed no effect of the intervention on everyday functioning. There were improvements favoring the intervention on quality of life 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.

Clare et al. (2010) conducted a single-blind randomized controlled trial of 69 patients with Alzheimer's disease or mixed Alzheimer's disease and vascular dementia. The study compared cognitive rehabilitation (n=23) with relaxation therapy (n=24) and no treatment (n=22).Primary outcomes were measured using the Canadian Occupational Performance Measure. Secondary outcome measurements included questionnaires assessing mood, quality of life assessments and a brief neuropsychological test. Patients in the cognitive rehabilitation group had 8 weekly one hour sessions. Cognitive rehabilitation consisted of setting individually relevant goals to address practical aids and strategies, techniques for learning new information, practice in maintaining attention and concentration, and techniques for stress management. The relaxation therapy group had the same amount of therapist time to learn progressive muscle relaxation and breathing exercises. The no treatment group had no contact with the research team. Patients were evaluated initially, post-treatment and at 6 months. At post-treatment follow-up, 4 patients withdrew or died. At 6 month follow-up, another 8 patients were lost to follow-up. Regardless of intervention, there was minimal change from pre-treatment to 6 month follow-up with the exception of a decrease in anxiety for the no treatment group and a slight increase in memory performance in the cognitive rehabilitation group. Despite minimal improvements, the authors concluded that the study results provide a basis for further development and application of cognitive rehabilitation as a means of assisting people with early-stage Alzheimer's disease and their families in managing the condition.

Farina et al. (2006) evaluated the efficacy of two different group procedures of non-pharmacological treatment in mild-to-moderate Alzheimer's disease (AD). Thirty-two patients entered the study and were divided in groups of four subjects. Recreational activities ('global' stimulation) was compared with a combination of procedural memory training on activities of daily living and neuropsychological rehabilitation of 'residual' functions ('cognitive-specific'). At follow-up (6 months later), compared with baseline, patients following the 'global' stimulation treatment showed an improvement at caregiver distress on Neuropsychiatric Inventory (NPI). No other significant difference was detected. The investigators concluded that a "global' treatment can lead to a significant improvement in AD patients, both for behavioral and functional aspects. The 'cognitive-specific' treatment that was used did not show better efficacy.

Sitzer et al. (2006) systematically reviewed the literature and summarized the effect of cognitive training (CT) for Alzheimer's disease (AD) patients. Effect sizes were calculated for 17 controlled studies identified through a comprehensive literature review. An overall effect size of 0.47 was observed for all CT strategies across all measured outcomes. The investigators concluded that CT shows promise in the treatment of AD, but further research is needed to evaluate the effect of treatment on function.

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 randomized controlled crossover trial comparing 144 patients and carers 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, quality of life, and carer strain. The investigators concluded that patients with Parkinson's disease decline significantly over six months, but a short spell of multidisciplinary rehabilitation may improve mobility.

Sonuga-Barke et al. (2013) conducted a meta-analysis of the efficacy attention deficit hyperactivity disorder (ADHD) treatments that included cognitive training. The authors concluded

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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.

Comatose Patients

The clinical evidence was reviewed on January 28, 2014 with no additional information identified that would change the unproven and not medically necessary conclusions.

Ellis and Rader (1990) reviewed various theories and studies on the effectiveness of sensory stimulation for minimally responsive comatose patients. They state that the operational definitions of states of altered consciousness are not consistent and ranges from clouding of consciousness, delirium to persistent vegetative state. The conclude that several factors complicate the issue of structured sensory stimulation for patients including outcome measures used across studies have not been equivalent, levels of severity of injury and responsiveness vary across studies and that the evidence suggests sensory stimulation affects different patients differently.

A Cochrane systematic review of sensory stimulation of brain-injured patients in coma or vegetative state was completed. This study included randomized and nonrandomized controlled trials. A very small number of studies met the inclusion criteria and had poor quality of methodology and study design. The Cochrane Review concluded that due to the diversity in reporting outcome measures, no reliable evidence to support the effectiveness of multisensory stimulation programs in comatose patients could be found (Lombardi, 2002).

The largest volume of research has been conducted on the middle band of brain injured patients, namely those with significant impairments but a clear ability to improve. Less progress has been made on the two extremes of the severity spectrum. Individuals in the PVS experience diminishing odds of significant recovery as time passes. Coma stimulation therapies have been recommended, but none of these has been definitely tested for efficacy (Wilson, 1993; Zasler, 1991).

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Cognitive rehabilitation is a procedure and, therefore, 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) do exist which address the development of cognitive skills. 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
- Low Vision Services
- Medicine: Occupational Therapy – Outpatient
- Medicine: Physical Therapy – Outpatient

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- Medicine: Speech Language Pathology - Outpatient
- Outpatient Occupational Therapy
- Outpatient Physical and Occupational Therapy Services
- Outpatient Rehab Therapy Services billed to Medicare Part B
- Outpatient Speech Language Pathology
- Physical Medicine and Rehab Policy
- Physical Medicine and Rehabilitation Services, Physical Therapy and Occupational Therapy
- Speech Language Pathology
- Speech Language Pathology (SLP) Services: Communication Disorders
- Therapy and Rehabilitation Services
- Therapy Services (PT, OT, SLP)

(Accessed February 11, 2014)

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
05/01/2014	• Reorganized policy content • Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate: o For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”) o Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to

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	provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans o The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage • Updated coverage rationale; added language to indicate if service is "medically necessary" or "not medically necessary" to applicable proven/unproven statement • Updated supporting information to reflect the most current description of services, clinical evidence, CMS information and references • Archived previous policy version 2013T0144L

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