

Cigna Medical Coverage Policy- Therapy Services Cognitive Rehabilitation

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- 2) any applicable laws/regulations*
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- 4) the specific facts of the particular situation*

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GUIDELINES

Under many benefit plans, coverage for cognitive rehabilitation is subject to the terms, conditions and limitations of the applicable benefit plan's Short Term Rehabilitative Therapy benefit and schedule of copayments.

Coverage for cognitive rehabilitation therapy varies across plans. Refer to the customer's benefit plan document for coverage details.

If coverage for cognitive rehabilitation is available, the following conditions of coverage apply.

Medically Necessary

An individualized program of cognitive rehabilitation is considered medically necessary for EITHER of the following:

- stroke/cerebral infarction
- moderate to severe traumatic brain injury

when ALL of the following requirements are met:

- A documented cognitive impairment with related compromised functional status exists.
- Neuropsychological testing or an appropriate assessment has been performed and these test or assessment results will be used in treatment planning and directing of rehabilitation strategies.
- The individual is willing and able to actively participate in the treatment plan.
- Significant cognitive improvement with improved related functional status is expected.

Outpatient is usually the most medically appropriate setting for cognitive rehabilitation. Cognitive rehabilitation provided in an acute inpatient or skilled facility may be considered medically necessary if the individual independently meets coverage criteria for that level of care.

Cognitive rehabilitation provided in a residential facility is considered medically necessary when the individual requires a 24-hour a day supervised environment because of cognitive impairment due to recent brain injury criteria listed above, manifested by severely impaired impulse control, judgement or executive function and cannot be safely managed in the home environment. Coverage for the residential facility placement is subject to benefit plan provisions.

Continuation of cognitive rehabilitation is considered medically when both of the following criteria are met:

- The criteria listed above are met
- There is documented progress toward the quantifiable, attainable short- and long-term goals.

Not Medically Necessary

Cognitive rehabilitation to improve academic or work performance is considered not medically necessary.

Experimental, Investigational, Unproven

Cognitive rehabilitation for ANY other indications is considered experimental, investigational or unproven. Examples include but are not limited to:

- Cerebral palsy
- Attention deficit disorder, attention deficit hyperactivity disorder
- Pervasive developmental disorders, including autism spectrum disorders
- Learning disabilities
- Developmental delay
- Epilepsy
- Schizophrenia
- Dementia
- Mild traumatic brain injury, including concussion and post-concussion syndrome

Coma stimulation for any indication, including coma or persistent vegetative state, is considered experimental, investigational or unproven.

DESCRIPTION

Cognition refers to information-processing functions carried out by the brain that include, attention, memory, executive functions (i.e., planning, problem solving, self-monitoring, self-awareness), comprehension and formation of speech, calculation ability, visual perception, and praxis skills. Cognitive processes can be conscious or unconscious and often are divided into basic level skills (e.g., attention and memory processes) and executive functions. Cognitive function pertains to the mental processes of comprehension, judgement, memory, and reasoning, as contrasted with emotional and volitional process. Cognitive dysfunction (or cognitive impairment) can be defined as functioning below expected normative levels or loss of ability in any area of

cognitive functioning. Cognitive training focuses on guided practice on a set of tasks that reflect particular cognitive functions, such as memory, attention or problem-solving. Cognitive rehabilitation is intended to improve cognitive functions and functional abilities, and increase levels of self-management and independence following neurological damage to the central nervous system. It focuses on identifying and addressing individual needs and goals, which may require strategies for taking in new information or compensatory methods such as using memory aids. Cognitive dysfunction may occur across the lifespan and may be associated with a wide range of clinical conditions. Cognitive dysfunction comes in many different forms and can come and go, remain over time, progress, be very specific or general and can range from mild to severe and affect different areas of life; like social participation, well-being, intellect, employment and functional performance. Cognitive impairments are typically categorized by severity or clinical conditions that cause the dysfunction. When rehabilitation therapy practitioners provide intervention to improve cognitive functioning (i.e., cognitive rehabilitation), the therapeutic goal is always to enhance some aspect of occupational or daily activity performance. Occupations refer to “everyday activities” that are important to the individual and that help define the individual to himself or herself and others and that serve an individual’s life roles (AOTA, 2013).

GENERAL BACKGROUND

Cognitive rehabilitation is a systematic, goal-oriented treatment program designed to improve cognitive functions and functional abilities, and increase levels of self-management and independence following neurological damage to the central nervous system. Although the specific tasks may be individualized to patients' needs, treatment generally emphasizes restoring lost functions; teaching compensatory strategies to circumvent impaired cognitive functions; and improving competence in performing instrumental activities of daily living (ADL) such as managing medications, using the telephone and handling finances. The term cognitive rehabilitation may be used to describe a variety of intervention strategies or techniques that are intended to help patients reduce, manage or cope with cognitive deficits. Cognitive rehabilitation may be provided as an integrated holistic program, or as a separate component used to treat a specific cognitive defect.

Restorative and compensatory approaches are utilized in cognitive rehabilitation. The restorative approach, also referred to as direct intervention or process-specific, is based on the theory that repetitive exercise promotes recovery of damaged neural circuits and restores lost function. Restorative cognitive rehabilitation targets specific internal cognitive processes in an effort to generalize improvements to real-world settings. Interventions typically involve exercises designed to isolate specific components of impaired cognition (e.g., selective attention, visual perception, prospective memory) and to rebuild cognition skills in a hierarchical manner. Restorative techniques include auditory, visual and verbal stimulation and practice, number manipulation, computer-assisted stimulation and practice, performance feedback, reinforcement, video feedback and meta-cognitive procedures such as behavior modification.

The compensatory approach, also referred to as the functional approach, focuses on teaching patients to employ various strategies to cope with underlying cognitive impairments and accompanying social deficits. The compensatory approach is based on the assumption that lost neurological functioning cannot be restored. The goal, therefore, is to teach strategies to circumvent impaired functioning, and encourage and reinforce intact abilities and strengths. Compensatory techniques generally focus on activities of daily living and social interactions. Group therapies may be important to strengthen the patient’s ability to interact effectively with others. Memory impairment may be addressed by external and internal methods of rehabilitation. External aids include memory notebook systems, electronic memory devices, alarms, calendars, posted reminders, and standardized locations for necessary items. Internal aids include learning of mnemonic strategies (e.g., acronyms, peg word systems, and associated imagery). Compensatory cognitive rehabilitation may involve modifying the physical or social environment in a way that cues a specific behavior and eliminates distraction or unwanted behavior. Although the compensatory approach to cognitive rehabilitation has been more widely accepted than the restorative approach, these techniques are not mutually exclusive. Many therapeutic programs employ both techniques.

A number of cognitive rehabilitation approaches have been proposed to address the issue of cognitive impairment such as: attention process training, integrated psychological therapy, cognitive enhancement therapy, neurocognitive enhancement therapy, and cognitive remediation therapy, the neuropsychological educational approach to remediation, errorless learning approaches, and attention shaping. Each approach shares the goal of enhancing cognitive processes or circumventing cognitive impairments in an effort to improve functional outcomes (Velligan et al., 2006).

Cognitive rehabilitation may be provided by various professionals, including speech/language pathologists, occupational therapists, psychiatrists, psychologists, neuropsychologists, psychiatric nurses, cognitive remediation therapists, and physical therapists. None of these disciplines provide specific training guidelines for cognitive rehabilitation, however. Cognitive rehabilitation is usually provided on an outpatient basis, although other settings may be indicated depending on the patient's stage of recovery and acuity level. Prior to initiation of a cognitive rehabilitation program, patients generally undergo comprehensive neuropsychological testing to evaluate and identify specific baseline deficits and impairments as well as to direct a treatment plan and develop measurable goals.

There is substantial variation in the delivery of cognitive rehabilitation with respect to essential components, program design and emphasis. Cognitive rehabilitation interventions should be structured, systematic, goal-directed (long- and short-term goals), individualized and restorative. There is no evidence in the medical literature to support a specific treatment intensity or duration for cognitive rehabilitation. Cognitive rehabilitation should be evaluated on the basis of goal achievement, including quantifiable rates of improvement in functional abilities and documented treatment outcomes. There is an expectation that some improvement can be demonstrated through documentation within two weeks. Contraindications to cognitive rehabilitation include the inability of the patient to participate in a treatment plan (i.e., orthopedic, medical, psychosocial or behavioral issues). Cognitive rehabilitation often involves the services of a multidisciplinary team.

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 available evidence, although not robust, indicates that cognitive rehabilitation may improve functional outcomes for some patients with moderate or severe TBI. Evidence is limited due to the heterogeneity of subjects, interventions and outcomes studied, small sample size, failure to control for spontaneous recovery, and the unspecified confounding effects of social contact. Evidence from available studies indicates, however, that cognitive rehabilitation may reduce anxiety, improve self-concept and relationships for people with TBI, and may improve memory, attention and executive skills. There is insufficient evidence in the published medical literature, however, to support the use of cognitive rehabilitation for patients with mild TBI, including concussion and post-concussion syndrome.

Patients who sustain a stroke may exhibit symptoms similar to those experienced by TBI patients, with cognitive deficits in the areas of memory, reasoning and perception. Both TBI and stroke may result in impairment of localized, higher-order, sensory and motor function corresponding to affected anatomic structures, but may also result in loss of a variety of functions that are not clearly localized, such as the ability to abstract and to reason. Although the evidence supporting the use of cognitive rehabilitation to treat cognitive deficits following stroke is limited, there is some evidence that it contributes to visuospatial rehabilitation and improvement in aphasia and apraxia. In addition, the medical community has recognized cognitive rehabilitation as a standard treatment modality for stroke as well as for TBI.

Although cognitive rehabilitation has been proposed for numerous other conditions that may cause impaired cognitive function, there is insufficient evidence to support its use for conditions other than moderate to severe TBI or stroke

Traumatic Brain Injury (TBI) and Stroke

A number of classification systems have been developed for assessment of neurological damage following head injury. The Glasgow Coma Scale (GCS) is generally used in the initial evaluation of the head injury. The initial GCS score helps determine prognosis and the extent of injury. GCS classifications are as follows: GCS 3–8, severe; GCS 9–13 (alternately, 9–12), moderate, and GCS 14–15 (alternately, 13–15), mild or minor. A GCS of 13-15 has traditionally been defined as a minor TBI, but many patients with a GCS of 13 have outcomes more consistent with moderate TBI, so some authorities now consider minor TBI as that producing a GCS of 14-15.

Mild or minor TBI is a temporary and brief interruption of neurologic function after head trauma, and may involve a loss of consciousness. A concussion is a type of minor TBI usually caused by acceleration-deceleration or rotational injury to a freely mobile head, and is commonly associated with collision sports. Almost all-patients with minor TBI will have rapid and complete symptom resolution; with no long-term sequelae. A small percentage of patients may report persistent symptoms (e.g., headache, sensory sensitivity, memory or concentration difficulties, irritability, sleep disturbance, depression) for extended periods after trauma. These symptoms are referred to as postconcussive syndrome (Biros and Hegaard, 2009).

Other conditions contribute to the degree of severity, including posttraumatic amnesia (PTA). PTA is defined as the interval between injury and return to day-to-day memory, and can be assessed during the subacute stage of recovery by testing orientation and memory. Scores include mild (< 24 hours), moderate (24 hours to 7 days), and severe (7 days or more). The Rancho Los Amigos Cognitive Functioning Scale (RLAS) is a commonly used method to characterize and stage TBI recovery in rehabilitation settings. RLAS cognitive levels range from I, no response, to VIII, purposeful and appropriate (Evans, et al., 2007; Arciniegas, 2008, Koehler, et al., 2011).

Patients with moderate or severe traumatic brain injury (TBI) may experience both cognitive and non-cognitive problems, including behavioral and emotional issues. Cognitive rehabilitation therefore is often provided as part of a comprehensive, holistic program that is focused on treatment of the cognitive, psychosocial, and behavioral issues associated with TBI. Most holistic programs include group and individual therapy in which patients are encouraged to be more aware of and accept their strengths and weaknesses, improve their social relatedness, and are provided with strategies to compensate for cognitive difficulties.

Dementia

Dementia is the development of cognitive impairments that diminish social, occupational, and intellectual abilities. It can be grouped into four major categories: degenerative (Alzheimer's disease, Parkinson's disease, Huntington's disease), vascular (following stroke), infectious (HIV Type-1 associated dementia), and metabolic diseases (Wilson's disease) (Small and Mayeux, 2005).

Schizophrenia

Schizophrenia is a severe and persistent debilitating psychiatric disorder that affects approximately 1% of the world's population. It is characterized by disturbances in perception, cognition, mood, thought process, expression of language, and relationships with others. Symptoms can include delusions, hallucinations, and thought disorder. Neuropsychiatric changes often include impairments in information processing.

Multiple Sclerosis

Multiple sclerosis (MS) is a neurologic condition that involves a disruption of the flow of information with the brain and between the brain and the body. The progress, severity and specific symptoms of MS in any one person is variable and inconsistent. Most people with MS are diagnosed between the ages of 20 and 50, with at least two to three times more women than men being diagnosed with the disease. It involves an immune-mediated process that causes damage to the central nervous system (CNS), which includes the brain, spinal cord and optic nerves. The inflammation caused by the immune system damages the myelin, or fatty substance that surrounds and insulated the nerve fibers, the cells that produce myelin, and the nerve fibers themselves. This damage causes scarring and creates altered nerve conduction, which results in a variety of neurological symptoms. These symptoms will vary among and within individuals with MS, and can include muscle weakness, spasticity, vision problems, numbness and tingling, fatigue, cognitive and emotional changes, dizziness, and/or gait disturbances. The cause of MS is not known, but it is hypothesized to involve genetic susceptibility, abnormalities in the immune system, and environmental factors that combine to trigger the disease. People with MS typically experience one of four disease courses.

Coma Stimulation

Sensory stimulation, also referred to as coma stimulation, coma arousal therapy, multisensory stimulation and coma care, is intended to promote awakening and enhance the rehabilitative potential of coma patients. It has been proposed that with intense and repeated stimulation and precise protocols, a patient could be awakened earlier from coma and returned to a higher level of functioning. Protocols may involve stimulation of any or all of the following senses: visual, auditory, olfactory, gustatory, cutaneous, and kinesthetic. The intensity of coma stimulation programs varies. Programs can range from one or two cycles of stimulation daily (approximately one hour each) to hourly stimulation cycles, lasting approximately 15–20 minutes, for 12–14 hours per day, six days a week. Professionals who perform the protocols include nurses, occupational therapists, physical therapists and speech-language therapists. Treatment may be delivered in the hospital, the patient's home, or a skilled nursing facility. Due to the intensity of the program, the patient's family may be trained in the techniques and given the primary responsibility for providing the therapy to ensure program continuation.

LITERATURE REVIEW

Cognitive rehabilitation interventions for persons with stroke, traumatic brain injury (TBI), and dementias have the most published empirical data (Cicerone et al., 2011; Rohling et al., 2009), and persons with these conditions are among the most frequently seen by rehabilitation therapy practitioners. Additionally, they may

address cognitive barriers to functioning resulting from developmental disorders, environmental factors, or disease. Specifically, these populations include those experiencing cognitive dysfunction related to:

- Genetics and/or development (e.g., environmental deprivation, fetal alcohol syndrome, learning disabilities, pervasive developmental disorders)
- Other neurologic disease, events, injuries, and disorders (e.g., Parkinson's and Huntington's diseases, HIV/AIDS, Alzheimer's disease and related dementias)
- Mental illness (e.g., schizophrenia, major depressive disorder, bipolar disorder, substance use disorders)
- Transient or continuing life stresses or changes (e.g., stress-related disorders, pain syndromes, anxiety disorders, grief and loss)

Traumatic Brain Injury (TBI) and Stroke

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 available evidence, although not robust, indicates that cognitive rehabilitation may improve functional outcomes for some patients with moderate or severe TBI. Evidence is limited due to the heterogeneity of subjects, interventions and outcomes studied, small sample size, failure to control for spontaneous recovery, and the unspecified confounding effects of social contact. Evidence from available studies indicates, however, that cognitive rehabilitation may reduce anxiety, improve self-concept and relationships for people with TBI, and may improve memory, attention and executive skills. There is insufficient evidence in the published medical literature, however, to support the use of cognitive rehabilitation for patients with mild TBI, including concussion and post-concussion syndrome. Patients who sustain a stroke may exhibit symptoms similar to those experienced by TBI patients, with cognitive deficits in the areas of memory, reasoning and perception. Both TBI and stroke may result in impairment of localized, higher-order, sensory and motor function corresponding to affected anatomic structures, but may also result in loss of a variety of functions that are not clearly localized, such as the ability to abstract and to reason. Although the evidence supporting the use of cognitive rehabilitation to treat cognitive deficits following stroke is limited, there is some evidence that it contributes to visuospatial rehabilitation and improvement in aphasia and apraxia. In addition, the medical community has recognized cognitive rehabilitation as a standard treatment modality for stroke as well as for TBI.

National Academy of Neuropsychology (NAN) published an official statement on cognitive rehabilitation that supports empirically and rationally based cognitive rehabilitation techniques that have been designed to improve the quality of life and functional outcomes for individuals with acquired brain injuries (NAN, 2002). In 2005, the cognitive rehabilitation task force of European Federation of Neurological Societies (EFNS) provided an updated statement and recommendations regarding the clinical effectiveness of cognitive rehabilitation for patients with TBI and stroke. The task force concluded that the current evidence is inconclusive due to methodological quality, insufficient sample size, failure to compare treatment methods, and inability to determine outcomes at the disability level. The authors stated that adequately designed randomized trials with patient homogeneity and treatment standardization are needed to evaluate the efficacy of cognitive rehabilitation for TBI (Cappa, et al., 2005). A systematic review by Koehler et al. 2011 found limited, and in some cases, modest evidence that cognitive rehabilitation is effective for treating some deficits related to TBI, including attention, executive function, social communication, and memory. A systematic review of 112 studies (Cicerone, et al., 2011) for cognitive rehabilitation following TBI and stroke the review indicate that regarding stroke that the evidence supports visuospatial rehabilitation after right hemisphere stroke and interventions for aphasia and apraxia after left hemisphere stroke and that based on the current meta-analysis, together with prior reviews, there is sufficient information to support evidence-based protocols and implement empirically-supported treatments for cognitive disability after TBI and stroke. Chung et al. (2013) investigated how effective cognitive rehabilitation interventions are at improving executive function after brain injury in a Cochrane review. Thirteen studies were included consisting of 770 participants in the meta-analyses (417 traumatic brain injury, 304 stroke, 49 other acquired brain injury) which reduced to 660 participants once non-included intervention groups were removed from some studies. Three studies (134 participants) compared cognitive rehabilitation with sensorimotor therapy. Six studies (333 participants) compared cognitive rehabilitation with no treatment or placebo. Ten studies (448 participants) compared two different cognitive rehabilitation approaches. They also explored the effect of restorative interventions (10 studies, 468 participants) and compensative interventions (four studies, 128 participants) and found no statistically significant effect compared with other interventions. They found no evidence that cognitive rehabilitation interventions were helpful for people with executive dysfunction for any other outcomes. Authors identified insufficient high-quality evidence to reach any generalized conclusions about the effect of cognitive rehabilitation on executive function, or other secondary outcome measures. Further high-

quality research comparing cognitive rehabilitation with no intervention, placebo or sensorimotor interventions was recommended.

The American Academy of Neurology (AAN) published an evidence-based guideline update on the evaluation and management of concussion in sports in 2013. Regarding the question of what interventions enhance recovery, reduce the risk of recurrent concussion, or diminish long term sequelae, the authors stated that on the basis of the available evidence, no conclusions can be drawn regarding the effect of postconcussive activity level on the recovery from sport related concussion or the likelihood of developing chronic post-concussion complications (Giza, et al., 2013).

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. Park et al. (2015) investigated the overall effect of occupation-based cognitive rehabilitation on patients' improvement in cognitive performance components, activity of daily living (ADL) performance, and values, beliefs and spirituality functions of patients with TBI. Evidence from this meta-analytic study suggests that occupation-based cognitive rehabilitation would be beneficial for individuals with TBI for improving daily functioning and positively be able to affect their psychosocial functions. Kumar et al. (2017) evaluated whether cognitive rehabilitation for people with TBI improves return to work, independence in daily activities, community integration and quality of life. Nine studies with 790 participants were included. Authors state that there is insufficient good-quality evidence to support the role of cognitive rehabilitation when compared to no intervention or conventional rehabilitation in improving return to work, independence in ADL, community integration or quality of life in adults with TBI. There is moderate-quality evidence that cognitive rehabilitation provided as a home program is similar to hospital-based cognitive rehabilitation in improving return to work status among active duty military personnel with moderate-to-severe TBI.

An Agency for Healthcare Research and Quality (AHRQ) comparative effectiveness review was conducted to determine the effectiveness and comparative effectiveness of multidisciplinary postacute rehabilitation for moderate to severe traumatic brain injury TBI in adults (Brasure et al., 2012; 2016). Twelve studies assessed a primary outcome and eight assessed secondary outcomes and four of these were considered to have a high risk of bias and were excluded from analysis. Studies of multidisciplinary postacute rehabilitation programs often do not define interventions sufficiently. Although newer studies provide more useful definitions, it remains difficult to decipher what the individual components of the program entailed and how, when and why individuals received specific therapies. The review found that currently available evidence is insufficient to draw conclusions about the effectiveness of multidisciplinary postacute rehabilitation for moderate to severe TBI. Although the authors found stronger evidence on the comparative effectiveness of different approaches to multidisciplinary postacute rehabilitation for participation outcomes, there were a limited number of eligible studies and no clear demonstration that one approach was superior to another. The authors stated that future research to identify and test hypothesized combinations between patient types and intervention approaches would have important clinical implications. Recommendations for brain injury rehabilitation in adults from the Scottish Intercollegiate Guidelines Network (SIGN) (2013) include:

- Assessment and treatment of mild brain injury

- Patients presenting with non-specific symptoms following mild traumatic brain injury should be reassured that the symptoms are benign and likely to settle within three months.
- Cognitive rehabilitation:
 - Patients with memory impairment after TBI should be trained in the use of compensatory memory strategies with a clear focus on improving everyday functioning rather than underlying memory impairment.
 - For patients with mild-moderate memory impairment both external aids and internal strategies (e.g. use of visual imagery) may be used.
 - For those with severe memory impairment external compensations with a clear focus on functional activities is recommended.
 - In the post-acute setting interventions for cognitive deficits should be applied in the context of a comprehensive/holistic neuropsychological rehabilitation program. This would involve an interdisciplinary team using a goal-focused program which has the capacity to address cognitive, emotional and behavioral difficulties with the aim of improving functioning in meaningful everyday activities.

American Occupational Therapy Association (AOTA): AOTA published occupational therapy practice guidelines for adults with traumatic brain injury (Wheeler, et al., 2016). The recommendation for occupational therapy interventions for adults with TBI include:

- Interventions to Improve Occupational Performance of People with Cognitive Impairments:
 - General memory interventions (involving restorative and/or compensatory approaches) to improve memory (A)
 - Attention regulation interventions with or without goal problem-solving training to improve attention and executive functioning (A)
 - Executive function strategy training such as goals management training and meta-cognitive strategy instruction to improve attention and executive functioning (A)
 - Training in encoding techniques to improve recall (A)
 - Training in use of cognitive assistive technology (except voice recorders and navigation devices) to improve memory (A)
 - Various memory-specific compensatory approaches to improve memory (A)
 - Use of compensatory interventions to improve multiple cognitive domains (B)
 - Cognitive interventions to improve self-awareness (B)
 - Computer-based interventions to enhance occupational performance (I)
 - General restorative and/or compensatory approaches to improve attention and executive dysfunction (I)
- Interventions to Improve Occupational Performance of People with Visual and Visual–Perceptual Impairments
 - Scanning training to improve search skills when measured with digit search, computer tests, and a functional search task (A)
 - Cognitive rehabilitation to improve performance in neuropsychological measures focused on visual perception (A)
 - Scanning training accompanied by a visual and/or auditory stimulus to improve visual search skills and reading performance (B)
 - Vision therapy to remediate oculomotor signs and symptoms (C)
 - Cognitive compensatory strategies such as pacing, chunking, and self-talk to improve activity of daily living (ADL) performance (C)
 - Fresnel 40-diopter prism to improve visual field awareness and functional mobility (C)
 - Scrolling text to improve reading performance of people with reading difficulties as a result of hemianopsia (C)
 - Cognitive strategies focused on social skills training to improve the ability to name basic emotions, interpret comments, and determine whether a person is lying or being sarcastic (I)
 - Scanning as a standalone intervention to improve reading (I)
- Interventions to Improve Occupational Performance of People with Psychosocial, Behavioral, or Emotional Impairments

- Cognitive-behavioral therapy (CBT) interventions to address psychosocial, behavioral, and emotional impairments and to improve occupational performance (A)
- Goal-directed outpatient rehabilitation to improve ratings of self-performance and satisfaction (A)
- Goal-directed outpatient rehabilitation to improve goal attainment, occupational performance, psychosocial reintegration, and adjustment levels (B)
- Aquatic exercise to improve tension, depression, anger, vigor, fatigue, and confusion (B)
- Functional skills training to improve social participation, community reintegration, independent living, emotional well-being, and quality of life (B)
- CBT modified to include mindfulness-based cognitive therapy (MBCT) to decrease depression and motivational interviewing to improve anxiety (C)
- CBT administered in the virtual context to address psychosocial and emotional distress, anxiety, and depression (C)
- Aerobic exercise to improve self-esteem, depression, quality of life, and community activity (C)

Strength of Recommendation

A—There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

B—There is moderate evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

C—There is weak evidence that the intervention can improve outcomes. It is recommended that the intervention be provided selectively on the basis of professional judgement and patient preferences. There is at least moderate certainty that the net benefit is small.

I—There is insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

D—It is recommended that occupational therapy practitioners do not provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

Note: Criteria for level of evidence and recommendations (A, B, C, I, D) are based on standard language from the U.S. Preventive Services Task Force (2012). Suggested recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using it.

The Stroke Council of the American Heart Association endorsed the Veterans Administration/Department of Defense guidelines for stroke rehabilitation (Duncan, et al., 2005). The panel was made up of experts from the Department of Veterans Affairs and the United States Department of Defense. The panel evaluated published literature through 2002. Recommendations were based on randomized clinical trials, uncontrolled studies, or consensus expert opinion if definitive data were lacking. The guidelines were developed as a means of direction for clinicians and also to assist researchers in identifying areas in need of further investigation. In the area of cognitive rehabilitation, the recommendation was that all patients be assessed for cognitive deficits and be given retraining if any of the following conditions were present: attention deficit, visual neglect, memory deficits, and executive function and problem-solving difficulties. das Nair and Lincoln (2007) reviewed cognitive rehabilitation for memory deficits following stroke in a Cochrane review. Only 2 trials, involving 18 participants, were included. One study compared the effectiveness of a mnemonic strategy treatment group with a 'drill and practice' control, while the other compared the effectiveness of an imagery mnemonics program with a 'pragmatic' memory rehabilitation control program. Authors conclude that there was no evidence to support or refute the effectiveness of memory rehabilitation on functional outcomes, and objective, subjective, and observer-rated memory measures. This review of two trials involving 18 participants found that there was little evidence to support the effectiveness of cognitive rehabilitation for memory problems after stroke and more research in this area is needed. das Nair et al. (2016) then published an updated Cochrane review for cognitive rehabilitation for memory deficits after stroke. The review included 13 trials involving 514 participants. The review found that participants who received cognitive rehabilitation for memory problems following a stroke reported benefits from the intervention on subjective measures of memory in the short term. The effect was not, however, observed in the longer term. There was limited evidence to support or refute the effectiveness of memory rehabilitation with the evidence limited due to the poor quality of reporting in many studies, lack of consistency in the choice of outcome measures, and small sample sizes. There is a need for more robust, well-designed, adequately

powered, and better-reported trials of memory rehabilitation using common standardized outcome measures. Hoffman et al. (2010) conducted a systematic review to determine whether interventions for cognitive impairment following stroke may improve functional performance of basic and/or instrumental activities of daily living (ADL). The authors concluded that the small number of high quality trials did not allow recommendations that support or refute the use of specific cognitive retraining interventions to improve functional outcomes following stroke.

Loetscher et al. (2013) reported on a Cochrane review that examined cognitive rehabilitation for attention deficits following stroke. The authors noted that there was limited evidence that cognitive rehabilitation may improve some aspects of attention in the short term, but there was insufficient evidence to support or refute the persisting effects of cognitive rehabilitation on attention, or on functional outcomes in either the short or long term and they concluded that the effectiveness of cognitive rehabilitation for this condition remains unconfirmed and that while the results suggest there may be a short-term effect on attentional abilities, future studies are needed to assess the persisting effects and measure attentional skills in daily life. Chung et al. (2013) reported on a Cochrane review for cognitive rehabilitation for executive dysfunction in adults with stroke or other adult non-progressive acquired brain damage. The review noted that there was insufficient high-quality evidence to reach any generalized conclusions about the effect of cognitive rehabilitation on any outcomes, for all comparisons and that further high-quality research comparing cognitive rehabilitation with no intervention, placebo or sensorimotor interventions is recommended. Bowen et al. (2013) authored a Cochrane review on cognitive rehabilitation for spatial neglect following stroke. Authors included 23 RCTs with 628 participants. Most studies measured outcomes using standardized neglect assessments. Meta-analyses demonstrated no statistically significant effect of cognitive rehabilitation, compared with control, for persisting effects on either ADL (five studies, 143 participants) or standardized neglect assessments (eight studies, 172 participants), or for immediate effects on ADL (10 studies, 343 participants). In contrast, they found a statistically significant effect in favor of cognitive rehabilitation compared with control, for immediate effects on standardized neglect assessments. The effectiveness of cognitive rehabilitation interventions for reducing the disabling effects of neglect and increasing independence remains unproven, thus no rehabilitation approach can be supported or refuted based on current evidence from RCTs. However, there is some very limited evidence that cognitive rehabilitation may have an immediate beneficial effect on tests of neglect which justifies further high quality clinical trials of cognitive rehabilitation for neglect. Gillespie et al. (2015) provided an overview of the evidence for the effectiveness of cognitive rehabilitation for patients with stroke and to determine the main gaps in the current evidence base. Data arising from 44 trials involving over 1500 patients was identified. Though there was support for the effectiveness of cognitive rehabilitation for some cognitive impairments, significant gaps were found in the current evidence base. All of the Cochrane reviews identified major limitations within the evidence they identified. Authors concluded that there is currently insufficient research evidence, or evidence of insufficient quality, to support clear recommendations for clinical practice.

Cicerone et al. (2019) conducted an updated, systematic review of the clinical literature, classify studies based on the strength of research design, and derive consensual, evidence-based clinical recommendations for cognitive rehabilitation of people with traumatic brain injury (TBI) or stroke. Articles were reviewed by the Cognitive Rehabilitation Task Force (CRTF) members according to specific criteria for study design and quality, and classified as providing class I, class II, or class III evidence. Of 121 studies, 41 were rated as class I, 3 as class Ia, 14 as class II, and 63 as class III. Recommendations were derived by CRTF consensus from the relative strengths of the evidence, based on the decision rules applied in prior reviews. CRTF has now evaluated 491 articles (109 class I or Ia, 68 class II, and 314 class III) and makes 29 recommendations for evidence-based practice of cognitive rehabilitation (9 Practice Standards, 9 Practice Guidelines, 11 Practice Options). Evidence supports Practice Standards for (1) attention deficits after TBI or stroke; (2) visual scanning for neglect after right-hemisphere stroke; (3) compensatory strategies for mild memory deficits; (4) language deficits after left-hemisphere stroke; (5) social-communication deficits after TBI; (6) metacognitive strategy training for deficits in executive functioning; and (7) comprehensive-holistic neuropsychological rehabilitation to reduce cognitive and functional disability after TBI or stroke. The results support moderate evidence for cognitive rehabilitation effects on function after TBI and CVA. Niemeijer et al. (2020) evaluated benefits and harms for computer based cognitive rehabilitation (CBCR) on working memory impairment after stroke. Literature was limited and reported effects of CBCR on working memory after stroke were very heterogeneous. A meta-analysis was not performed as all studies used different measures of working memory. An additional analysis was performed in order to cautiously estimate the difference between the control interventions (whether passive or active) and CBCR interventions. The analysis revealed no meaningful differences in increase of working memory measures between control conditions and intervention conditions. However, this additional

analysis should be interpreted with caution as it does not take the heterogeneity of outcome measures or the differences in sample sizes between studies into account. No harms were observed. Authors concluded that there is insufficient evidence to conclude if CBCR is beneficial for patients with working memory deficits after stroke.

Dementia: Clare et al. (2019) sought to determine whether individual goal-oriented cognitive rehabilitation (CR) improves everyday functioning for people with mild-to-moderate dementia. Participants allocated to CR received 10 weekly sessions over 3 months and four maintenance sessions over 6 months. The primary outcome was self-reported goal attainment at 3 months. At 3 months, there were statistically significant large positive effects for participant-rated goal attainment. These effects were maintained at 9 months. The observed gains related to goals directly targeted in the therapy. There were no significant differences in secondary outcomes. Authors concluded that CR enables people with early-stage dementia to improve their everyday functioning in relation to individual goals targeted in the therapy. More studies are necessary to confirm results.

A Cochrane review (Bahar-Fuchs, et al., 2013) evaluated the effectiveness and impact of cognitive training and cognitive rehabilitation for mild Alzheimer's disease or vascular dementia. Eleven randomized controlled trials of cognitive training were considered in the review. The overall quality of the trials was low to moderate. Cognitive training was not associated with any positive or negative effects for any reported outcomes. One randomized controlled trial of cognitive rehabilitation was included that allowed evaluation of effect sizes, but no meta-analysis could be conducted. Results of this trial were promising but preliminary in nature. Well-designed studies of cognitive training and cognitive rehabilitation are required to obtain more definitive evidence.

Clare et al. (2010) conducted a single-blind randomized controlled trial to compare cognitive rehabilitation (n=23) to relaxation therapy (n=24) and no treatment (n=22) in participants with a diagnosis of Alzheimer Disease (AD) or mixed AD and vascular dementia. Cognitive rehabilitation consisted of eight weekly individual sessions consisting of personalized interventions to address relevant goals, supported by components addressing practical aids and strategies, techniques for learning new information, practice in maintaining attention and concentration, and stress management techniques. Relaxation therapy included the same amount of therapist time and equivalent level of between-session practice. Participants were taught progressive muscle relaxation and breathing exercises and encouraged to practice these strategies when experiencing anxiety. Six-month follow-up was completed in 16 participants in the cognitive rehabilitation group, and 20 in both the relaxation and no-treatment groups. The primary outcomes were goal performance and satisfaction as assessed by the Canadian Occupational Performance Measure (COPM). At six months, ratings on the COPM scale indicated improvement in perceived performance ($p < 0.001$) and satisfaction ($p < 0.001$), and improvements were corroborated by therapist observation-based ratings of performance. It is difficult to draw conclusions from this study due to the small number of participants and significant numbers lost to follow-up.

In a meta-analysis of the literature regarding cognitive training (CT) and Alzheimer's disease, Sitzer et al. (2006) reviewed 19 controlled trials, 14 of which were RCTs. The authors used Cohen's description of effect size magnitude (0.2=small, 0.5=medium, 0.8=large) to measure outcomes. A small effect size for CT in general was reported but, more specifically, there were negative or minimal effects on visuospatial functioning and language, small effects on motor speed and visual learning, medium effects on executive functioning, and large effects on verbal and visual learning. The authors did note that the large effect size for verbal and visual learning was the result of one study and not aggregate scores. Only a few studies reported follow-up data suggesting that gains may be maintained an average of 4.5 months after discontinuing treatment. Many limitations in the studies were identified such as: the limited number of well-controlled studies, small sample sizes, and the variable outcome measures and techniques used. The authors concluded that CT may improve the cognitive and functional abilities of patients with Alzheimer's disease, but further research is needed, including effectiveness studies in various settings and the use of performance-based measures to evaluate the effects of treatment on daily functioning.

Schizophrenia: Eack et al. (2010) evaluated the one-year durability of the effects of cognitive enhancement therapy on functional outcomes in patients with early schizophrenia (n=28) or schizoaffective disorder (n=20). Functional outcome was measured using the Social Adjustment Scale-II (SAS-II) and the Major Role Adjustment Inventory (MRA). Patients were randomized to receive cognitive enhancement therapy (CET) or an Enriched Supportive Therapy (EST) control. CET consisted of 60 hours of computer-based training in attention, memory, and problem-solving, integrated with 45 1.5 hour social-cognitive group therapy sessions. EST is a personalized, individual approach including illness management and psychoeducation. Participants met

individually with a clinician to learn about schizophrenia, effects of stress and how to develop and apply healthy coping strategies. Significant differences in effects favoring CET on overall social adjusted persisted at one-year follow-up and no significant decreases in adjustment were observed in CET patients during the follow-up period. Patients treated with EST showed a slight but significant level of continued improvement in overall adjustment at one year post-treatment. Maintenance of CET effects was found on social functioning in relationships outside the household and participation in social leisure activities, as well as on major role adjustment and overall ratings of global functioning. The authors concluded that the beneficial effects of CET on functional outcome in early schizophrenia can be maintained a year after completion of treatment, and that CET has the potential of a lasting impact on the early trajectory of the disease. The authors acknowledged limitations of the study, including the lack of durability data on cognition, as well as the use of non-blinded raters.

McGurk et al. (2007) conducted a meta-analysis of 26 randomized controlled trials that evaluated the effects of cognitive remediation on cognitive performance, symptoms and psychosocial functioning in 1,151 patients with schizophrenia. The authors reported a medium effect size for cognitive performance (0.41), a slightly smaller effect size for psychosocial functioning (0.36), and a small effect size for symptoms (0.28). According to the authors, the impact of cognitive remediation on function was moderated by several factors including the addition of adjunctive psychiatric rehabilitation, cognitive training method, and patient age. They also noted there was a lack of data regarding long term effects as only six studies examined if results were maintained at a post treatment follow-up (average of eight months). The authors concluded that cognitive remediation may have a moderate effect on cognitive performance and when combined with psychiatric rehabilitation, may improve functional outcomes. Retention of benefit beyond eight months was not explored.

Wykes et al. (2007b) conducted a single-blind randomized controlled trial of 40 young early onset patients with schizophrenia to evaluate the efficacy of cognitive remediation therapy (CRT) in alleviating cognitive deficits compared to treatment as usual. Twenty-one patients received CRT and 19 received standard care. Primary outcome measures included: cognitive flexibility (measured on the Wisconsin Cars Sort Test [WCST]), memory (measured on Digit Span), planning (measured on the Modified Six Elements Test). Secondary outcomes included: symptoms, social contacts and self-esteem. Assessments took place at baseline, post-treatment (week 14) and follow-up (week 28). The only measure that reached statistical significance when compare to the standard care group was the WCST scores ($p = 0.04$). The authors stated that larger trials that evaluate the long-term maintenance of the effects of CRT are warranted.

Wykes et al. (2007a) conducted a randomized controlled trial to evaluate if cognitive remediation improved cognition in people with schizophrenia. Eighty-five participants with schizophrenia and cognitive difficulties were randomized to 40 sessions of cognitive remediation ($n=43$) or treatment as usual ($n=42$). Outcome measures included working memory, cognitive flexibility, and planning. Evaluations took place at 1, 14, and 40 weeks. For working memory, 21 in the therapy group and 18 in the control group had abnormal working memory scores at baseline. After the intervention, the authors reported a significant advantage to the therapy group at the 14-week post-therapy assessment ($p=0.037$), but at the time of the 40-week follow-up, there was no longer any statistical significance ($p=0.10$). There was no difference between the two groups for cognitive flexibility, and there was no statistically significant difference at any point in time for planning. The authors noted that there was a significant group by medication interaction, suggesting that medications may hinder or enhance the effects of cognitive remediation. Methodological considerations, according to the authors, included: some improvement may have been due to increased social interaction, medications may have affected the outcomes, blinding was not maintained, and the sample size was small. Although most of the improvements did not obtain statistical significance, the authors stated that cognitive improvement was noted in many areas.

Velligan et al. (2006) conducted a literature review to examine research findings on the eight evidence-based approaches to cognitive rehabilitation, as listed in the 2005 Training Grid Outlining Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness, developed by the American Psychological Association Committee for the Advancement of Professional Practice, for patients with schizophrenia. 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. According to the authors, the studies that were included varied considerably in areas such as criteria for study inclusion, the conceptual organization of studies, and interpretation of findings. The authors stated that few approaches had more than three data-based studies supporting their efficacy in schizophrenia and that there are no agreed upon guidelines for levels of intensity or duration of training. The authors concluded that the findings of this

review were not uniformly positive but encouraging, which is what they would expect at this stage of cognitive rehabilitation development.

Multiple Sclerosis

Mousavi et al. (2018) evaluated the effectiveness of cognitive rehabilitation on everyday memory in multiple sclerosis patients. A total of 60 multiple sclerosis patients with cognitive impairment were randomly assigned to three groups, experimental, placebo and control. The results indicated that a cognitive rehabilitation program had a positive effect on the everyday memory of patients in the experimental group post-intervention. However, there was no significant effect of intervention 5 weeks post-intervention. Authors concluded that this study demonstrated that cognitive rehabilitation had a positive effect on the everyday function of the multiple sclerosis patients. However, the effect did not last, and that everyday memory function returned to its pre-intervention level. Rilo et al. (2018) aimed to determine the efficacy of the integrative group-based cognitive rehabilitation program, REHACOP, on improving cognitive functions in multiple sclerosis (MS). Forty-two MS patients were randomized to the treatment program or waiting list control condition. The REHACOP group received cognitive rehabilitation in group format for three months focused on attention, processing speed, learning and memory, language, executive functioning, and social cognition. Patients receiving REHACOP showed improvements in several cognitive domains. Authors suggested that this study provided initial evidence for integrative group-based cognitive rehabilitation efficacy in MS patients through the implementation of the REHACOP cognitive rehabilitation program.

Stuifbergen et al. (2018) sought to determine the effectiveness of a novel computer-assisted cognitive rehabilitation intervention MAPSS-MS (Memory, Attention, Problem Solving Skills in MS) in a multi-site trial with persons with MS. Persons with MS with cognitive concerns were randomly assigned to either the 8-week MAPSS-MS intervention or usual care plus freely available computer games. Results demonstrated that both groups improved significantly on all outcome measures. The intervention group outperformed the comparison group on all measures, and there were statistically significant differences on selected measures. Dardiotis et al. (2018) aim to quantitatively investigate the effect of computer-based cognitive rehabilitation on the neuropsychological performance of patients with MS. In total, 9 studies fulfilled the criteria for inclusion. Authors concluded that computer-based cognitive training was found to improve the performance in the memory domain of MS patients compared to control interventions. Goverover et al. (2018) updated the clinical recommendations for cognitive rehabilitation of people with multiple sclerosis (MS) in a systematic review. Fifty-nine articles were selected for inclusion after initial screening. Forty studies were fully reviewed and evaluated. Authors concluded that substantial progress has been made since the previous review regarding the identification of effective treatments for cognitive impairments in persons with MS. However, more research is required with better methodology to support this therapy for patients with MS.

Messinis et al. (2017) studied the efficacy of a computer-assisted CR intervention in relapsing-remitting MS (RRMS) patients. Fifty-eight clinically stable RRMS patients with mild to moderate cognitive impairment and relatively low disability status were randomized to receive either computer assisted (RehaCom) functional cognitive training with an emphasis on episodic memory, information processing speed/attention, and executive functions for 10 weeks or standard clinical care. Only the intervention group showed significant improvements in verbal and visuospatial episodic memory, processing speed/attention, and executive functioning from pre – to post-assessment. Also, treated patients rated the intervention positively and were more confident about their cognitive abilities following treatment. Mani et al. (2018) investigated the efficacy of group compensatory cognitive rehabilitation (CR) in patients with MS-related cognitive impairment. CR intervention consisted of eight 2-hour sessions of comprehensive group CR over a 4-week period that focused on improvement of memory, attention, and executive function. As placebo, the control group received the same number of non-therapeutic group sessions. Assessment of cognitive function was performed before intervention (pretest), at the end of intervention (post-test), and 3 months later (follow-up). Results demonstrated significantly higher scores in the CR group for memory and executive function. Authors concluded that this study supported the efficacy of group CR in the improvement of cognitive function in patients with MS.

Rosti-Otajärvi and Hämäläinen (2014) addressed neuropsychological rehabilitation for multiple sclerosis in a Cochrane review. The aim of this review was to evaluate the effects of cognitive (neuropsychological) rehabilitation in MS through consideration of the effects of rehabilitation on cognitive test performance and

everyday cognitive performance, as well as on depression, fatigue, personality/behavior disturbances, anxiety and quality of life. Twenty relevant studies comprising a total of 986 participants (966 MS participants and 20 healthy controls) were identified and included in this review. Low-level evidence was found that neuropsychological rehabilitation reduces cognitive symptoms in MS. Cognitive training was found to improve memory span and working memory. Cognitive training combined with other neuropsychological rehabilitation methods was found to improve attention, immediate verbal memory and delayed memory. However, small sample sizes and some methodological weaknesses reduce the rating of the evidence to a low-level. And there was no evidence of an effect of neuropsychological rehabilitation on emotional functions. In conclusion, this review found low-level evidence for positive effects of neuropsychological rehabilitation in MS. The interventions and outcome measures included in the review were heterogeneous, which limited the comparability of the studies. New trials may therefore change the strength and direction of the evidence.

Parkinson's Disease

Díez-Cirarda et al. (2018) performed a critical review to present up-to-date neurorehabilitation effects of cognitive rehabilitation in Parkinson's Disease (PD), with special emphasis on the efficacy on cognition, quality of life aspects, brain changes, and the longitudinal maintenance of these changes. Thirteen studies were reviewed, including 6 randomized controlled trials for the efficacy on cognition, 2 randomized controlled trials regarding the brain changes after cognitive training, and 5 studies which evaluated the long-term effects of cognitive treatments. Authors concluded that cognitive rehabilitation programs have demonstrated to be effective on improving cognitive functions, but more research is needed focusing on the efficacy on improving behavioral aspects and producing brain changes in patients with PD. Moreover, authors state there is a need of randomized controlled trials with long-term follow-up periods. Alzahrani and Venneri (2018) reviewed the existing literature on the efficacy of cognitive rehabilitation in PD. Authors identified 15 articles that examined the effects of cognitive rehabilitation in PD and met inclusion criteria. The main outcomes of this review indicated that, although previous studies used different CR methodologies, all studies reported cognitive improvements on at least 1 cognitive domain. Additionally, the most frequent cognitive domains showing improvements were executive functions and attention. The authors concluded that this review reported the outcomes of studies that examined the effectiveness of CR in PD. It also pointed out the drawbacks of the studies indicating the limited availability of follow-up data on the long-term effects of CR. The review also high-lighted the fact that some of the studies did not include a PD group who did not undergo training. Thus, these researchers noted that there is a need for longitudinal studies to examine the potential long-term benefits of cognitive training. In addition, future investigations should determine if any disease characteristics such as disease stage, degree of cognitive impairment and/or the dominant side (right/left) or specific motor symptoms (rigidity/tremor) influence treatment efficacy. Svaerke et al. (2020) evaluated effects of computer-based cognitive rehabilitation (CBCR) on working memory (WM) in patients with PD. Only six studies were included despite broad inclusion criteria. Study results were heterogeneous, and the risk of bias in study methodology was either unclear or high. Two studies were eligible for meta-analysis. A meta-analysis was not performed, because these studies used different measures of WM which were not rated as equally valid and reliable. Authors concluded that the existing literature is sparse and provides insufficient evidence to conclude if CBCR benefits WM in PD patients.

Additional Conditions: Cognitive rehabilitation has been proposed for numerous other conditions that cause, or may cause, impaired cognitive function, including:

- cerebral palsy
- attention deficit disorder, attention deficit hyperactivity disorder
- pervasive developmental disorders, including autism
- learning disabilities
- developmental delay

There is insufficient evidence in the published medical literature to support the use of cognitive rehabilitation for these conditions. The role of cognitive rehabilitation for the treatment of conditions other than moderate to severe traumatic brain injury or stroke/cerebral infarction has not been established.

Coma Stimulation

The American Academy of Neurology in a 1995 summary statement (reaffirmed 2006), "Practice Parameters: Assessment and Management of Patients in the Persistent Vegetative State," makes no reference to sensory

stimulation as a treatment modality. Karma and Rawat (2006) conducted a randomized controlled trial of 60 patients to determine the efficacy and benefits of early stimulation therapy in pediatric patients who were in a coma. Patients were randomized to the study group, who received stimulation to each of the six senses five times a day for two weeks (n=30) or to the control group, who received no stimulation (n=30). The level of consciousness was measured using the Glasgow Coma Scale (GCS) and AVPU scale prior to and after stimulation therapy. The authors reported statistically significant improvement in coma in the treatment group compared to the control group, as measured by GCS and AVPU. The authors reported that when the stimulation started less than 15 days from onset of coma, the results were better than when the stimulation was initiated after 15 days from onset. The authors concluded that stimulation therapy can reduce the duration for children in non-traumatic coma, but acknowledged the small sample size and short duration of follow-up as limitations of the study.

A Cochrane systematic review (Lombardi, et al., 2002) was conducted to assess the effectiveness of sensory stimulation programs in patients in a coma or vegetative state. The Cochrane review evaluated randomized controlled trials and nonrandomized controlled clinical trials comparing any type of stimulation programs to standard rehabilitation in patients in a coma or vegetative state. Three studies (one randomized controlled trial [Johnson, 1993] and two nonrandomized controlled trials [Kater, 1989; Mitchell, 1990]) with 68 traumatic brain-injured patients in total, met the inclusion criteria. The overall methodological quality was poor, and the studies differed widely in terms of study design and conduct. Also, due to the diversity in reporting of outcome measures, a quantitative meta-analysis was not possible. None of the three studies in the Cochrane review provided useful and valid results on outcomes of clinical relevance for coma patients. The Cochrane researchers concluded that there is no reliable evidence to support or rule out the effectiveness of multisensory programs in patients in a coma or vegetative state. The researchers further stated that the need to improve knowledge in this field and the lack of effective treatments indicates that treatment interventions based on sensory stimulation should be provided only in the context of well-designed, adequately sized, randomized controlled trials. The AOTA published occupational therapy practice guidelines for adults with traumatic brain injury (Wheeler, et al., 2016). The recommendations for individuals in a coma or persistent vegetative state include:

- Interventions to Improve Arousal and Alertness of People in a Coma or Persistent Vegetative State
 - Multimodal sensory stimulation to improve arousal and enhance clinical outcomes (A)
 - Auditory stimulation, especially when completed in a familiar voice, to increase arousal in the short term (B)
 - Increased complexity, rather than intensity, of stimulation to increase intervention effectiveness (C)
 - Median nerve stimulation to improve arousal and alertness (I)

Strength of Recommendation

A—There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

B—There is moderate evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

C—There is weak evidence that the intervention can improve outcomes. It is recommended that the intervention be provided selectively on the basis of professional judgement and patient preferences. There is at least moderate certainty that the net benefit is small.

I—There is insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

Note: Criteria for level of evidence and recommendations (A, B, C, I, D) are based on standard language from the U.S. Preventive Services Task Force (2012). Suggested recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using it.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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 (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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)

ICD-10-CM Diagnosis Codes	Description
G97.31- G97.32	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a procedure
I61.0-I61.9	Nontraumatic intracerebral hemorrhage
I62.00- I62.9	Other and unspecified nontraumatic intracranial hemorrhage
I63.00- I63.09	Cerebral infarction due to thrombosis of precerebral arteries
I63.10- I63.19	Cerebral infarction due to embolism of precerebral arteries
I63.20- I63.29	Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries
I63.30- I63.39	Cerebral infarction due to thrombosis of cerebral arteries
I63.40- I63.49	Cerebral infarction due to embolism of cerebral arteries
I63.50- I63.59	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
I63.6	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery
I63.89	Other cerebral infarction
I63.9	Cerebral infarction, unspecified
I69.010	Attention and concentration deficit following nontraumatic subarachnoid hemorrhage
I69.011	Memory deficit following nontraumatic subarachnoid hemorrhage
I69.012	Visuospatial deficit and spatial neglect following nontraumatic subarachnoid hemorrhage
I69.013	Psychomotor deficit following nontraumatic subarachnoid hemorrhage
I69.014	Frontal lobe and executive function deficit following nontraumatic subarachnoid hemorrhage
I69.015	Cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage
I69.018	Other symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage
I69.019	Unspecified symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage
I69.110	Attention and concentration deficit following nontraumatic intracerebral hemorrhage
I69.111	Memory deficit following nontraumatic intracerebral hemorrhage
I69.112	Visuospatial deficit and spatial neglect following nontraumatic intracerebral hemorrhage

ICD-10-CM Diagnosis Codes	Description
I69.113	Psychomotor deficit following nontraumatic intracerebral hemorrhage
I69.114	Frontal lobe and executive function deficit following nontraumatic intracerebral hemorrhage
I69.115	Cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage
I69.118	Other symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage
I69.119	Unspecified symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage
I69.210	Attention and concentration deficit following other nontraumatic intracranial hemorrhage
I69.211	Memory deficit following other nontraumatic intracranial hemorrhage
I69.212	Visuospatial deficit and spatial neglect following other nontraumatic intracranial hemorrhage
I69.213	Psychomotor deficit following other nontraumatic intracranial hemorrhage
I69.214	Frontal lobe and executive function deficit following other nontraumatic intracranial hemorrhage
I69.215	Cognitive social or emotional deficit following other nontraumatic intracranial hemorrhage
I69.218	Other symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage
I69.219	Unspecified symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage
I69.310	Attention and concentration deficit following cerebral infarction
I69.311	Memory deficit following cerebral infarction
I69.312	Visuospatial deficit and spatial neglect following cerebral infarction
I69.313	Psychomotor deficit following cerebral infarction
I69.314	Frontal lobe and executive function deficit following cerebral infarction
I69.315	Cognitive social or emotional deficit following cerebral infarction
I69.318	Other symptoms and signs involving cognitive functions following cerebral infarction
I69.319	Unspecified symptoms and signs involving cognitive functions following cerebral infarction
I69.810	Attention and concentration deficit following other cerebrovascular disease
I69.811	Memory deficit following other cerebrovascular disease
I69.812	Visuospatial deficit and spatial neglect following other cerebrovascular disease
I69.813	Psychomotor deficit following other cerebrovascular disease
I69.814	Frontal lobe and executive function deficit following other cerebrovascular disease
I69.815	Cognitive social or emotional deficit following other cerebrovascular disease
I69.818	Other symptoms and signs involving cognitive functions following other cerebrovascular disease
I69.819	Unspecified symptoms and signs involving cognitive functions following other cerebrovascular disease
I69.910	Attention and concentration deficit following unspecified cerebrovascular disease
I69.911	Memory deficit following unspecified cerebrovascular disease
I69.912	Visuospatial deficit and spatial neglect following unspecified cerebrovascular disease
I69.913	Psychomotor deficit following unspecified cerebrovascular disease
I69.914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease
I69.915	Cognitive social or emotional deficit following unspecified cerebrovascular disease
I69.918	Other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease
I69.919	Unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease
I97.810- I97.811	Intraoperative cerebrovascular infarction during surgery
I97.820- I97.821	Postprocedural cerebrovascular infarction following surgery
S06.1X0S	Traumatic cerebral edema without loss of consciousness, sequela
S06.1X1S	Traumatic cerebral edema with loss of consciousness of 30 minutes or less, sequela
S06.1X2S	Traumatic cerebral edema with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.1X3S	Traumatic cerebral edema with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.1X4S	Traumatic cerebral edema with loss of consciousness of 6 hours to 24 hours, sequela

ICD-10-CM Diagnosis Codes	Description
S06.1X5S	Traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.1X6S	Traumatic cerebral edema with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.1X9S	Traumatic cerebral edema with loss of consciousness of unspecified duration, sequela
S06.2X0S	Diffuse traumatic brain injury without loss of consciousness, sequela
S06.2X1S	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, sequela
S06.2X2S	Diffuse traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.2X3S	Diffuse traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.2X4S	Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.2X5S	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious levels, sequela
S06.2X6S	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.2X9S	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela
S06.300S	Unspecified focal traumatic brain injury without loss of consciousness, sequela
S06.301S	Unspecified focal traumatic brain injury with loss of consciousness of 30 minutes or less, sequela
S06.302S	Unspecified focal traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.303S	Unspecified focal traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.304S	Unspecified focal traumatic brain injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.305S	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.306S	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.309S	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, sequela
S06.310S	Contusion and laceration of right cerebrum without loss of consciousness, sequela
S06.311S	Contusion and laceration of right cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.312S	Contusion and laceration of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.313S	Contusion and laceration of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.314S	Contusion and laceration of right cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.315S	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.316S	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.319S	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, sequela
S06.320S	Contusion and laceration of left cerebrum without loss of consciousness, sequela
S06.321S	Contusion and laceration of left cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.322S	Contusion and laceration of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.323S	Contusion and laceration of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela

ICD-10-CM Diagnosis Codes	Description
S06.324S	Contusion and laceration of left cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.325S	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing consciousness level, sequela
S06.326S	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing consciousness level with patient surviving, sequela
S06.329S	Contusion and laceration of left cerebrum with loss of consciousness of unspecified duration, sequela
S06.330S	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, sequela
S06.331S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, sequela
S06.332S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.333S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.334S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, sequela
S06.335S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.336S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.339S	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of unspecified duration, sequela
S06.340S	Traumatic hemorrhage of right cerebrum without loss of consciousness, sequela
S06.341S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.342S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.343S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.344S	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.345S	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.346S	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.349S	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, sequela
S06.350S	Traumatic hemorrhage of left cerebrum without loss of consciousness, sequela
S06.351S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, sequela
S06.352S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.353S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.354S	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, sequela
S06.355S	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.356S	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.359S	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, sequela

ICD-10-CM Diagnosis Codes	Description
S06.360S	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, sequela
S06.361S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, sequela
S06.362S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.363S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.364S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, sequela
S06.365S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.366S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.369S	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, sequela
S06.370S	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, sequela
S06.371S	Contusion, laceration and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, sequela
S06.372S	Contusion, laceration and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.373S	Contusion, laceration and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.374S	Contusion, laceration and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, sequela
S06.375S	Contusion, laceration and hemorrhage of cerebellum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.376S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.379S	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, sequela
S06.380S	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, sequela
S06.381S	Contusion, laceration and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, sequela
S06.382S	Contusion, laceration and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.383S	Contusion, laceration and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.384S	Contusion, laceration and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, sequela
S06.385S	Contusion, laceration and hemorrhage of brainstem with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.386S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.389S	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, sequela
S06.4X0S	Epidural hemorrhage without loss of consciousness, sequela
S06.4X1S	Epidural hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.4X2S	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.4X3S	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.4X4S	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.4X5S	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela

ICD-10-CM Diagnosis Codes	Description
S06.4X6S	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.4X9S	Epidural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.5X0S	Traumatic subdural hemorrhage without loss of consciousness, sequela
S06.5X1S	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.5X2S	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.5X3S	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.5X4S	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.5X5S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.5X6S	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.5X9S	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
S06.6X0S	Traumatic subarachnoid hemorrhage without loss of consciousness, sequela
S06.6X1S	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, sequela
S06.6X2S	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.6X3S	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.6X4S	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, sequela
S06.6X5S	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.6X6S	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.6X9S	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela
S06.810S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, without loss of consciousness, sequela
S06.811S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, with loss of consciousness of 30 minutes or less, sequela
S06.812S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.813S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.814S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, with loss of consciousness 6 hours to 24 hours, sequela
S06.815S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.816S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.819S	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, sequela
S06.820S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, sequela
S06.821S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, sequela
S06.822S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, sequela

ICD-10-CM Diagnosis Codes	Description
S06.823S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.824S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, sequela
S06.825S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.826S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.829S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, sequela
S06.890S	Other specified intracranial injury without loss of consciousness, sequela
S06.891S	Other specified intracranial injury with loss of consciousness of 30 minutes or less, sequela
S06.892S	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.893S	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.894S	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.895S	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
S06.896S	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.899S	Other specified intracranial injury with loss of consciousness of unspecified duration, sequela
S06.9X0S	Unspecified intracranial injury without loss of consciousness, sequela
S06.9X1S	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, sequela
S06.9X2S	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, sequela
S06.9X3S	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela
S06.9X4S	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela
S06.9X5S	Unspecified intracranial injury with loss of consciousness of greater than 24 hours with return to pre-existing conscious level, sequela
S06.9X6S	Unspecified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela
S06.9X9S	Unspecified intracranial injury with loss of consciousness of unspecified duration, sequela
S06.A0XS	Traumatic brain compression without herniation, sequela
S06.A1XS	Traumatic brain compression with herniation, sequela
Z87.820	Personal history of traumatic brain injury

Considered Experimental/Investigational/Unproven:

ICD-10-CM Diagnosis Codes	Description
	All other codes

Considered Experimental/Investigational/Unproven when used to report coma stimulation:

HCPCS Codes	Description
S9056	Coma stimulation per diem

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