MEDICAL REVIEW GUIDELINE

Acquired Brain Injury

Adopted by Medical Care Management Committee on October 20, 2011
MCMC Approval Date: October 17, 2025

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Acquired Brain Injury

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures and therapy. This Guideline does not specifically address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

APPLIES TO

☐ STAR
☒ Health Insurance Marketplace
☐ STAR+PLUS
☐ CHIP/CHIP-P
☐ Medicare Advantage (i.e. D-SNP)

PURPOSE

The purpose of this Guideline is to provide criteria used by Utilization Management to review requests for authorization related to an acquired brain injury. The goal of Community in adopting these guidelines is not to disrupt the physician-patient relationship, nor to diminish physician autonomy. Instead, it is to promote patient safety and improved clinical outcomes through the adherence of evidence-based practices.

This Guideline is intended to facilitate the utilization management process by providing an overview of how Community appropriately determines medical necessity. The goal of Community in adopting this guideline is not to disrupt the physician-patient relationship nor to diminish physician autonomy. Instead, it is to promote patient safety and improved clinical outcomes through the adherence to evidence-based practices. Community has developed this Guideline via an ongoing process that includes a review of the most current evidence-based literature and input from clinical and program staff, and often from external clinical experts. Deeming a particular service or supply medically necessary does not guarantee that the service or supply is covered and will be paid by Community for a particular member.

DEFINITIONS

Acquired brain injury (ABI) is a neurological insult to the brain that is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal

activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. ABI may be traumatic or non-traumatic in nature.

Traumatic Brain Injury (TBI) is a subcategory of ABI defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force that damages the brain (such as a blow to the head).

Non-Traumatic Brain Injury (NTBI) is a subcategory of ABI defined as an alteration in brain function, or other evidence of brain pathology, caused by an internal event (such as a stroke, infection, tumor or toxin).

Cognitive Therapy is defined as a "systematic, functionally oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain-behavior deficits." "Services are directed to achieve functional changes by (1) reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems."

- Cognitive communication therapy--Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- Cognitive rehabilitation therapy--Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

GUIDELINE

Medically necessary is generally defined as services or items that are reasonable and necessary to prevent illnesses or medical conditions, or services to provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life.

Background

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, moderate, and GCS 14–15, mild. The Rancho Los Amigos Cognitive Functioning Scale (RLAS) is a commonly used method to characterize and stage recovery in rehabilitation settings. RLAS cognitive levels range from I, no response, to VIII,

purposeful and appropriate. The CBI-M, a new TBI classification framework introduced by the National Institute of Neurological Disorders and Stroke (NINDS), consists of four pillars: **C**linical Measures, **B**iomarkers, **I**maging and **M**odified measurements. This classification system provides a multidimensional view into each TBI that allows physicians to create more informed, individualized management programs for each patient.

Patients with acquired brain injury (ABI) may experience both cognitive and non-cognitive problems, including behavioral and emotional issues:

- *Physical*: Balance difficulties, fatigue, pain, weakness on one side of body, uneven gait, decreased motor speed, seizures, sensory deficits (such as altered visual perception, visual impairment, altered sense of touch and hearing changes)
- *Psychosocial:* Personality changes, mood swings, lack of emotional responses, depression, substance abuse, decreased ability to tolerate frustration, lack of initiative
- *Cognitive:* Impairments in attention/concentration, memory, language, visual or auditory perceptual processing, verbal reasoning, critical thinking/logic, planning and judgement skills, awareness/insight, and problem-solving skills

Cognitive impairments in memory, reasoning, attention, judgment and self-awareness are prominent roadblocks on the path to functional independence and a productive lifestyle for the person with a brain injury. In the early development of brain injury treatment programs, it became apparent that medical physical rehabilitation services alone are not sufficient for comprehensive treatment. 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 ABI. 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.

Medical care for ABI includes not only cognitive rehabilitation therapy, but must include, when needed, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. These treatments should be considered part of the complete ABI care plan when properly documented and deemed medically necessary.

Continuum of Care

1. **Acute Rehabilitation**

   During acute rehabilitation, a team of health professionals work with the patient to regain as many activities of daily living as possible. Activities of daily living which includes dressing, eating, toileting, walking, speaking. This can be done in an inpatient setting or an outpatient setting (SNF or Home Health).

2. **Post-acute Rehabilitation**

   The goal of post-acute rehabilitation is to help the patient regain the most independent level of functioning possible after acute care confinement/treatment. It involves assessment of an individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms. Rehabilitation channels the body's natural healing abilities and the brain's relearning processes so an individual may recover as quickly and efficiently as possible.

3. **Subacute Rehabilitation**

   Subacute rehabilitation programs are designed for persons with brain injury who need a less intensive level of rehabilitation services over a longer period of time. Subacute programs may also be designed for persons who have made progress in the acute rehabilitation setting and are still progressing but are not making rapid functional gains.

4. **Outpatient Therapy**

   Following acute, post-acute or subacute rehabilitation, a person with a brain injury may continue to receive outpatient therapies to maintain and/or enhance their recovery. Individuals whose injuries were not severe enough to require hospitalization or who were not diagnosed as having a brain injury when the incident occurred may attend outpatient therapies to address functional impairments. In some instances, the need for long-term care may require the individual to reside in an assisted living facility. This is not a standard occurrence and is based on thorough medical documentation that would make any other form of after-care unreasonable.

5. **Long-Term Interdisciplinary Follow-up**

   Involves a coordinated care plan incorporating a team of specialists who provide ongoing support for individuals with a traumatic brain injury. The team often includes neurologists, neuropsychologists, speech and language therapists, physiatrists, social workers, case

managers, vocational counselors and social support (family and friends). The goal is to address the wide range of persistent physical, cognitive, emotional, and social challenges that can arise years after the initial injury. The outcome is to manage chronic symptoms, improve quality of life, and support reintegration into the community and workforce.

PROCESS FOR REVIEW

Coverage of therapy

Coverage of medical/surgical therapies or services for brain injury is subject to medical necessity in accordance with Community policy and is dependent on the physician documentation in the medical record.

Medical therapy is generally directed at preventing further brain injury or damage and reducing/preventing any medical complications. Medical/surgical complications include, but are not limited to (not exhaustive):

- Posttraumatic seizures
- Infections
- Hydrocephalus
- Deep vein thrombosis
- Heterotopic ossification
- Spasticity, weakness
- GI and GU complications
- Neuroendocrine dysfunction
- Gait abnormalities
- Sleep disturbances
- Headaches (chronic)
- Behavioral and emotional
- Cognitive deficits
- Sensory deficits
- Communication deficits

Community covers an individualized program of cognitive rehabilitation as medically necessary following an acquired brain injury when ALL of the following requirements are met:

- A documented cognitive impairment with related compromised functional status exists.
- The individual is willing and able to actively participate in the treatment plan.
- Significant cognitive improvement with improved related functional status is expected.

Community, in accordance with the Texas Administrative Code, Coverage for Acquired Brain Injury (Title 28, Part 1, Chapter 21, Subchapter W), **will not limit** the number of days of covered post-acute care, including any therapy, treatment, or rehabilitation, testing, remediation, or other service or the number of days of covered inpatient care to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury.

Community, in accordance with the Texas Administrative Code, Coverage for Acquired Brain Injury (Title 28, Part 1, Chapter 21, Subchapter W), **will not exclude** coverage for services for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services, if such services are necessary as a result of and related to an acquired brain injury.

Outpatient cognitive rehabilitation is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care.

Continuation of therapy may be approved if the following conditions are met:

- Based on documentation of ongoing response to therapy and/or attainment of goals.
- If the individual presents with new deficits related to the ABI or was previously unresponsive to therapy and becomes responsive at a later date.
- If upon re-evaluation, there is continued need and advances and/or changes in technology have become available which may improve deficits as deemed medically necessary & within standard guidelines of medical practices.

Services Not Covered

- Continued therapy may not be approved when there is no evidence of any response/improvement over an extended period of time. Community understands that initial response/improvement may not occur for weeks to months.
- Cognitive rehabilitation to improve academic or work performance because it is not medically necessary.
- Cognitive rehabilitation for ABI when the request is made solely for educational, experimental, or investigational purposes or is not medically necessary.
- Services that do not meet the definition of a therapy (ex. biofeedback/neurofeedback therapy).
- Services for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which coverage for other medical conditions under the health benefit plan is limited or excluded (for example, acts of war, participation in a riot, etc.).

- Cognitive rehabilitation for ANY other indications, including but not limited to the following, because it is considered experimental, investigational or unproven:
    - Dementia (e.g., human immunodeficiency virus [HIV] dementia, Alzheimer's disease, Wernicke encephalopathy)
    - Concussion/post-concussion syndrome
    - Coma and persistent vegetative (minimally conscious) states
    - Parkinson's disease
    - Multiple Sclerosis
    - Cerebral Palsy
    - Attention deficit disorder, attention deficit hyperactivity disorder
    - schizophrenia
    - Pervasive developmental disorders, including autism
    - Learning disabilities
    - Developmental delay
    - Substance use disorders/addiction
    - Social phobias

CPT CODES	DESCRIPTION
CPT Codes for Acquired Brain Injury include a large number of codes associated with various forms of treatment that are provided to patients other than those with Acquired Brain Injury. The following is a list of CPT codes that may potentially identify services provided to those with ABI.	
90785	Interactive complexity
90832-90899	Psychophysiological testing and treatment
90901	Biofeedback
90911	Biofeedback training
92507	Speech Therapy
92650-92653	Auditory Evoked Response (AEP)
95812, 95813, 95816, 95819, 95822	Electroencephalograms (EEG)-Routine
95700-95726	Electroencephalograms (EEG)-Continuous
95925-95930	Somatosensory and Visual evoked potential studies
95961-95962	Functional cortical and subcortical mapping
96104-96117, 96121-96155	CNS assessments (including neurobehavioral and neuropsych)
97001-97546	Physical/occupational therapies
97750-97755	Physical performance test, assistive technology assessment
97799	Unlisted physical medicine/rehabilitation service or procedure
99301-99380	Evaluation and Management codes

REFERENCES

Texas Administrative Code, Coverage for Acquired Brain Injury (Title 28, Part 1, Chapter 21, Subchapter W)

This Guideline is reviewed annually and is approved by the Medical Care Management Committee.

POLICY HISTORY (reviews and revisions)	Date	Approval Date
Policy developed		10/2011
Archived policies: annually reviewed but policy history not recorded	--	--
Policy updated	06/2023	07/2023
Policy updated	08/2024	10/17/2024
Added clarification for cognitive therapy. Added additional information in background. Added long-term follow-up. Added to list of med/surg complications. Added clause for non-exclusion. Added additional indications for non-coverage of cognitive rehabilitation.	10/2025	10/16/2025