See Policy CPT CODE section below for any prior authorization requirements

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare Only

**DOCUMENTATION REQUIREMENTS**

1. The Medical record and assessment report should document the diagnosis and treatment recommendations.
2. The patient’s medical record should contain documentation that fully supports the medical necessity for testing performed. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation should include the following information:
   a. any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction
   b. the initial evaluation that determines the need for testing
   c. the types of testing indicated
   d. the time involved and whether this is initial testing or follow-up
   e. previous testing by the same or different provider, and efforts to obtain previous test results performed
   f. the test(s) administered, scoring and interpretation
   g. treatment recommendations
3. Documentation should be legible, signed, and maintained in the patient’s medical record. Upon request it must be available to the Medicare Contractor.
4. If the total time for the tests exceeds eight hours, a report may be requested asking for the medical necessity of the extended testing.
5. The time spent with the interpretation and the preparation of the report, and explanation of the report to the patient and/family are billed with the code used to perform the test.
6. The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report that will be given to the referring provider.

**POLICY CRITERIA**

**Note:** This policy only addresses the medical application of neuropsychological testing. For cases where a mental health condition is present or suspected or for the differential diagnosis of psychogenic and neurogenic syndromes (e.g., depression versus dementia) the determination of the request must be made by Optum®.

This policy is based on the Centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD): Psychological and Neuropsychological Testing (L34646) and CMS Publication 100-02; *Medicare Benefit Policy Manual*, Chapter 15- Covered Medical and Other Health Services: §80.2 Psychological and Neuropsychological Tests.¹ ² This CMS guidance was identified as of the last policy review date on 6/12/2018.

**Neuropsychological Testing:**

I. Neuropsychological assessment is considered **medically necessary and covered** for the following indications:

A. When there are mild or questionable deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or

B. When neuropsychological data can be combined with clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or

C. When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or

D. When there is a need for a pre-surgical or treatment-related cognitive evaluation to determine whether one might safely proceed with a medical or surgical procedure that may affect brain function (e.g., deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient’s functional status; or

E. When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (e.g., radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or

F. When there is a need to monitor progression, recovery, and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or
G. When there is a need for objective measurement of the patient’s subjective complaints about memory, attention, or other cognitive dysfunction, which serves to determine treatment by differentiating psychogenic from neurogenic syndromes (e.g., dementia vs. depression); or

H. When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or

I. When there is a need to determine whether a patient can comprehend and participate effectively in complex treatment regimens (e.g., surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision-making, work, independent living, managing financial affairs, etc.; or

J. When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or

K. When there is a need to establish treatment planning through identification and assessment of the neurocognitive sequelae of systemic disease (e.g., hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or

L. Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders; or

M. When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

Examples of problems that might lead to neuropsychological testing include:

1. Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injuries, anoxic injuries, AIDS dementia);
2. Differential diagnosis between psychogenic and neurogenic syndromes;
3. Delineation of the neurocognitive effects of CNS disorders;
4. Neurocognitive monitoring of recovery or progression of CNS disorders; and/or
5. Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.
6. Determining the management of the patient by confirmation or delineation of diagnosis.

II. Neuropsychological testing is **not considered reasonable and necessary** when:

A. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process, or

B. Used as screening tests given to the individual or to general populations [Section 1862(a)(7) of the Social Security Act does not extend coverage to screening procedures], or

C. Administered for educational or vocational purposes that do not establish medical management, or

D. Performed when abnormalities of brain function are not suspected, or
E. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS, Folstein Mini-Mental Status Examination, or

F. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy), or

G. Administered when the patient has a substance abuse background and any of the following apply:
   1. the patient has ongoing substance abuse such that test results would be inaccurate, or
   2. the patient is currently intoxicated, or

H. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer’s diseases and there is no expectation that the testing would impact the patient’s medical management.

I. The test is being given solely as a screening test for Alzheimer’s disease - Medicare does not cover this screening for this diagnosis.

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**UTILIZATION GUIDELINES**

The CPT codes in this LCD do not represent psychotherapeutic modalities, but are diagnostic aids. Each test performed must be medically necessary and therefore, standardized batteries of tests are not acceptable, unless the use of each test in the battery is medically necessary.

Self-administration or self-scored inventories such as the Holmes and Rahe Social Readjustment Rating Scale or screening tests of cognitive function such as the Folstein Mini-Mental Exam (or similar tests) is not separately reimbursable by Medicare and is included in the clinical interview or E/M service.

One initial testing evaluation followed by one additional re-testing evaluation within a 12-month period by the same provider or group may be performed without prepay review.

The time selected for billing purposes include face-to-face administration, scoring, interpretation, and report preparation for the neuropsychological test(s) being administered.

More than 8 hours per patient per evaluation is considered excessive and supporting documentation in the medical record must be present to justify greater than 8 hours per patient per evaluation.

The billed amount may include time spent with the patient explaining the results of the test.

**CPT CODES**

Medicare Only
### Prior Authorization Required

**Note:** Some of the following codes may be used for psychological testing, which this policy does not address.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour</td>
</tr>
<tr>
<td>96118</td>
<td><strong>TERMED 12/31/2018</strong> Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96119</td>
<td><strong>TERMED 12/31/2018</strong> Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td>96121</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96132</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour</td>
</tr>
<tr>
<td>96133</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes</td>
</tr>
<tr>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96138</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes</td>
</tr>
<tr>
<td>96139</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
DESCRIPTION

Neuropsychological Evaluation

These evaluations are requested for patients with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning. The evaluations include a history of medical or neurological disorders compromising cognitive or behavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; reported impairments in cognitive functioning; and evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations.

Components of the Neuropsychological Evaluation

1. Record Review

   The provider reviews the medical records and referral question, and determines whether an evaluation is appropriate.

2. Neurobehavioral Status Examination

   The face-to-face evaluation begins with a neurobehavioral status exam conducted by the provider (CPT code 96116; in rural areas or where there is a shortage of providers, the neurobehavioral status exam may be administered as a telehealth service using the telehealth/"GT" modifier):

   A neurobehavioral status exam is completed prior to the administration of neuropsychological testing. The status exam involves clinical assessment of the patient, collateral interviews as appropriate, and review of prior records. The interview includes clinical assessment of several domains including but not limited to; thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities. The clinical assessment would determine the types of tests and how those tests should be administered (AMA CPT Assistant, November, 2006).

   A neurobehavioral status examination, in the absence of neuropsychological testing, is insufficient to diagnose mild cognitive impairment.

3. Test Selection
Information from medical records, clinical interviews, and behavioral observations is integrated to guide the selection of specific neuropsychological tests. The selection of tests is a strategic process that varies as a function of patient characteristics (level of education, premorbid level of functioning, sensory abilities, physical limitations, fatigue level, age, and ethnicity) and the goals of the evaluation (establishing a diagnosis, measuring treatment effects, etc.).

4. Test Administration

Tests are administered directly by either a Medicare Provider with an appropriate State licensed provider or by a trained technician. The technician who administers the neuropsychological test must be directly supervised by the provider.

Neuropsychological tests include direct question-and-answer, object manipulation, inspection and responses to pictures or patterns, paper-and-pencil written or multiple choice tests, which measure functional impairment and abilities in:

a. General intellect
b. Reasoning, sequencing, problem-solving, and executive function
c. Attention and concentration
d. Learning and memory
e. Language and communication
f. Visual-spatial cognition and visual-motor praxis
g. Motor and sensory function
h. Mood, conduct, personality, quality of life
i. Adaptive behavior (Activities of Daily Living)
j. Social-emotional awareness and responsivity
k. Psychopathology (e.g., psychotic thinking or somatization)
l. Motivation and effort (e.g., symptom validity testing)

5. Feedback session

A post-evaluation feedback session with the patient and family members is a customary part of the neuropsychological evaluation (American Psychological Association, 2010). This service is usually billed with CPT code 96118.

The feedback session emphasizes the following:

a. Discussion of the relationship between neuropsychological test results and information about diagnosis and prognosis.
b. Explanation of treatment recommendations. In addition to those recommendations that are directly managed by the patient’s medical provider (e.g. changes in medication or treatment), patients are provided with evidence-based treatment recommendations that are not typically managed by medical providers, and which are best elaborated on by providers with expertise in neuropsychological assessment, including tailored behavioral strategies to maximize...
functioning, referrals to other specialty providers (e.g. psychiatry, rehabilitative therapists), recommendations for nonpharmacological interventions, and community resources.

c. Communication of results to family members in order to enhance treatment outcome for the patient.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES
