INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting and administering behavioral health benefit plans that are managed by Optum, and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)). When deciding coverage, the member-specific benefit plan document must be referenced. The terms of the member-specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member’s specific benefit plan document supersedes this Coverage Determination Guideline.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the COC/SPD prior to using this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. Optum reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice. Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

Pre-Service Notification
Psychological testing is considered a non-routine outpatient service and requires authorization/notification unless otherwise stated in the coverage document.

Authorization and/or notification for neuropsychological testing are not routinely required by Optum, unless otherwise stated in the coverage document.

Additional Information
The lack of a specific exclusion for a service does not necessarily mean that the service is covered. For example, depending on the specific plan requirements, services that are inconsistent with Level of Care Guidelines and/or

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prevailing medical standards and clinical guidelines may be excluded. Please refer to the member’s benefit document for specific plan requirements.

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

**COVERAGE RATIONALE**

Psychological and neuropsychological testing benefits must be available under the member’s coverage document, and the request for coverage must be within the terms, limitations, and exclusions of the member’s coverage document.

**Psychological testing (CPT Codes 96101, 96102, 96103)** is a set of formal procedures utilizing reliable and valid tests designed to measure areas of intellectual, cognitive emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills.

- Psychological testing is considered a non-routine outpatient services, and requires authorization/notification unless otherwise stated in the member’s specific benefit plan.
- Psychological testing is typically not covered for the following:
  - Psychological exams required solely for the purposes of school, sports, camp, travel, career or employment, insurance, marriage, or adoption;
  - Psychological exams related to judicial or administrative proceedings or orders;
  - Psychological exams conducted for purposes of medical research;
  - Psychological exams required to obtain or maintain a license of any type.

**Neuropsychological testing (CPT Codes 96118, 96119, 96120)** is a set of formal procedures utilizing reliable and valid tests specifically focused on identifying the presence of brain damage, injury, or dysfunction, and any associated functional deficits.

- Depending on the nature of the presenting problem and purpose for testing, neuropsychological testing may be covered by the medical benefit. Please see [www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit](http://www.unitedhealthcareonline.com).
- Pre-notification is not routinely required by Optum unless otherwise stated in the coverage document.
- Neuropsychological testing is typically not covered for the following:
  - Baseline neuropsychological testing in asymptomatic persons at risk for sport-related concussions;
  - Computerized neuropsychological testing when used alone for evaluating concussions;
  - Any of the following conditions alone without other covered conditions:
    - Headaches, including migraine headache;
    - History of myocardial infarction;
    - Intermittent explosive disorder.
  - Computerized cognitive testing, such as Mindstreams® Cognitive Health Assessment and BrainCare™.

Please refer to the member’s benefit document for ASO plans with benefit language other than the generic benefit document language. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines:

- **Optum Level of Care Guidelines**
- **UnitedHealthcare Benefit Plan Definitions**
- **Evidence-Based Clinical Guidelines**

All services must be provided by or under the direction of a properly qualified behavioral health provider.
APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

<table>
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<th>CPT Code</th>
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LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)
Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)
Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in the Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
• Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits.
• Not excluded in the Certificate under Section 2: Exclusions and Limitations.

**Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

**EVIDENCE-BASED CLINICAL GUIDELINES**

**COMMON ADMISSION CRITERIA FOR TESTING**

- The member is eligible for benefits.
  AND
- The member’s condition and proposed services are covered by the benefit plan.
  AND
- Services are within the scope of the provider’s professional training and licensure, and test user’s qualifications.
  AND
- Services are:
  - Consistent with generally accepted standards of clinical practice;
  - Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;
  - Clinically appropriate for the member’s mental health/substance use disorder, based on generally accepted standards of clinical practice and benchmarks.
  AND
- Prior to testing, a clinical evaluation of the member is completed by a behavioral health or medical professional who is the referring provider or the psychologist conducting the psychological assessment.
  - The member’s condition cannot be conclusively assessed with a standard clinical evaluation due to the nature of the member’s signs and symptoms and/or psychological and environmental factors (i.e., the factors leading to the request for testing). Examples include:
    - A differential diagnosis between more than one behavioral health condition or between a behavioral health and a medical condition cannot be made.
    - The member presents with atypical symptoms.

**COMMON CLINICAL BEST PRACTICES FOR TESTING**

- The clinical evaluation completed prior to testing:
  - Identifies specific, outstanding clinical questions that must be answered by testing in order to establish the member’s diagnosis or inform the treatment plan.
  - Verifies that outstanding clinical questions cannot be answered by the clinical evaluation.
  - Informs the test battery.
• The tests in the battery and the number of hours requested are appropriate to answer specific clinical questions that could not be answered by the clinical evaluation.
  o The number of hours includes the total time necessary to complete face-to-face administration, scoring, interpretation, and report writing up to 150% of the standard administration time recommended by the test publisher. A request in excess of 150% of the standard administration time is supported by extenuating circumstances with evidence submitted by the provider. Examples of extenuating circumstances include the following:
    ▪ The member has significant functional impairment. Examples include but are not limited to: sensory deficits and/or physical disabilities which necessitate modification in standard administration procedures; severe oppositional behavior; attentional deficits or developmental disabilities which require the examiner to provide frequent re-direction and/or breaks for the member during testing. Note: testing should not be conducted if extenuating circumstances such as these are so severe that it could reasonably pose a threat to the reliability or validity of test results.
    ▪ The member has an intellectual disability.
  o At least one (1) hours of service (i.e., 1 unit) is required.
• The member has abstained from using alcohol or drugs for at least six (6) weeks prior to testing, or however long is required for results to be usefully interpretable.
• Tests are administered in a variety of face-to-face formats, including paper-and-pencil, computer, and visual aids.
• The provider monitors administration to ensure that the member is giving sufficient effort and attention to completing the test battery so as to ensure a valid and reliable measure is obtained.
• There is a rationale for re-testing if testing was completed within the last six (6) months, such as re-testing needed to measure changes in functional impairment or disease progression (e.g., acute head injury, stroke, speech, motor or sensory dysfunction).

PSYCHOLOGICAL TESTING ADMISSION CRITERIA AND CLINICAL BEST PRACTICES
• See common admission criteria and common clinical best practices for testing above.
AND
• The provider’s professional training and licensure include any of the following:
  o A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  o A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
    ▪ The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
    ▪ The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
  o A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    ▪ The masters-degreed provider has professional expertise in the types of tests/assessments being administered.
    ▪ The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.
• Psychological testing related to the treatment of chronic pain may be conducted when:
  o There is a need to further assess mood and personality characteristics which may influence the member’s experience or perception of the basis or tolerance of pain, as well as the member’s ability to cope with his/her pain;
  OR
  o When the member shows changes in cognitive or intellectual functioning after the long-term use of alcohol, street or prescription drugs, or upon the discontinuation of, or non-response to pain-relieving or psychotropic medications.
• Psychological testing as a component of pre-surgical evaluation may be conducted to rule out behavioral health conditions that could contraindicate surgery, to determine the member’s ability to understand the related risks and benefits or surgery, and/or to evaluate the member’s ability to participate responsibly in post-surgical recovery behaviors and lifestyle changes.

NEUROPSYCHOLOGICAL TESTING ADMISSION CRITERIA AND CLINICAL BEST PRACTICES
• See common admission criteria and common clinical best practices for testing above.
AND

- Neuropsychological testing is within the scope of the provider’s professional training and licensure when the provider is any of the following:
  - A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
    - The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
    - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
  - A credentialed psychiatrist who meets the following requirements:
    - Recognized certification in neurology through the American Board of Psychiatry and Neurology;
    - Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
    - State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
    - Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
    - Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

- Medical application of Neuropsychological testing may be covered under the medical benefit for members with the following conditions when the result of testing will influence clinical decision making (for more information, see www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit):
  - Attention-deficit/hyperactivity disorder (ADHD) when all of the following are present:
    - Specific neurocognitive behavioral deficits related to ADHD need to be evaluated AND
    - Testing has been recommended by a physician and is related or secondary to a known or suspected organic-medical condition resulting from brain injury or disease process (e.g., concussion, intractable seizure disorder, cancer treatment effects, genetic disorders, inborn errors of metabolism)
    *The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.*
  - Confirmed space-occupying brain lesion including but not limited to the following:
    - Brain abscess;
    - Brain tumors;
    - Arteriovenous malformations within the brain.
  - Dementia or symptoms of dementia such as memory impairment or memory loss (including extrapyramidal disorders such as Parkinson’s disease) that is associated with a new onset or progressive memory loss and a decline in at least one of the following cognitive domains (DSM-5):
    - Complex attention;
    - Executive function;
    - Learning and memory;
    - Language;
    - Perceptual-motor;
    - Social cognition.
  - Demyelinating disorders, including multiple sclerosis
  - Intellectual disability or intellectual developmental disorder, when all of the following are present:
    - The intellectual disability or intellectual developmental disorder is associated with a known or suspected medical cause (e.g., traumatic brain injury, in utero toxin exposure, early seizure disorder, sickle cell disease, genetic disorders)
    *AND*
    - The intellectual disability or intellectual developmental disorder meets all of the following criteria (DSM-5):
      - Deficits in intellectual function, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing;
AND

- Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living across multiple environments, such as home, school, work and community;
- Onset of intellectual and adaptive deficits during the developmental period

The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.

- Encephalopathy including acquired immunodeficiency syndrome (AIDS) encephalopathy, human immunodeficiency virus (HIV) encephalopathy, hepatic encephalopathy, Lyme disease encephalopathy including neuroborreliosis, Wernicke's encephalopathy, and systemic lupus erythematosus (SLE) encephalopathy.
- Neurotoxin exposure with at least one of the following:
  - Demonstrated serum levels of neurotoxins
  - Individual with documented significant prenatal alcohol, drug, or toxin exposure
- Seizure disorder, including patients with epilepsy and patients being considered for epilepsy surgery
- Stroke
- Traumatic brain injury (TBI): TBI is defined as a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

Neuropsychological testing is unproven and not medically necessary for the following (for more information, see [www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34646)):

- Baseline neuropsychological testing in asymptomatic persons at risk for sport-related concussions
- Computerized neuropsychological testing when used alone for evaluating concussions
- Neuropsychological testing for the following diagnoses alone without other covered conditions as noted above:
  - Headaches, including migraine headache;
  - History of myocardial infarction;
  - Intermittent explosive disorder.
- Computerized cognitive testing, such as Mindstreams® Cognitive Health Assessment and BrainCare™.

REFERENCES*


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

**ADDITIONAL RESOURCES**

**Clinical Protocols**
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on www.providerexpress.com.

**Peer Review**
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

**Second Opinion Evaluations**
Optum facilitates obtaining a second opinion evaluation when requested by an member, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

**Referral Assistance**
Optum provides assistance with accessing care when the provider and/or member determine that there is not an appropriate match with the member’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

**HISTORY/REVISION INFORMATION**

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