



United Behavioral Health

Medicare Coverage Summary: Psychological and Neuropsychological Testing

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INTRODUCTION

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum®¹.

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This 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.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

¹ Optum is a brand used by United Behavioral Health and its affiliates.

APPLICABLE STATES

Note: Part A services are typically inpatient. Part B services are typically outpatient.

This Medicare Coverage Summary is applicable to the following States/jurisdictions:

CMS L34520 (All states & territories Part A Inpatient Services and Part B Outpatient Services apply)

- Florida
- Puerto Rico
- Virgin Islands

CMS L34646 (Part A Inpatient Services and Part B Outpatient Services vary, see each state)

- Alabama (Part A Inpatient Services)
- Alaska (Part A Inpatient Services)
- Arizona (Part A Inpatient Services)
- Arkansas (Part A Inpatient Services)
- California (Part A Inpatient Services)
- Colorado (Part A Inpatient Services)
- Connecticut (Part A Inpatient Services)
- Delaware (Part A Inpatient Services)
- Florida (Part A Inpatient Services)
- Georgia (Part A Inpatient Services)
- Hawaii (Part A Inpatient Services)
- Idaho (Part A Inpatient Services)
- Illinois (Part A Inpatient Services)
- Indiana (Part A Inpatient Services **and** Part B Outpatient Services)
- Iowa (Part A Inpatient Services **and** Part B Outpatient Services)
- Kansas (Part A Inpatient Services **and** Part B Outpatient Services)
- Kentucky (Part A Inpatient Services)
- Louisiana (Part A Inpatient Services)
- Maine (Part A Inpatient Services)
- Maryland (Part A Inpatient Services)
- Massachusetts (Part A Inpatient Services)
- Michigan (Part A Inpatient Services **and** Part B Outpatient Services)
- Missouri (Part A Inpatient Services **and** Part B Outpatient Services)
- Mississippi (Part A Inpatient Services)
- Montana (Part A Inpatient Services)
- North Carolina (Part A Inpatient Services)
- North Dakota (Part A Inpatient Services)
- Nebraska (Part A Inpatient Services **and** Part B Outpatient Services)
- New Hampshire (Part A Inpatient Services)
- New Jersey (Part A Inpatient Services)

- New Mexico (Part A Inpatient Services)
- Nevada (Part A Inpatient Services)
- Ohio (Part A Inpatient Services)
- Oklahoma (Part A Inpatient Services)
- Oregon (Part A Inpatient Services)
- Pennsylvania (Part A Inpatient Services)
- Rhode Island (Part A Inpatient Services)
- South Carolina (Part A Inpatient Services)
- South Dakota (Part A Inpatient Services)
- Tennessee (Part A Inpatient Services)
- Texas (Part A Inpatient Services)
- Utah (Part A Inpatient Services)
- Virginia (Part A Inpatient Services)
- Vermont (Part A Inpatient Services)
- Washington (Part A Inpatient Services)
- West Virginia (Part A Inpatient Services)
- Wisconsin (Part A Inpatient Services)
- Wyoming (Part A Inpatient Services)

If services are delivered in another state not listed above, please apply the Optum Psychological and Neuropsychological Testing Supplemental Clinical Criteria.

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY

Psychological Testing Coverage Indications (CMS L34646, 2020)

Psychological testing and neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain dysfunction through testing of the neuro-cognitive domains responsible for language, perception, memory, learning, problem solving, adaptation, and constructional praxis.

Psychological Tests

A psychological test is an instrument designed to measure unobserved constructs, also known as latent variables. Psychological tests are typically, but not necessarily, a series of tasks or problems that the respondent has to solve. Psychological tests can strongly resemble questionnaires, which are also designed to measure unobserved constructs, but differ in that psychological tests ask for a respondent's maximum performance whereas a questionnaire asks for the respondent's typical performance. A useful psychological test must be both valid (i.e., there is evidence to support the specified interpretation of the test results) and reliable (i.e., internally consistent or give consistent results over time, across raters, etc.).

Psychological Assessment

Psychological assessment is similar to psychological testing but usually involves a more comprehensive assessment of the individual. Psychological assessment is a process that involves the integration of information from multiple sources, such as tests of normal and abnormal personality, tests of ability or intelligence, tests of interests or attitudes, as well as information from personal interviews. Collateral information is also collected about personal, occupational, or medical history, such as from records or from interviews with parents, spouses, teachers, or previous therapists or physicians. A psychological test is one of the sources of data used within the process of assessment; usually more than one test is used. Many psychologists do some level of assessment when providing services to clients or patients, and may use for example, simple check lists to assess some traits or

symptoms. Psychological assessment is a complex, detailed, in-depth process. Typical types of focus for psychological assessment provide a diagnosis for treatment settings; assess a particular area of functioning or disability often for school settings; help select type of treatment or assess treatment outcomes; help courts decide issues such as child custody or competency to stand trial; or to help assess job applicants or employees and provide career development counseling or training.

Psychological Testing Indications

Psychological tests are used to assess a variety of mental abilities and attributes, including Central Nervous System (CNS) Assessments such as neuro-cognitive, mental status, achievement and ability, personality, and neurological functioning.

Psychological testing requires a clinically trained examiner. All psychological tests should be administered, scored, and interpreted by a trained professional such as a clinical psychologist, psychologist, advanced nurse practitioner with education in this area, or a physician assistant who works with a psychiatrist with expertise in the appropriate area. The purpose of psychological testing includes the following:

1. To assist with diagnosis and management following clinical evaluation when a mental illness or psychological abnormality is suspected.
2. To provide a differential diagnosis from a range of neurological/psychological disorders that present with similar constellations of symptoms, e.g., differentiation between pseudodementia and depression.
3. To determine the clinical and functional significance of a brain abnormality.
4. To delineate the specific cognitive basis of functional complaints.

Neuropsychological Testing Coverage Indications (CMS L34646, 2020)

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.

Neuropsychological assessment is considered medically necessary for the following indications:

1. 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
2. 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
3. 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;
4. 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
5. 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
6. 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

7. 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
8. When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
9. 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
10. 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
11. 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
12. Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders; or
13. 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 injury, 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.

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; in rural areas or where there is a shortage of providers, the neurobehavioral status exam may be administered as a telehealth service.

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.

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.

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.

Psychological and Neuropsychological Testing Coverage Indications (CMS L34520, 2020)

Neuropsychological tests provide measurements of brain function that are objective, valid, and reliable. Neuropsychological tests are quantifiable in nature and require patients to directly demonstrate their level of cognitive competence in a particular cognitive domain. Neuropsychological tests are administered in the context of a comprehensive assessment that synthesizes data from clinical

interview, record review, medical history, and behavioral observations. Information from neuropsychological assessments directly impacts medical management of patients by providing information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning. In addition, neuropsychological assessments predict functional abilities across a variety of disorders.

Indications for neuropsychological assessments include a history of medical or neurological disorder 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 (e.g., deep brain stimulators, epilepsy surgery). Neuropsychological assessments are not limited in relevance to patients with evidence of structural brain damage, and are frequently necessary to document impairments in patients with probable neuropsychological and neurobehavioral disorders, and are the tool of choice whenever objective documentation of subjective cognitive complaints and symptom validity testing are indicated. In children and adolescents, a significant inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands warrants a neuropsychological evaluation.

Neuropsychological testing is not supported or excluded from medical necessity based on diagnosis alone. Rather, indications for testing are based on whether there is known or suspected neurocognitive involvement or effects, or where neuropsychological testing will impact the management of the patient by confirmation or delineation of diagnosis, or otherwise providing substantive information regarding diagnosis, treatment planning, prognosis, or quality of life.

Neuropsychological testing is useful in persons with documented changes in cognitive function to differentiate neurologic diseases (i.e., one of the types of dementia) or injuries (e.g., traumatic brain injury, stroke) from depressive disorders or other psychiatric conditions (e.g., psychosis, schizophrenia) when the diagnosis is uncertain after complete neurological examination, mental status examination, and other neurodiagnostic studies (e.g., CT scanning, MR imaging). The clinician presented with complaints of memory impairment or slowness in thinking in a patient who is depressed or paranoid may be unsure of the possible contribution of neurological changes to the clinical picture. Neuropsychological testing may be particularly helpful when the findings of the neurological examination and ancillary procedures are either negative or equivocal. The differential diagnosis of incipient dementia from depression is a case in point, particularly when computed tomography (CT) fails to yield definitive results.

Neuropsychological testing may be indicated in persons with epilepsy. Neuropsychological testing is used in these patients to monitor the efficacy and possible cognitive side effects of drug therapy (e.g., new anti-convulsant drug therapy) by comparing baseline performance with subsequent testing performance. Neuropsychological testing is also used to assess post-surgical changes in cognitive functioning to guide further treatment services. Preferably, these tests should be administered by a psychiatrist or certified psychologist trained to conceptualize the neuro-anatomical and the neuro-behavioral implications of the diagnostic entities under consideration and who is capable of interpreting patterns of test scores in view of principles of lateralization and localization of cerebral function.

Neuropsychological testing is considered medically necessary for the following indications:

- When there are 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 other disease processes; or
- When neuropsychological data could provide clarification of clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, and the information will be useful in determining a prognosis or treatment planning by determining the rate of disease progression; or
- When there is a need for a pre-surgical or treatment-related cognitive evaluation to inform 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) or significantly alter a patient's functional status; or

- 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), and this information is utilized in treatment planning; or
- When there is a need to assess progression, recovery, and response to changing treatments, in patients with CNS disorders, in order to determine the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which directly impacts medical management by differentiating psychogenic from neurogenic syndromes (e.g., dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need for treatment planning purposes of determining functional abilities/impairments in individuals with known or suspected CNS disorders (e.g., capacity for independent living or movement from a family home into an institutional setting); or
- When there is a need to determine whether a patient can comprehend and participate effectively in complex treatment regimens and to determine functional capacity for health care decision-making, independent living, etc.; or
- When there is a need to design, administer, and/or assess outcomes of cognitive rehabilitation procedures, often in collaboration with other specialists such as speech pathologists, occupational therapists, physiatrists, and rehabilitation psychologists; or
- When there is a need for treatment planning of identification and assessment of neurocognitive sequelae of disease; or
- Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies for certain individuals with neuropsychiatric disorders; or
- 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.

The content of neuropsychological testing procedures (96132, 96133, 96136, 96137, 96138, and 96139) differs from that of psychological testing (96112, 96113, 96130, 96131, 96138, and 96139 and G0451) in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.).

Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT). In circumstances when additional time is necessary to integrate other sources of clinical data including previously completed and reported technician- and/or computer-administered tests, the neuropsychological testing may include time spent integrating self-report questionnaires.

Psychological testing codes (96130, 96131, 96138, and 96139) include the administration, interpretation, and scoring of the tests mentioned in the CPT descriptors and other medically accepted tests for the evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Psychological tests are used to address a variety of questions about people's functioning, diagnostic classification, co-morbidity, and choice of treatment approach. For example, personality tests and inventories evaluate the thoughts, emotions, attitudes, and behavioral traits that contribute to an individual's interpersonal functioning. The results of these tests determine an individual's personality strengths and weaknesses and may identify certain disturbances in personality or psychopathology. One type of personality test is the projective personality assessment, which asks a subject to interpret some ambiguous stimuli, such as a series of inkblots. The subject's responses can provide insight into his or her thought processes and personality traits.

Examples of problems that might require psychological testing include:

1. Assessment of mental functioning for individuals with suspected or known mental disorders for purposes of differential diagnosis and/or treatment planning.
2. Assessment of patient strengths and disabilities for use in treatment planning or management when signs or symptoms of a mental disorder are present.
3. Assessment of patient capacity for decision-making when impairment is suspected that would affect patient care or management.
4. Assessment of mental function in certain chronic pain patients when indicated after psychological screening prior to surgical pain management intervention (e.g., implantable neurostimulator).
5. Assessment of mental function in a chronic pain patient with suspected somatization disorder.

When a psychiatric condition or the presence of dementia has already been diagnosed, there is value to the testing only if the information derived from the testing would be expected to have significant impact on the understanding and treatment of the patient. Examples include a significant change in the patient's condition, the need to evaluate a patient's capacity to function in a given situation or environment, and/or the need to specifically tailor therapeutic and/or compensatory techniques to particular aspects of the patient's pattern of strengths and disabilities.

Limitations (CMS L34646)

1. Psychological and Neuropsychological testing is not considered reasonable and necessary when:
2. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process, or
3. 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
4. Administered for educational or vocational purposes that do not establish medical management, or
5. Performed when abnormalities of brain function are not suspected, or
6. 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
7. 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
8. Administered when the patient has a substance abuse background and any of the following apply:
 - a. the patient has ongoing substance abuse such that test results would be inaccurate, or
 - b. the patient is currently intoxicated, or
9. 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.
10. The test is being given solely as a screening test for Alzheimer's disease - Medicare does not cover this screening for this diagnosis.

Limitations (CMS L34520)

Psychological and Neuropsychological testing is not considered reasonable and necessary when:

- The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process;
- Used as screening tests given to the individual or to general populations;
- Administered for educational or vocational purposes that do not establish medical management;
- Performed when abnormalities of brain or emotional function are not suspected;
- Used for self-administered or self-scored inventories or screening tests of cognitive function (paper-and-pencil or computerized), e.g., AIMS, Folstein Mini-Mental Status Examination;
- Repeated when not required for medical decision-making. Examples of medical decision making include: whether to start or continue a particular rehabilitative or pharmacologic therapy);
- Administered when the patient has a substance abuse background, and any of the following apply: the patient has ongoing substance abuse such that test results would be inaccurate, or the patient is currently intoxicated;

Testing conducted when no mental illness/disability is suspected would be considered screening and would not be covered. Non-specific behaviors that do not suggest the possibility of mental illness or disability are not an acceptable indication for testing.

Evaluations of the mental status that can be performed within the psychiatric diagnostic evaluation, (e.g., a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires or screening measures such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, or use of other mental status exams in isolation) should not be classified separately as psychological or neuropsychological testing since they are typically part of a more general psychiatric/psychological clinical exam or interview.

Psychological/neuropsychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home does not constitute medical necessity for testing. Testing of every patient upon entry to a nursing home would be considered a routine service and would not be covered. However, some individuals enter a nursing home at a time of physical and cognitive decline and may require psychological/neuropsychological testing to arrive at a diagnosis and plan of care. Decisions to test individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis.

Each psychological/neuropsychological test administered must be individually medically necessary. A standard battery of tests is only medically necessary if each individual test in the battery is medically necessary.

The psychological/neuropsychological testing codes should not be reported by the treating physician for only reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services. Psychological and neuropsychological testing codes should be reported by the performing provider (i.e., clinical psychologist, neuropsychologist, or physician) who administered the test.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary.

For the formal evaluation of aphasia using a psychometric instrument such as the Boston Diagnostic Aphasia Examination, testing is typically performed once during treatment, and the medical necessity for such testing should be documented. Repeat testing should only be done if there is a significant change in the patient's aphasic condition.

Supporting documentation in the medical record must be present to justify the medical necessity and hours tested per patient per evaluation. If the testing time exceeds eight (8) hours, medical necessity for the extended testing should be documented in the report.

Routine re-evaluation of chronically disabled patients that is not required for a diagnosis or continued treatment is not medically necessary.

Documentation Requirements (CMS L34646)

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.

The services 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.

Psychological or psychiatric evaluations performed on patients with psychiatric disorders that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing and such testing might be considered medically unnecessary.

Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

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.

Documentation Requirements (CMS L34520)

The medical record must indicate testing is necessary as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved for services that are time-based.

The medical record should include all of the following information:

- Reason for referral.
- Tests administered, scoring/interpretation and time involved.
- Present evaluation.
- Diagnosis (or suspected diagnosis that was the basis for the testing if no mental/neurocognitive illness was found).
- Recommendations for interventions, if necessary.
- Identity of person performing service.

Typically, psychological testing/neuropsychological testing may require four (4) to six (6) hours to perform (including administration, scoring, and interpretation.) If the testing is done over several days, the testing time should be combined and reported all on the last date of service. Supporting documentation in the medical record must be present to justify the medical necessity and hours tested per patient per evaluation. If the testing time exceeds eight (8) hours, medical necessity for the extended testing should be documented in the report.

Use of such tests when mental or neurocognitive illness is not suspected would be a screening procedure and not covered. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.

Routine re-evaluation of chronically disabled patients that is not required for a diagnosis or continued treatment is not medically necessary.

REFERENCES

Centers for Medicare and Medicaid Services, Local Coverage Determination, Psychological and Neuropsychological Testing, L34646; Wisconsin Physicians Service Insurance Corporation. January 1, 2019. Retrieved from <https://www.cms.gov/>

Centers for Medicare and Medicaid Services, Local Coverage Determination, Psychological and Neuropsychological Tests, L34520; First Coast Service Options, Inc., Florida, Puerto Rico, Virgin Islands. July 01, 2020. Retrieved from <https://www.cms.gov/>

REVISION HISTORY

Date	Action/Description
October, 2014	• Version 1
May, 2015	• Version 2
June, 2016	• Version 3
June, 2017	• Version 4
January, 2018	• Version 5
March 18, 2019	• Version 6
May 20, 2019	• Version 7

Date	Action/Description
August, 2019	• Update to clarify Part A and Part B services
April, 2020	• Version 8 – Annual Review
July, 2020	• Update to remove Alzheimer’s disease language for L34520