Neuropsychological Testing
Frequently Asked Questions: Mental Health Benefits

Please read these FAQs as a guide; authorization is only required for specific accounts.

Q1: Is prior authorization required for Neuropsychological Testing?

A1: In most cases, it is not necessary to obtain prior authorization for benefit plans that cover neuropsychological testing services. In general, UnitedHealthcare Plans and public sector plans will not require prior authorization for neuropsychological testing. However, it is important that you check eligibility and benefit structure for each member since benefit plans may vary in coverage and/or authorization requirements for these services. For example, services and/or conditions not covered under the Member’s benefit plan are not eligible for payment. You may inquire about eligibility and benefits at providercareexpress.com or by calling the number on the back of the Member’s insurance card. You should clarify, for example, whether neuropsychological testing is a covered benefit and whether there are excluded diagnoses or services. For in-network providers, it is your responsibility to check eligibility and benefits.

*Note: Since psychological testing does require prior authorization under most benefit plans, changing the service codes and billing CPT 96101-96103 will likely result in psychological testing units being denied for lack of pre-certification.

Q2: Can I obtain a pre-service review for Neuropsychological Testing if I submit a request for authorization?

A2: For plans that do not require authorization, Mental Health Parity regulations prohibit the use of any procedures that are more restrictive than the medical benefit plan requires. Therefore, for these plans, a pre-service review cannot be conducted and authorization will not be issued. For plans requiring authorization, you can and should submit a formal pre-service request for coverage to obtain authorization.

Q3: How are benefits applied to make a determination about coverage and payment?

A3: In general, we cover neuropsychological testing for certain behavioral health conditions while medical plans cover these assessments for medical conditions.

For an overview of the UnitedHealthcare procedures for qualifying medical conditions, we invite you to review the current neuropsychological testing medical policy, “Neuropsychological Testing Under the Medical Benefit,” which provides a guide to documents and processes for determining application of benefits for neuropsychological testing. The policy is available online:


1 We comply with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in our knowledge of a Member’s eligibility status. As a result, the Member is usually the best source of timely information about eligibility or coverage changes.
Optum’s behavioral health Psychological and Neuropsychological Testing Guidelines are available on providerexpress.com.

Provider Express > Clinical Resources > Guidelines/Policies > Psych/Neuropsych Testing Guidelines
You may also call the number on the back of the Member’s insurance card.

Q4: Are all diagnostic codes eligible for reimbursement of neuropsychological testing?
A4: Specific diagnostic exclusions may be set forth in the member benefit plan or certificate of coverage. You should inquire about benefit coverage for specific conditions prior to providing services.

Q5: Is Neuropsychological testing covered for assessment related to Learning Disorders?
A5: Generally, psychological or neuropsychological testing purely for educational evaluations or learning disorders is not covered under most benefit plans. Because benefit plans may vary, it is important that you check eligibility and benefit structure prior to providing services. When excluded from coverage, a record review may be requested and/or claims may be denied following post-service clinical reviews where it is determined that the testing service was to evaluate for learning disorders/educational purposes.

Q6: May I bill using ICD-9 diagnostic codes?
A6: Yes. In accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations, claims filed electronically should use ICD-9 coding. Effective October 1, 2015, the U.S. Department of Health and Human Services (HHS) has mandated the replacement of ICD-9-CM with ICD-10-CM. HIPAA requires the use ICD diagnostic codes for billing. Most mental health clinicians continue to use the ICD codes embedded in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The current edition, DSM-5, includes “mapping” to both ICD-9-CM and ICD-10-CM code sets. For the most accurate claim processing, please submit claims using ICD-9-CM as your primary diagnosis on a claim. After October 1, 2015, you should start using ICD-10-CM codes which are embedded in DSM-5. You may file claims electronically on providerexpress.com or through an EDI clearinghouse.

Q7: Does the member diagnosis guide claim routing?
A7: Previous FAQs outlined a process by which the member’s diagnosis guided whether payment fell to the member’s medical or behavioral benefit. In order to simplify the administrative process and improve the provider’s experience, all neuropsychological testing claims (codes 96118, 96119, 96120) are now routed to Optum for processing. As long as the claim falls within the member’s eligibility and benefit guidelines and does not exceed the maximum allowable units for testing, the claim should process correctly. Providers should routinely check eligibility and benefits prior to providing services to include inquiring about diagnostic exclusions for a specific member’s benefit. Optum and United Healthcare recognize that neuropsychologists provide valuable services to members that are sometimes covered under the member’s medical benefits and sometimes under the member’s behavioral health benefits. The focus of this initiative to have Optum manage all neuropsychological testing claims is to improve the claims processing experience of providers and it not meant to suggest that neuropsychologists treat only behavioral health conditions. Providers will continue to be recognized as valued resources on both our medical and behavioral health network panels.
Q8: Since prior authorization is not generally required, does this mean record reviews will not be required?

A8: No. Record reviews may still be required. We may review your records during a scheduled on-site audit or may ask you to submit copies of the records to us for review. Audits may occur for a variety of reasons including, but not limited to, completion of routine review of medical records, to address claims coding or billing issues, or to address potential quality of care issues. In addition, records may be requested to assist in making coverage determinations when needed. In these cases, claims may be pended until that review is complete. We also continue to monitor utilization to identify and address unusual billing patterns which may result in a record review.

Q9: Can I join the UnitedHealthcare Network?

A9: The network needs may vary. You can inquire with UnitedHealthcare’s Network Management team for your state to learn more about network participation. UnitedHealthcare’s Contact Us page (scroll down to Network Contacts) allows you to select your state in order to obtain contact information.

Q10: How were the Neuropsychological Guidelines developed?

A10: When developing our neuropsychological testing guidelines, we took into consideration the following:

**APA**

The APA Presidential Task Force on the Assessment of Age-Consistent Memory Decline and Dementia published guidelines for the evaluation of dementia and age-related cognitive decline (APA, 1998). These guidelines state that, "Comprehensive neuropsychological evaluations for dementia and age-related cognitive decline include: tests or assessments of a range of multiple cognitive domains, typically including memory, attention, perceptual and motor skills, language, visuospatial abilities, problem solving, and executive functions. It is recognized, however, that detection of profound dementia may not require a comprehensive neuropsychological test battery."

**NAN**

In a policy for the evaluation of childhood learning disorders, the NAN states that when comprehensive information about a child’s brain-related strengths and weaknesses is necessary to understand potential sources of the problem and implications for functioning, a neuropsychological evaluation is most often the best choice (Silver, 2006).

In a position paper on the diagnosis and management of sports-related concussion, the NAN states that neuropsychological evaluation is recommended for the diagnosis, treatment, and management of sports-related concussion at all levels of play (Moser, 2007).

**Additional notable information submitted by both the APA and NAN:**

Separate listings of those specific diagnostic conditions for which neuropsychological testing service is reportedly frequently administered does not explicitly appear in the policy itself. That level of information is more detailed than that typically contained in a policy-level document which does not seek explicitly to itemize the hundreds of conditions for which neuropsychological testing service could potentially be administered. It should be noted, however, that all of the specific diagnostic codes submitted by both the APA and NAN were specifically reviewed and matched to the broader-category diagnostic conditions listed in the policy, such that we believe it is possible to use the policy document to help guide coverage determinations regarding all specific diagnostic code conditions submitted by the APA and NAN for consideration.
We are also evaluating the position papers available through the American Academy of Clinical Neuropsychologists (AACN) as part of our annual guideline review process.

**Q11: How can I find contact information to speak with a representative from claims customer service or a representative from network services?**

A11: Provider Express has a [Contact Us](#) page that lists resource and contact information for claims and network questions and for technical support with the website.

The best number to call for claims-related issues is the number on the back on the member’s insurance card. Some Plans have dedicated phone numbers which will support routing of your call.

The network contact information, including the name, address, and fax number of Network Managers by state, is also posted to the website. We have a centralized phone number for calls into Network Management that supports documentation of your call and its immediate resolution or, when needed, the referral of your call to the appropriate network team. The Network Management phone number is (877) 614-0484.

As a reminder, you may handle most of your practice demographic updates on [Provider Express > Log In > My Practice Info](#).