

Medical Necessity Guidelines: Neuropsychological Testing and Assessment

Effective: October 16, 2019

| Prior Authorization Required | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
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| If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request. | |
| <p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</p> <p>TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products • Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List • Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</p> | |

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Neuropsychological testing and assessment provide information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning, and predict functional abilities across a variety of disorders.

Neuropsychological testing and assessment is a covered benefit when specific cognitive impairments are suspected or have been identified, and when the testing is performed to address questions that have not been able to be answered after a medical or behavioral health evaluation. To be covered, a request must meet our guidelines for medical necessity, and be authorized by a Tufts Health Plan Utilization Management reviewer.

CLINICAL COVERAGE CRITERIA

Neuropsychological testing and assessment is considered a medically necessary procedure when it meets the following guidelines.

ONE of these:

- Cognitive impairment(s) are suspected or have been identified that cannot be clearly attributed to normal aging or the expected progression of an already diagnosed disease.
- Appropriate treatment or other clinical decision-making cannot commence or progress without quantifying changes in cognitive functioning, or cognitive or behavioral deficits related to possible CNS impairment.

And **ALL** of these:

- The questions to be addressed through neuropsychological testing cannot be answered through means of conventional clinical interview, collateral data collection, or adequate trial of evidence-based treatment (or those steps have been attempted and were unsuccessful).

- The selected assessment procedures have been established as valid (or, if validity testing is not available, are accepted as the standard of care), and are likely to be effective in answering the identified questions.
- The results of testing are likely to have a direct and significant impact on the clinical management of the patient (e.g., elucidation of why treatment has not resulted in the expected progress, what lifestyle modifications are indicated, or whether treatment or rehabilitation is necessary or likely to be effective).
- Reasonable effort has been made to obtain reports of relevant previous psychological, neuropsychological, language, educational, and/or neurological assessment, if any, and results have been reviewed.

LIMITATIONS

Neuropsychological testing and assessment is not covered under the following circumstances:

- The testing is primarily for the purpose of qualifying for services that are covered under applicable state or federal special education laws.
- The testing is being conducted primarily for educational (including learning disabilities), vocational or legal purposes.
- The testing is being conducted primarily to make or confirm a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that can reasonably be made or confirmed via conventional interviewing, history, and collateral contact/data collection.
- The testing is a request to repeat previous or similar testing, and there has not been a significant change in functioning or there isn't a clear reason to expect that the testing would yield new information or further impact the clinical management of the patient.
- Known medication side effects or substance use explain the symptoms and/or suggest that test results would be invalid or inaccurate. Current abstinence from substances is required.
- The patient is actively psychotic to a degree that testing is unlikely to be successful or results are likely to be invalid.
- Lab work or other clinical studies of potentially acute and/or reversible conditions that could explain the symptoms have not been performed.
- The testing is being used as a screening tool or as the primary or initial approach to evaluation.
- The time requested for the testing exceeds the time that has been indicated by the publisher or in the scientific literature (plus ancillary time covered by the procedure code, if any), and the clinical information submitted does not support a need for the requested amount of time. In such circumstances Tufts Health Plan may approve less time than requested.

Please note that IMPACT testing and NEUROTRAX are both listed on the [Noncovered Investigational Services](#) list by Tufts Health Plan and will not be covered.

CODES

The following codes require prior authorization:

| Code | Description |
|-------|--|
| 96132 | 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 |
| 96133 | Each additional hour (List separately in addition to code for primary procedure) |
| 96136 | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes |
| 96137 | Each additional 30 minutes (List separately in addition to code for primary procedure) |
| 96138 | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes |
| 96139 | Each additional 30 minutes (List separately in addition to code for primary procedure) |
| 96146 | Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only |

Note: Codes 96116 (neurobehavioral status exam, per hour) and 96121 (Neurobehavioral status exam each additional hour) can be billed without authorization for up to three hours.

For psychological testing and assessment (CPT codes 96130, 96131, 96136, 96137, and 96138), please refer to [Medical Necessity Guidelines: Psychological Testing and Assessment](#).

Note: Often an assessment has elements of and uses standardized tests from both the psychological and neuropsychological domains. Services should be coded as, and guidelines should be applied using, whichever psychological or neuropsychological assessment best addresses the primary diagnosis and/or referral question.

APPROVAL HISTORY

September 27, 2016: Reviewed by Behavioral Health Policy and Operations Committee; new policy to implement separate guidelines for neuropsychological testing and psychological testing.

Subsequent endorsement date(s) and changes made:

- December 14, 2016: Reviewed and approved by the Integrated Medical Policy Advisory Committee, with no changes, effective date April 1, 2017.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 8, 2017: Reviewed and approved by the Integrated Medical Policy Advisory Committee, with no changes.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- January 1, 2019: AMA CPT® coding update, effective January 1, 2019, the following CPT codes added to Table 2: 96132, 96133, 96136, 96137, 96138, 96139 and 96146. Removal of codes 96118, 96119 and 96120
- October 16, 2019: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

[Provider Services](#)