Medical Necessity Guidelines: Psychological Testing and Assessment

Effective: September 21, 2022

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

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

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

Psychological testing and assessment is a technique performed by licensed psychologists in order to measure and evaluate behavior, cognition, mood, affect, and/or personality in order to improve understanding of capabilities and symptoms. It typically entails a combination of activities, measures, and tools including the use of norm-referenced psychometric instruments.

Psychological testing and assessment are covered by Tufts Health Plan benefits when performed as part of a medical or behavioral health evaluation, intended to address a specific clinical question that impacts clinical management of the member, meets our guidelines for medical necessity, and is authorized by a Tufts Health Plan Utilization Management reviewer.

CLINICAL COVERAGE CRITERIA

Psychological testing and assessment is considered medically necessary when the following guidelines are met:

ONE of these:
- A current medical or behavioral health evaluation has been conducted and a specific diagnostic or treatment question still exists which cannot be answered through further conventional interviewing, history-taking, or adequate trial of evidence-based treatment; **or**
- A diagnostic formulation and adequate trial of an evidence-based treatment has been attempted but has been unsuccessful or has not resulted in the expected progress

And **BOTH** of these:
- The selected assessment procedures are targeted to the identified referral question
- The answer to the identified referral question will lead to specific recommendations and actionable steps that are likely to directly impact clinical management

And if applicable:

- Reasonable effort has been made to obtain reports of relevant previous psychological, neuropsychological, language, educational, and/or neurological assessment, and results have been reviewed.

LIMITATIONS

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

- 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 request is solely for the use of instruments or processes that do not require licensed psychologists to administer or interpret.
- The testing is requested primarily to guide titration of medication.
- 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 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.
- The testing is being used as a screening tool or as the primary or initial approach to evaluation.
- Medication side effects, impaired mental status such as active psychosis or other confounds including substance use are present that suggest that test results would potentially be invalid or inaccurate. Current abstinence from substances is required.
- The time requested for the testing significantly exceeds the time that has been indicated by the publisher or in the scientific literature, and the clinical information submitted does not support a need for the amount of time requested (including ancillary time allowed under the procedure code, if any). In such circumstances Tufts Health Plan may approve less time than requested.

CODES

The following codes require prior authorization:

Code	Description
96130	Psychological 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
96131	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: For neuropsychological testing and assessment, please see Medical Necessity Guidelines: Neuropsychological 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 of psychological or neuropsychological assessment best addresses the primary diagnosis and/or referral question.

References:

1. American Psychiatric Association. Practice guideline for psychiatric evaluation of adults, third edition. American Psychiatric Association practice guidelines for the treatment of psychiatric disorders. Washington: American Psychiatric Association; 2016: 1-64. Accessed at https://doi.org/10.1176/appi.books.9780890426760, on November 17, 2022.
2. American Academy of Clinical Neuropsychology (2007). American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *The Clinical neuropsychologist*, *21*(2), 209–231. https://doi.org/10.1080/13825580601025932.

APPROVAL HISTORY

September 27, 2016: Reviewed and approved by the 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: 96130, 96131, 96136, 96137, 96138, 96139 and 96146. Removal of codes 96101 and 96102, 96103 and 96120
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), 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