



2019 Psychological and Neuropsychological Testing *Billing and Coding Guide*

EXECUTIVE SUMMARY

The 2019 Psychological and Neuropsychological Testing Billing and Coding Guide is an essential comprehensive billing and coding resource.

Extensive changes to psychological and neuropsychological testing services took effect on January 1, 2019. This Guide was developed by APA Services Inc. and is specifically designed to provide an objective explanation of the changes established by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), as well as describe the structure, function, and utilization of the new CPT® code set.

The information contained in each of the Guide's six (6) sections is provided to the right. APA encourages payers and providers to utilize the Guide to navigate the new landscape of psychological and neuropsychological testing guidelines and procedures.

Please direct any questions about this Guide to Ms. Sheila Kerr-Wilson, Program Director of Legal & Regulatory Affairs, at SKerr@apa.org or 202-336-5878. She will direct your question to the appropriate APA Services expert. Additional APA Services resources are publicly available on APA's website (apaservices.org/practice/reimbursement/health-codes/testing).

SECTIONS

- **Coverage Indications, Limitations, and Medical Necessity:** This section provides descriptions of the assessment, test administration and scoring, and evaluation services; an explanation of the individual components of each service; specifics on determining medical necessity (pages 1-7); and limitations of coverage (pages 7-8).
- **Coding Information:** This section contains a complete listing and description of the new psychological and neuropsychological testing CPT® codes that went into effect on January 1, 2019 (pages 8-9).
- **General Information:** This section includes a description of the elements typically required to be documented in the patient record and provides guidelines for billing testing services that occur over multiple days—a standard of practice for both psychological and neuropsychological assessment (pages 9-10).
- **Utilization Guidelines:** This section provides instructions to assess coverage provisions (i.e., whether a service or procedure is considered medically necessary) and appropriateness of services provided to a patient or group of patients. The instructions are intended to improve quality and efficiency of care, reduce unnecessary and/or inappropriate services, and manage the cost of health care benefits (pages 10-11).
- **Sources of Information:** This section lists the scientific evidence and educational resources to support the contents of this Guide (pages 11-12).
- **Clinical Examples:** This *separate* addendum provides expanded clinical examples as well as tips for proper coding, billing and documentation of testing services.



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2019 Psychological and Neuropsychological Testing Billing and Coding Guide

The information provided throughout this Guide relates to both Neuropsychological and Psychological Testing services. Given the differences in scope, however, the two types of testing services are discussed separately as needed.

COVERAGE INDICATIONS, LIMITATIONS, AND MEDICAL NECESSITY

Neuropsychological Assessment

Neuropsychological assessments provide measurements of brain function that are objective, valid, and reliable. Information from neuropsychological assessments directly impacts medical management of patients by providing information about diagnosis, progression or course of conditions, 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 (Chaytor & Schmitter-Edgecombe, 2003; Gure, Kabeto, Plassman, Piette, & Langa, 2010; Marcotte & Grant, 2010; Sbordone & Long, 1996; Stillely, Bender, Cunbar-Jacob, Sereika, & Ryan, 2010; Wilson, 1993; Wojtasik et al., 2009), and information from neuropsychological assessments are incorporated into physician discharge summaries a majority of the time (Temple, Carvalho, & Tremont, 2006). Reliable and research-validated neuropsychological tests are administered in the context of a comprehensive evaluation that synthesizes data from clinical interview, record review, medical history, and behavioral observations. Where appropriate, these evaluations consider neuroimaging and other neuro-diagnostic studies and inform neuropsychologically-oriented interventions (AACN 2007).

Neuropsychological evaluations are frequently requested to assess cognitive functioning for patients with a history of medical or neurological disorders that compromise cognitive or neurobehavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; and reported impairments in cognitive functioning. Neuropsychological evaluations are also requested to assess cognitive function as a part of treatment planning and determining response to interventions, and to evaluate 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 assessment is not limited in relevance to patients with evidence of structural brain damage. It is frequently necessary to document impairments in patients with possible/probable neuropsychological and neurobehavioral disorders. It is the evaluative approach of choice whenever objective documentation of subjective cognitive complaints and symptom validity testing are indicated.

Neuropsychological testing involves administration of standardized tests of cognitive and emotional functioning by a qualified health care professional (QHP) or clinically-trained technician under the direction and supervision of the QHP. There is no definition or guideline in Medicare of what a technician is, and definitions differ on a state-by-state basis. Technician training and supervision, test selection, data interpretation and analysis, report writing and consultation are the responsibility of the QHP who is independently licensed at the doctoral level. Interpretation of neuropsychological tests and integration of testing results with other relevant clinical data must be conducted by a QHP, such as a clinical psychologist, or a physician with appropriate training and expertise in neuropsychological assessment and cognitive functioning.

Other related neuropsychological evaluation services include review of relevant medical records, clinical decision making that occurs throughout the course of testing, integration of test results with other clinically relevant information, and interactive feedback of evaluation results to the patient and caregiver. *(For more information see description of individual services below.)*

Neuropsychological examination consists of detailed measurement of brain function through standardized testing typically of multiple domains, including but not limited to: general intellect, abstract reasoning, attention, language, problem-solving, memory, visual-spatial abilities, motivation and performance validity, adaptive skills, and mood.

Neuropsychological testing is considered medically necessary for one or more of the following indications, where initial assessment or assessment over time is needed in order to:

1. Measure cognitive or behavioral deficits related to known or suspected CNS impairment, trauma, or neuropsychiatric disorders, including when the information will be useful in determining a diagnosis, prognosis, or informing treatment planning; or
2. Establish a treatment plan by measuring functional abilities/ impairments in individuals with known or suspected CNS and neuropsychiatric disorders; or
3. Determine the potential impact of substances that may cause cognitive impairment (e.g., radiation, chemotherapy, prescribed or illicit drugs, toxins) or result in measurable improvement in cognitive function, including when this information is utilized to determine treatment planning; or
4. Conduct pre-surgical or treatment-related measurement of cognitive function 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 or organ transplant) or significantly alter a patient's functional status; or
5. Determine through measurement of cognitive abilities whether a patient's medical condition impairs his/her ability to comprehend and participate effectively in treatment regimens (e.g., surgical procedures, determining functional capacity for health care decision-making) or to function independently after treatment (e.g., work, independent living, managing financial affairs); or

6. Design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or
7. Measure cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to cognitive, social, emotional, or physical demands; or
8. Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

Psychological Assessment

Psychological assessment involves the use of reliable and research-validated methods (including but not limited to clinical interviewing) and standardized tests to evaluate cognitive, behavioral, and emotional functioning, intellectual abilities, personality, and psychopathology (Meyer et al., 2001).

When appropriate, these evaluations also consider an individual's medical history and condition, psychosocial factors, and interpersonal relationship dynamics to formulate diagnoses and treatment plans and answer other clinical questions, as enumerated below (Meyer et al., 2001). Psychological assessment is a complex, integrative process that requires specialized training and expertise (Society for Personality Assessment Board of Trustees, 2006).

Psychological tests are used to assess a broad range of mental abilities and attributes, mood states, mental status, achievement and ability, personality characteristics, and emotional functioning in a variety of settings and across various populations and disorders. Psychological testing requires a QHP or clinically trained technician for test administration and scoring. Psychological test interpretation and integration of test results with other relevant clinical data must be performed only by a QHP, such as a clinical psychologist, with training and expertise in psychodiagnostic assessment. Associated psychological assessment services by the QHP include review of relevant medical records, clinical decision making that occurs throughout the course of testing, integration of test results with other relevant clinical information, report writing, and interactive feedback of assessment results to the patient and caregiver. *(For more information see description of individual services below.)*

Domains assessed in a psychological assessment typically consist of mood/emotional conditions and symptoms, cognitive status, adaptive functioning, and behavioral and interpersonal adjustment. Examples include, but are not limited to: depression, anxiety, suicide and/or violence risk, anger expression and

management, resilience and stress management capacities, psychological traits and states, personality dynamics, intellectual ability, information processing capacities, social-skill deficits, and family dynamics.

Psychological testing is considered medically necessary for one or more of the following indications, where there is a need to:

1. Measure a psychological disorder and its severity and functional impairment to determine psychiatric diagnosis when a mental illness is suspected, or to achieve a differential diagnosis from a range of medical/psychological disorders that present with similar constellations of symptoms (e.g., determination and measurement of anxiety severity and impact in the presence of ongoing asthma or heart disease); or
2. Measure behavioral factors that impact disease management in scenarios that include but are not limited to: (a) pre-surgical evaluation to identify psychological factors that may potentially affect or complicate the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery); (b) assessment of emotional/personality factors impacting physical disease management and ability to comply with and benefit from medical interventions; (c) assessment of psychological factors in chronic pain patients; and (d) compliance to treatment regimens; or
3. Measure functional capacity to delineate specific cognitive, emotional, or behavioral bases of functional complaints and/or disability, and/or to assess patient capacity for decision-making when impairment is suspected that would affect patient care or case management or independent living; or
4. Measure psychological barriers and strengths to aid in treatment planning, including but not limited to the selection of treatment options when several different approaches may be indicated, to determine treatment prognosis and outcomes, or to identify reasons for poor response to treatment; or
5. Measure risk factors needed to determine patients' risk of harm to self and/or others; or
6. Perform symptom measurement to objectively measure treatment effectiveness and/or determine the need to refer for pharmacological treatment or other medical evaluation (e.g., based on severity and chronicity of symptoms); or
7. Measure and confirm or refute clinical impressions obtained from interactions with patients, particularly when malingering or denial of psychological difficulty is suspected; or

8. Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

Components of Neurobehavioral Status Exam and Clinical/Diagnostic Interview

▪ **Neurobehavioral Status Examination**

This is a clinical assessment of cognitive functions and behavior, and may include an interview with the patient, other informants, and/or staff, as well as integration of prior history and other sources of clinical data with clinical decision making, further assessment and/or treatment planning and report. Evaluation domains may include language, memory, acquired knowledge, attention, planning and problem solving, and visual-spatial abilities. When it precedes a neuropsychological or psychological evaluation, the clinical assessment would determine the type of tests and how those tests should be administered (AMA CPT Assistant, November 2006).

Note: The new coding structure for the Neurobehavioral Status Examination includes a time-based/per hour code to report the first hour of service (i.e., 96116), plus an add-on code to report each additional hour required to complete the service (i.e., 96121).

A neurobehavioral status examination, in the absence of neuropsychological testing, is insufficient to objectify and quantify mild cognitive impairment.

▪ **Clinical/Diagnostic Interview**

The face-to-face psychological evaluation typically begins with a diagnostic interview conducted by the provider. The diagnostic interview 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: presenting problems and symptoms, history of maladjustment, reasoning and judgment, coping and problem solving, attention and concentration, mood and range of affect, functional impairment, and relevant developmental and family history. When it precedes a psychological testing evaluation, the clinical assessment would determine the types of tests and how those tests should be administered.

Note: CPT® code 90791; *Psychiatric diagnostic evaluation*, is a comprehensive psychiatric diagnostic evaluation of psychological and psychosocial conditions, without medical services (see CPT® code 90792; *Psychiatric diagnostic evaluation with medical services*, for psychodiagnostic interview that includes medication management and medication services). This service remains unchanged for Calendar Year 2019. It is an untimed procedure code and can be billed only one time for the service provided during a single encounter.

Components of Neuropsychological and Psychological Evaluation

Neuropsychological testing evaluation services typically include integration of patient data with other sources of clinical data, data interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s) when performed. Evaluation domains for neuropsychological evaluation may include memory, language and communication, attention, executive function, intellectual function, visual-spatial function, sensorimotor function, validity and motivation, emotional and personality features, and adaptive behavior.

Psychological testing evaluation services typically include integration of test data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It includes interactive feedback to the patient and to family members or caregiver(s) when indicated. Evaluation domains for psychological evaluation may include emotional, behavioral and interpersonal functioning, intellectual functioning, thought processes, validity and response bias, personality, and psychopathology.

Components that are included within neuropsychological and psychological testing evaluation services are described below.

▪ Record Review

- › The provider reviews available medical and other records and referral question and determines whether an evaluation is appropriate; reviews presenting signs and symptoms; reviews other relevant medical history; and reviews any other relevant information contained within that will potentially affect results and interpretation of the neuropsychological or psychological evaluation.

▪ Test Selection

- › Information from medical and other records, clinical interviews, and behavioral observations are integrated to guide the selection of specific neuropsychological or psychological 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), the goals of the evaluation (establishing a diagnosis, measuring functional capacities, measuring treatment effects, etc.), and clinical decision making during the testing process itself based on the patient's ongoing performance.
- › Neuropsychological and psychological tests may include direct question-and-answer, performance-based tests

involving object manipulation, inspection and responses to pictures or patterns, self-report questionnaires, paper-and-pencil written, computer-based or multiple-choice tests that measure functional impairment and abilities in areas such as:

- Intellectual abilities
- Abstract reasoning and categorical thinking
- Attention and concentration
- Language and communication
- Decision-making, strategy formation, and executive functioning (e.g., planning, organization, self-monitoring, mental flexibility, pragmatics)
- Learning and memory
- Motor function, sensorimotor function, lateralized functions
- Perception and perceptual organization
- Visual-spatial cognition and visual-motor praxis
- Mood and affect, conduct, personality, quality of life
- Motivation, response style, response validity (e.g., performance validity, symptom validity)
- Adaptive behavior (Activities of Daily Living)
- Social-emotional adjustment, awareness and responsivity
- Psychopathology (e.g., psychotic thinking or somatization)
- Impulse control and conduct
- Personality characteristics
- Stress, coping, and problem-solving
- Interpersonal adjustment

▪ Clinical Decision Making

- › The QHP evaluates how the patient is responding throughout the psychological or neuropsychological testing process through direct observation via test administration and/or communication with the technician. The QHP alters the test selection or approach as needed based on clinically significant elements of the patient's ongoing behavior within the testing session. There will be variability across patients depending on a wide variety of factors including patient complexity, comorbidities, severity of medical condition(s) and other factors that drive the clinical decision making. Examples of factors that require intra-session clinical decision making include, but are not limited to:
 - Discovery of physical, sensory, or cognitive impairment impeding patient's ability to demonstrate their cognitive abilities on previously planned test instruments
 - Emotional/behavioral response

- Level of patient functioning
 - Level of patient impairment
 - Nature of symptoms
 - Level of literacy
 - Level of language proficiency and/or acculturation
 - Whether test results being collected are valid, reliable, and believed to be representative of domain intended to be measured
 - Determination that a higher level or more nuanced tests are required for accurate diagnosis
- › Another important aspect of clinical decision making, based on observed intra-test behavior, may include the need to go beyond the standardized testing procedure to evaluate the level at which specific skills are present and for clarification and elaboration of the cognitive components leading to an individual's test responses. This modification of the standardized testing approach requires a high degree of professional judgment by the QHP and expertise beyond technical competence in test administration and, when needed, is essential for accurate interpretation of the underlying reasons an individual may demonstrate low test performance.
 - › When utilizing a technician for test administration, the QHP initially discusses with and directs the technician as to tests and testing procedures to be used. During the testing session, the QHP must be available for consultation throughout the testing session in order to adjust testing activity.
 - › Clinical decision making by a QHP occurs throughout the testing process, whether a QHP or technician is administering the tests (as documented in codes 96132 and 96133 for neuropsychological evaluation services and 96130 and 96131 for psychological evaluation services described below).
- **Interpretation and Integration of Test Results with Other Sources of Clinical Data**
 - › Test scores collected as part of a neuropsychological or psychological evaluation require interpretation by a QHP with specific training and experience in neuropsychological or psychological assessment. Further, test scores are interpreted in the context of other sources of clinical data (e.g., patient demographic information, behavioral observations, relevant medical history, relevant psychosocial and contextual factors, etc.) and all information is integrated into a clinical report. (See “Documentation Requirements” below)
 - **Creation of Clinical Report** (See “Interpretation and Integration of Test Results with Other Sources of Clinical Data” above and “Documentation Requirements” below)
 - **Medical Management and Treatment Planning**
 - › The QHP uses results of cognitive, emotional and other assessment methods to respond to a referral question or assist with medical management and treatment planning (e.g., provides recommendations for medications and medical management strategies, rehabilitative therapies, strategies or supports to assist with medication and treatment plan adherence, psychological and other medical interventions, supervision needs, compensatory strategies that would be beneficial to minimize effects of cognitive impairments, increased awareness of and interventions to manage a patient's functional limitations).
 - **Interactive Feedback Session**
 - › The interactive feedback session is performed as part of neuropsychological and psychological evaluation services.
 - › A post-evaluation feedback session with the patient and/or family members is a typical part of the neuropsychological and psychological evaluation (American Psychological Association, 2017; Finn, 1996; Pegg et al., 2008; Postal and Armstrong, 2013). It is empirically shown to be produce clinically meaningful benefits (Poston & Hanson, 2010) including symptomatic improvements (Miller, Cano, & Wurm, 2013; Smith, Eichler, Norman, & Smith, 2015) and is highly valued by patients (Westervelt, Brown, Tremont, Javorsky, & Stern, 2007) and physicians who refer their patients for neuropsychological assessments (Postal et al, 2017).
 - › The interactive feedback session typically emphasizes any or all of the following:
 - Discussion of the relationship between test results and information about diagnosis and prognosis.
 - Patient education about their diagnosed condition and functioning with the goal of improving adherence to treatment plans, and safety.
 - 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 explained by providers with expertise in neuropsychological or psychological assessment, including tailored

behavioral strategies to maximize functioning, safety measures such as driving recommendations, referrals to other specialty providers (e.g., psychiatry, rehabilitative therapists), recommendations for nonpharmacological interventions, and community resources.

- Communication of results to family members in order to explain treatment recommendations enhances treatment outcome for the patient (Postal 2018). In some cases, a patient may be undergoing treatment or may be too cognitively impaired to engage in such feedback. In such circumstances, where the QHP determines that feedback is necessary to ensure adherence to treatment plans including safety issues, feedback may be given to the patient's caregiver (with appropriate permissions and release of information).

Note: The new coding structure for the psychological/neuropsychological testing evaluation services includes a time-based/per hour code to report the first hour of service (i.e., 96130/96132), plus an add-on code to report each additional hour required to complete the service (i.e., 96131/96133).

Components of Psychological or Neuropsychological Test Administration and Scoring (Data Gathering)

- This set of codes is used for administration and scoring of psychological or neuropsychological testing by either

The QHP directly

OR

A trained technician under the general supervision of a QHP

- Psychological and neuropsychological testing involves administration of standardized tests of cognitive and emotional functioning by a QHP or clinically-trained technician under the direction and supervision of the QHP. As noted above, there is no definition or guideline in Medicare of what a technician is, and definitions differ on a state-by-state basis. Technician training and supervision, test selection, data interpretation and analysis, report-writing and consultation are the responsibility of the QHP who is independently licensed at the doctoral level.
- Regardless of the individual administering and scoring the testing, these codes always involve general supervision of the technician and clinical decision making by the QHP, and will always be billed in combination with the corresponding neuropsychological or psychological evaluation services code as follows.
 - › A state-licensed QHP provides a high degree of professional judgment and expertise in addition to technical competence in test administration.

- › When testing is administered by a technician (96138, 96139), general supervision of the technician, oversight of the data and test battery modification is typical. (See “Clinical Decision Making” above and note that these activities are billed separately from this code.)

- › Psychological or neuropsychological test administration and scoring services should be reported with codes 96136-96139.

- When a physician or QHP personally administers and scores the psychological or neuropsychological test (i.e., without the use of a technician), code 96136 will be reported for the first 30 minutes, and add-on code 96137 will be reported for each additional 30-minute increment of time required to complete the test administration service.
- When a technician (non-physician or non-QHP under the supervision of a physician or QHP) administers and scores the test, code 96138 should be reported for the first 30 minutes of technician test administration services, and add-on code 96139 is reported for each additional 30-minute increment.

- It is a common practice for both a psychologist and a technician to provide test administration and scoring for the same patient. Even when utilizing testing technicians, many psychologists and neuropsychologists incorporate their own test administration into the evaluation protocol. However, a National Correct Coding Initiative (NCCI) edit prevents CPT® codes 96136 and 96138 to be billed on the same day with the same patient without including an appropriate modifier.
- When clinically appropriate, appending a modifier to the service that would have been denied will result in a bypass of the NCCI edit. This modifier indicates the medical necessity (as evidenced in the documentation) of the psychologist and the technician to perform separate, distinct and non-overlapping test administration and scoring services.
- Choosing the appropriate modifier for services that are not normally reported together, but are appropriate under certain circumstances, depends on how the test administration and scoring services were provided to the same patient on the same date of service.
- **Modifier XE** indicates the testing was performed during **separate encounters**:
 - › When the patient has an initial test administration encounter with the psychologist and then leaves the office—possi-

bly to get lunch—but returns to the office later that day for a second encounter of test administration performed by the technician, **Modifier XE** would be appended to the base code for the second test administration and scoring service.

- Modifier XE is used to identify a service that is distinct because it occurred during a separate encounter on the same date of service.
 - The submission of Modifier XE appended to a procedure code indicates that documentation is available in the patient’s records which will support the medical necessity of the psychologist and the technician to perform separate, distinct and non-overlapping test administration and scoring services during separate encounters on the same date of service.
 - This is unlikely to be a frequent circumstance, as often there is overlap between the technician and the psychologist for a given patient “encounter”, and XE would therefore not be the appropriate modifier (see discussion regarding Modifier 59 below).
- **Modifier 59** indicates the testing was performed during the **same encounter**, but was a distinct procedural service
 - › When the psychologist begins administering the test battery and then the technician takes over (*i.e.*, the patient doesn’t leave the office), **Modifier 59** would be appended to the base code for the second test administration and scoring service.
 - Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances, however, Modifier XE would not be appropriate.
 - Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than Modifier 59 (see discussion regarding Modifier XE above).
 - It should also be noted that if both a psychologist and a technician (under the supervision of the psychologist) provide test administration and scoring services with the same patient but on different dates of service, no modifier is required to be reported on the claim form.

Psychological or Neuropsychological Test Administration, with Single Automated Instrument via Electronic Platform, with Automated Result

- CPT® code 96146 is for a single, automated test (*e.g.*, brief testing for given condition, monitoring progression of disease or condition, monitoring of response to intervention, etc.), administered via electronic platform (*e.g.*, computer, iPad), that produces an automated report. This new code was created to distinguish between providing a limited, single psychological or neuropsychological automated test versus providing a robust battery of tests (APAPO’ 2014; Roebuck-Spencer et al., 2017; Block et al., 2016).
- These services do not require a psychologist/physician/technician for test administration and/or scoring (*i.e.*, no physician work component).
- The CPT® code 96146 is reported when a single automated test with automated result is administered. If more than one automated test is administered, 96146 can only be billed once.
- When computer-generated interpretations are used as part of a battery of tests (*i.e.*, two or more tests), they are integrated with other data by the QHP using evaluation services codes (96130-96133).

Limitations of Coverage

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

1. The patient is neurologically, cognitively, or psychologically unable to participate in a meaningful way in the testing process; or
2. The patient will not benefit from reasonable therapeutic or care options – there must be a reasonable expectation from a medical management perspective; or
3. Used as a routine screening tool given to the individual or to general populations; or
4. Administered for educational or vocational purposes that do not inform medical or health management (*i.e.*, the purpose of testing is to alter or direct medical or health management); or
5. Comprised exclusively of self-administered or self-scored inventories, or as screening tests of cognitive function or neurological disease (whether paper-and-pencil or computerized; *e.g.*, AIMS, Folstein Mini-Mental Status Examination). (*For description of differences between screening tests and comprehensive testing batteries, see APAPO, 2014;*

Roebuck-Spencer et al., 2017; Block et al., 2016); or

6. Repeat testing is not required for medical decision-making (e.g., the repeat testing is because of patient preference or request); or
7. Administered when the patient is currently under the influence or impaired by alcohol, drugs (prescription or illicit), or other substances; or
8. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer's disease, and there is no expectation that the testing would impact the patient's medical, functional, or behavioral management.

CODING INFORMATION

Below are the CPT® code and code descriptors for psychological and neuropsychological testing services:

96116; Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; **first hour**

96121; Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; **each additional hour** (List separately in addition to code for primary procedure)

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; 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; **each additional hour** (List separately in addition to code for primary procedure)

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; 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; **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; Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; **each additional 30 minutes** (List separately in addition to code for primary procedure) (96136, 96137, 96138, 96139 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days)

96138; Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **first 30 minutes**

96139; Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **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

96112; Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; **first hour**

96113; Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; **each additional 30 minutes** (List separately in addition to code for primary procedure)

ICD-10 Codes that Support Medical Necessity for Neuropsychological and Psychological Testing

Neuropsychological and psychological assessment is considered medically necessary for the following indications:

- ICD-10 codes must be coded to the highest level of specificity. There are no ICD-10 codes listed in this Guide because coverage of the service is not based on diagnosis. Providers should use the appropriate ICD-10 code.

GENERAL INFORMATION

Documentation Requirements

1. The patient’s medical record should contain documentation that supports the medical necessity for testing or other services performed, and examination results. When appropriate, documentation includes the following information:
 - a. Referral question and referral diagnosis
 - b. Relevant medical history
 - c. Relevant psychosocial history
 - d. Sources of information (e.g., patient interview, record review, behavioral observations)
 - e. Procedures administered
 - f. Clinical decision making (*See description in the section “Components of Neuropsychological and Psychological Evaluation” above*)
 - g. Interpretation of test data and other clinical information (e.g., test results)
 - h. Integration of sources of information (e.g., summary and impressions)
 - i. Diagnosis
 - j. Treatment planning and recommendations
2. The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report. All Testing Evaluation services and Test Administration and Scoring services provided by the QHP and technician must be documented in clearly understandable terms, and feedback provided for the benefit of referral sources and other reviewers.
3. Documentation should be legible, signed, and maintained in the patient’s medical record. Upon request, it must be available to the payer.

Episode of Care over Multiple Dates of Service

It is typical for QHPs to provide Testing Evaluation Services (96130-96133) and/or Test Administration and Scoring services (96136-96139) across multiple dates of service. This could include multiple testing sessions with test scoring, non-face-to-face time engaged in professional services and test scoring, and interactive feedback. When a service is spread out over multiple visits, the total cumulative time spent performing each

type of service in the evaluation process (*i.e.*, clinical/diagnostic interview, testing evaluation services, and test administration and scoring) should be reported at the completion of the entire episode of care (Centers for Medicare & Medicaid Services [CMS], National Correct Coding Initiative [NCCI] April 1, 2019 Change Report for Add-On Code Edit Changes; MLN Matters® SE17023 *Guidance on Coding and Billing Date of Service on Professional Claims*). The single bill should list both base and add-on codes with the different dates of service linked to the entire episode of evaluation. A single base code should only be submitted for the first unit of each type of service of the evaluation process. Only add-on codes should be used to capture subsequent units of service on the same or different days.

The episode of care concludes when the evaluation report is complete. It is expected that interactive feedback with the patient and/or family member(s) and caregiver(s) will be a typical component of the evaluation process. When more extensive feedback services with the patient and/or family member(s) and caregiver(s) are required, those services should be considered a new episode of care.

Important notes regarding proper reporting and billing for an entire Neuropsychological or Psychological Assessment episode of care over multiple dates of service:

- CPT® codes are reported based on the cumulative time spent performing each individual service category (*i.e.*, clinical interview, testing evaluation services, and test administration and scoring) even if time occurs on the same or different dates of service. Time spent performing the activities associated with each service category **is cumulative over the entire episode of care, but the activities in each service category do not necessarily happen chronologically.**
- For each service category provided, time is cumulated over the episode of care based on the time stated in the CPT® code descriptors.
 - › Test administration and scoring services are cumulated in 30-minute increments
 - › Neurobehavioral status exam and Testing evaluation services are cumulated in 60-minute increments
 - › Psychiatric diagnostic evaluation (90791) is an untimed procedure and can be billed only one time for the service provided during a single encounter

Cumulated time is then converted to units of CPT codes reported. A single unit of a base code should be reported with multiple units

(as needed) of the corresponding add-on code for the individual services performed. *(See Addendum for clinical examples and tips for proper documentation, coding and billing for episodes of care over multiple dates of service)*

UTILIZATION GUIDELINES

The CPT® codes in this Guide do not represent psychotherapeutic modalities but are diagnostic in nature. Each test performed must contribute meaningfully to the evaluation services for the condition being assessed.

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

With regard to neuropsychological and psychological evaluations, the combination of test administration and psychological/neuropsychological testing evaluation services will vary depending on a wide variety of factors including patient complexity, comorbidities, severity of medical condition(s) and other factors that drive the clinical decision making *(See “Clinical Decision Making” above)*. A summary of any significant complicating factors, when present and relevant to test selection or clinical decision making, should be included in the clinical report, using simple straightforward language to explain why the procedures were necessary in the particular case.

The new neuropsychological and psychological evaluation codes now include interactive feedback. This service was not included in the previous codes. Interactive feedback should be billed using the evaluation services codes and only when the service is provided face-to-face.

If the testing time exceeds eight (8) hours, medical necessity for extended testing time should be documented in the report. Supporting documentation in the medical record must be present to justify greater than eight hours of testing per patient. If the testing is done over several days, the total time for the evaluation should be reported at the completion of the entire episode of the evaluation. The single bill should list both base and add-on codes with the different dates of service linked to the entire episode of evaluation.

It is a common practice for both QHP test administration and scoring and technician test administration (under the supervision of the QHP) and scoring to occur on the same patient. Even when utilizing technicians, many psychologists and neuropsychologists

have incorporated test administration of at least several tests into their evaluation protocol, the medical necessity of which is determined by the complexity and degree of clinical decision making required. Therefore, both the QHP and technician test administration and scoring codes (96136-96139) can be used together to accurately document and report the time spent by each. *(See information regarding modifier XE versus 59 in the section “Components of Neuropsychological and Psychological Evaluation” above)*

There are cases in which a provider can administer and interpret standardized tests that can be used in both psychological and neuropsychological evaluations. In these cases, the QHP should choose the code that is the predominant service being provided. The psychological test evaluation codes (96130-96131) and neuropsychological test evaluation services (96132-96133) should not be billed together in the same episode of care.

If a computer test is given that does not require any supervision (i.e., QHP or technician is out of the room) and has automated scoring, the actual administration time for the computer test would not be billed, but the time spent integrating this measure with other test results would be captured in the test evaluation services (96130-96133) billed by the QHP.

The QHP is required to give two (2) or more tests in order to utilize the Test Administration and Scoring codes 96136-96139). A single standalone test, even a multifaceted one, would not represent a neuropsychological evaluation or psychological evaluation service.

The QHP should use Developmental Testing CPT® codes 96112 and 96113 when standardized developmental measures are used to assess skill development in multiple areas that include: receptive and expressive language, social, cognitive, gross and fine motor, and adaptive functioning.

When the primary referral question for young children or older children who are delayed is to assess: (a) developmental skill acquisition appropriate for age; (b) loss of previously acquired skills; or (c) failure to attain expected skills, the QHP should use 96112 and 96113 for the total time spent administering, scoring, observing, interpreting, and clinical decision making related to the entire test battery, which must include the use of a standardized developmental instrument.

When the primary referral question is not for developmental concerns, but a standardized developmental instrument is used to determine loss of previously acquired skills/failure to attain expected skills for age, in the context of neuropsychological and/or psychological measures that directly address the referral

question, the QHP should use 96112 and 96113 only for the time spent administering, scoring, observing, interpreting, and clinical decision making related to the standardized developmental instrument. Additional neuropsychological and/or psychological CPT® testing codes would then be used to capture the time spent administering, scoring, observing, interpreting, and clinical decision making related to the other types of measures included in the test battery (psychological and/or neuropsychological).

SOURCES OF INFORMATION

- American Medical Association. CPT® Assistant. Coding communication: Central nervous system assessments and tests. November 2006. P.15.
- American Psychological Association (2017). *Ethical principles of psychologists and code of conduct*. Effective date June 1, 2003 with amendments effective June 1, 2010 and January 1, 2017. <http://www.apa.org/ethics/code/>. Accessed August 4, 2018.
- APAPO (2014). Statement from an American Psychological Association and American Psychological Association Practice Organization work group on screening and psychological Assessment. <http://www.apapracticecentral.org/reimbursement/billing/assessment-screening.aspx>. Accessed August 4, 2018.
- Block, C., Johnson-Greene, D., Pliskin, N., & Boake. (2016). Discriminating cognitive screening and cognitive testing from neuropsychological assessment: Implications for professional practice. *The Clinical Neuropsychologist*, 31:3, 487-500.
- Board of Directors. (2007). American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *The Clinical Neuropsychologist*, 21, 209–231.
- Centers for Medicare & Medicaid Services. (2019). MLN Matters® SE17023 *Guidance on Coding and Billing Date of Service on Professional Claims*. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf>. Accessed February 1, 2019.
- Centers for Medicare & Medicaid Services. (2019). National Correct Coding Initiative (NCCI) Change Report for Add-on Code Edit Changes 04/01/2019 for Medicare. Retrieved from <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/Change-Report-Add-on-04012019.zip>
- Chaytor, N. & Schmitter-Edgecombe, M. (2003). The ecological validity of neuropsychological tests: A review of the literature on everyday cognitive skills. *Neuropsychology Review*, 13, 181-197.
- Finn, S. E. (1996). *Manual for using the MMPI-2 as a therapeutic intervention*. Minneapolis: University of Minnesota Press.
- Gure, T. R., Kabeto, M. U., Plassman, B. L., Piette, J. D., & Langa, K. M. (2010). Differences in functional impairment across subtypes of dementia. *Journals of Gerontology: Biological Sciences and Medical Sciences*, 65, 434-441
- Marcotte, T. D. & Grant, I. (Eds.). (2010). *Neuropsychology of everyday functioning*. New York: Guilford.
- Matarazzo, J. (1990). Psychological assessment versus psychological testing: Validation from Binet to the school, clinic, and courtroom. *American Psychologist*, 45, 999-1017.
- Meyer, G., Finn, S., Eyde, L., Kay, G., Moreland, K., Dies, R., et al. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist*, 56, 128-165.
- Miller, L. R., Cano, A., & Wurm, L. H. (2013). A motivational therapeutic assessment improves pain, mood, and relationship satisfaction in couples with chronic pain. *The Journal of Pain*, 14(5), 525-537.
- Pegg et al. (2008). The impact of patient-centered information on patients' treatment satisfaction and outcomes in traumatic brain injury research. *Rehabilitation Psychology*, 50 (4), 366-374.
- Postal, K., & Armstrong, K. (2013). *Feedback that sticks: The art of communicating neuropsychological assessment results*. New York: Oxford University Press.
- Postal, K., Chow C., Jung, S., Erickson-Moreo, K., Geier, F., & Lanca, M. (2017): The stakeholders' project in neuropsychological report writing: A survey of neuropsychologists' and referral sources' views of neuropsychological reports, *The Clinical Neuropsychologist*. <http://dx.doi.org/10.1080/13854046.2017.1373859>
- Postal, K. S. (2018 in press). The multigenerational family system in dementia assessment and management. In L. Ravdin & H. Katzen (Eds.) *Handbook on the Neuropsychology of Aging and Dementia*. NY: Springer Publishing.
- Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment*, 22(2), 203-212.
- Roebuck-Spencer, T.M., Glen, T., Puente, A.E., Denney, R.L., Ruff, R.M., Hostetter, G., & Bianchini, K.J., (2017). Cognitive screening tests versus comprehensive neuropsychological test batteries: A National Academy of Neuropsychology education paper. *Archives of Neuropsychology*, 32, 491-498.
- Sbordone, R. J & Long, C. J. (1996). *Ecological validity of neuropsychological testing*. New York: CRC Press.
- Smith, J. D., Eichler, W. C., Norman, K. R., & Smith, S. R. (2015). The effectiveness of collaborative/therapeutic assessment for psychotherapy consultation: A pragmatic replicated single-case study. *Journal of Personality Assessment*, 97(3), 261-270.
- Society for Personality Assessment Board of Trustees. (2006). Standards for education and training in psychological assessment: Position of the Society for Personality Assessment. *Journal of Personality Assessment*, 87, 355-357.
- Stilley, C. S., Bender, C. M., Dunbar-Jacob, J., Sereika, S., & Ryan, C. (2010). The impact of cognitive function on medication management: Three studies. *Health Psychology*, 29, 50-55.
- Temple R. O., Carvalho, J., & Tremont, G. (2006). A national survey of physicians' use of and satisfaction with neuropsychological services. *Archives of Clinical Neuropsychology*, 21(5), 371-382.
- Westervelt, H. J., Brown, L. B., Tremont, G., Javorsky, D. J., & Stern, R. A. (2007). Patient and family perceptions of the neuropsychological evaluation: how are we doing? *The Clinical Neuropsychologist*, 21, 263-273.

Wilson, B. A. (1993). Ecological validity of neuropsychological assessment: Do neuropsychological indexes predict performance in everyday activities? *Applied and Preventive Psychology, 2*, 209-215.

Wojtasik, V., Olivier, C., Lekeu, F., Quittre, A., Adam, S., & Salmon, E. (2009). A grid for precise analysis of daily activities. *Neuropsychological Rehabilitation, 20*, 120-136.