Clinical Policy: Psychological Testing

Reference Number: WA.CP.MP.506
Date of Last Revision: 05/22
Effective Date: 06/01/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for psychological testing.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Billing Guidelines, that psychological testing is considered **medically necessary** when the following conditions are met:

A. There is a strong indication that significant, useful information impacting patient care and treatment would be generated from the testing.

B. A detailed diagnostic evaluation has been completed by a licensed behavioral health provider that includes:

1. Detailed clinical interview with the patient
2. Complete history of the patient and a review of psychological, medical, education and other relevant records
3. Last six months of clinical notes from requesting provider and/or specialist
4. Relevant collateral information, including information and observations from parents, guardians, teachers, and others involved in the patient's life if the patient is a child.

C. The diagnostic evaluation identifies one of the following exists:

1. Member's history and symptomatology are not clearly attributable to a specific psychiatric diagnosis and psychological testing would aid in the differential diagnosis of behavioral and psychiatric conditions. The psychological testing questions must be questions that could not otherwise be answered during:
   a. A psychiatric or diagnostic evaluation,
   b. Observation during therapy,
   c. An assessment for level-of-care determinations at a mental health or substance-abuse facility
2. Member has tried various medications and psychotherapies but has not progressed and continues to be symptomatic. All the following criteria must be met:
   a. The number of hours or units requested for testing does not exceed the reasonable time necessary to address the clinical questions with the identified measures..
   b. The testing techniques are validated for the proposed diagnostic question or treatment plan.
   c. The testing techniques do not represent redundant measurements of the same cognitive, behavioral or emotional domain.
   d. The testing techniques are validated for the age and population of the member.
   e. The testing technique uses the most current version of the instrument.

f. The testing instrument must have empirically-substantiated reliability, validity, standardized administration and clinically-relevant normative data needed to assess the diagnostic question or treatment planning goals.

II. It is the policy of Coordinated Care of Washington, Inc., that psychological testing is **not medically necessary** for the purposes of diagnosing any of the following conditions, except in instances of complex cases with overlapping symptoms that need differential diagnosing, as more suitable approaches are available:
- **A.** Autism spectrum disorders
- **B.** Attention deficit disorder
- **C.** Attention deficit hyperactivity disorder
- **D.** Tourette's syndrome

III. It is the policy of Coordinated Care of Washington, Inc., that psychological testing is **not covered** for the following:
- **A.** Testing is primarily for the purpose of non-treatment related issues (e.g., routine evaluation of occupational or career aptitudes, forensic or child custody evaluations)
- **B.** Testing performed as simple self-administered or self-scored inventories, screening tests (e.g., AIMS, Folestein Mini-Mental Status Exam) or similar tests. These are considered included in an E&M service and are not separately payable as psychological testing
- **C.** Testing done for educational or vocational purposes primarily related to employment.
- **D.** Testing that would otherwise be the responsibility of a child's school system.
- **E.** The member is actively abusing a substance, having acute withdrawal symptoms, or has recently entered recovery because test results may be invalid.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes	Description
96130	Psychological testing evaluation services; first hour
96131	Psychological testing evaluation services; each additional hour
96136	Psychological test administration and scoring, physician or qualified health care professional, two or more tests; first 30 minutes
96137	Psychological test administration and scoring, physician or qualified health care professional, two or more tests; each additional 30 minutes
96138	Psychological test administration and scoring by technician; first 30 minutes
96139	Psychological test administration and scoring by technician; each additional 30 minutes

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted. Previously WA.UM.39	09/19	09/19
Annual review. References updated. Minor grammatical changes.	06/20	07/20
Annual review. Moved non-covered items to section IV and added reference in section I to sections III and IV. Replaced "member" with "member/enrollee' in all instances. References updated.	05/21	06/21
Annual review. Policy updated to more closely mirror HCA Billing Guidelines.	04/22	05/22

References

1. Washington State Health Care Authority. Mental Health Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20220401.pdf Revision effective April 1, 2022.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrolles and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.