Clinical Policy: Psychological Testing
Reference Number: WA.CP.MP.506
Last Review Date: 06/20

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., 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 such 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.
      2. Member has tried various medications and psychotherapies but has not progressed and continues to be symptomatic.
      3. Psychological testing would aid in diagnosing an intellectual disability.
      4. Member has had a recent mild traumatic brain injury (e.g., concussion) and a screening of cognitive status is desired to answer questions about cognitive and emotional functioning and ability to return to accustomed life’s activities.
      5. Member has experienced a change in memory and testing is needed to clarify extent of memory and cognitive change and impact on functioning.
   D. The member is not actively abusing a substance, having acute withdrawal symptoms or recently entered recovery.

II. It is the policy of Coordinated Care of Washington, Inc., that psychological testing is considered medically necessary only when the testing instrument meets the following guidelines:
   A. The psychological testing questions are questions that could not otherwise be answered during:
      1. A psychiatric or diagnostic evaluation
      2. Observation during therapy
3. An assessment for level-of-care determinations at a mental health or substance-abuse facility

B. All of the following criteria must be met:
   1. The number of hours or units requested for testing does not exceed standard administration time for the instrument selected.
   2. The testing techniques are empirically valid and reliable for the diagnoses being considered.
   3. The testing techniques do not represent redundant measurements of the same cognitive, behavioral or emotional domain.
   4. The testing techniques are validated for the age and population of the member.
   5. The testing technique uses the most current version of the instrument.
   6. 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.

III. 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

IV. 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.

Coding Implications
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## Clinical Policy

**Psychological Testing**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>96130</td>
<td>Psychological testing evaluation services; first hour</td>
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<tr>
<td>96131</td>
<td>Psychological testing evaluation services; each additional hour</td>
</tr>
<tr>
<td>96136</td>
<td>Psychological test administration and scoring, physician or qualified health care professional, two or more tests; first 30 minutes</td>
</tr>
<tr>
<td>96137</td>
<td>Psychological test administration and scoring, physician or qualified health care professional, two or more tests; each additional 30 minutes</td>
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<td>96138</td>
<td>Psychological test administration and scoring by technician; first 30 minutes</td>
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<tr>
<td>96139</td>
<td>Psychological test administration and scoring by technician; each additional 30 minutes</td>
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### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>Policy adopted. Previously WA.UM.39</td>
<td></td>
<td>09/19</td>
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<tr>
<td>Annual review. References updated. Minor grammatical changes.</td>
<td>06/20</td>
<td>07/20</td>
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### References


### 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.

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**Note: For Medicaid members**, 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.

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