Medical Policy

Psychological and Neuropsychological Testing

MEDICAL POLICY NUMBER: 274

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Policy Criteria Links

- ***Psychological Testing:*** *based on InterQual® Behavioral Health Procedures Psychological Testing policies.*
  - Millon® Adolescent Clinical Inventory (MACI®)
  - Minnesota Multiphasic Personality Inventory-2®
  - Minnesota Multiphasic Personality Inventory-Adolescent® (MMPI-A®)
  - Personality Assessment Inventory™ (PAI®)
  - Unspecified Symptom Validity Test (SVT)
  - Unspecified Test
- Neuropsychological Testing

Psychological Testing

Millon® Adolescent Clinical Inventory (MACI®)

I. Psychological testing with the Millon® Adolescent Clinical Inventory (MACI®) may be considered **medically necessary and covered** when all of the following criteria are met (A.-M.):

   A. Patient is between the ages of 13 and 18 years of age; **and**
   B. Psychological testing has been requested and a testing plan is in place; **and**
   C. Clinical interview has been performed; **and**
   D. Case-specific question has been formulated; **and**

E. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
F. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
G. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
H. At least one parent or guardian has been interviewed; **and**
I. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and all of the following criteria are met (1.-4.):
    1. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
    2. Patient psychiatric and medical history obtained; **and**
    3. Functional impairment or report of internal distress; **and**
    4. Family psychiatric and medical history explored; **and**
J. At least one of the following criteria are met (1.-4.):
    1. Provider reviewed records of previous treatment or psychological testing; **or**
    2. Provider consulted with previous or current service provider; **or**
    3. Provider is unable to obtain this information despite at least 2 attempts; **or**
    4. No other psychiatric or substance use services provided to patient within last 2 years; **and**
K. At least one of the following structured or semi-structured interviews have been performed (1.-5.):
    1. Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID); **or**
    2. Anxiety Disorders Interview Schedule for Children (ADIS) Child and Parent Interview Schedules; **or**
    3. Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS); **or**
    4. Children's Interview for Psychiatric Syndromes (ChIPS) Child and Parent (P-ChIPS) Versions; **or**
    5. Diagnostic Interview Schedule for Children (DISC); **and**
L. If behavioral disturbance is suspected or confirmed, at least one of the following criteria are met (1.-3.):
    1. Validated rating scale completed by teacher(s); **or**
    2. Consultation with school personnel or other important persons in patient's life; **or**
    3. Direct observation of parent-child interactions or child in natural settings; **and**
M. All assessment activities have failed to answer the case-specific question.

Minnesota Multiphasic Personality Inventory-2®

II. Psychological testing with the Minnesota Multiphasic Personality Inventory-2® may be considered **medically necessary and covered** when all of the following criteria are met (A.-L.):

A. Patient is at least 18 years of age; **and**
B. Psychological testing has been requested and a testing plan is in place; **and**
C. Clinical interview has been performed; **and**
D. Case-specific question has been formulated; **and**
E. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
F. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
G. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
H. At least one of the following criteria are met (1.-3.):
    1. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and **all** of the following criteria are met (a.-d.):
        a. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
        b. Patient psychiatric and medical history obtained; **and**
        c. Functional impairment and medical history explored; **and**
        d. Family psychiatric and medical history explored; **or**
    2. Behavioral prediction for judicial or correctional purposes; **or**
    3. Detection of malingering for disability adjudication or forensic purposes; **and**
I. At least one of the following criteria are met (1.-4.):
    1. Provider reviewed records of previous treatment or psychological testing; **or**
    2. Provider consulted with previous or current service provider; **or**
    3. Provider is unable to obtain this information despite at least 2 attempts; or
    4. No other psychiatric or substance use services provided to patient within last 2 years; **and**
J. At least one of the following structured or semi-structured interviews have been performed (1.-3.):
    1. Structured Clinical Interview for DSM Disorders (SCID)**; or**
    2. Mini-International Neuropsychiatric Interview (MINI)**; or**
    3. Schedule for Affective Disorders and Schizophrenia (SADS); **and**
K. In seeking collateral information from significant other or family members that

live with patient, at least one of the following criteria are met (1.-6.):

1. Interview at least 1 family member**; or**
2. All other adults in the home contacted and each refuses to participate; or
3. Contact with any other adult in the home contraindicated because abuse by family member suspected or confirmed**; or**
4. Contact with any other adult in the home contraindicated because family member cognitively impaired due to medical condition or persistent substance use or dementia**; or**
5. Patient refuses to allow significant other or family member involvement due to profound distrust or paranoia**; or**
6. Patient does not live with significant other or any adult family members**; and**

L. All assessment activities have failed to answer the case-specific question.

<u>Minnesota Multiphasic Personality Inventory-Adolescent® (MMPI-A®)</u>

III. Psychological testing with the Minnesota Multiphasic Personality Inventory-Adolescent® (MMPI-A®) may be considered **medically necessary and covered** when all of the following criteria are met (A.-N.):

A. Patient is between 13 and 18 years of age; **and**
B. Psychological testing has been requested and a testing plan is in place; **and**
C. Clinical interview has been performed; **and**
D. Case-specific question has been formulated; **and**
E. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
F. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
G. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
H. At least one of the following criteria are met (1.-3.):
    1. Lack of expected progress in evidence-based psychiatric or psychological treatment, <u>or</u> psychiatric disorder is evident but there is uncertainty about differential diagnosis <u>and</u> **all** of the following criteria are met (a.-d.):
        a. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
        b. Patient psychiatric and medical history obtained; **and**
        c. Functional impairment and medical history explored; **and**
        d. Family psychiatric and medical history explored; **or**
    2. Behavioral prediction for judicial or correctional purposes; **or**

3. Detection of malingering for disability adjudication or forensic purposes; **and**

I. At least one parent or guardian has been interviewed; **and**

J. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and all of the following criteria are met (1.-4.):
   1. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
   2. Patient psychiatric and medical history obtained; **and**
   3. Functional impairment or report of internal distress; **and**
   4. Family psychiatric and medical history explored; **and**

K. At least one of the following criteria are met (1.-4.):
   1. Provider reviewed records of previous treatment or psychological testing; **or**
   2. Provider consulted with previous or current service provider; **or**
   3. Provider is unable to obtain this information despite at least 2 attempts; or
   4. No other psychiatric or substance use services provided to patient within last 2 years; **and**

L. At least one of the following structured or semi-structured interviews have been performed (1.-5.):
   1. Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID); **or**
   2. Anxiety Disorders Interview Schedule for Children (ADIS) Child and Parent Interview Schedules; **or**
   3. Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS); **or**
   4. Children's Interview for Psychiatric Syndromes (ChIPS) Child and Parent (P-ChIPS) Versions; **or**
   5. Diagnostic Interview Schedule for Children (DISC); **and**

M. If behavioral disturbance is suspected or confirmed, at least one of the following criteria are met (1.-3.):
   1. Validated rating scale completed by teacher(s); **or**
   2. Consultation with school personnel or other important persons in patient's life; **or**
   3. Direct observation of parent-child interactions or child in natural settings; **and**

N. All assessment activities have failed to answer the case-specific question.

Personality Assessment Inventory™ (PAI®)

IV. Psychological testing with the Personality Assessment Inventory™ (PAI®) may be considered **medically necessary and covered** when all of the following criteria are met (A.-L.):

A. Patient is at least 18 years of age; **and**
B. Psychological testing has been requested and a testing plan is in place; **and**
C. Clinical interview has been performed; **and**
D. Case-specific question has been formulated; **and**
E. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
F. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
G. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
H. At least one of the following criteria are met (1.-3.):
    1. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and **all** of the following criteria are met (a.-d.):
        a. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
        b. Patient psychiatric and medical history obtained; **and**
        c. Functional impairment and medical history explored; **and**
        d. Family psychiatric and medical history explored; **or**
    2. Behavioral prediction for judicial or correctional purposes; **or**
    3. Detection of malingering for disability adjudication or forensic purposes; **and**
I. At least one of the following criteria are met (1.-4.):
    1. Provider reviewed records of previous treatment or psychological testing; **or**
    2. Provider consulted with previous or current service provider; **or**
    3. Provider is unable to obtain this information despite at least 2 attempts; or
    4. No other psychiatric or substance use services provided to patient within last 2 years; **and**
J. At least one of the following structured or semi-structured interviews have been performed (1.-3.):
    1. Structured Clinical Interview for DSM Disorders (SCID)**; or**
    2. Mini-International Neuropsychiatric Interview (MINI)**; or**
    3. Schedule for Affective Disorders and Schizophrenia (SADS); **and**
K. In seeking collateral information from significant other or family members that

live with patient, at least one of the following criteria are met (1.-6.):

1. Interview at least 1 family member**; or**
2. All other adults in the home contacted and each refuses to participate; or
3. Contact with any other adult in the home contraindicated because abuse by family member suspected or confirmed**; or**
4. Contact with any other adult in the home contraindicated because family member cognitively impaired due to medical condition or persistent substance use or dementia**; or**
5. Patient refuses to allow significant other or family member involvement due to profound distrust or paranoia**; or**
6. Patient does not live with significant other or any adult family members**; and**

L. All assessment activities have failed to answer the case-specific question.

Unspecified Symptom Validity Test (SVT)

V. Psychological testing with the Unspecified Symptom Validity Test (SVT) may be considered **medically necessary and covered** when all of the following criteria are met (A.-H.):

A. Patient is at least 18 years of age; **and**
B. Psychological testing has been requested and a testing plan is in place; **and**
C. Clinical interview has been performed; **and**
D. Case-specific question has been formulated; **and**
E. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
F. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
G. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
H. Test is intended to detect malingering for disability adjudication or forensic purposes and both of the following criteria are met (1.-2.):
    1. No psychiatric disorder is evident and there is no uncertainty about differential diagnosis; **and**
    2. Lack of expected progress in evidence-based psychiatric or psychological treatment.

Unspecified Test

VI. Psychological testing with an unspecified test may be considered **medically necessary and covered** when all of the following criteria are met (A.-N.):

A. Psychological testing has been requested and a testing plan is in place; **and**
B. Clinical interview has been performed; **and**
C. Case-specific question has been formulated; **and**
D. Provider has documented what action will be taken or how treatment plan will be affected by testing results; **and**
E. Provider confirms that patient has the cognitive and language skills required for the proposed test; **and**
F. Provider confirms that any existing medical condition, substance use, psychotic features, or recent trauma do not contraindicate testing; **and**
G. Medical evaluation has been performed since onset of symptoms to rule out medical causes
H. At least one of the following criteria are met (1.-3.):
    1. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and all of the following criteria are met (a.-d.):
        a. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
        b. Patient psychiatric and medical history obtained; **and**
        c. Functional impairment and medical history explored; **and**
        d. Family psychiatric and medical history explored; **or**
    2. Behavioral prediction for judicial or correctional purposes; **or**
    3. Detection of malingering for disability adjudication or forensic purposes; **and**
I. Lack of expected progress in evidence-based psychiatric or psychological treatment, or psychiatric disorder is evident but there is uncertainty about differential diagnosis and all of the following criteria are met (1.-4.):
    1. At least 1 validated symptom inventory or rating scale administered to patient or caregiver; **and**
    2. Patient psychiatric and medical history obtained; **and**
    3. Functional impairment or report of internal distress; **and**
    4. Family psychiatric and medical history explored; **and**
J. At least one of the following criteria are met (1.-4.):
    1. Provider reviewed records of previous treatment or psychological testing; **or**
    2. Provider consulted with previous or current service provider; **or**
    3. Provider is unable to obtain this information despite at least 2 attempts; or
    4. No other psychiatric or substance use services provided to patient within last 2 years; **and**
K. One of the following criteria are met (1.-3.):

1. If patient is younger than 13 years of age, all of the following criteria are met (a.-c.):
    a. At least ONE parent or guardian has been interviewed; **and**
    b. To rule out medical causes, medical evaluation has been performed since the onset of symptoms to rule out medical causes via either of the following (i.-ii.)
        i. Provider performed physical examination and appropriate follow-up medical tests or imaging; **or**
        ii. Provider consulted with patient's physician or previous physicians.
    c. At least one of the following structured or semi-structured interviews has been performed (i.-v.):
        i. Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID); **or**
        ii. Anxiety Disorders Interview Schedule for Children (ADIS) Child and Parent Interview Schedules; **or**
        iii. Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS); **or**
        iv. Children's Interview for Psychiatric Syndromes (ChIPS) Child and Parent (P-ChIPS) Versions; **or**
        v. Diagnostic Interview Schedule for Children (DISC); **or**
2. If patient is between 13 and 18 years of age, both of the following criteria are met (a.-b.)
    a. At least one parent or guardian has been interviewed; **and**
    b. At least one of the following structured or semi-structured interviews has been performed (i.-iv.)
        i. Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID); **or**
        ii. Anxiety Disorders Interview Schedule for Children (ADIS) Child and Parent Interview Schedules; **or**
        iii. Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS); **or**
        Children's Interview for Psychiatric Syndromes (ChIPS) Child and Parent (P-ChIPS) Versions; **or**
        iv. Diagnostic Interview Schedule for Children (DISC); **or**
3. If patient is more than 18 years of age, at least one of the following structured or semi-structured interviews has been performed (a.-c.):
    a. Structured Clinical Interview for DSM Disorders (SCID); **or**
    b. Mini-International Neuropsychiatric Interview (MINI); **or**
    c. Schedule for Affective Disorders and Schizophrenia (SADS); **and**

L. In seeking collateral information from significant other or family members

that live with patient, at least one of the following criteria are met (1.-6.):

1. Interview at least 1 family member**; or**
2. All other adults in the home contacted and each refuses to participate; or
3. Contact with any other adult in the home contraindicated because abuse by family member suspected or confirmed**; or**
4. Contact with any other adult in the home contraindicated because family member cognitively impaired due to medical condition or persistent substance use or dementia**; or**
5. Patient refuses to allow significant other or family member involvement due to profound distrust or paranoia**; or**
6. Patient does not live with significant other or any adult family members**; and**

M. If behavioral disturbance is suspected or confirmed, at least one of the following criteria are met (1.-3.):

1. Validated rating scale completed by teacher(s); **or**
2. Consultation with school personnel or other important persons in patient's life; **or**
3. Direct observation of parent-child interactions or child in natural settings; **and**
4. All assessment activities have failed to answer the case-specific question.

Frequency Limits

VII. Billing of psychological testing (including evaluation, administration, scoring, and interpretation) in excess of 8 hours or more than once (1) per calendar year is subject to medical necessity review.

Non-Covered Testing

VIII. Non-computerized psychological testing is considered **not medically necessary and is not covered** when criteria I.-VI. above is not met, including, but not limited to the following:

A. Testing for any vocational or educational purposes
B. Return to sports or recreational activities assessment
C. Disability determination
D. General screening without symptoms of a neurologic disorder
E. Legal competency determination
F. Determining age-appropriate mental changes
G. Migraine headache
H. Mild cognitive impairment

I. Chronic fatigue syndrome
J. Baseline assessments in the absence of signs or symptoms

IX. Computerized psychological testing (CPT: 96146) is considered **not medically necessary and not covered** for the treatment of any indication.

Neuropsychological Testing

Non-computerized Neuropsychological Testing

X. The medical application of non-computerized neuropsychological testing may be considered **medically necessary and covered** when **all** of the following (A.-B.) criteria are met:

A. The patient meets **one or more** of the following (1.-3.) criteria:
1. Testing is required for the diagnosis of a neurologic disorder or injury (see note below for examples of disorders or injuries that may require neuropsychological testing); **or**
2. Testing is required to measure changes in functional impairment or disease progression (e.g., head injury, stroke, concussion); **or**
3. The patient has an established diagnosis of a neurologic disorder or injury and testing is required for the formulation of rehabilitation and/or management strategies; **and**

B. Neuropsychological testing is intended to alter patient management.

Note: Clinical *examples* of neurologic disorders or injuries that may require neuropsychological testing when the above criteria are met, include, but are not limited to:

1. Early, undifferentiated dementia (not age related)
2. Differential diagnosis of Alzheimer's disease, Pick's disease, Lewy body disease, etc.
3. Diseases of the brain, including tumors, malformations, demyelinating, and extrapyramidal disease
4. History of intracranial surgery
5. Cerebral anoxic or hypoxic event
6. Toxic, infectious, metabolic, or anoxic encephalopathy
7. Encephalitis or meningitis
8. Seizure disorders
9. Stroke or cerebral vascular injury (e.g., brain aneurysm, subdural hematoma)
10. Moderate or severe traumatic brain injury, including post-concussion syndrome

XI. Non-computerized neuropsychological testing is considered **not medically necessary and is not covered** when criterion X. above is not met, including, but not limited to the following:

A. Testing for any vocational or educational purposes
B. Return to sports or recreational activities assessment
C. Disability determination
D. General screening without symptoms of a neurologic disorder
E. Legal competency determination
F. Determining age appropriate mental changes
G. Migraine headache
H. Mild cognitive impairment
I. Chronic fatigue syndrome
J. Baseline assessments in the absence of signs or symptoms

Repeat Non-computerized Neuropsychological Testing

XII. Repeat non-computerized neuropsychological testing may be considered **medically necessary and is covered** when **all** of the following (A.-C.) criteria are met:

A. The initial test was completed within the last 12 months; **and**
B. Repeat testing is needed to measure changes in functional impairment or disease progression (e.g., head injury, stroke, concussion); **and**
C. Results of repeat neuropsychological testing will alter the patient's treatment plan.

XIII. Repeat non-computerized neuropsychological testing is considered **not medically necessary and is not covered** when criterion III. above is not met.

Frequency Limitation

XIV. Billing of neuropsychological testing (including evaluation, administration, scoring, and interpretation) in excess of 8 hours or more than once (1) per calendar year is subject to medical necessity review.

Computerized Neuropsychological Testing

XV. Computerized neuropsychological testing with computerized cognitive assessment systems is considered **not medically necessary and is not covered** for any indication**.**

Link to Evidence Summary

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

Non-computerized Neuropsychological Testing

Neuropsychological testing is a performance-based method to assess a patients cognitive functioning.[1] Testing can be used to examine the cognitive consequences of brain damage, brain disease, and severe mental illness. "There are several specific uses of neuropsychological assessment, including collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and functional recovery."[1] Neuropsychological evaluation involves a clinical interview along with the administration, scoring, and interpretation of assessments that objectively and quantitatively assess the functional integrity of the brain.

Computerized Neuropsychological Testing

Computerized cognitive assessment systems, such as MindStreams® Cognitive Health Assessment (Neuropteran); Cambridge Neuropsychological Testing Automated Battery (CANTAB); Alzheimer's, CANTAB ADHD; CANTAB's Core Cognition battery; CNS Vital Signs; MicroCog; and Computer-Administered Neuropsychological Screen for Mild Cognitive Impairment (CANS-MCI) are computerized cognitive testing systems for the assessment and treatment of cognitive health. "Computerized neurocognitive assessments have been deemed advantageous due to the ease of administration, ability for immediate scoring, and reported increases in test-retest reliability."[2]

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW

Non-Computerized Neuropsychological Testing

Neurologic disorders/injuries that may require neuropsychological testing:	Evidence:
Dementia, Alzheimer's disease, Lewy body disease, etc.	- A 2017 systematic review and meta-analysis by Belleville et al. found high sensitivity and specificity values for 61 neuropsychological tests; thus indicating a good predictive value of neuropsychological testing to detect the progression of mild cognitive impairment to Alzheimer's demention.[3] - In 2017, the Joint Program for Neurodegenerative Disease Work Group conducted a systematic review to evaluate the role of neuropsychological assessments in evaluating neurodegenerative dementias.[4] Neuropsychological testing was shown to aid in the differentiation of Alzheimer's dementia from dementia due to other causes (e.g., vascular disease). - In 2015, a study by Yoon et al. found that neuropsychological testing helped to predict conversion of mild cognitive impairment to dementia with Lewy bodies or Alzheimer's dementia.[5]
Traumatic brain injury (TBI)	- Historical and more recent studies support the clinical utility of neuropsychological testing in patients with traumatic brain injury.[6,7] These more recent studies indicate neuropsychological testing can aid in the classification of TBI (i.e., mild, moderate, severe) and help predict concurrent TBI symptoms.
Brain lesions, including tumors and malformations	- A 2017 study by Pranckeviciene et al. found that neuropsychological evaluation of brain tumor patients was predictive of cognitive impairments and psychological distress.[8] - A 2016 systematic review by Meskal et al. found that neuropsychological testing in meningioma patients resulted in the adequate diagnosis and treatment of cognitive deficits. The results also suggested that neuropsychological testing may lead to improved outcomes and quality of life in meningioma patients.[9] - Cochereau et al. found that patients with low-grade gliomas (LGG) have neuropsychological impairments, and neuropsychological testing in LGG patients can aid in the diagnosis of insidious cognitive deficits.[10]
Demyelinating diseases (e.g., multiple sclerosis)	- A 2018 study by von Bismarck et al. found a high prevalence of patients with early-stage multiple sclerosis had neuropsychological symptoms, and these symptoms were accurately diagnosed with neuropsychological testing.[11] - Ruet and Brochet (2018) found neuropsychological testing in patients with multiple sclerosis (MS) to be validated methods for evaluating and characterizing the extent and severity of cognitive impairment in MS patients.[12] - A 2016 systematic review by Vollmer et al. found an association between neuropsychological testing diagnosed cognitive decline and associated brain volume loss in MS patients.[13]

Encephalopathies	- A 2017 study by Moore et al. established the clinical utility of neuropsychological testing for diagnosing cognitive impairment in adults living with HIV/AIDS.[14] - A 2017 systematic review and meta-analysis by Burton et al. found that neuropsychological testing diagnosed ongoing specific cognitive impairments in post childhood acute disseminated encephalomyelitis.[15]
Epilepsy and seizure disorder	- A 2017 systematic review by Parra-Diaz and colleagues found that pre-surgical neuropsychological testing along with a functional MRI predict memory outcome after surgical treatment of refractory mesial temporal lobe epilepsy.[16] - In 2017, Grau-Lopez evaluated neuropsychological and clinical features in predicting seizure control in patients with mesial temporal epilepsy.[17] Neuropsychological testing identified moderate-severe cognitive impairment in patients with poor seizure control.
Neurotoxin exposure	- A 2016 study by Nascimento et al. demonstrated the clinical utility of neuropsychological testing for diagnosing neurotoxicity in children due to environmental exposure to manganese.[18]
Stroke	- Recent studies have demonstrated the clinical benefits of neuropsychological testing in post-stroke patients.[19,20] The early diagnosis of neurological and functional deficits may improve quality of life and the rehabilitative process in these patients.

Computerized Neuropsychological Testing

Systematic Reviews

- In 2017, Farnsworth et al. conducted a systematic review and meta-analysis to evaluate the reliability of computerized neurocognitive tests (CNTs) for concussion assessment.[21] The literature review identified 18 studies encompassing 2,674 patients. Of the CNTs evaluated, the proportion of acceptable outcomes was highest for the Axon Sports CogState Test (75%) and lowest for the ImPACT test (25%). The authors concluded that the Axon Sports CogState Test may be a reliable CNT; however, "future studies are needed to compare the diagnostic accuracy of these instruments."[21]

Nonrandomized Studies

- In 2017, Nelson 2017 et al. conducted a nonrandomized study to evaluate the reliability and validity of three computerized neurocognitive assessment tools (CNTs) for assessing mild traumatic brain injury (mTBI).[22] A total of 94 mTBI patients and matched trauma control (n=80) patients were recruited from an emergency department and given neurocognitive assessments within 72 hours of injury and at 15 and 45 days post-injury.
- The CNTs evaluated did not yield significant differences between patients with mTBI versus other injuries. Other measures (e.g., symptom scores) better differentiated groups than CNTs. The authors concluded that, "(n)onspecific injury factors, and other characteristics common in ED settings, likely

affect CNT performance across trauma patients as a whole and thereby diminish the validity of CNTs for assessing mTBI in this patient population."[22]

CLINICAL PRACTICE GUIDELINES

Non-computerized Neuropsychological Testing

American Academy of Neurology (AAN)

In 1996, the AAN published an evidence-based assessment of neuropsychological testing of adults.[23] The assessment indicated that neuropsychological testing in adults is most useful for the management and treatment of patients with suspected dementia, multiple sclerosis, Parkinson's disease, traumatic brain injury, stroke, and HIV encephalopathy. The authors also concluded that neuropsychological testing is useful in patients undergoing epilepsy surgery.

The 2010 AAN (reaffirmed in 2013) evidence-based practice parameter regarding the evaluation and management of driving risk in patients with dementia indicated there was inadequate or conflicting data to reach a conclusion regarding the clinical utility of neuropsychological testing or other interventions for drivers with dementia.[24]

The 2013 AAN evidence-based guideline for the evaluation and management of concussion in sports recommends the use of neuropsychological testing of memory performance, reaction time, and speed of cognitive processing to identify the presence of concussion.[25]

A 2018 AAN evidence-based practice guideline for mild cognitive impairment (MCI) concluded the following regarding neuropsychological testing to diagnose MCI:

"When screening or assessing for MCI, validated assessment tools should be used. Various instruments have acceptable diagnostic accuracy for detecting MCI, with no instrument being superior to another. Because brief cognitive assessment instruments are usually calibrated to maximize sensitivity rather than specificity, patients who test positive for MCI should then have further assessment (e.g., more in-depth cognitive testing, such as neuropsychological testing with interpretation based on appropriate normative data) to formally assess for this diagnosis."[26]

American Psychological Association (APA)

The 2012 evidence-based APA guidelines for the evaluation of dementia and age-related cognitive changes recommended the following:

- "Neuropsychological evaluation and cognitive testing remain the most effective differential diagnostic methods in discriminating pathophysiological dementia from age-related cognitive decline, cognitive difficulties that are depression related, and other related disorders. Even after reliable biological markers have been discovered, neuropsychological evaluation and cognitive testing will still be necessary to determine the onset of dementia, the functional expression of the

disease process, the rate of decline, the functional capacities of the individual, and hopefully, response to therapies.

- Comprehensive neuropsychological evaluations for dementia and cognitive change include tests of multiple cognitive domains, typically including memory, attention, perceptual and motor skills, language, visuospatial abilities, reasoning, and executive functions."[27]

American Psychiatric Association (APA)

The 2007 evidence-based APA guideline for the treatment of patients with Alzheimer's disease and other dementias recommends the following regarding neuropsychological testing:

"Neuropsychological testing may be helpful in a number of ways. It may help in deciding whether a patient with subtle or atypical symptoms actually has dementia as well as in more thoroughly characterizing an unusual symptom picture. It is particularly useful in the evaluation of individuals who present with mild cognitive impairment, which requires evidence of memory and/or other cognitive difficulties in the presence of intact functioning, and in the evaluation of individuals with the onset of dementia early in life. Testing may help to characterize the extent of cognitive impairment, to distinguish among the types of dementias, and to establish baseline cognitive function. Neuropsychological testing may also help identify strengths and weaknesses that could guide expectations for the patient, direct interventions to improve overall function, assist with communication, and inform capacity determinations."[28]

American Heart Association/American Stroke Association (AHA/ASA)

A 2016 evidence-based AHA/ASA guideline for adult stroke rehabilitation and recovery recommended the following regarding neuropsychological testing in post-stroke patients:

"A formal neuropsychological examination (including assessment of language, neglect, praxis, memory, emotional responses, and specific cognitive syndromes) may be helpful after the detection of cognitive impairment with a screening instrument. Neuropsychological protocols must be sensitive to a wide range of abilities, especially the assessment of executive and attentional functions."[29]

The guidelines go on to state that screening for cognitive deficits is recommended for all stroke patients before being discharged, and if deficits are identified a more detailed neuropsychological evaluation may be beneficial.

Computerized Neuropsychological Testing

American Psychological Association (APA)

The 2012 evidence-based APA guidelines for the evaluation of dementia and age-related cognitive changes stated the following regarding computerized neuropsychological testing:

"Technology assisted assessments (e.g., computer administered cognitive batteries, telehealth visits) are rapidly advancing, but appropriate psychometric properties and normative data are nascent. These technologies may have significant advantages for older persons with limited mobility or health care access but may also disadvantage older persons with limited experience and expertise interacting with technology."[27]

EVIDENCE SUMMARY

Evidence demonstrates the clinical validity and utility of non-computerized neuropsychological testing for diagnosing neurologic disorders or injuries. These neurologic disorders or injuries include, but are not limited to, dementia, Alzheimer's disease, traumatic brain injury, brain lesions, demyelinating diseases, encephalopathies, seizure disorders, neurotoxin exposure, and stroke. In addition, several evidence-based clinical practice guidelines recommend neuropsychological testing for the evaluation and treatment of neurologic disorders and injuries.

There is insufficient published evidence to establish the accuracy and clinical utility of computerized neuropsychological testing. Additional studies of good methodological quality are required to establish the validity of these neuropsychological assessment technologies.

BILLING GUIDELINES AND CODING

For all lines of business except Providence St. Joseph Health (except Providence St. Joseph Health Northern California):

- The CPT codes below will pay when paired with one of the diagnosis codes present in the Billing Guidelines Appendix below.
- Billing of psychological or neuropsychological testing (including evaluation, administration, scoring, and interpretation) in excess of 8 hours or more than once (1) per calendar year is subject to medical necessity review.

CODES*		
CPT	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, 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, [eg, 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)
	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, standardized instrument via electronic platform, with automated result only

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for

Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.

BILLING GUIDELINES APPENDIX

Psychological and neuropsychological testing may be considered medically necessary and covered when billed with any of the following ICD-10 codes:

E6601	F24	F309	F3163	F321
E662	F250	F310	F3164	F322
F0280	F251	F3110	F3170	F323
F0281	F258	F3111	F3171	F324
F200	F259	F3112	F3172	F325
F201	F28	F3113	F3173	F3281
F202	F29	F312	F3174	F3289
F203	F3010	F3130	F3175	F329
F205	F3011	F3131	F3176	F330
F2081	F3012	F3132	F3177	F331
F2089	F3013	F314	F3178	F332
F209	F302	F315	F3181	F333
F21	F303	F3160	F3189	F3340
F22	F304	F3161	F319	F3341
F23	F308	F3162	F320	F3342

F338	F40290	F438	F5000	F5222
F339	F40291	F439	F5001	F5231
F340	F40298	F440	F5002	F5232
F341	F408	F441	F502	F524
F3481	F409	F442	F5081	F525
F3489	F410	F444	F5082	F526
F349	F411	F445	F5089	F528
F39	F413	F446	F509	F529
F4000	F418	F447	F5101	F530
F4001	F419	F4481	F5102	F531
F4002	F422	F4489	F5103	F54
F4010	F423	F449	F5104	F550
F4011	F424	F450	F5105	F551
F40210	F428	F451	F5109	F552
F40218	F429	F4520	F5111	F553
F40220	F430	F4521	F5112	F554
F40228	F4310	F4522	F5113	F558
F40230	F4311	F4529	F5119	F59
F40231	F4312	F4541	F513	F600
F40232	F4320	F4542	F514	F601
F40233	F4321	F458	F515	F602
F40240	F4322	F459	F518	F603
F40241	F4323	F481	F519	F604
F40242	F4324	F482	F520	F605
F40243	F4325	F488	F521	F606
F40248	F4329	F489	F5221	F607

F6081	F66	F949	A5042	A871
F6089	F6810	F950	A5141	A872
F609	F6811	F951	A5213	A878
F630	F6812	F952	A5214	A879
F631	F6813	F958	A5481	A9231
F632	F688	F959	A6921	B003
F633	F68A	F980	A811	B004
F6381	F69	F981	A830	B010
F6389	F900	F9821	A831	B020
F639	F901	F9829	A832	B021
F640	F902	F983	A833	B050
F641	F908	F984	A834	B051
F642	F909	F985	A835	B0601
F648	F910	A0101	A836	B0602
F649	F911	A0221	A838	B1001
F650	F912	A170	A839	B1009
F651	F913	A1782	A840	B261
F652	F918	A203	A841	B262
F653	F919	A2781	A848	B2702
F654	F930	A3211	A849	B2712
F6550	F938	A3212	A850	B2782
F6551	F939	A390	A851	B2792
F6552	F940	A3981	A852	B375
F6581	F941	A4281	A858	B384
F6589	F942	A4282	A86	B4081
F659	F948	A5041	A870	B5741

B5742	F23	F314	F3289	F40230
B582	F24	F315	F329	F40231
B6011	F250	F3160	F330	F40232
B941	F251	F3161	F331	F40233
C710	F258	F3162	F332	F40240
C711	F259	F3163	F333	F40241
C712	F28	F3164	F3340	F40242
C713	F29	F3170	F3341	F40243
C714	F3010	F3171	F3342	F40248
C715	F3011	F3172	F338	F40290
C716	F3012	F3173	F339	F40291
C717	F3013	F3174	F340	F40298
C718	F302	F3175	F341	F408
C719	F303	F3176	F3481	F409
D8681	F304	F3177	F3489	F410
E701	F308	F3178	F349	F411
F200	F309	F3181	F39	F413
F201	F310	F3189	F4000	F418
F202	F3110	F319	F4001	F419
F203	F3111	F320	F4002	F422
F205	F3112	F321	F4010	F423
F2081	F3113	F322	F4011	F424
F2089	F312	F323	F40210	F428
F209	F3130	F324	F40218	F429
F21	F3131	F325	F40220	F430
F22	F3132	F3281	F40228	F4310

F4311	F8082	G042	G40219	G40911
F4312	F8089	G0430	G40301	G40919
F4320	F809	G0431	G40309	G40A01
F4321	F840	G0432	G40311	G40A09
F4322	F900	G0439	G40319	G40A11
F4323	F901	G0481	G40401	G40A19
F4324	F902	G0489	G40409	G40B01
F4325	F908	G0490	G40411	G40B09
F4329	F909	G0491	G40419	G40B11
F438	G000	G053	G40501	G40B19
F439	G001	G054	G40509	G800
F440	G002	G10	G40801	G801
F441	G003	G300	G40802	G802
F442	G008	G3184	G40803	G803
F444	G009	G35	G40804	G804
F445	G01	G40001	G40811	G808
F446	G02	G40009	G40812	G809
F447	G030	G40011	G40813	G910
F4481	G031	G40019	G40814	G911
F4489	G032	G40101	G40821	G912
F449	G038	G40109	G40822	G913
F800	G039	G40111	G40823	G914
F801	G0400	G40119	G40824	G918
F802	G0401	G40201	G4089	G919
F804	G0402	G40209	G40901	G931
F8081	G041	G40211	G40909	G9349

I6300	I63219	I63411	I63531	P0725
I63011	I6322	I63412	I63532	P0726
I63012	I63231	I63413	I63533	P0730
I63013	I63232	I63419	I63539	P0731
I63019	I63233	I63421	I63541	P0732
I6302	I63239	I63422	I63542	P0733
I63031	I6329	I63423	I63543	P0734
I63032	I6330	I63429	I63549	P0735
I63033	I63311	I63431	I6359	P0736
I63039	I63312	I63432	I636	P0737
I6309	I63313	I63433	I6381	P0738
I6310	I63319	I63439	I6389	P0739
I63111	I63321	I63441	I639	Q040
I63112	I63322	I63442	I69391	Q041
I63113	I63323	I63443	P0700	Q042
I63119	I63329	I63449	P0701	Q043
I6312	I63331	I6349	P0702	Q044
I63131	I63332	I6350	P0703	Q045
I63132	I63333	I63511	P0710	Q046
I63133	I63339	I63512	P0714	Q048
I63139	I63341	I63513	P0715	Q049
I6319	I63342	I63519	P0720	Q8501
I6320	I63343	I63521	P0721	Q8711
I63211	I63349	I63522	P0722	Q8719
I63212	I6339	I63523	P0723	Q9351
I63213	I6340	I63529	P0724	Q992

R410	S061X0S	S062X0S	S06300S	S06310S
R411	S061X1A	S062X1A	S06301A	S06311A
R412	S061X1D	S062X1D	S06301D	S06311D
R413	S061X1S	S062X1S	S06301S	S06311S
R414	S061X2A	S062X2A	S06302A	S06312A
R4181	S061X2D	S062X2D	S06302D	S06312D
R4182	S061X2S	S062X2S	S06302S	S06312S
R4183	S061X3A	S062X3A	S06303A	S06313A
R41840	S061X3D	S062X3D	S06303D	S06313D
R41841	S061X3S	S062X3S	S06303S	S06313S
R41842	S061X4A	S062X4A	S06304A	S06314A
R41843	S061X4D	S062X4D	S06304D	S06314D
R41844	S061X4S	S062X4S	S06304S	S06314S
R4189	S061X5A	S062X5A	S06305A	S06315A
R419	S061X5D	S062X5D	S06305D	S06315D
S060X0A	S061X5S	S062X5S	S06305S	S06315S
S060X0D	S061X6A	S062X6A	S06306A	S06316A
S060X0S	S061X6D	S062X6D	S06306D	S06316D
S060X1A	S061X6S	S062X6S	S06306S	S06316S
S060X1D	S061X7A	S062X7A	S06307A	S06317A
S060X1S	S061X8A	S062X8A	S06308A	S06318A
S060X9A	S061X9A	S062X9A	S06309A	S06319A
S060X9D	S061X9D	S062X9D	S06309D	S06319D
S060X9S	S061X9S	S062X9S	S06309S	S06319S
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S061X0D	S062X0D	S06300D	S06310D	S06320D

S06320S	S06330S	S06340S	S06350S	S06360S
S06321A	S06331A	S06341A	S06351A	S06361A
S06321D	S06331D	S06341D	S06351D	S06361D
S06321S	S06331S	S06341S	S06351S	S06361S
S06322A	S06332A	S06342A	S06352A	S06362A
S06322D	S06332D	S06342D	S06352D	S06362D
S06322S	S06332S	S06342S	S06352S	S06362S
S06323A	S06333A	S06343A	S06353A	S06363A
S06323D	S06333D	S06343D	S06353D	S06363D
S06323S	S06333S	S06343S	S06353S	S06363S
S06324A	S06334A	S06344A	S06354A	S06364A
S06324D	S06334D	S06344D	S06354D	S06364D
S06324S	S06334S	S06344S	S06354S	S06364S
S06325A	S06335A	S06345A	S06355A	S06365A
S06325D	S06335D	S06345D	S06355D	S06365D
S06325S	S06335S	S06345S	S06355S	S06365S
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S06326D	S06336D	S06346D	S06356D	S06366D
S06326S	S06336S	S06346S	S06356S	S06366S
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S06328A	S06338A	S06348A	S06358A	S06368A
S06329A	S06339A	S06349A	S06359A	S06369A
S06329D	S06339D	S06349D	S06359D	S06369D
S06329S	S06339S	S06349S	S06359S	S06369S
S06330A	S06340A	S06350A	S06360A	S06370A
S06330D	S06340D	S06350D	S06360D	S06370D

S06370S	S06380S	S064X0S	S066X0S	S06810S
S06371A	S06381A	S064X1A	S066X1A	S06811A
S06371D	S06381D	S064X1D	S066X1D	S06811D
S06371S	S06381S	S064X1S	S066X1S	S06811S
S06372A	S06382A	S064X2A	S066X2A	S06812A
S06372D	S06382D	S064X2D	S066X2D	S06812D
S06372S	S06382S	S064X2S	S066X2S	S06812S
S06373A	S06383A	S064X9S	S066X3A	S06813A
S06373D	S06383D	S065X3D	S066X3D	S06813D
S06373S	S06383S	S065X3S	S066X3S	S06813S
S06374A	S06384A	S065X4A	S066X4A	S06814A
S06374D	S06384D	S065X4D	S066X4D	S06814D
S06374S	S06384S	S065X4S	S066X4S	S06814S
S06375A	S06385A	S065X5A	S066X5A	S06815A
S06375D	S06385D	S065X5D	S066X5D	S06815D
S06375S	S06385S	S065X5S	S066X5S	S06815S
S06376A	S06386A	S065X6A	S066X6A	S06816A
S06376D	S06386D	S065X6D	S066X6D	S06816D
S06376S	S06386S	S065X6S	S066X6S	S06816S
S06377A	S06387A	S065X7A	S066X7A	S06817A
S06378A	S06388A	S065X8A	S066X8A	S06818A
S06379A	S06389A	S065X9A	S066X9A	S06819A
S06379D	S06389D	S065X9D	S066X9D	S06819D
S06379S	S06389S	S065X9S	S066X9S	S06819S
S06380A	S064X0A	S066X0A	S06810A	S06820A
S06380D	S064X0D	S066X0D	S06810D	S06820D

S06820S	S06826D	S06893D	S069X0D	S069X6A
S06821A	S06826S	S06893S	S069X0S	S069X6D
S06821D	S06827A	S06894A	S069X1A	S069X6S
S06821S	S06828A	S06894D	S069X1D	S069X7A
S06822A	S06829A	S06894S	S069X1S	S069X8A
S06822D	S06829D	S06895A	S069X2A	S069X9A
S06822S	S06829S	S06895D	S069X2D	S069X9D
S06823A	S06890A	S06895S	S069X2S	S069X9S
S06823D	S06890D	S06896A	S069X3A	Z01818
S06823S	S06890S	S06896D	S069X3D	Z77010
S06824A	S06891A	S06896S	S069X3S	Z77011
S06824D	S06891D	S06897A	S069X4A	Z77012
S06824S	S06891S	S06898A	S069X4D	Z77018
S06825A	S06892A	S06899A	S069X4S	Z77098
S06825D	S06892D	S06899D	S069X5A	Z87820
S06825S	S06892S	S06899S	S069X5D	Z982
S06826A	S06893A	S069X0A	S069X5S	Z98890