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**

Psychological Testing

I. Psychological testing may be considered **medically necessary** when both of the following criteria are met (A.-B.):

A. The psychological test is administered, scored, and interpreted by a trained professional (e.g. clinical psychologist, psychologist, advanced nurse practitioner with education in this area, or a physician assistant who works with a psychiatrist with expertise in the appropriate area); and

B. Psychological testing is intended for any of the following (1.-4.):

1. To assist with diagnosis and management following clinical findings where a mental illness or psychological abnormality is suspected; or
2. To provide a differential diagnosis from a range of neurological/psychological disorders that present with constellations of symptoms (e.g. differentiation between pseudodementia and depression); or
3. To determine the clinical and functional significance of a brain abnormality; or
4. To delineate the specific cognitive basis of functional complaints.

II. Psychological testing is considered **not medically necessary** when criterion I. above is not met, including but not limited to any of the following:

*Frequency Limits*

III. 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

IV. Psychological testing is considered not medically necessary when criterion I. above is not met, including, but not limited to the following:

A. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process;
B. Used as screening tests given to the individual or to general populations;
   • Note: This policy does not address the use of standardized screening tools in primary care and other settings (e.g. Patient Health Questionnaire-9, Generalized Anxiety Disorder-7), as these are not considered psychological testing services.
C. Performed when abnormalities of brain function are not suspected;
D. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized) (e.g., AIMS, Folstein Mini-Mental Status Examination);
E. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy);
F. Administered when the patient has a substance abuse background and the patient has ongoing substance abuse such that test results would be inaccurate, or the patient is currently intoxicated;
G. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer’s diseases and there is no expectation that the testing would impact the patient's medical management.
H. Testing for any vocational or educational purposes
I. Return to sports or recreational activities assessment
J. Disability determination
K. General screening without symptoms of a neurologic disorder
L. Legal competency determination
M. Determining age-appropriate mental changes
N. Migraine headache
O. Mild cognitive impairment
P. Chronic fatigue syndrome
Q. Baseline assessments in the absence of signs or symptoms

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

Neuropsychological Testing

Non-computerized Neuropsychological Testing
VI. The medical application of non-computerized neuropsychological testing may be considered **medically necessary** 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:

A. Early, undifferentiated dementia (not age related)
B. Differential diagnosis of Alzheimer's disease, Pick's disease, Lewy body disease, etc.
C. Diseases of the brain, including tumors, malformations, demyelinating, and extrapyramidal disease
D. History of intracranial surgery
E. Cerebral anoxic or hypoxic event
F. Toxic, infectious, metabolic, or anoxic encephalopathy
G. Encephalitis or meningitis
H. Seizure disorders
I. Stroke or cerebral vascular injury (e.g., brain aneurysm, subdural hematoma)
J. Moderate or severe traumatic brain injury, including post-concussion syndrome

VII. Non-computerized neuropsychological testing is considered **not medically necessary** 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*

VIII. 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.

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

**Frequency Limitation**

**X.** 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**

**XI.** Computerized neuropsychological testing with computerized cognitive assessment systems is considered **not medically necessary** 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**

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidance resources:

- Local Coverage Document, Psychological and Neuropsychological Testing ([L34646](#))

**DOCUMENTATION REQUIREMENTS**

- The medical record and assessment report should document the diagnosis and treatment recommendations.
- The patient’s medical record should contain documentation that fully supports the medical necessity for testing performed. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation should include the following information:
• Any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction
• The initial clinical findings that determine the need for testing
• The types of testing indicated
• The time involved and whether this is initial testing or follow-up
• Previous testing by the same or different provider, and efforts to obtain previous test results performed
• The test(s) administered, scoring and interpretation, treatment recommendations

• Documentation should be legible, signed, and maintained in the patient’s medical record.
• If the total time for the tests exceeds eight hours, a report may be requested asking for the medical necessity of the extended testing.
• The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report that will be given to the referring provider.

BACKGROUND

Psychological Testing

A psychological test is an instrument designed to measure unobserved constructs, also known as latent variables. Psychological tests are typically, but not necessarily, a series of tasks or problems that the respondent has to solve. Psychological tests can strongly resemble questionnaires, which are also designed to measure unobserved constructs, but differ in that psychological tests ask for a respondent’s maximum performance whereas a questionnaire asks for the respondent’s typical performance. A useful psychological test must be both valid (i.e., there is evidence to support the specified interpretation of the test results) and reliable (i.e., internally consistent or give consistent results over time, across raters, etc.).

Non-computerized Neuropsychological Testing

Neuropsychological testing is a performance-based method to assess a patient’s cognitive functioning. 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.” 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 (Neuopteran); 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.”

### 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**

<table>
<thead>
<tr>
<th>Neurologic disorders/injuries that may require neuropsychological testing:</th>
<th>Evidence:</th>
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| 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 dementia. 
- 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. 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.
| Traumatic brain injury (TBI) | - Historical and more recent studies support the clinical utility of neuropsychological testing in patients with traumatic brain injury. 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.
- 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.\textsuperscript{10} 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.\textsuperscript{11}

### 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.\textsuperscript{12}
- 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.\textsuperscript{13}
- 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.\textsuperscript{14}

### 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.\textsuperscript{15}
- 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.\textsuperscript{16}

### 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.\textsuperscript{17}
- In 2017, Grau-Lopez evaluated neuropsychological and clinical features in predicting seizure control in patients with mesial temporal epilepsy.\textsuperscript{18} 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.\textsuperscript{19}

### Stroke

- Recent studies have demonstrated the clinical benefits of neuropsychological testing in post-stroke patients.\textsuperscript{20,21} 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.\textsuperscript{22} 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.”

Nonrandomized Studies

- In 2017, Nelson 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). 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.”

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. 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.

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.

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.”

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.”

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.”

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.”
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.”

**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.
- This policy does not address the use of standardized screening tools in primary care and other settings (e.g. Patient Health Questionnaire-9, Generalized Anxiety Disorder-7) that may be billed with CPT 96160, as these are not considered psychological testing services.
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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.

REFERENCES
17. Parra-Diaz P, Garcia-Casares N. Memory assessment in patients with temporal lobe epilepsy to predict memory impairment after surgery: A systematic review. *Neurologia (Barcelona, Spain)*. 2017


**POLICY REVISION HISTORY**

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**BILLING GUIDELINES APPENDIX**

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

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