MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Psychological Testing**
Policy Number	**3.01.02**
Category	**Contract Clarification**
Original Effective Date	**10/18/01**
Committee Approval Date	**03/28/02, 03/27/03, 02/26/04, 04/28/05, 06/22/06, 08/23/07, 06/26/08, 06/25/09, 08/26/10, 08/25/11, 08/23/12, 08/22/13, 06/26/14, 06/25/15, 08/25/16, 08/25/17, 08/23/18, 10/24/19, 10/22/20, 12/16/21, 04/21/22, 12/22/22, 12/21/23, 12/19/24**
Current Effective Date	**12/19/24**
Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, psychological testing has been medically proven to be effective and, therefore, is considered **medically appropriate** when **ALL** of the following are met:
   A. Testing is recommended by a licensed behavioral health provider;
   B. When the referring provider has documented a persistent diagnostic question after a thorough evaluation has been conducted. Thorough evaluations include interviews, review of medical records, consultation with other treating providers, and collateral interviews when appropriate.
   C. Testing results are expected to generate necessary information to impact the member's care and treatment.

II. Based upon our criteria and assessment of the peer-reviewed literature, psychological testing to aid in diagnosing an intellectual disability is considered **medically appropriate** when **BOTH** of the following are met:
   A. A diagnostic question remains following a thorough evaluation and recommendation by the treating medical provider;
   B. The testing results are expected to generate necessary information to impact the member's care and treatment.

III. Based upon our criteria and assessment of the peer-reviewed literature, pre-surgical psychological testing has been medically proven to be effective and, therefore, is considered **medically appropriate** when **ALL** of the following are met:
   A. Testing is recommended by a licensed behavioral health provider;
   B. Standardized, validated testing is needed to evaluate preparedness for surgical intervention or psychosocial factors that may affect successful outcomes.
   C. Testing results are expected to generate necessary information to impact the member's care and treatment.

IV. Based upon our criteria and assessment of the peer-reviewed literature, the routine use of psychological testing as part of an initial assessment has not been proven to be effective and, therefore, is considered **not medically necessary** for **ANY** of the following indications, as more suitable approaches are available (e.g., interview):
   A. Attention-deficit/hyperactivity disorder (ADHD);
   B. Tourette's syndrome;
   C. Autism spectrum disorder (ASD);
   D. Complex medical condition (e.g., chronic pain).

V. Psychological testing is considered **not medically necessary** if it has been performed in the last 12 months.

VI. Psychological testing is **ineligible for coverage** when the testing is primarily for the purpose of non-treatment-related requests (e.g., custody evaluations, parenting assessments, court ordered requests) or service eligibility issues (e.g., vocational aptitude or educational services, renewal of services for a person who has well-documented decreased cognition/IQ).

Refer to Corporate Medical Policy #2.01.50 Neuropsychological Testing

POLICY GUIDELINES

I. Preauthorization is contract dependent.

II. Psychological tests are only one (1) element of a psychological assessment and should never be used alone as the sole basis for a diagnosis. All the following documentation is required to determine medical necessity and the requesting provider should submit these records within 30 days of the diagnostic evaluation.
   A. Detailed description of the diagnostic question from the referring provider (e.g., overlapping behavioral health symptoms leading to diagnostic uncertainty); and
   B. A copy of the initial diagnostic evaluation with the patient, including review of the patient's relevant history (e.g., developmental, psychological, medical, educational), collateral interviews, and behavioral observation when applicable.

III. A complete psychological evaluation with test batteries including administration, scoring and interpretation, generally takes between two and eight hours to complete. Occasionally, it is necessary to complete the evaluation over two or more sessions. Requests for more than eight hours of testing will require a detailed list of the testing battery and rationale for the extended time. The medical record must include supporting documentation to justify more than eight hours per patient per evaluation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight hours, medical necessity for extended time should be documented. Medical records may be requested.

IV. Psychological testing performed as simple, self-administrated or self-scored inventories, or screening tests such as, but not limited to, AIMS, Folstein Mini-Mental Status Exam, PHQ-9, Hamilton Rating Scale for Depression, Connors Rating Scale, Eat-26, Quotient ADHD System, are considered inclusive of an Evaluation and Management service. In addition, brief emotional/behavioral assessments are not covered as psychological testing. Likewise, tests that are patient-completed tools or that are administered by ancillary staff in an office (e.g., PHQ-2, PHQ-9, MAST, CAGE, AUDIT, ORT, and Pain scale) are not considered psychological testing and should not be billed utilizing these codes.

V. A single psychological test is appropriate when it is combined with other rating scales and the clinical interview for pre-surgical psychological testing (e.g., Minnesota Multiphasic Personality Inventory [MMPI] or Million Behavioral Medicine Diagnostic [MBMD]). Otherwise, a single, stand-alone test, even a multi-faceted one, does not constitute a psychological evaluation service. At least two validated psychological tests are required to bill for psychological testing for the purposes of diagnostic clarification. Psychological testing may include, but is not limited to, the following: Minnesota Multiphasic Personality Inventory-2 or -3 (MMPI-2 or -3), Minnesota Multiphasic Personality Inventory-A (MMPI-A), Wechsler Adult Intelligence Scale-Revised (WAIS-III/IV), Personality Assessment Inventory (PAI), and Rorschach Inkblot Method.

VI. Coverage is not available for services provided by school districts for pre-school-aged children (three to five years) and school-aged children (five to 21 years), as they are considered free care.
   A. When applicable, in accordance with applicable state and federal rules, members should have a committee on special education evaluation completed through the school district before a request for coverage is submitted to the Health Plan. Documentation should be provided demonstrating the evaluation and results, and the timing of any testing associated with the evaluation.
   B. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for services for home-schooled children outside New York State will be reviewed on an individual basis in accordance with state regulations for the state in which the child lives.
   C. Psychological testing that is denied by the school district will be reviewed by the Health Plan for medical necessity in accordance with the member's subscriber contract.

VII. Psychological testing requires a clinically trained examiner. All psychological tests should be administered, scored, and interpreted by a trained professional, preferably a psychologist or psychiatrist with expertise in the appropriate area. The interpretation and written report should be completed by the psychologist. These services are all-inclusive in the number of hours authorized.

VIII. Compared to clinical interviews, psychological testing has not been found to reliably improve diagnostic accuracy of ADHD.

IX. For diagnosing a neurodevelopmental disorder, developmental testing codes may be appropriate when a diagnosis is unable to made by other methods (e.g., standardized parent interviews or direct, structured behavioral observation).

X. The number of hours requested includes the total time necessary to complete administration of two or more tests, scoring, interpretation, clinical decision-making, treatment-planning, and report, as well as interactive feedback to the patient, family member(s) or caregiver(s). The proposed time for test administration and scoring of the selected tests may not exceed the administration time established by the test's publishers, plus appropriate time to score. A request for additional test administration time may be considered medically necessary when supported by evidence of extenuating circumstances that is submitted by the provider. Examples of extenuating circumstances include the following:
   A. The patient has significant functional impairment, for example:
      1. Sensory deficits and/or physical disabilities that necessitate modification in standard administration procedures.
      2. Severe oppositional behavior.
      3. Attention deficits or an intellectual developmental disability (intellectual disability) that require the examiner to provide frequent redirection and/or breaks for the patient during testing.

      *****Note: Testing should not be conducted if extenuating circumstances such as these are so severe that it could reasonably pose a threat to the reliability or validity of test results.
   B. The patient has an intellectual disability.
   C. The patient requires an interpreter, as English is not the patient's primary language.

DESCRIPTION

Psychological tests, also known as psychometric tests, are standardized instruments that are used to measure behavior or mental attributes. These attributes may include attitudes, emotional functioning, intelligence and cognitive abilities, aptitude, personality characteristics, and to evaluate mental health (e.g., psychological functioning or signs of psychological or neurological disorders) (APA, 2022).

Tests include standardized aptitude and achievement instruments, diagnostic and evaluative devices, interest inventories, personality inventories, and projective instruments. Psychological test administration and scoring is the formal process of administering reliable and validated tests selected by the trained professional according to standardized test manual instructions and scoring the respondent's answers to test items.

The APA Guidelines (2020) indicates individual performance on psychological tests is only one piece of assessment and is conceptualized in a context of presenting concerns (e.g., reason for referral, background, course of illness, influential factors, and population-specific contributions) that are secured from multiple sources. These may include clinical interview with the examinee, clinical interview with sources other than the examinee, completion of valid self-report and third-party report measures, observation of behavior, and review of relevant records. The more information gathered prior to the testing, assessment, or evaluation and an understanding of these characteristics or variables should assist in selecting a reliable and valid test or instrument to use among the myriad ones available commercially or in research.

Advances in technology have impacted the field of psychological assessment, including the real-time role-play simulations, virtual reality exercises. The QbTest is a 20-minute test that has received approval from the United States Food and Drug Administration (FDA) for use in conjunction with a clinical assessment, to provide clinicians with objective measures of hyperactivity, impulsivity, and inattention to aid in the clinical assessment of ADHD. The test involves infrared motion-tracking to measure activity, and results are interpreted by qualified professionals. The Quotient ADHD System is a computerized test that measures hyperactivity, inattention, and impulsivity. After completion of the approximately 30-minute, self-administered test, patterns of motion, accuracy of the responses, and fluctuation in attention state are analyzed and scored using proprietary algorithms. The patient's scores are then compared to those of other individuals of the same age and gender, to aid in the clinical assessment of ADHD. The Test of Variables of Attention (TOVA) received Food & Drug Administration (FDA) 501(k) premarket clearance in 2018. TOVA is a culture- and language-free, sufficiently long computerized test that requires no left/right discrimination or sequencing. The computer-based test provides healthcare professionals with objective measurements of attention and inhibitory control. Results should only be interpreted by qualified professionals.

Presurgical psychological assessment (PPA) is to provide recommendations to both the surgical team and the patient addressing how psychosocial factors may affect surgical outcomes. If adverse factors are identified, psychologists work with the patient and the medical team to develop presurgical treatment interventions and recommendations, recommend postsurgical follow-ups, or discuss whether surgery is the best treatment option at that time (Marek and Block 2023).

RATIONALE

Psychological testing has proven to be beneficial in a variety of ways. The objective information that is produced is helpful in accurately diagnosing the nature of a patient's problem, but also in developing recommendations and strategies to address the problem.

Psychological testing beyond a standard parent interview and direct structured behavioral observation is rarely needed for diagnosing autism, according to the practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder from the American Academy of Child & Adolescent Psychiatry.

Patients who have complex medical conditions or who are contemplating a complex surgical procedure such as bariatric surgery may require a psychological/psychiatric evaluation to determine an underlying psychopathology that could hinder treatment plans. A standard psychiatric evaluation provides a sufficient assessment in many instances, without the need for the complete test battery involved in psychological testing. The pre-surgical evaluation process is designed to optimize surgical outcomes and implement interventions that can address disordered eating, severe uncontrolled mental illness, or active substance abuse. A multidisciplinary team can help assess and manage the patient's modifiable risk factors with a goal of reducing risk of perioperative complications and improving outcomes; the decision for surgical readiness should be primarily determined by the surgeon (Eisenberg et al., 2023).

In general, attention deficit disorders are best diagnosed using structured diagnostic interviews, involving a careful history including whenever possible, collateral information. Dimensionally based rating scales may be used as an adjunct.

The American Academy of Pediatrics (AAP) published updated clinical practice guidelines for the diagnosis, evaluation, and treatment of ADHD in children and adolescents stating there is evidence that appropriate diagnosis can be accomplished in the primary care setting for children and adolescents. The pediatrician or primary care provider should initiate an evaluation for ADHD for any child or adolescent age 4 years to the 18th birthday who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity. To make a diagnosis of ADHD the

provider should determine that DSM-5 criteria have been met and should rule out any alternative causes (Grade B: strong recommendation). Appropriate further assessment is indicated if an underlying etiology is suspected.

According to a guidance from National Institute for Health and Care Excellus (NICE, 2019), a diagnosis of ADHD should only be made by a specialist psychiatrist, pediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of a full clinical and psychosocial assessment that should include discussion about behavior and symptoms in the different domains and settings of the person's everyday life, a full developmental and psychiatric history, and observer reports and assessment of the person's mental state. Rating scales are valuable adjuncts, and observations (e.g., at school) are useful when there is doubt about symptoms.

Pre-Surgical Psychological Testing

The American Society of Metabolic and Bariatric Surgery (ASMBS) published several consensus statements supporting a multidisciplinary team evaluation of patient to optimize surgical outcomes including:

- Comprehensively evaluating patients seeking metabolic and bariatric surgery through assessment of psychosocial history (e.g., functioning, substance use, maladaptive eating patterns), lifestyle/nutritional evaluation (e.g., sleep hygiene, smoking, healthy eating index) (Carter et al., 2021; Mechanick et al., 2019).
- Management of modifiable risk factors prior to elective surgery, with the goal of reducing the risk of perioperative complications and improving outcomes, by making proactive referrals to specialists to mitigate identified risks and to coordinate pre- and post-surgical care (Sogg et al., 2016).
- Pre-surgical evaluation process to optimize surgical outcomes and implement interventions that can address disordered eating, severe uncontrolled mental illness, or active substance abuse (Eisenberg et al., 2022).

In 2023, the American Psychological Association published evidence-based procedures and practices, divided into 14 indication-specific chapters related to psychological assessment of surgical candidates (Marek and Block, eds. 2023). Chapter 4 examines psychopathology that is commonly assessed among bariatric surgery patients (mood disorders, eating disorders, anxiety disorders, substance use disorder, and cognitive functioning), how these factors are associated with poorer outcomes, and provides recommendations to mitigate risk factors (e.g., broadband and narrowband assessments such as the Minnesota Multiphasic Personality Inventory [MMPI] Restructured Form) (Diggins and Peterson, 2023). Chapter 5 reviews the best available research evidence for the use of PPA in spine surgery interventions. Acknowledging the lack of a standard approach to conducting PPAs for spine surgeries, the authors suggest a risk identification and mitigation (RIM) model, which includes psychometric testing to identify objective psychosocial risk factors that been empirically linked to a full range of surgical outcomes (Murray et al., 2023).

Marek et al. (2024) sought to add to the body of literature that suggest that the updated version of the Minnesota Multiphasic Personality Inventory (MMPI), the MMPI-3, is a psychometrically sound instrument for the use in preoperative psychological assessment of patients seeking metabolic and bariatric surgery (MBS). A sample of 790 consecutive patients completed a preoperative psychological evaluation and took the MMPI-3. The MMPI-3 scale scores demonstrated good convergent and discriminant validity. For instance, the Emotional/Internalizing Dysfunction scales correlated with depression and anxiety disorder, suicide history, sexual abuse history, psychotropic medication use, and eating behaviors. Behavioral/Externalizing Dysfunction scales correlated with alcohol, nicotine, and substance use and eating behaviors such as loss-of-control overeating. The Eating Concerns scale demonstrated the highest correlational patterns with various eating behaviors such as loss-of-control overeating, binge eating, and stress eating. In addition to good convergent validity, the MMPI-3 scale scores demonstrate good discriminant validity, and this suggests that the scale scores of the MMPI-3 are good measures of the sole constructs that they intend to measure. The authors concluded that this investigation indicates that MMPI-2-RF research findings generalize to use of the updated MMPI-3 in evaluations of patients seeking MBS and that newly added MMPI-3 scales provide additional MBS-relevant data.

Walter et al. (2024) conducted a retrospective review of archival data for 279 patients who were psychologically screened for eligibility for bariatric surgery. The authors sought to replicate and further clarify psychological variables associated with not moving forward with bariatric surgery in a sample of patients who had equivocal access to healthcare. The study compared the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) profiles of bariatric

surgery candidates who did versus did not move forward with surgery. Results suggest that most bariatric surgery candidates will show variability and elevations in certain scale domains, but that the pattern of these elevations does not systematically differ between patient groups who do and do not undergo bariatric surgery. Differences were evident between groups on MMPI-2-RF validity scales with regard to whether or not candidates underwent bariatric surgery. Those who did not undergo surgery had higher scores on two scales measuring the validity of reported psychological and cognitive concerns (i.e., Infrequent Responses and Response Bias scales). On clinical domains, those who did not have surgery had higher scores on a scale measuring thought dysfunction, which encompasses a variety of symptoms related to disordered thinking (e.g., paranoia). Patients who did not have surgery also had higher scores on scales that measure blaming others for difficulties, lacking insight, having interpersonal difficulties due to suspiciousness or mistrustfulness, and engaging in unrealistic thinking (i.e., Ideas of Persecution, Aberrant Experiences, Psychoticism). Finally, higher scores were also observed on scales measuring cynicism, feelings of hopelessness and helplessness, complaints about physical health problems, and neurologically-based complaints (e.g., feeling weak, dizzy, or losing balance) in those who did not move forward with surgery.

Kenfack et al. (2022) retrospective, single-center study on 70 participants who completed the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) and the Patient-Reported Outcomes Measurement Information System-29 (PROMIS-29) survey prior to spinal surgery. The authors report that it has been well established that psychological comorbidities have been linked to poor preoperative status, increased perioperative complications (e.g., perception of pain, prolonged length of stay, higher rates of readmission), and prolonged postoperative recovery in elective spine surgery candidates. The purpose of the study was to investigate how best to enhance the utility of the PROMIS-29 survey with the hope to establish cutoff values, similar to MMPI-2-RF, for PROMIS-29 anxiety and depression domains that might warrant attention preoperatively, formulating the survey as an advantageous presurgical screening tool. These scores may help identify patients whose postoperative recovery may be negatively impacted by these psychiatric comorbidities. The authors identified several limitations of their study and recommend further studies; however, based on findings the suggestion was made that spine surgery candidates with PROMIS-29 scores of 15 or greater on the depression domain and 15 or greater on the anxiety domain might have psychopathologies that warrant addressing in the perioperative period given their increased likelihood of having poorer outcomes after surgery than the general population.

Marek et al. (2015) acknowledged that psychopathology and patient expectations have been linked to poor results, leading to an increasing reliance on presurgical psychological screening (PPS) as part of the surgical diagnostic process. Since the utility of the MMPI-2RF in predicting spine surgery outcomes had not yet been studied, the authors investigated the associations of MMPI-2-RF scale scores with multiple outcomes of spine surgery candidates (n = 172 men and 210 women) and to assess whether MMPI-2-RF test scores add incrementally to the prediction of poor outcome beyond other available information. Results indicated that presurgical MMPI-2-RF findings provide incrementally valid prediction of early postoperative outcomes. Hierarchical regression analyses demonstrated that MMPI-2-RF scores added significantly to the prediction of postoperative functioning for all of our outcome measures, accounting for up to 11% of additional variance in outcome after controlling for presurgical expectations and functioning variables. MMPI-2-RF measures of emotional/internalizing dysfunction and interpersonal problems added explained significant amounts of variance in all models. Specifically, Demoralization was the most frequent predictor of poor functional outcome. Measures of somatoform dysfunction also emerged as significant predictors in our models, with the most notable being Somatic Complaints and Malaise.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN)*

CPT Codes

Code	Description
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	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 professional, two or more tests, any method; first 30 minutes
96137	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	each additional 30 minutes (List separately in addition to code for primary procedure)

HCPCS Codes

Code	Description
No code	

REVENUE

Code	Description
918	Psychiatric/Psychological Services-Testing

ICD10 Codes

Code	Description
	Multiple diagnosis codes

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*Key Article

KEY WORDS

Psychological testing.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a Local Coverage Determination (LCD) L33632 for Psychiatry and Psychological Services. Please refer to the following LCD website for Medicare Members: [https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33632] accessed 10/29/24.