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Medical Policy

Psychological and Neuropsychological Testing

Policy Number: 1009

Policy History			
Approve Date:	06/01/2018	Effective Date:	06/01/2018
Reviewed/Revised Date:	10/1/2019, 10/1/2020, 10/01/2021		

Preauthorization	
All Plans	Benefit plans vary in coverage and some plans may not provide coverage for certain service(s) listed in this policy. Decisions for authorization are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations as well as applicable state and/or federal laws. Please review the benefit plan descriptions for details. NOTE: All Commercial Products except Premier One and 65+ Prior authorization is not required for BadgerCare Plus members when performed in- network.

Policy

Indications of Coverage

Neuropsychological testing uses psychometric techniques to understand brain function and help identify dysfunctional cognition and brain networks.

I. May be a covered benefit when the referring provider documents the need for confirmation of a diagnosis and how the treatment plan will be modified based on the results of the requested testing. The requesting practitioner must provide Health Tradition with the specific questions the testing is intended to answer.

II. May be considered when symptoms of concussion have been present for at least three months in an otherwise healthy individual without co-morbid medical/psychiatric issues; may be considered sooner in members with such co-morbidities.

III. May be considered when a member is not intoxicated or in withdrawal at the time of the testing in cases involving substance abuse.

IV. May be considered only after thorough clinical, laboratory, and/or imaging exams have been performed, yet diagnostic uncertainty remains AND the neuropsychological testing is expected to provide a more comprehensive profile of function. Documentation of the medical evaluation must be submitted to Health Tradition for review with the request for testing and must contain corroboration of the member's concerns from the member's significant other or family members or household contacts or employer.

V. May be medically necessary:
   A. When there is a need for objective measurement of a member's subjective complaints of compromise to cognitive or behavioral functioning by differentiating psychogenic from neurogenic disorders (depression vs. dementia)
   B. When there is history of an acute brain insult, such as TBI, anoxic/hypoxic brain injury, history of brain surgery, confirmed neurotoxin exposure, CVA or encephalitis/meningitis
   C. As part of the evaluation for the appropriateness of deep brain stimulation or epilepsy surgery

D. To differentiate neurologic disease or injury from psychiatric conditions
E. To assess post-surgical changes in cognitive function
F. To assess response to treatment in members with CNS disorders to help determine an effective plan of care
G. To determine competency and the need for guardianship

VI. Is generally limited to one course of testing per year, although it may be considered more frequently under individual consideration when requested by the performing neuropsychologist after previous testing confirms a neurologic deficit. Repeat testing to track the status of an illness or recovery progress is generally not warranted.

Psychological testing is used to evaluate intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, and motivation as well as response to treatments

I. May be a covered benefit when:
   A. The referring provider documents the need for confirmation of a diagnosis AND
   B. The referring provider has performed thorough clinical, laboratory, and/or imaging exams, yet diagnostic uncertainty remains. Documentation of the medical evaluation must be submitted to Health Tradition for review with the request for testing and must contain corroboration of the member's concerns from the member's significant other or family members/household contacts or school/work, as in the case of ADD/ADHD testing requests AND
   C. The psychological testing is expected to provide a more comprehensive profile of function AND
   D. The requesting practitioner must provide the Plan with the specific questions the testing is intended to answer as well as how the treatment plan will be modified based on the results of the requested testing.

II. May be considered when a member is not intoxicated or in withdrawal at the time of the testing in cases involving substance abuse.

III. May be medically necessary:
   A. To assess patient capacity and competency
   B. As part of the evaluation for the appropriateness of surgery or surgical management techniques (implantable neurostimulators, morphine pumps, gastric bypass surgery, etc.)
   C. When the member is treated with medication and psychotherapy but has not progressed in treatment and continues to be symptomatic.

IV. Repeat testing is generally not a covered benefit

These tests would be a covered benefit only when the above criteria is met, otherwise they would not be covered benefits. The request for psychological testing must be submitted by an in-network pediatrician when the member is equal to or less than 12 years old. Testing is not covered when adjustment disorder is suspected, or when used for educational or vocational purposes; or in children when the testing is available within the school system.

Definitions

"Pre-service Claim" means any claim for a benefit that requires approval before obtaining medical care. This includes any benefits requiring a referral, prior authorization or pre-certification, including prior authorization for prescription drugs. A Pre-service Claim also includes any situation when a member receives less of a benefit than what the member requested in terms of time, services, or duration.

"Urgent Care Claim" means a pre-service claim that requires immediate determination. Urgent care refers to an actual medical condition, not going to an urgent care clinic. The criteria for an urgent care claim are:

I. Could seriously jeopardize life, health or ability to regain maximum function. This determination must be made by an individual acting on behalf of the plan (for example, utilization review staff or a medical director) or a physician with knowledge of the member's medical condition OR

II. Would subject the member to severe pain that cannot be adequately managed without such care or treatment, determined by a physician with knowledge of the member's medical condition.

References

1. Department of Labor Regulations 2650.503-1 of the Employer Retirement Income Security Act of 1974 – Claims Procedure
2. URAC Health Plan for Health Insurance Marketplace (HIM) Accreditation, Version 7.2, P-MHP 2-UM Protocols Applied to MH/SUD Benefits
3. URAC Health Plan for Health Insurance Marketplace (HIM) Accreditation, Version 7.2, P-HUM 1 - Review Criteria Requirements
4. URAC Health Plan for Health Insurance Marketplace (HIM) Accreditation, Version 7.2, P-HUM 40 - Written Notice of Upheld Non-Certifications