

MEDICAL POLICY

Medical Policy Title	Neuropsychological and Psychological Testing
Policy Number	3.01.24
Current Effective Date	April 29, 2026
Next Review Date	April 2027

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.

(Link to [Product Disclaimer](#))

POLICY STATEMENT(S)

Neuropsychological Testing

- I. Neuropsychological testing (NPT) is considered **medically appropriate** for the assessment of cognitive impairment due to a suspected medical or psychiatric condition(s) when **ALL** of the following criteria are met:
 - A. Testing is supervised and interpreted by qualified health professional (e.g., licensed psychologist, board certified in neuropsychology, neurologist, or psychiatrist with specialized training and expertise in the types of tests/assessment being requested);
 - B. When a comprehensive evaluation has been insufficient to establish or inform a diagnosis and additional testing is necessary; ([See Policy Guidelines](#))
 - C. When testing is needed for the assessment of **one or more** of the following:
 1. There has been a significant mental status change, behavior change, cognitive function change, memory loss, or organic brain dysfunction, resulting from illness or injury;
 2. To establish a baseline for **either** of the following:
 - a. prior to brain surgery (e.g., epilepsy surgery, tumor resection, deep brain stimulation); **or**
 - b. for individuals under the age of 26 who have been diagnosed with a pediatric cancer or brain tumor that affects, or whose treatment may affect, brain development or function;
 3. When a child presents with significant failure to progress cognitively or behaviorally at an expected neurodevelopmental pace; **or**
 4. When there is a lack of response to ongoing treatment and a licensed behavioral health provider has determined that NPT is needed for a definitive diagnosis;
 - D. Testing results are expected to provide information that will be used to effectively guide treatment or rehabilitation planning;
 - E. When there is clinical evidence or suspicion of **any** of the following clinical indications:

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1. Acquired immunodeficiency syndrome (AIDS) encephalopathy;
2. Brain tumor;
3. Central nervous system (CNS) infection (e.g., herpes encephalitis, human immunodeficiency virus (HIV) infection);
4. Cerebral anoxic or hypoxic episode;
5. Cerebrovascular accident (stroke);
6. Concussion: when the functional impairment has not improved after 3-6 months of standard care;
7. Cyanotic congenital heart disease;
8. Dementia;
9. Demyelinating disorders (e.g., multiple sclerosis);
10. Epilepsy or seizure disorder;
11. Extrapyrimal disease (e.g., Parkinson's, Huntington's disease);
12. Metabolic encephalopathy;
13. Metabolic insult to the brain;
14. Mild cognitive impairment (MCI), when the functional impairment has not improved after 3-6 months of standard care;
15. Neurodevelopmental condition (e.g., attention deficit/hyperactivity disorder, autism spectrum disorder, dyslexia, fetal alcohol syndrome, intellectual disability, Tourette syndrome);
16. Neurotoxin exposure (e.g., lead poisoning, cranial irradiation, chemotherapeutic agents);
17. Post concussion syndrome: when the functional impairment has not improved after 3-6 months of standard care;
18. Post-operative assessment of cognitive functioning following an appropriate interval (3-6 months) to allow for healing and ruling out acute delirium;
19. Psychiatric disorder with overlapping neurological features where an accurate diagnosis is essential for treatment planning;
20. Traumatic brain injury, mild, when functional impairment has not improved after 3-6 months of standard care;
21. Traumatic brain injury, moderate or severe.

II. NPT is considered **not medically necessary** for the following indications:

- A. When a comprehensive clinical evaluation has not yet been performed;
- B. As a screening tool for individuals who are asymptomatic, with an absence of a significant

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decline in cognitive or behavioral functioning, including assessment of individuals at risk for sports-related concussion or brain injuries;

- C. Repeat testing within 2 years, unless the original diagnosis is brought into question or there is an unexpected significant change in cognitive or behavioral functioning that requires objective confirmation to guide treatment and management;
- D. When the requested time for test administration and scoring exceeds the administration time established by the test's publishers, plus appropriate time for interpretation, unless there is documented evidence of an extenuating circumstance requiring additional time;
- E. When an individual is currently under the influence of substances (prescription or illicit) or within 14 days post-detoxification, and the effects of these substances have not been ruled out as potentially impacting tests results.

III. Neuropsychological testing is considered **investigational** for the following:

- A. Computerized NPT (e.g., CognICA) for any indication that does not require a physician, psychologist, or licensed mental health professional to provide interpretation and preparation of a report;
- B. For the diagnosis of chronic traumatic encephalopathy (CTE).

IV. Unless otherwise excluded from contract coverage, neuropsychological testing will be reviewed for medical necessity when testing is primarily for:

- A. Non-treatment-related requests (e.g., custody evaluations, parenting assessments, court ordered requests); or
- B. Service eligibility issues (e.g., vocational aptitude or educational services, renewal of services for a person who has well-documented decreased cognition/IQ).

Psychological Testing

V. Psychological testing 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;
- D. Testing is supervised and interpreted by qualified health professional (e.g., licensed psychologist, psychiatrist).

VI. Psychological testing to aid in diagnosing an intellectual disability is considered **medically appropriate** when **ALL** of the following are met:

- A. A diagnostic question remains following a thorough evaluation and recommendation by the

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treating medical provider;

- B. The testing results are expected to generate necessary information to impact the member's care and treatment;
- C. Testing is supervised and interpreted by qualified health professional (e.g., licensed psychologist, psychiatrist).

VII. Pre-surgical psychological testing 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;
- D. Testing is supervised and interpreted by qualified health professional (e.g., licensed psychologist, psychiatrist).

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

IX. Unless otherwise excluded from contract coverage, psychological testing will be reviewed for **medical necessity** when the testing is primarily for:

- A. Non-treatment-related requests (e.g., custody evaluations, parenting assessments, court ordered requests); or
- B. Service eligibility issues (e.g., vocational aptitude or educational services, renewal of services for a person who has well-documented decreased cognition/IQ).

RELATED POLICIES

Corporate Medical Policy

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

Documentation Requirements

- I. Neuropsychological testing: The requesting provider must provide documentation of an adequate mental status examination, review of the individual's pertinent medical and psychosocial history, and appropriate medical or neurological consultations (e.g., primary care, geriatrician, neurologist). Comprehensive evaluation documentation to support the need for neuropsychological testing includes, but not limited to:
 - A. Referral question and diagnosis;
 - B. Proposed battery of tests and the estimated testing time;

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- C. Details of how the test results will inform or influence the patient's medical or psychological treatment plan;
 - D. Interpretation of preliminary assessments and other collateral clinical information (e.g., neurological, and mental status exam, laboratory or neuroimaging results patient interviews, child/parent interviews, behavioral observations, school psychologist assessment or Individual Education Plan (IEP), Woodcock Johnson [WJ3], Conners Rating Scales, Mini-Mental State Examination [MMSE], Montreal Cognitive Assessment [MoCA]).
- II. Psychological testing: 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. Psychological evaluations that can be accomplished through the clinical interview alone would not require psychological testing. The requesting provider should be prepared to submit the following documentation to support the necessity for psychological testing, including but not limited to:
- A. Detailed description of the persistent diagnostic question following a thorough evaluation from the referring provider (e.g., overlapping behavioral health symptoms leading to diagnostic uncertainty);
 - B. The thorough evaluation, including review of the patient's relevant history (e.g., developmental, psychological, medical, educational), collateral interviews (e.g., parents, teachers, functional behavior assessment [FBA], Student Risk Screening), and behavioral observation when applicable (e.g., Momentary Time Sampling [MTS], Behavioral Observation of Students in Schools [BOSS], ABC Observation).

Testing Guidelines

- III. The total hours requested include the time necessary for test selection and administration, scoring, interpretation, clinical decision-making, treatment-planning, report writing, and interactive feedback. The interpretation and written report require a psychologist or behavioral health qualified health professional (QHP) with specific training and experience.
- IV. 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.
- V. If the time required to complete testing exceeds eight (8) hours, requests for additional time must include supporting documentation and clinical justification for extended testing time (e.g., complex diagnostic needs, multiple domains requiring assessment, or patient-specific factors):
- VI. If the testing is done over several days, the total time for the evaluation should be reported at the completion of the entire episode of the evaluation. The single bill should list both base and add-on codes with the different dates of service linked to the entire episode of evaluation (APA 2024).
- VII. The following examples are not considered psychological tests:
 - A. Self-administrated or self-scored screening (e.g., AIMS, Folstein Mini-Mental Status Exam,

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PHQ-9, Hamilton Rating Scale for Depression, Connors Rating Scale, Eat-26, Quotient ADHD System);

- B. Patient-completed or administered by ancillary office staff (e.g., PHQ-2, PHQ-9, MAST, CAGE, AUDIT, ORT, and Pain scale).

DESCRIPTION

Neuropsychological Testing (NPT)

NPT uses standardized methods to objectively measure and examine cognitive processes and brain-behavior relationships to assess the neurocognitive effects of medical conditions by comparing the patient's results to normative values. NPT is intended to describe and diagnose the neurocognitive effects of medical disorders that impact, directly or indirectly, the functional integrity of the brain when other diagnostic methods have been insufficient. The neuropsychological evaluation begins with integrating patient information from multiple sources including behavioral observations, clinical interviews (e.g., patient, family, teacher), medical history, screening tools (e.g., Vanderbilt ADHD Rating Scales, M-CHAT-R/F), and diagnostic assessments (e.g., Autism Diagnostic Observation Schedule [ADOS-2] and Connors Rating Scales).

To inform remaining diagnostic conclusions, guide treatment planning, and contribute to medical decision-making, clinicians often use a flexible test battery approach to select specific tests to assess domains such as memory, attention, executive functioning, language, visuospatial skills, and sensorimotor abilities. NPT is conducted by licensed psychologists or qualified health professionals (QHPs), with psychometrists or technicians assisting under appropriate supervision.

The neurobehavioral status examination is a related clinical assessment that focuses on cognitive and behavioral functioning for conditions such as mild cognitive impairment, dementia, traumatic brain injury, and stroke. Along with the initial integration of patient information (e.g., interviews and review of history), the results of brief cognitive screening measures (e.g., Montreal Cognitive Assessment [MoCA], Patient Health Questionnaire-9 [PHQ-9]) are used to determine if a full NPT evaluation is needed to Evaluate domains such as language, memory, acquired knowledge, attention, planning and problem-solving, and visual-spatial abilities. When a neurobehavioral status exam precedes a neuropsychological evaluation, the clinical assessment would determine the type of tests and how those tests should be administered.

Computerized neuropsychological assessment device (CNAD) is defined by the American Academy of Clinical Neuropsychology (AACN) and the National Academy of Neuropsychology as any instrument that uses a computer, digital tablet, handheld device, or other digital interface, rather than a human examiner, to administer, score, or interpret tests of brain function and related factors relevant to neurologic health and illness (AACN; Bauer 2012). CNADs differ from traditional examiner-administered tests in that examinees interact with a computer rather than a person, often without supervision, and may incorporate adaptive algorithms that adjust task difficulty based on performance. They can be marketed to non-experts, rely on proprietary scoring systems, and are influenced by technical factors such as hardware and software configurations, making them qualitatively and technically distinct from traditional tests. CNADs range from computerized versions of established tests (e.g., Wisconsin Card Sorting Test) to fully web-integrated platforms designed for

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general cognitive screening or specialized applications such as concussion evaluation and management.

Computer-based neuropsychological assessment for sports-related concussion uses an abbreviated 20–30-minute battery administered pre-season for baseline comparison and post-injury to guide return-to-play decisions. These tests measure attention, processing speed, and reaction time, and can be administered by coaches, athletic trainers, or physicians with minimal training. Examples of computerized neuropsychological tests used in sports-related concussion management include ImPACT, CogState CCAT, ANAM, CNS Vital Signs.

Psychological Testing

Psychological testing differs from NPT in both scope and purpose. NPT examines cognitive processes and brain–behavior relationships, whereas psychological testing focuses on evaluating emotional, behavioral, and personality functioning. When combined with clinical history, psychological testing is used to diagnose psychiatric and developmental disorders such as depression, autism spectrum disorder (ASD), and attention-deficit/hyperactivity disorder (ADHD).

Psychological tests (psychometric instruments) are standardized tools that provide objective data to support accurate assessment of cognitive, emotional, and behavioral functioning. The results guide targeted treatment recommendations and intervention planning, contributing to individualized care. These assessments measure behavioral and mental attributes such as emotional functioning, attitudes, intelligence, cognitive abilities, aptitude, personality traits, and indicators of psychological or neurological disorders. Commonly used instruments include personality and mood inventories, structured interviews, and self-report scales. Frequently used psychological tools include the Minnesota Multiphasic Personality Inventory (MMPI), Beck Depression Inventory, and the Wechsler Intelligence Scale for Children (WISC).

In ASD assessment, the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) is widely regarded as a gold-standard observational measure when used as part of a comprehensive evaluation that includes developmental and medical history and interviews (e.g., ADI-R, teachers, parents). According to APA (2024), the ADOS-2 and ADI-R may be billed as developmental tests when interactive feedback is not provided and billed with psychological testing evaluation services when feedback is included.

Presurgical psychological assessment provides recommendations to the surgical team and the patient regarding how psychosocial factors may influence surgical outcomes. When adverse factors are identified, psychologists collaborate with the patient and medical team to develop presurgical interventions, recommend postsurgical follow-up, or determine if surgery is appropriate at that time (Marek and Block 2023).

Advances in technology have introduced computerized tools that objectively measure attention, impulsivity, and activity level to support clinical evaluations. Examples include the QbTest, the Quotient ADHD System, and Test of Variables of Attention (TOVA). These are tools intended to supplement, not replace, comprehensive clinical assessment and must be interpreted by qualified professionals, consistent with APA-supported standards for psychological testing.

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SUPPORTIVE LITERATURE

Neuropsychological Testing (NPT)

NPT – Neurodevelopmental Conditions

Peterson et al (2024) published the Agency for Healthcare Research and Quality (AHRQ) systematic review and meta-analysis that evaluated the diagnostic performance of tools used to identify ADHD in children and adolescents. The purpose was to assess the accuracy and reliability of various diagnostic methods, including parental ratings, teacher ratings, youth self-reports, clinician tools, neuropsychological tests, biospecimen, EEG, and neuroimaging. The review included 231 studies addressing diagnosis that met eligibility criteria. While multiple tools showed promising diagnostic performance, estimates varied considerably across studies and the overall strength of evidence was generally low. Rating scales for parent, teacher, or self-assessment demonstrated high internal consistency but poor to moderate reliability between raters, suggesting that obtaining ratings from multiple informants may be valuable to inform clinical judgment. The review concluded that a valid and reliable diagnosis of ADHD requires the judgment of an experienced clinician, supported by standardized rating scales and input from multiple informants across settings. Neuropsychological tests, including executive functioning measures such as the Continuous Performance Test, showed inconsistent performance and were often used in study-specific combinations, limiting comparability. In head-to-head comparisons, parent rating scales typically demonstrated better diagnostic accuracy than neuropsychological test measures. Neuropsychological tests do not yet have sufficient evidence to serve as standalone diagnostic tools.

Randall et al (2018) conducted a Cochrane systematic review to evaluate the diagnostic accuracy of commonly used tools for identifying autism spectrum disorder (ASD) in preschool-aged children, comparing them against multidisciplinary clinical judgment. The review analyzed 21 datasets from 13 studies involving over 2,900 children under six years of age. The reference, gold standard assessment for diagnosis involves multiple professionals and multiple assessment mechanisms. A variety of tests are used in both research and clinical settings for diagnosis of ASD. Among the tools assessed, the Autism Diagnostic Observation Schedule (ADOS) demonstrated the highest sensitivity (0.94) and acceptable specificity (0.80), making it the most effective at correctly identifying children with ASD. The Childhood Autism Rating Scale (CARS) showed a sensitivity of 0.80 and specificity of 0.88, while the Autism Diagnostic Interview-Revised (ADI-R) had lower sensitivity (0.52) but comparable specificity (0.84). The review found that combining ADOS and ADI-R did not improve diagnostic accuracy beyond ADOS alone. The authors emphasized that diagnostic tools should not be used in isolation; rather, they should be part of a comprehensive, multidisciplinary assessment. Overall, the findings support current clinical guidelines recommending the use of structured tools like ADOS within a broader diagnostic framework.

NPT- Neurocognitive Disorders

The U.S. Preventive Services Task Force (USPSTF 2020) issued a Grade I recommendation, concluding that evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment, including dementia and mild cognitive impairment, in asymptomatic, community-dwelling adults aged 65 years and older.

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Mild cognitive impairment (MCI) The use of stand-alone cognitive assessments for generalized screening, including those utilizing AI such as CognICA, do not require a physician, psychologist, or licensed mental health professional to provide interpretation and preparation of a report. There is a lack of evidence that screening for cognitive impairment or early diagnosis of cognitive impairment improves patient or clinical decision making. Furthermore, there is little evidence for any interventions that preserve or improve the functioning of patients with MCI and there are no identified studies directly addressing the adverse psychological effects of this screening or adverse effects from false-positive or false-negative testing.

The routine use of NPT to differentiate Alzheimer's disease from other neurocognitive disorders is usually not necessary, as more suitable approaches are available. However, NPT may be considered necessary for complicated cases when the usual diagnostic techniques are not adequate to provide a diagnosis, and the diagnosis will alter the course of treatment. There are cases of neurocognitive decline for which etiology may be unclear. At the current time there is no simple, reliable, accurate test to make the diagnosis of Alzheimer's disease or many other neurocognitive disorders. Diagnosis of these conditions should be based on several pieces of information, including basic laboratory testing, history-taking (including mental health and substance use issues), with input from collaborating others; neurologic and mental status examination; and imaging. Many practitioners utilize a brief screening tool like MMSE, MOCA, Mini-Cog, or CamCog to make an estimate of deficits.

Prior to the advent of highly active antiretroviral therapy (HAART), dementia was a common source of morbidity and mortality in HIV infected patients. With HAART, a less severe dysfunction, mild cognitive motor disorder, has become more common than ADC. Early signs and symptoms are subtle and may be overlooked. Cognitive screening tests should be part of the routine care of HIV-infected patients. Changes in the management of the patient, based on the cognitive findings, center around use of different antiretroviral therapy, including HAART. Cognitive screening tools have been developed (e.g., MoCA, HDS, IHDS) that can assist in identifying those patients who are at higher risk; however, based on their sensitivity and specificity, traditional NPT still appears to be the gold standard and is required to provide a definitive diagnosis.

LoBue et al (2025) conducted a systematic review and meta-analysis to investigate the relationship between chronic traumatic encephalopathy (CTE) and cognitive impairment, including dementia-related diagnoses. A total of 36 studies comprising 563 unique CTE cases were included. Only 22 CTE cases (<5%) had objective neuropsychological data available from studies of acceptable quality. Deficits in memory, language, and attention were the most prevalent cognitive features, but all cases had comorbid non-CTE neuropathologies that may have been associated with cognitive impairment. Diverse neuropsychological impairments were observed, resulting in no consistent cognitive pattern, even for high CTE severity. Dementia-related diagnoses were prevalent in the meta-analysis, yet not strongly related to non-CTE neuropathologies ($p= 0.714$), including Alzheimer-type neuropathology ($p = 0.084$). While the findings suggest that CTE may be associated with cognitive impairment, further investigation is needed because heterogeneity in study designs prohibits clear conclusions.

NPT- Computerized Testing

Wild et al (2008) conducted a systematic review of computerized cognitive testing, focusing on its

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ability to detect cognitive decline in the aging population. The heterogeneity across selected studies and test batteries made a meta-analysis impossible. The study included review of 11 test batteries that were either developed to screen for cognitive decline in the elderly or have been applied to that function. In slightly more than half the tests, normative data for elderly subjects were rated as less than adequate as a result of either small sample size or lack of data specific to older adults in a larger sample. Reliability data was typically presented in some form, although only three test batteries met the highest rating achieved by describing more than one type of reliability. Few of the batteries were fully self-administered; the tests ranged widely in the amount of interaction required of an examiner. One of the persistent issues was the general lack of adequately established psychometric standards. Other concerns include failure to demonstrate equivalence between the examinee's experience of computer use versus traditional test administration, which is of particular importance in the elderly population.

Nelson et al (2017) conducted a prospective study that evaluated the reliability and validity of three computerized neurocognitive assessment tests (CNT) for assessing mild traumatic brain injury (mTBI). Specific tests included the Automatic Neuropsychological Assessment Metrics (ANAM), Defense Automated Neurobehavioral Assessment (DANA), and Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT). Patients with mTBI (n=94) and matched trauma control (n=80) were recruited from a level I trauma emergency department to complete symptom and neurocognitive assessments within 72 hours of injury and at 15- and 45-days post-injury. Concussion symptoms were also assessed via phone at day 8 post-injury. CNTs did not differentiate between groups at any time point. In contrast, concussion symptom score differentiated mTBI versus control groups acutely, with this effect size diminished over time (72-hr and day 8, 15, and 45 Cohen's $d = -.78, -.60, -.49, \text{ and } -.35$, respectively). The CNTs did not yield significant differences between patients with mTBI versus other injuries. Symptom scores better differentiated groups than CNTs, with effect sizes weaker than those reported in sport-related concussion studies. The authors concluded that symptom-based assessments may be more reliable than computerized neurocognitive tools for evaluating mTBI in acute care settings.

Wojcik et al (2019) conducted a systematic review of 120 peer-reviewed studies and identified 11 test batteries and 33 individual tests utilized in MS populations. CNADs such as the CogState Brief Battery, Cognitive Drug Research Battery, NeuroTrax, CNS Vital Signs, and computerized versions of the Symbol Digit Modalities Test demonstrated the strongest psychometric support, particularly for measuring cognitive processing speed. While these tools show promise as screening instruments or supplements to conventional neuropsychological assessments, most CNADs do not yet exhibit sufficient reliability and validity to replace established clinician-administered batteries such as BICAMS, MACFIMS, or MS-COG. Further research is needed to confirm their sensitivity across cognitive domains and their applicability in real-world clinical settings. At present, CNADs may be considered for adjunctive use in MS cognitive evaluation, but they should not supplant comprehensive, standardized neuropsychological testing.

Psychological Testing (PT)

In their 2020 guidelines, the American Psychological Association emphasized that psychological testing is only one component of a comprehensive assessment process. Individual performance on

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psychological tests must be interpreted within the broader context of presenting concerns (e.g., reason for referral, background, course of illness, influential factors, and population-specific contributions). These contextual elements are gathered from multiple sources, such as 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 integration of reliable collateral information and clinical judgment is essential to the assessment process. Furthermore, understanding these variables prior to testing supports the selection of appropriate, reliable, and valid instruments from the wide array of commercially and research-based tools available.

PT- Neurodevelopmental Conditions

Randall et al (2018) conducted a Cochrane systematic review to evaluate the diagnostic accuracy of commonly used tools for identifying autism spectrum disorder (ASD) in preschool-aged children, comparing them against multidisciplinary clinical judgment. The review analyzed 21 datasets from 13 studies involving over 2,900 children under six years of age. The reference (also known as gold) standard assessment for diagnosis involves multiple professionals and multiple assessment mechanisms. A variety of tests are used in both research and clinical settings for diagnosis of ASD. Among the tools assessed, the Autism Diagnostic Observation Schedule (ADOS) demonstrated the highest sensitivity (0.94) and acceptable specificity (0.80), making it the most effective at correctly identifying children with ASD. The Childhood Autism Rating Scale (CARS) showed a sensitivity of 0.80 and specificity of 0.88, while the Autism Diagnostic Interview-Revised (ADI-R) had lower sensitivity (0.52) but comparable specificity (0.84). The review found that combining ADOS and ADI-R did not improve diagnostic accuracy beyond ADOS alone. The authors emphasized that diagnostic tools should not be used in isolation; rather, they should be part of a comprehensive, multidisciplinary assessment. Overall, the findings support current clinical guidelines recommending the use of structured tools like ADOS within a broader diagnostic framework.

Peterson et al (2024) published the Agency for Healthcare Research and Quality (AHRQ) comprehensive systematic review and meta-analysis evaluating the diagnostic performance of tools used to identify ADHD in children and adolescents. The review aimed to assess the reliability and validity of various diagnostic approaches, including parent and teacher rating scales, youth self-reports, clinician-administered tools, neuropsychological tests, biospecimen analyses, EEG, and neuroimaging. A total of 231 eligible studies were included. Although several tools demonstrated promising diagnostic capabilities, performance estimates varied widely across studies, and the overall strength of evidence was generally low. Rating scales completed by parents, teachers, or the youth themselves showed high internal consistency but only poor to moderate inter-rater reliability, underscoring the importance of gathering input from multiple informants to support clinical decision-making. The review concluded that accurate ADHD diagnosis requires the expertise of a trained clinician, supplemented by standardized rating scales and multi-informant data across settings. Neuropsychological tests, particularly those assessing executive function (e.g., the Continuous Performance Test), exhibited inconsistent diagnostic performance and were often used in study-specific combinations, limiting comparability. In direct comparisons, parent rating scales consistently outperformed neuropsychological measures in diagnostic accuracy. Overall, neuropsychological tests currently lack sufficient evidence to be used as standalone diagnostic tools.

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PT- Pre-Surgical Psychological Testing

Patients with complex medical conditions or those preparing for procedures such as bariatric surgery may benefit from psychological or psychiatric evaluation to identify factors that could interfere with treatment planning. In many cases, a standard psychiatric assessment is sufficient and does not require a full psychological test battery. Pre-surgical evaluation aims to improve surgical outcomes by identifying issues such as disordered eating, unmanaged mental illness, or active substance use. A multidisciplinary team is essential for addressing modifiable risk factors to reduce complications and support recovery (Eisenberg, 2023).

Kenfack et al (2022) conducted a 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 before spinal surgery. The authors noted established links between psychological comorbidities and poorer preoperative status, higher perioperative complications, and longer postoperative recovery. Their goal was to improve the usefulness of PROMIS-29 by identifying cutoff values for anxiety and depression similar to those used with the MMPI-2-RF. PROMIS-29 scores may help identify patients at risk for poorer postoperative outcomes. Although the authors reported several study limitations and recommended further research, they suggested that preoperative attention may be warranted for individuals scoring 15 or higher on the PROMIS-29 depression or anxiety domains.

Marek et al (2024) evaluated the psychometric validity of the MMPI-3 among 790 patients seeking metabolic and bariatric surgery. MMPI-3 scores showed strong convergent and discriminant validity. Emotional/Internalizing Dysfunction scales correlated with depression, anxiety, suicide history, sexual abuse, psychotropic medication use, and problematic eating behaviors. Behavioral/Externalizing Dysfunction scales were associated with substance use and loss-of-control eating. The eating concerns scale showed the strongest links to binge-eating and stress-related eating. The findings support MMPI-3 as a tool that measures relevant psychological constructs in this population and extends the predictive features of the MMPI-2-RF. The authors concluded that MMPI-3 not only replicates the predictive utility of MMPI-2-RF but also offers additional insights through its newly added scales, making it a robust tool for preoperative psychological evaluation.

Walter et al (2024) review of 279 patients evaluated for bariatric surgery to clarify psychological factors associated with not proceeding to surgery in a setting without insurance barriers. MMPI-2-RF profiles were compared between patients who did and did not undergo surgery. A total of 86 individuals (30.8%) did not move forward with surgery. Significant differences were found in demographic factors and MMPI-2-RF scales. Patients who did not proceed had higher scores related to somatic and neurological complaints, cynicism, and feelings of helplessness and hopelessness. Although not all elevations reached clinical thresholds, the results suggest that psychological and psychosocial factors may influence the decision to proceed with surgery.

PROFESSIONAL GUIDELINE(S)

American Academy of Child and Adolescent Psychiatry (AACAP)

- ASD (Volkmar 2014): Positive screen should be followed by a comprehensive diagnostic

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evaluation (child/family interviews, developmental and medical history, record review) aligned with DSM-5. Although a variety of instruments have been developed to assess ASD, their clinical utility varies. These tools are intended to support, not replace, the clinical judgment of experienced professionals. While AACAP acknowledges neuropsychological correlates of ASD (e.g., deficits in executive functioning and weak central coherence) formal neuropsychological testing is not discussed in the Practice Parameter.

- Intellectual disability, also referred to as intellectual developmental disorder (IDD) (Siegel 2020): As part of standard well-child visits, children are screened using standardized developmental tools. A positive screen should prompt a diagnostic evaluation by a qualified clinician to determine the nature and extent of impairment. A diagnosis is established when DSM-5 criteria are met and other potential etiologies (e.g., communication disorders, neurocognitive conditions, affective disorders, or autism spectrum disorder) have been adequately ruled out.

American Academy of Neurology (AAN)

In 2024, the AAN reaffirmed the 2010 practice guideline on evaluating and managing the driving risk in patients with dementia. While neuropsychological testing itself may better define dementia severity, there is insufficient evidence to support or refute the benefit of neuropsychological testing in evaluating driving risk in patients with dementia.

American Academy of Pediatrics (AAP)

- ADHD (Wolraich 2019): 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 (ages 4-17) who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity. Appropriate further assessment is indicated if an underlying etiology is suspected.
- Autism Spectrum Disorder (Hyman 2020; reaffirmed 2025): Standardized autism-specific screening at 18 and 24 months of age during primary care visits, complementing general developmental screening. Screening results are not diagnostic but help identify children at risk who require further evaluation. Children with developmental delays, with or without an ASD diagnosis, should be referred to early intervention or school services, where cognitive and language testing may be completed. Structured observation of ASD symptoms during clinical evaluation informs application of DSM-5 criteria. General pediatricians and child psychologists familiar with DSM-5 can make an initial clinical diagnosis, supported by validated tools such as the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) and the Childhood Autism Rating Scale, Second Edition (CARS-2). Co-occurring conditions (e.g., intellectual or learning disabilities, ADHD, anxiety, and speech or language disorders) may affect symptom presentation and functional impairment across development. Assessment of cognitive and language ability is an important component of the diagnostic evaluation, and in the United States, early intervention services and school systems will evaluate children in these domains to assess educational.
- Sport-Related Concussion (Halstead 2018): Neurocognitive testing is only one tool and not a sole determinant for return-to-play. Athletes with prolonged symptoms should be evaluated for coexisting problems that may be contributing to the lack of symptom resolution and may benefit

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from referral to an appropriate health care provider.

American Heart Association (AHA)

In 2024, the AHA published a Scientific Statement recommending that individuals with cyanotic congenital heart disease who underwent surgical repair receive routine neurodevelopmental and neuropsychological evaluation across the lifespan, with standardized testing at key developmental stages from infancy through adulthood. This population is at high risk for deficits in attention, executive function, processing speed, and memory, with a 4-fold increased risk of impairment compared to the general population, and adults face 1.5-2.6 times greater risk of dementia. Evaluation by a qualified professional using standardized tests is considered the gold standard to identify specific strengths and deficits and guide appropriate interventions. The statement outlines age based timing for evaluation in childhood (6 months, 18 months, 3 years, and before kindergarten), during school age years and adolescence (third–fourth grade transition, middle school, high school, and transition to adulthood), and continuing into adulthood as needed, noting an increased risk of dementia compared with the general population (Sood 2024).

American Medical Society

Harmon et al (2019) published the position statement on concussions in sport, which includes recommending a review of detailed history of concussion and screening for premorbid and comorbid conditions that may complicate concussion diagnosis. Baseline testing may be useful in some cases but is not necessary, required or an accepted standard of care for the appropriate management of sport-related concussion (SRC). Athletes and former athletes who present with neuropsychiatric symptoms and signs that have been ascribed to CTE should be evaluated for potentially treatable comorbid conditions that share symptoms and not be assumed to have CTE.

American Psychological Association (APA)

- **Dementia/Age-Related Cognitive Changes (2021):** A diagnosis of dementia requires evidence of decline from a previously higher level of cognitive functioning. While objective testing provides valuable data for diagnostic purposes, the clinical interview remains a foundational component of a comprehensive assessment. When brief mental status evaluations yield inconclusive results, psychologists may consider a referral for a neuropsychological evaluation for assessment of complex diagnostic questions and informing treatment planning.
- **Presurgical Psychological Assessment (Diggins and Peterson 2023; Murray 2023):** Endorses risk identification and mitigation approaches (e.g., psychometric testing to identify objective psychosocial risk factors), test selection, and ethical standards across surgeries (e.g., bariatric, spine, transplant).

American Society of Metabolic and Bariatric Surgery (ASMBS)

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**

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patterns), lifestyle/nutritional evaluation (e.g., sleep hygiene, smoking, healthy eating index) (Carter 2021; Mechanick 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 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 2022).

Centers for Disease Control and Prevention (CDC)

- Pediatric Mild Traumatic Brain Injury/Concussion (Lumba-Brown 2018):
 - Recommendation 5B: "Health care professional may use validated, age-appropriate computerized cognitive testing in the acute period of injury as a component of the diagnosis of mild TBI (moderate; level C)."
 - Recommendation 19C: "Health professionals may refer children with persisting problems related to cognitive function for a formal neuropsychological evaluation to assist in determining the etiology and recommending targeted treatment (high; level C)."

Children's Oncology Group (COG)

- Baseline evaluation (Nathan 2007; Walsh 2016): NPT is recommended for initial (baseline) evaluation and periodic assessment when clinically indicated for specific therapeutic exposures, including brain tumor resection, CRT, intrathecal chemotherapy, and specific high dose chemotherapy agents given intravenously.
- Long-term follow-up (2023, version 6.0): neuropsychological testing is recommended at baseline when entering into long-term follow-up, followed by periodic assessments as clinically indicated for patients demonstrating impaired educational or vocational progress.

National Comprehensive Cancer Network (NCCN)

According to the National Comprehensive Cancer Network (NCCN) survivorship guidelines (Version 2.2025), cognitive impairment is a common concern among cancer survivors and may be a consequence of the tumors themselves or of the direct effects of cancer-related treatment (e.g., chemotherapy, radiation therapy). Neuropsychological evaluation can be therapeutic and validating.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Hoyme et al (2016) published consensus guidelines for diagnosing Fetal Alcohol Spectrum Disorders (FASD). Evaluation of individuals with prenatal alcohol exposure should include a medical assessment by a pediatrician or clinical geneticist/dysmorphologist experienced in human malformation syndromes and dysmorphology. In addition, exposed children should undergo expert psychological and neuropsychological testing, and a skilled interviewer should obtain a detailed history of maternal alcohol use during pregnancy. Because the primary effects of alcohol are on brain structure and

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function, a comprehensive neurodevelopmental assessment is essential. These assessments help identify deficits at least 1.5 standard deviations below the normative mean, providing objective criteria for diagnosis within a multidisciplinary framework.

REGULATORY STATUS

Pursuant to New York State law, effective November 1, 2012, every contract providing physician services, or providing medical, major medical, or similar comprehensive-type coverage must provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders (ASDs) when prescribed or ordered by a licensed physician or a licensed psychologist for medically necessary services. Treatment includes services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, and social worker when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative. The law prohibits the imposition of limitations that are solely applied to the treatment of ASD. However, as long as the visit limit is not imposed solely on services required to treat an ASD, a visit limit continues to be permissible, as long as such visit limit also passes the testing requirements under the Mental Health Parity Addiction and Equity Act of 2008.

The Dyslexia Diagnosis Access Act (A.2898/S.5481) effective January 1, 2025, requires that health plans pay for neuropsychological exams for the purpose of diagnosing dyslexia and determining the psychological emotional and educational wellness of the individual tested. Every policy that provides coverage for physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for testing for suspected dyslexia in accordance with this mandate and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy. The bill aims to increase access to effective diagnostic testing for dyslexia.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., 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

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Code	Description
96121	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	; 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	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)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

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HCPCS Codes

Code	Description
Not Applicable	

Revenue Codes

Code	Description
918	Psychiatric/Psychological Services-Testing

ICD10 Codes

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Code	Description
Multiple Codes	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Neuropsychological testing is not addressed in a National Medicare coverage determination or policy. However, neuropsychological testing is addressed in Chapter 15, Section 80.2 in the Medicare Benefit Policy Manual. Please refer to the following website for Medicare Members: <https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pdf> [accessed 2026 Mar 24].

[LCD - Psychiatry and Psychology Services \(L33632\)](#) [accessed 2026 Mar 24]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, 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

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service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
04/16/26	
Date	Summary of Changes
04/29/26	<ul style="list-style-type: none">• Original effective date
04/16/26	<ul style="list-style-type: none">• New policy to merge content from CMP #2.01.50 Neuropsychological Testing and #3.01.02 Psychological Testing. The not medically necessary statement for routine psychological testing was deleted from psychological testing.