Overview

Neuropsychological testing is a sub-classification of psychological testing considered a well-established method in the evaluation of patients with cognitive or behavioral abnormalities.

Neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain dysfunction through testing of the neurocognitive domains responsible for language, perception, memory, learning, problem solving, adaptation, and constructional praxis.

These evaluations are requested for patients with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning. The evaluations include a history of medical or neurological disorders compromising cognitive or behavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; reported impairments in cognitive functioning; and evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations.

Policy

Fallon Health requires prior authorization for all Neuropsychological Testing. For a diagnosis related to behavioral health prior authorization and criteria can be obtained via Beacon Health Strategies. For any other diagnosis Fallon Health’s Prior Authorization Department will review this request based on the below criteria, the request must be supported by the treating provider(s) medical records.

1. A comprehensive clinical Neurological evaluation performed within the past 12 months indicating a specific diagnosis and/or a course of treatment cannot be determined without further testing.
2. The evaluation must consider and rule out other possible causes of the neurological issues.
3. The clinical evaluation must support the testing will establish a diagnosis and have an impact on the clinical management of the member.

Exclusions

- Any Neuropsychological Testing performed which does not meet the above criteria.
- Testing for Educational or Vocational purposes.
- Testing performed as a primary or initial screening evaluation.
### Codes

<table>
<thead>
<tr>
<th>Code type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>96116</td>
<td>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), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing report</td>
</tr>
<tr>
<td></td>
<td>96118</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td></td>
<td>96119</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td></td>
<td>96120</td>
<td>Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
</tbody>
</table>

### References


Policy History

<table>
<thead>
<tr>
<th>Origination date:</th>
<th>11/01/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval(s):</td>
<td>Technology Assessment Committee: 10/22/2014 (new policy), 10/28/2015 (updated references), 10/26/2016 (updated references), 10/25/2017 (updated references)</td>
</tr>
</tbody>
</table>

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member’s particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product’s Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member’s benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.