Magellan HEALTHCARE

Request for Neuropsychological and Psychological Testing Preauthorization

The testing provider must complete Section XII, *Requested Testing* and, if applicable, Section XIV, *Technician Attestation*. Either the referring provider or the testing provider may complete other sections of the form. Please provide all requested information, subject to applicable law. In most cases, an initial assessment by a behavioral healthcare provider must be administered before psychological testing will be authorized.

Authorization for neuropsychological or psychological testing will not be considered until all sections of this form are completed. To avoid potential issues with reimbursement, neuropsychological and psychological testing should not be initiated until an authorization has been received.

Send the completed form to:

For **Blue Shield of California** members: fax **1-888-656-0467**

For **Sharp Health Plan** and **Scripps Health Plan** members: fax **1-888-656-0259**

I.

Today's Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Unique ID or Policy #: _____

Requested Start Date of Authorization: _____

Insurance Plan: _____

Policy Holder Name (if different from patient): _____

Policy Holder ID (if different from patient): _____

Policy Holder Address: _____

II. Person or Agency Making the *Initial* Referral to the Testing Psychologist:

☐ Psychiatrist ☐ Other Psychologist ☐ School Staff (Specify): _____

☐ Psychotherapist ☐ Parent ☐ PCP/Medical Specialist: _____

☐ Testing Psychologist ☐ Court ☐ Other: _____

III. Testing Provider Information:

Name: _____ **Degree:** _____

Name of Agency/Org: _____

Telephone #: _____ **Extension:** _____

Fax #: _____ **Email:** _____

Service Address: _____

City, State, ZIP: _____

NPI: _____ **Tax ID:** _____ **Tax ID Owner Name:** _____

IV. ICD-10 Diagnosis:

Code	Current or Provisional Diagnosis		Description
_____	☐ Current	☐ Provisional	_____
_____	☐ Current	☐ Provisional	_____
_____	☐ Current	☐ Provisional	_____

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For the following questions, attach additional sheet if needed.

V. What is the clinical question that needs to be answered by testing?

_____

VI. Why can't this question be answered by a diagnostic interview, a medical and/or neurological consult, review of psychological/psychiatric records, or second opinion?

_____

_____

VII. What are the current symptoms and/or functional impairments related to the testing referral question?

_____

_____

VIII. How will testing results inform medical or health management, as well as affect the treatment plan (be specific)?

_____

_____

Is the patient neurologically, cognitively, or psychologically able to participate in the testing process in a meaningful way?
☐ Yes
☐ No
Will testing results inform therapeutic or care options for medical or psychological management?
☐ Yes Identify treatment: _____
☐ No
Have routine screening tools been used already?
☐ Yes List: _____
☐ No

IX. Medical/Psychological Evaluation and Treatment:

1. Has a psychologist or psychiatrist, or other behavioral health professional **already** completed an initial psychiatric/psychological diagnostic evaluation 90791 (no med svcs) or 90792 (w/med svcs)] OR initial office visit with E/M services (99203, 99204, 99205) **PRIOR** to this testing request?

   ☐ Yes If yes, date of evaluation: _____ ☐ No

   Submit treatment record (encounter documentation) from diagnostic interview and evaluation.

2. Has the patient had a neurological evaluation? ☐ Yes If yes, date of evaluation: _____ ☐ No

3. Has patient had previous psychological testing? ☐ Yes If yes, date: _____ ☐ No

4. If repeat testing is being requested, explain how re-testing will inform medical or clinical decision-making

   _____

5. Current psychotropic medications (include *dose* and *date began*): _____

   _____

   ☐ None ☐ Unknown

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X. **Current Substance Use**: Has the member abused any substance in the last 30 days?

☐ Yes Elaborate: _____

☐ No

XI. **Purpose of testing (answer Yes or No to all items below**):

1. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer's disease, and there is no expectation that the testing would impact the patient's medical, psychological, clinical, functional, or behavioral management.
   ☐ Yes ☐ No
2. Testing is being administered for educational, vocational, or other non-clinical purposes.
   ☐ Yes ☐ No
3. Testing is to assess cognitive or behavioral deficits related to known or suspected CNS impairment, trauma, or neuropsychiatric disorders.
   ☐ Yes ☐ No ***Describe deficits below.***
4. Testing is to establish a treatment plan by measuring functional abilities/impairments.
   ☐ Yes ☐ No ***Describe how results will inform treatment below.***
5. Testing is to conduct pre-surgical or treatment-related measurement of cognitive function to determine whether one might safely proceed with a medical or surgical procedure that may affect brain function or significantly alter functional status.
   ☐ Yes ☐ No ***Describe the safety concerns below.***
6. Testing is to determine whether a medical condition impairs a patient's ability to comprehend and participate effectively in treatment regimens.
   ☐ Yes ☐ No ***Identify the medical condition and describe the impairment below. Describe the safety concerns below.***
7. Testing is to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures.
   ☐ Yes ☐ No ***Describe the treatment (attach most recent encounter notes).***
8. Testing is to measure cognitive or functional deficits in children and adolescents based on an inability to achieve developmental milestones.
   ☐ Yes ☐ No ***Describe the milestones that have not been achieved below.***
9. Testing is to evaluate primary symptoms of impaired attention and concentration that can occur in many medical and psychiatric conditions.
   ☐ Yes ☐ No ***Describe the onset and current functional impairment below.***

Provide description below, including how testing measures will inform care:

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XII. Requested Testing: (This section must be completed by the testing psychologist.)

Names and Type(s) of Tests: (To avoid confusion or processing delays, please **be precise** when listing test names/acronyms.)
Name(s) of tests:
Self-administered or self-scored inventories:
Screening tests of cognitive function or neurological disease, whether paper-and-pencil or computerized:
USE ONLY APPROVED CODES BELOW IN SECTION XIII.

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XIII. CPT® Codes for Psychological and Neuropsychological Testing Services

CPT® Codes and Descriptions[1]	CPT Codes and Number of Requested Units
96116 Neurobehavioral status exam by physician or other QHP, interpreting test results and preparing the report; **first hour**	_____ **unit** (*Only <u>one</u> unit of one hour allowed*)
96121 Neurobehavioral status exam by physician or other QHP, interpreting test results and preparing the report; each additional hour	_____ **# of additional hours**
96130 Psychological testing evaluation services by physician or other QHP, 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**	_____ **unit** (*Only <u>one</u> unit of one hour allowed)*
+96131 Psychological testing evaluation services, by physician or other QHP, each additional hour	_____ **# of additional hours**
96132 Neuropsychological testing evaluation services by physician or other QHP, 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**	_____ **unit** (*Only <u>one</u> unit of one hour allowed*)
+96133 Neuropsychological testing evaluation services by physician or other QHP, each additional hour	_____ **# of additional hours**
96136 Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, first 30	_____ **unit** (*Only <u>one</u> unit of 30 minutes allowed*)
+96137 Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, each additional 30 minutes	_____ **unit(s)** *(# of additional units of 30 minutes each*)
96138 Psychological or neuropsychological test admin and scoring by technician, two or more tests, any method, first 30	_____ **unit** (*Only <u>one</u> unit of 30 minutes allowed*)
+96139 Psychological or neuropsychological test admin and scoring by technician, two or more tests, any method, each	_____ **unit(s)** *(# of additional units of 30 minutes each*)
96146 Psychological or neuropsychological test admin, with single automated, standardized instrument via electronic platform, with automated result only	_____ **unit** (*Only <u>one</u> unit allowed*)
Total number of hours requested (count automated test admin as one hour): If the time required to complete testing exceeds 8 hours, medical necessity for extended testing time should be documented. If your request exceeds 8 hours, provide medical necessity rationale: _____ _____ _____	_____ **total hours** (*may include .5 to represent half an hour e.g., 5.5*)

Please note: Codes on reimbursement schedules may vary by state or plan. Nothing in this document should be construed as altering your currently contracted services. There may be codes above for which you are not contracted. The presence of them here does not add them to your current contract.

[1]CPT® is a registered trademark of the American Medical Association.

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XIV. Technician Attestation: If technician CPT codes (96138 or 96139) are requested, the supervising psychologist must complete the following attestation. **I attest to the following:**

1. The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
2. The services will be delivered under my direct personal supervision;
3. The services will be provided in the office/facility where I render psychological services;
4. My employment and supervision of the technician complies with all applicable state laws and regulations including those governing psychologists;
5. I am responsible for the quality and accuracy of the services provided by the technician; and
6. I am responsible for the analysis and interpretation of the test results and final report.

Signature of supervising psychologist _____ Date _____