Psychological Testing Authorization Criteria

Sources: APA Psychological and Neuropsychological Testing Billing and Coding Guide; CMS Psychological and Neuropsychological Tests Coverage Guide

Introduction

Requests for psychological testing authorization must meet established criteria for Specialty Mental Health Services (SMHS). In addition, requested services need to align with evidence-based practices, the American Psychological Association's (APA) Psychological and Neuropsychological Testing Billing and Coding Guide, and Centers for Medicare and Medicaid Services (CMS) Psychological and Neuropsychological Tests Coverage Guide. The information below provides further guidance regarding provider qualifications, coverage rationale, and limitations/exclusions that need to be identified when requesting evaluations through Specialty Mental Health Services (SMHS). This guideline is provided for informational purposes. It does not constitute medical or clinical advice.

Benefit Considerations

Before submitting a request for authorization of psychological testing services, please verify whether the beneficiary is assigned to a Medi-Cal managed care health plan (MCP). If the client is assigned to a MCP, please contact the Behavioral Health contact number for the appropriate managed care plan. Per All Plan Letter 22-006 (APL 22-006 (ca.gov), the provision of clinically appropriate and covered non-specialty mental health services (NSMHS) is the responsibility of the Medi-Cal managed care health plan (MCP).

Provider Qualifications

Psychological Test Evaluation Services involve the use of reliable and research-validated methods and standardized tests to evaluate intellectual abilities, adaptive skills, interpersonal processing, cognitive, emotional, personality, psychopathology, and behavioral functioning. Psychological assessment is a complex, integrative process that requires specialized training and expertise.

The provider's professional training and licensure must be a doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience to practice within their scope of licensure and competence.

Coverage Rationale/Medical Necessity

As outlined by the State of California Department of Health Care Services, services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting conditions. When requesting pre-authorization for psychological testing, a completed Medi-Cal Psychological Testing Request Form needs to be submitted to Optum Utilization Management; this form can be located on the Optum San Diego website www.optumsandiego.com with the following pathway: BHS Provider Resources > Fee for Service Providers > SMHS Authorization Requests. The request needs to contain documentation that supports the medical necessity for testing as outlined by SMHS, including how testing will measure the suspected constellation of mental health concerns, the severity of the disorder, and functional impairment. Please also document the specific diagnoses that are under consideration along with the rationale for the proposed assessment battery and requested units of service.

Exclusions/Limitations of Coverage Per CMS and APA Billing and Coding Guide

Following the APA and CMS guidelines, psychological testing is not considered reasonable and necessary when:

- The beneficiary is neurologically, cognitively, or psychologically unable to participate in a meaningful way in the testing process.
- The beneficiary will not benefit from reasonable therapeutic or care options – there must be a reasonable expectation from a medical management perspective.
- Used as a routine screening tool given to the individual or to general populations.
- Administered for educational or vocational purposes that do not inform medical or health management.
- Comprised exclusively of self-administered or self-scored inventories, or as screening tests of cognitive function or neurological disease[1].
- Repeat testing is not required for medical decision-making.
- Administered when the beneficiary is currently under the influence or impaired by alcohol, drugs (prescription or illicit), or other substances.
- The beneficiary has been diagnosed previously with brain dysfunction and there is no expectation that the testing would impact the patient's medical, functional, or behavioral management.
- Performed when abnormalities of brain or emotional function are not suspected. Testing conducted when no mental illness/disability is suspected would be considered screening and would not be covered. Non-specific behaviors that do not suggest the possibility of mental illness or disability are not an acceptable indication for testing.

[1] For further information pertaining to differences between screening tests and comprehensive batteries, *see APAPO, 2014; Roebuck-Spencer et al., 2017; Block et al., 2016*

- Evaluations of the mental status that can be performed within the psychiatric diagnostic evaluation (e.g., a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires or screening measures such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, or use of other mental status exams in isolation) should not be classified separately as psychological or neuropsychological testing since they are typically part of a more general psychiatric/psychological clinical exam or interview.
- Each psychological/neuropsychological test administered must be individually medically necessary. A standard battery of tests is only medically necessary if each individual test in the battery is medically necessary that addresses the referral need and diagnoses in question.
- Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary.
- Supporting documentation in the medical record must be present to justify the medical necessity and hours tested per patient per evaluation. If the testing time exceeds eight (8) hours, medical necessity for the extended testing should be documented in the report.
- Routine re-evaluation of chronically disabled patients that is not required for a diagnosis or continued treatment is not medically necessary.

Sources of Information

American Psychological Association (2019). 2019 Psychological and Neuropsychological Testing Billing and Coding Guide.

APAPO (2014). Statement from an American Psychological Association and American Psychological Association Practice Organization work group on screening and psychological Assessment.

Block, C., Johnson-Greene, D., Pliskin, N., & Boake. (2016). Discriminating cognitive screening and cognitive testing from neuropsychological assessment: Implications for professional practice. *The Clinical Neuropsychologist, 31:3*, 487-500.

Centers for Medicare & Medicaid Services. (2019). LCD – Psychological and Neuropsychological Tests.

Department of Health Care Services. Behavioral Health Information Notice (BHIN) No: 21-073.

Roebuck-Spencer, T.M., Glen, T., Puente, A.E., Denney, R.L., Ruff, R.M., Hostetter, G., & Bianchini, K.J., (2017). Cognitive screening tests versus comprehensive neuropsychological test batteries: A National Academy of Neuropsychology education paper. *Archives of Neuropsychology, 32,* 491-498.

Introduction

Effective January 1, 2022, the definition of medical necessity and the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) is as established below.

Medical Necessity

- Pursuant to Welfare and Institutions Code section 14184.402(a)
  - For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.
  - For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.
- Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition[2].

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

For beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet **both of the following** criteria, (1) and (2) below:

1) The beneficiary has **one or both** of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
   b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:
   a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders[3] and the International Statistical Classification of Diseases and Related Health Problems.
   b. A suspected mental disorder that has not yet been diagnosed.

Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department[4], involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness:

OR

2) The beneficiary meets **both of the following** requirements in a) and b), below:
   a. The beneficiary has at least one of the following:
      i. A significant impairment.
      ii. A reasonable probability of significant deterioration in an important area of life functioning.
      iii. A reasonable probability of not progressing developmentally as appropriate.
      iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

[2] 42 C.F.R. §§ 456.5 and 440.230 (b)

[3] A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

[4] The Pediatric ACES and Related Life-Events Screener (PEARLS) tool is one example of a standard way of measuring trauma for children and adolescents through age 19. The ACE Questionnaire is one example of a standard way of measuring trauma for adults beginning at age 18. DHCS will explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement. MHPs are not required to implement the tool until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

b. The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders[5] and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.[6]

[5] A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above

[6] Welf. & Inst. Code, § 14184.402(d)