

**Policy terminated because coverage is provided under equivalent Medicaid
Policy 8C, Outpatient Behavioral Health Services Provided by Direct-
Enrolled Providers**

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1.0 Description of the Procedure, Product, or Service

Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a recipient's psychological or cognitive functioning. Testing is viewed as a potentially helpful second opinion for treatment failures and/or difficult to diagnose cases. Psychological testing may include one or more tests given to aid in the evaluation of a recipient with emotional, psychiatric, neuropsychiatric, personality illness(es) or developmental delays.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Psychological testing to be utilized in the evaluation for psychiatric care is covered when rendered by:
 1. A doctor of psychology licensed or certified in the state in which he or she performs any service covered by the North Carolina Health Choice Program (NCHC). He or she must have a doctorate practice degree in psychology and at least two years clinical experience in a recognized health setting or have met the standards of the National Register of Health Service Provider in Psychology.
 2. A licensed psychological associate supervised by a psychiatrist or licensed/certified doctoral psychologist, when completed within the requirements as under N.C.G.S. Chapter 90, Article 18A, Psychology Practice Act; and N.C. G.S. 90-270.21.

- b. Benefits for psychological testing are provided as for other diagnostic tests.
- c. Professional fees for services by the attending psychiatrist or co-admitting psychologist are covered during any certified period except when services are provided on the same day.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Psychological testing is generally not approved for those recipients with a chemical dependency diagnosis until 30 consecutive days of abstinence are obtained.
- b. The following are not covered:
 - 1. Educational or achievement testing for the sole purpose of resolving educational performance questions.
 - 2. Psychological testing for conditions which are classified solely as a learning disability.
 - 3. Psychological testing performed by a psychiatric nurse, social worker or any other allied mental health professional, for whom psychological testing is beyond his/her "scope of practice" and/or for which he/she is not licensed.
 - 4. Claims submitted by an eligible provider for a service not personally performed by that provider and for which he/she is not legally responsible.
 - 5. Scoring of psychological testing, report writing, and sessions to review test results are considered integral to the testing and are not eligible for separate reimbursement.

Note: Refer to **Subsection 5.1.d**.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is not required when psychological testing is done on an outpatient basis within the first 26 visits allowed without case management in any 12 month enrollment period.

- b. Prior approval by the DMA's vendor is required when psychological testing is done:
 1. on an outpatient basis after the 26 visit limit has been exhausted;
 2. during a stay at any higher level of care (inpatient, partial hospitalization, residential treatment center, intensive outpatient program, 23 hour observation stay).
- c. Information needed by DMA's vendor prior to the testing includes, names of tests, rationale for testing, number of hours requested, and name and credentials of the provider who plans to do the testing. DMA's vendor must render a decision regarding the medical necessity of requested psychological testing prior to the testing being performed. Testing is rarely, if ever, needed on an emergency basis; therefore requests for psychological testing must be prior approved.
- d. Routine testing (as may be regularly requested by facilities at admission or upon initiation of treatment) may not be considered medically necessary.

5.2 Itemization

Itemization per test is required. For example, a "Standard Battery of Psychological Tests" is not covered.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Code(s)				
96101	96102	96103	96105	96110
96111	96116	96118	96119	96120
96125				

Refer to **Subsection 5.2.**

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Office, Residential Treatment Center

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Psychologists (or other behavioral health practitioners) may at times need to see a recipient who has been hospitalized under the care of an admitting psychiatrist. When it is necessary for the outpatient provider to see an inpatient, that provider may be reimbursed when prior authorization is obtained from DMA's vendor.