MEDICAL POLICY

Excellus
An independent licensee of the Blue Cross Blue Shield Association

Medical Policy Title	**Psychological Testing**
Policy Number	**3.01.02**
Current Effective Date	**December 18, 2025**
Next Review Date	**December 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. 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.

II. Psychological testing to aid in diagnosing an intellectual disability is considered **medically appropriate** when **BOTH** of the following are met:
   A. A diagnostic question remains following a thorough evaluation and recommendation by the treating medical provider;
   B. The testing results are expected to generate necessary information to impact the member's care and treatment.

III. 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.

IV. The routine use of psychological testing as part of an initial assessment is considered **not medically necessary** for **ANY** of the following indications, as more suitable approaches are available (e.g., interview):
   A. Attention-deficit/hyperactivity disorder (ADHD);
   B. Tourette's syndrome;
   C. Autism spectrum disorder (ASD);

D. Complex medical condition (e.g., chronic pain).

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

VI. Psychological testing is **ineligible for coverage** when the testing is primarily:

A. For the purpose of 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

2.01.50 Neuropsychological Testing

POLICY GUIDELINE(S)

I. Preauthorization is contract dependent.

II. Psychological testing requires a clinically trained examiner. All psychological tests should be administered, scored, and interpreted by a trained professional, preferably a psychologist or psychiatrist with expertise in the appropriate area. The interpretation and written report should be completed by the psychologist. These services are all-inclusive in the number of hours authorized.

III. Psychological 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.

A. Detailed description of the diagnostic question from the referring provider (e.g., overlapping behavioral health symptoms leading to diagnostic uncertainty); and

B. A copy of the initial diagnostic evaluation with the patient, including review of the patient's relevant history (e.g., developmental, psychological, medical, educational), collateral interviews, and behavioral observation when applicable.

IV. A complete psychological evaluation with test batteries including administration, scoring and interpretation, generally takes between 2 to 8 hours to complete. Occasionally, it is necessary to complete the evaluation over two or more sessions. Requests for more than 8 hours of testing will require a detailed list of the testing battery and rationale for the extended time. The medical record must include supporting documentation to justify more than 8 hours per patient per evaluation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds 8 hours, medical necessity for extended time should be documented. Medical records may be requested.

V. Psychological testing performed as simple, self-administrated or self-scored inventories, or

screening tests such as, but not limited to, AIMS, Folstein Mini-Mental Status Exam, PHQ-9, Hamilton Rating Scale for Depression, Connors Rating Scale, Eat-26, Quotient ADHD System, are considered inclusive of an Evaluation and Management service. Brief emotional/behavioral assessments are not considered psychological testing. Likewise, tests that are patient-completed tools or that are administered by ancillary staff in an office (e.g., PHQ-2, PHQ-9, MAST, CAGE, AUDIT, ORT, and Pain scale) are not considered psychological testing and should not be billed utilizing these codes.

VI. A single psychological test is appropriate when it is combined with other rating scales and the clinical interview for pre-surgical psychological testing (e.g., Minnesota Multiphasic Personality Inventory [MMPI] or Million Behavioral Medicine Diagnostic [MBMD]). Otherwise, a single, stand-alone test, even a multi-faceted one, does not constitute a psychological evaluation service. At least two validated psychological tests are required to bill for psychological testing for the purposes of diagnostic clarification. Psychological testing may include, but is not limited to, the following: Minnesota Multiphasic Personality Inventory-2 or -3 (MMPI-2 or -3), Minnesota Multiphasic Personality Inventory-A (MMPI-A), Wechsler Adult Intelligence Scale-Revised (WAIS-III/IV), Personality Assessment Inventory (PAI), and Rorschach Inkblot Method.

VII. Coverage is not available for services provided by school districts for pre-school-aged children (three to five years) and school-aged children (five to 21 years), as they are considered free care.

A. When applicable, in accordance with applicable state and federal rules, members should have a committee on special education evaluation completed through the school district before a request for coverage is submitted to the Health Plan. Documentation should be provided demonstrating the evaluation and results, and the timing of any testing associated with the evaluation.

B. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for services for home-schooled children outside New York State will be reviewed on an individual basis in accordance with state regulations for the state in which the child lives.

C. Psychological testing that is denied by the school district will be reviewed by the Health Plan for medical necessity in accordance with the member's subscriber contract.

VIII. Compared to clinical interviews, psychological testing has not been found to reliably improve diagnostic accuracy of ADHD.

IX. For diagnosing a neurodevelopmental disorder, developmental testing codes may be appropriate when a diagnosis is unable to made by other methods (e.g., standardized parent interviews or direct, structured behavioral observation).

X. The number of hours requested includes the total time necessary to complete administration of two or more tests, scoring, interpretation, clinical decision-making, treatment-planning, and report, as well as interactive feedback to the patient, family member(s) or caregiver(s). 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. A request for additional test administration time may be considered medically necessary when supported by evidence of extenuating circumstances that is submitted by the provider. Examples of extenuating circumstances include the following:

A. The patient has significant functional impairment, for example:
    1. Sensory deficits and/or physical disabilities that necessitate modification in standard administration procedures.
    2. Severe oppositional behavior.
    3. Attention deficits or an intellectual developmental disability (intellectual disability) that require the examiner to provide frequent redirection and/or breaks for the patient during testing.

    *Note: Testing should not be conducted if extenuating circumstances such as these are so severe that it could reasonably pose a threat to the reliability or validity of test results.

B. The patient has an intellectual disability.

C. The patient requires an interpreter, as English is not the patient's primary language.

DESCRIPTION

Psychological tests, also referred to as psychometric instruments, are standardized tools designed to measure behavioral and mental attributes. These attributes may include emotional functioning, attitudes, intelligence, cognitive abilities, aptitude, personality traits, and indicators of psychological or neurological disorders. Common types of psychological tests include standardized aptitude and achievement assessments, diagnostic and evaluative tools, interest inventories, personality inventories, and projective instruments.

Test administration and scoring involve a formal process conducted by a trained professional who selects reliable and validated instruments and follows standardized procedures outlined in the test manual. This includes administering the test under appropriate conditions and accurately scoring the examinee's responses to ensure valid interpretation.

Advances in technology have impacted the field of psychological assessment, including the real-time role-play simulations, virtual reality exercises. The QbTest is a 20-minute test for use in conjunction with a clinical assessment, to provide clinicians with objective measures of hyperactivity, impulsivity, and inattention to aid in the clinical assessment of ADHD. The test involves infrared motion-tracking to measure activity, and results are interpreted by qualified professionals. The Quotient ADHD System is a computerized test that measures hyperactivity, inattention, and impulsivity. After completion of the approximately 30-minute, self-administered test, patterns of motion, accuracy of the responses, and fluctuation in attention state are analyzed and scored using proprietary algorithms. The patient's scores are then compared to those of other individuals of the same age and gender, to aid in the clinical assessment of ADHD. The Test of Variables of Attention (TOVA) is a culture- and language-free, sufficiently long computerized test that requires no left/right

discrimination or sequencing. The computer-based test provides healthcare professionals with objective measurements of attention and inhibitory control. Results should only be interpreted by qualified professionals.

Presurgical psychological assessment (PPA) is intended to provide recommendations to both the surgical team and the patient addressing how psychosocial factors may affect surgical outcomes. If adverse factors are identified, psychologists work with the patient and the medical team to develop presurgical treatment interventions and recommendations, recommend postsurgical follow-ups, or discuss whether surgery is the best treatment option at that time (Marek and Block 2023).

SUPPORTIVE LITERATURE

Psychological testing provides valuable objective data that supports accurate assessment of a patient's cognitive, emotional, and behavioral functioning. Beyond identifying the nature of the presenting problem, psychological testing informs the development of targeted treatment recommendations and intervention strategies, contributing to more effective and individualized care planning.

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

The Cochrane systematic review by Randall et al (2018) evaluated 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.

In 2024, the Agency for Healthcare Research and Quality (AHRQ) released a comprehensive systematic review and meta-analysis evaluating the diagnostic performance of tools used to identify ADHD in children and adolescents (Peterson 2024). 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.

Pre-Surgical Psychological Testing

Patients with complex medical conditions or those considering intricate surgical procedures (e.g., bariatric surgery) may benefit from a psychological or psychiatric evaluation to identify any underlying psychopathology that could interfere with treatment planning. In many cases, a standard psychiatric evaluation is sufficient and does not require the full battery of psychological tests. The purpose of the pre-surgical evaluation is to enhance surgical outcomes by identifying and addressing issues such as disordered eating, severe unmanaged mental illness, or active substance use. A multidisciplinary team plays a critical role in evaluating and managing modifiable risk factors to reduce perioperative complications and improve recovery. Ultimately, the decision regarding surgical readiness should rest primarily with the surgeon (Eisenberg, 2023).

Marek et al (2015) highlighted that psychopathology and patient expectations have been linked to poor results, which has led to increased use of presurgical psychological screening (PPS) in surgical evaluations. To explore the predictive value of the MMPI-2-RF in spine surgery outcomes, the authors examined its associations with various postoperative results in a sample of 172 men and 210 women. Their findings demonstrated that Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) scores significantly enhanced the prediction of early postoperative functioning beyond what could be explained by presurgical expectations and baseline functioning. Hierarchical regression analyses revealed that MMPI-2-RF scores accounted for up to 11% of additional variance in outcomes. Emotional/internalizing dysfunction and interpersonal problems were key contributors, with demoralization emerging as the most consistent predictor of poor functional outcomes. Somatoform dysfunction, particularly somatic complaints and malaise also significantly predicted adverse outcomes.

Kenfack et al (2022) 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 prior to spinal surgery. The authors report that it has been well established that psychological comorbidities have been linked to poor preoperative status, increased perioperative complications (e.g., perception of pain, prolonged length of stay, higher rates of readmission), and prolonged postoperative recovery in elective spine surgery candidates. The purpose of the study was to investigate how best to enhance the utility of the PROMIS-29 survey with the hope to establish cutoff values, similar to MMPI-2-RF, for PROMIS-29 anxiety and depression domains that might warrant attention preoperatively, formulating the survey as an advantageous presurgical screening tool. These scores may help identify patients whose postoperative recovery may be negatively impacted by these psychiatric comorbidities. The authors identified several limitations of their study and recommend further studies; however, based on findings the suggestion was made that spine surgery candidates with PROMIS-29 scores of 15 or greater on the depression domain and 15 or greater on the anxiety domain might have psychopathologies that warrant addressing in the perioperative period given their increased likelihood of having poorer outcomes after surgery than the general population.

Marek et al (2024) expanded on previous research by evaluating the psychometric validity of the updated MMPI-3 in the psychological assessment of patients seeking metabolic and bariatric surgery (MBS). In a sample of 790 consecutive patients, MMPI-3 scores demonstrated strong convergent and discriminant validity. Emotional/Internalizing Dysfunction scales were significantly correlated with depression, anxiety, suicide history, sexual abuse, psychotropic medication use, and problematic eating behaviors. Behavioral/externalizing dysfunction scales were linked to substance use and loss-of-control eating. The eating concerns scale showed the strongest correlations with behaviors such as binge eating and stress-related eating. These findings support the MMPI-3's ability to measure distinct psychological constructs relevant to MBS candidates. 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) conducted a retrospective review of archival data for 279 patients who were psychologically screened for eligibility for bariatric surgery. The authors sought to replicate and further clarify psychological variables associated with not moving forward with bariatric surgery. The study aimed to clarify psychological factors associated with patients not proceeding to surgery, particularly in a setting where insurance was not a barrier to access. Researchers compared Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) profiles between patients who did and did not undergo surgery. Of the sample, 86 patients (30.8%) did not proceed with surgery. Statistical analyses revealed significant differences in demographic variables (e.g., sex, age, employment status, arthritis) and MMPI-2-RF scale scores between groups. Specifically, patients who did not undergo surgery had higher scores on scales measuring somatic and neurological complaints, cynicism, and feelings of helplessness and hopelessness. While not all scale elevations reached clinical cut-offs, the findings suggest that psychological and psychosocial factors—rather than diagnosable psychopathology—may influence whether eligible patients proceed with bariatric surgery, even when financial barriers are removed.

PROFESSIONAL GUIDELINE(S)

Attention-Deficit/Hyperactive Disorder (ADHD)

Wolraich et al (2019) published the American Academy of Pediatrics (AAP) updated clinical practice guidelines for the diagnosis, evaluation, and treatment of ADHD in children and adolescents stating:

- 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 age 4 years to the 18th birthday who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.
- To make a diagnosis of ADHD the provider should determine that DSM-5 criteria have been met and should rule out any alternative causes (Grade B: strong recommendation).
- Appropriate further assessment is indicated if an underlying etiology is suspected.

The 2019 National Institute for Health and Care Excellence (NICE 2019) guideline recommends that a diagnosis of ADHD should only be made by a specialist psychiatrist, pediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of a full clinical and psychosocial assessment that should include discussion about behavior and symptoms in the different domains and settings of the person's everyday life, a full developmental and psychiatric history, and observer reports and assessment of the person's mental state. Rating scales are valuable adjuncts, and observations (e.g., at school) are useful when there is doubt about symptoms.

Autism Spectrum Disorder (ASD)

In its 2014 Practice Parameter, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends that when initial screening suggests significant symptoms of autism spectrum disorder (ASD), a comprehensive diagnostic evaluation should follow to confirm the diagnosis (Volkmar 2014). A standard assessment should include interviews with both the child and their family, a thorough review of developmental and medical history, examination of past records, and collection of relevant historical information. These components should be evaluated in alignment with DSM-5 diagnostic criteria. Although a variety of instruments have been developed to assess ASD, their clinical utility varies, and some require specialized training for proper administration and interpretation. These tools are intended to support, not replace, the clinical judgment of experienced professionals. Psychological assessment is also recommended to identify individual strengths and weaknesses that can inform treatment planning. This includes evaluating cognitive abilities and adaptive functioning, which helps contextualize observed social-communication challenges within the child's broader developmental profile. While AACAP acknowledges neuropsychological correlates of ASD (e.g., deficits in executive functioning and weak central coherence) formal neuropsychological testing is not explicitly recommended in the Practice Parameter.

Intellectual Disability

According to the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter (Siegel et al., 2020), intellectual disability (ID), also referred to as intellectual developmental disorder (IDD), is characterized by impairments in general mental abilities that affect adaptive functioning across three domains: conceptual, social, and practical. 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 of ID 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. The DSM-5 criterion for intellectual deficits requires confirmation through both clinical assessment and individualized, standardized intelligence testing. With standardized intelligence testing, individual cognitive profiles based on neuropsychological testing are more useful for understanding intellectual disability than a single IQ score.

Pre-Surgical Psychological Testing

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 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).

In 2023, the American Psychological Association published evidence-based procedures and practices, divided into 14 indication-specific chapters related to psychological assessment of surgical candidates (Marek and Block 2023).

- Chapter 4 examines psychopathology that is commonly assessed among bariatric surgery patients (mood disorders, eating disorders, anxiety disorders, substance use disorder, and cognitive functioning), how these factors are associated with poorer outcomes, and provides recommendations to mitigate risk factors (e.g., broadband and narrowband assessments such as the Minnesota Multiphasic Personality Inventory [MMPI] Restructured Form) (Diggins and Peterson 2023).
- Chapter 5 reviews the best available research evidence for the use of PPA in spine surgery interventions. Acknowledging the lack of a standard approach to conducting PPAs for spine surgeries, the authors suggest a risk identification and mitigation (RIM) model, which includes psychometric testing to identify objective psychosocial risk factors that been empirically linked to a full range of surgical outcomes (Murray 2023).

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.

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
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)
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)

HCPCS Codes

Code	Description
Not Applicable	

Revenue Codes

Code	Description
918	Psychiatric/Psychological Services-Testing

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

American Psychological Association; American Educational Research Association, American Psychological Association, and the National Council on Measurement in Education [Internet]. The standards for educational and psychological testing. 2014 [accessed 2025 Nov 21]. Available from: https://www.apa.org/science/programs/testing/standards.

American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC, American Psychiatric Association, 2022.

American Psychological Association; APA Task Force [Internet]. APA guidelines for psychological assessment and evaluation. 2020 Mar [accessed 2025 Nov 21]. Available from: https://www.apa.org/science/programs/testing

American Psychological Association (APA) [Internet]. Psychological and neuropsychological testing codes for psychologists. Last updated 2024 Sep. [accessed 2025 Nov 21]. Available from: https://www.apaservices.org/practice/reimbursement/health-codes/testing

Carter J, et al. ASMBS position statement on preoperative patient optimization before metabolic and bariatric surgery. Surg Obes Relat Di.s 2021 Dec;17(12):1956-1976. PMID: 34629296

Diggins A. and Peterson N. Metabolic and bariatric surgery. In R. J. Marek, & A. R. Block (Eds.), Psychological assessment of surgical candidates: Evidence-based procedures and practices (pp. 57-80, 270 Pages). Washington, DC: American Psychological Association, American Psychological Association; 2023.

Eisenberg D, et al. 2022 American Society of Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) indications for metabolic and bariatric surgery. Obesity Surgery. 2022 Oct 20;18(12):1345-1356.

Gibbons MM, et al. Mental Health Assessment and Psychosocial Interventions for Bariatric Surgery [Internet]. Washington (DC): Department of Veterans Affairs (US); 2014 Oct [accessed 2025 Nov 21]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK343838/pdf/Bookshelf_NBK343838.pdf

Kenfack YJ, et al. The Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) and Patient-Reported Outcomes Measurement Information System-29 (PROMIS-29) comparison study: assessing for PROMIS-29 depression and anxiety psychopathologic cutoff values amongst patients undergoing elective complex spine procedures. World Neurosurg. 2022 Aug;164:e908-e914.

Marek RJ, et al. The Minnesota Multiphasic Personality Inventory–2–Restructured Form (MMPI-2-RF): Incremental validity in predicting early postoperative outcomes in spine surgery candidates. Psychological Assessment. 2015 Mar;27(1):114-124.

Marek RJ, et al. Further evidence regarding the convergent and discriminant validity of Minnesota Multiphasic Personality Inventory-3 (MMPI-3) scores in the preoperative psychological evaluation of patients seeking metabolic and bariatric surgery. Surg Obes Relat Dis. 2024 Jun;20(6):577-586. Epub 2024 Jan 21. PMID: 38373868.

Marek RJ, et al. Using the presurgical psychological evaluation to predict 5-year weight loss outcomes in bariatric surgery patients. Surg Obes Relat Dis. 2017 Mar;13(3):514-521.

Marek RJ and Block A, Eds. Psychological assessment of surgical candidates : evidence-based procedures and practices. 1st ed. Washington, D.C.: American Psychological Association; 2023.

Mechanick JI, et al. Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures - 2019 update: cosponsored by American Association of Clinical Endocrinologists/American College of Endocrinology, The Obesity Society, American Society for Metabolic & Bariatric Surgery, Obesity Medicine Association, and American Society of Anesthesiologists. Surg Obes Relat Dis. 2020 Feb;16(2):175-247.

Murray J, et al. Spine surgery. In R. J. Marek, & A. R. Block (Eds.), Psychological assessment of surgical candidates: Evidence-based procedures and practices (pp. 81-100, 270 Pages). Washington, DC: American Psychological Association, American Psychological Association; 2023.

National Institute for Health and Care Excellence (NICE) [Internet]. Attention deficit hyperactivity disorder: diagnosis and management. NICE guideline [NG87]. 2018 Mar, last updated 2019 Sep. [accessed 2025 Nov 21]. Available from: https://www.nice.org.uk/guidance/ng87

New York State Senate [Internet]. Senate Bill S5845. Relates to coverage for the screening, diagnosis and treatment of autism spectrum disorder. Laws affected: Amd §§3216, 3221 & 4303, Ins L; amd §5, Chap of 2011. 2011 June 22. [accessed 2025 Nov 21]. Available from: https://www.nysenate.gov/legislation/bills/2011/s5845

Peterson BS, et al. ADHD diagnosis and treatment in children and adolescents. Rockville (MD): Agency for Healthcare Research and Quality (US); 2024 Mar. Report No.: AHRQ 24-EHC003. PMID: 38657097. [accessed 2025 Nov 21]. Available from: https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

Randall M, et al. Diagnostic tests for autism spectrum disorder (ASD) in preschool children. Cochrane Database Syst Rev. 2018 Jul 24;7:CD009044.

Siegel M, et al.; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues. Practice parameter for the assessment and treatment of psychiatric disorders in children and adolescents with intellectual disability (intellectual developmental disorder). J Am Acad Child Adolesc Psychiatry. 2020 Apr;59(4):468-496. Epub 2019 Nov 29. [accessed 2025 Nov 21]. Available from: https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

Sogg S, et al. Recommendations for the presurgical psychosocial evaluation of bariatric surgery patients. Surg Obes Relat Dis. 2016 May;12(4):731-749.

U.S. Department of Education [Internet]. Individuals with Disabilities Education Act. Statute Chapter 33, Part B, §1414 - Assistance for education of all children with disabilities. 2019 Nov 7 [accessed 2025 Nov 21]. Available from: https://sites.ed.gov/idea/statute-chapter-33/subchapter-ii

Volkmar F, et al.; American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. J Am Acad Child Adolesc Psychiatry. 2014 Feb;53(2):237-57. Erratum in: J Am Acad Child Adolesc Psychiatry. 2014 Aug;53(8):931. [accessed 2025 Nov 21]. Available from: https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

Walter FA, et al. When insurance is not a barrier: psychological factors predicting whether bariatric candidates undergo surgery. Surg Obes Relat Dis. 2024;20:953-961.

Walter HJ, et al. Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders. J Am Acad Child Adolesc Psychiatry. 2023;62(5):479-502. [accessed 2025 Nov 21]. Available from: https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

Wolraich ML, et al; subcommittee on children and adolescents with attention-deficit/hyperactive disorder. Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2019 Oct;144(4):e20192528. Erratum in: Pediatrics. 2020 Mar;145(3):e20193997.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Psychiatry and Psychological Services (LCD L33632) [accessed 2025 Nov 10]

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 service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
02/01/01, 03/28/02, 03/27/03, 02/26/04, 04/28/05, 06/22/06, 08/23/07, 06/26/08, 06/25/09, 08/26/10, 08/25/11, 08/23/12, 08/22/13, 06/26/14, 06/25/15, 08/25/16, 08/25/17, 08/23/18, 10/24/19, 10/22/20, 12/16/21, 04/21/22, 12/22/22, 12/21/23, 12/19/24, 12/18/25	
Date	**Summary of Changes**
12/18/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
02/01/01	• Original effective date