Guide for Psychological Testing Documentation/Billing

This guide is intended to provide clarification regarding the codes that should be used for billing of psychological testing activities. Providers also should follow guidance from their licensure boards related to testing practices and published policies and manuals. This guide is intended as an overview of information and not as a replacement of the more detailed information outlined in the policies and formal CPT codebook.

Psychological testing (96101) and Neuropsychological exam/testing (96116 and 96118) include the following activities:

- Clinical interview with the individual and collateral to gather social history and relevant information
- Psychodiagnostic assessment of emotionality, intellectual ability, personality, and psychopathology using validated testing measures
- Face to face time administering tests
- Time spent interpreting these tests
- Preparation of the report
- Time spent integrating other sources of clinical data, including previously completed reports
- Time spent reviewing the results with the individual and family

Time spent on the activities above should not be billed under separate codes such as 90791 (comprehensive clinical assessment), outpatient individual/family therapy (90832-90838, 90846-90847). These are separate clinical services that are not specifically related to the psychological testing.

Examples of when multiple services would be provided and billed separately rather than just using testing codes:

- A provider receives a referral for a clinical assessment (CCA). During the completion of this assessment, a need for specific testing is identified to clarify the diagnosis further, but a need for testing was not the original intent of the referral. A complete CCA is developed with the recommendation for testing.
- After completion of the testing, the psychologist determines that there is a need for therapy related to the identified goals. A treatment plan is developed for therapy services that will be provided by the psychologist on an ongoing basis.
- During a scheduled session, the individual is in need of immediate crisis intervention and testing is unable to be performed. Psychotherapy for crisis (90839 and 90840, if needed) can be utilized and supporting service note documentation would be provided. Testing would be completed at a later date.

** If codes for various services are used, documentation meeting the full requirements for each individual service as outlined in the Clinical Coverage Policy and Records Manual must be followed.

Currently, the policy does have a limit of eight hours per date of service, with the date on the claims being the date of the face-to-face contact. If time were spent on days that were not face-to-face for test interpretation and report writing, the hours would be accounted for in the claims for the face-to-face dates. If testing requires greater than eight hours, billing may need to be split across separate days. However, review of the current service utilization indicates that most psychologists are performing testing in eight hours or less.
The provider should have documentation either on the testing report or in a service note of the activities provided on each date and the hours spent. Claims should not be submitted prior to the completion of the full psychological testing report.

Examples:

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Activity</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1 – 3 hours</td>
<td>Clinical interview/test administration</td>
<td>May 1 – 5 hours</td>
</tr>
<tr>
<td>May 2 – 2 hours</td>
<td>Scoring/interpretation and writing report</td>
<td></td>
</tr>
<tr>
<td>May 3 – 3 hours</td>
<td>Test administration</td>
<td></td>
</tr>
</tbody>
</table>

** These are examples to illustrate how to bill for all hours, given that the claim dates must be the dates of face-to-face contact. In the above examples, the hours could have been billed on different dates, as long as eight hours were not exceeded.

The above information was compiled from the following:

2015 CPT Standard Edition published by the American Medical Association

North Carolina Division of Medical Assistance Clinical Coverage Policy 8C


North Carolina Records Management and Documentation Manual