



# Psychological/Neuropsychological Testing Update

## Why are my psychological/neuropsychological testing claims denying?

The American Medical Association (AMA) released new psychological/neuropsychological testing CPT codes effective for dates of service on or after January 1, 2019. This change resulted in confusion related to obtaining appropriate authorizations and billing for these services. Carelon determined there are five common denial trends specific with psychological/neuropsychological testing claim submissions:

1. Lack of prior authorization on file to provide psychological/neuropsychological testing services
2. Billed add-on codes without primary standalone code (these must be billed together on the same claim form using the service conclusion date)
3. Claims submitted with a medical diagnosis
4. Out of network provider does not have not proper authorization on file to see a member using an in-network benefit
5. Claims submitted outside of timely filling limits

## Frequently Asked Questions

### Q. How do I request prior authorization for psychological/neuropsychological testing?

- A. Providers can submit their psychological/neuropsychological testing request through our provider portal [providerportal.carelonbehavioralhealth.com](http://providerportal.carelonbehavioralhealth.com). Providers are strongly encouraged to utilize our portal instead of faxing in the requests.

A paper version of the request can be located on our Clinical Forms page under “Psychological Evaluation Forms” here: [www.carelonbehavioralhealth.com/providers/forms-and-guides](http://www.carelonbehavioralhealth.com/providers/forms-and-guides).

### Q. Is there anything I can do if I received a claim denial and did not submit the proper prior authorization?

- A. Yes. If you have already completed a psychological or neuropsychological testing service without a prior authorization and received a claim denial, you may wish to follow your standard appeals processes.

### Q. Why is my psychological/neuropsychological testing claim denying when I bill add-ons separately from primary billing codes?

- A. By definition, add-on billing codes are services that are performed in conjunction with another primary service; therefore, add-on codes must be billed with a primary billing code. Add-on codes must always be billed along with the primary, stand-alone code, on the same date of service, for the same patient, on the same claim form in order to process correctly. If the services described in the primary, stand-alone code and the matching add-on code were provided over multiple days, the services should not be billed until the service is concluded. The conclusion date should be used as the date of service for the primary code and the add-on code, and should reflect the total time spent to provide that particular service.



Please note: Provider documentation should reflect all dates of service, the duration of service conducted on each date, along with sufficient detail describing services rendered and supporting medical necessity for all services performed.

### Billing Code Examples

Primary	Add-on
96130	96131
96132	96133
96136	96137
96138	96139
96116	96121
96112	96113

Example: John Doe was seen for 1 unit of 96136 and 2 units of 96137 on 04012019. He returned on 04042019 for additional 2 units of 96137, which concluded the testing and evaluation services. The provider would submit a single claim listing 1 unit of 96136 and 4 units of 96137 with a date of service of 04042019. However, medical record documentation would indicate all dates of service, duration, and include sufficient detail describing the services rendered for each date.

**Solution:** If you have received a psychological/neuropsychological testing claim denial due to an add-on code not being billed in conjunction with a primary, stand-alone billing code for the same patient on the same date of service, on the same claim form, please resubmit your claim and make sure your primary billing code is billed with the add-on code. **Both billing codes should have the same date of service and be billed on the same claim form.** Please note: Timely filing may still apply.

**Solution:** If you have already billed and received payment for the primary, stand-alone code, it is recommended that you send a corrected claim on paper. Reference the original claim in your resubmission and use the actual service conclusion date as the date of service for both the primary, stand-alone code and the add-on codes. Carelon claim adjusters will review these claims manually, although there may be valid reasons why a claim will still be denied. An example would be if the primary code was received in a timely manner but the add-on code was not included on any claim submitted within timely filing limits.

#### Q. Why isn't a medical diagnosis accepted for psychological/neuropsychological testing claims?

- A. Psychological/neuropsychological testing is most often completed for members experiencing psychological symptoms; therefore, a medical diagnosis cannot be accepted on a claim.

**Solution:** If psychological/neuropsychological testing was performed due to a medical diagnostic reason, the claim is likely not covered under the member's behavioral health benefit; therefore, the provider should consider submitting the claim to the member's medical insurance carrier for consideration.



## Q. Why is my claim denying for timely filing?

- A. Providers are responsible to submit their claims within the plans timely filing. This applies to providers who are waiting on a single case agreement or authorization approval as well. If you are not sure how long timely filing limit is for a specific plan, please reach out to Carelon's Customer Service Department based on the number on the member's identification card.

Example: A provider renders psychological testing to a member whose authorization is still pending approval. The provider submits the claim and this denies for no authorization, once the authorization is approved, the provider can follow up with the Carelon Customer Service Department to have the claim reprocessed.

**Solution:** If you have received a psychological/neuropsychological testing claim denial due to timely filing, please send your paper claim referencing the timely denied claim and a letter explaining why it was submitted outside of timely filing limits to the following address:

Carelon  
Attn: Claims  
PO Box 1866  
Hicksville, NY 11802

If you feel that you qualify for a 60-day waiver, please complete a 60-day waiver request form and submit it along with your claim. 60-day waivers are granted for the following reasons:

- Provider retroactively eligible for reimbursement
- Member retroactively enrolled
- Third party coverage
- Member retroactively authorized for service

If applicable, you can find the 60-day waiver form located on our website. Visit [www.carelonbehavioralhealth.com/providers/forms-and-guides](http://www.carelonbehavioralhealth.com/providers/forms-and-guides) to view the form.

If you have additional questions regarding your psychological/neuropsychological testing claim denials, please reach out to Carelon's Customer Service Department based on the number located on the member's identification card.

Please note: Billing practices are subject to change if additional AMA CPT guidance is received in the future. If and when this occurs, Carelon will make changes accordingly to internal processes and provide additional communication to providers on these updates.