

# Psychological and Neuropsychological Tests

L34520

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09101 - MAC A	J - N	Florida
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09102 - MAC B	J - N	Florida
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09202 - MAC B	J - N	Puerto Rico
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09302 - MAC B	J - N	Virgin Islands

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## LCD Information

Document Information

**LCD ID**

L34520

**LCD Title**

Psychological and Neuropsychological Tests

**Proposed LCD in Comment Period**

N/A

**Source Proposed LCD**

N/A

**Original Effective Date**

For services performed on or after 10/01/2015

**Revision Effective Date**

For services performed on or after 07/01/2020

**Revision Ending Date**

N/A

**Retirement Date**

N/A

**Notice Period Start Date**

N/A

**Notice Period End Date**

N/A

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## CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for Psychological and Neuropsychological Tests. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for Psychological and Neuropsychological Tests and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

### Internet Only Manual (IOM) Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*,
  - Chapter 15, Section 80.2 Psychological Tests and Neuropsychological Tests, Section 160 Clinical Psychologist Services, Section 170 Clinical Social Worker (CSW) Services
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
  - Chapter 23, Section 20.9 National Correct Coding Initiative (CCI)
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*,
  - Chapter 3, Section 3.3.2.6 Psychotherapy Notes
  - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

### National Correct Coding Initiative (NCCI) Citation:

- NCCI Policy Manual for Medicare Services
  - Chapter 11, Section M Central Nervous System Assessments/Tests.

### Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

### **Federal Register References:**

- Code of Federal Regulations (CFR), Title 42, Volume 2, Chapter IV, Part 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions and Part 410.33 Independent diagnostic testing facility.

## Coverage Guidance

### **Coverage Indications, Limitations, and/or Medical Necessity**

#### **History/Background and/or General Information**

Neuropsychological tests provide measurements of brain function that are objective, valid, and reliable. Neuropsychological tests are quantifiable in nature and require patients to directly demonstrate their level of cognitive competence in a particular cognitive domain. Neuropsychological tests are administered in the context of a comprehensive assessment that synthesizes data from clinical interview, record review, medical history, and behavioral observations. Information from neuropsychological assessments directly impacts medical management of patients by providing information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning. In addition, neuropsychological assessments predict functional abilities across a variety of disorders.

Indications for neuropsychological assessments include a history of medical or neurological disorder compromising cognitive or behavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; reported impairments in cognitive functioning; and evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations (e.g., deep brain stimulators, epilepsy surgery). Neuropsychological assessments are not limited in relevance to patients with evidence of structural brain damage, and are frequently necessary to document impairments in patients with probable neuropsychological and neurobehavioral disorders, and are the tool of choice whenever objective documentation of subjective cognitive complaints and symptom validity testing are indicated. In children and adolescents, a significant inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands warrants a neuropsychological evaluation.

Neuropsychological testing is not supported or excluded from medical necessity based on diagnosis alone. Rather, indications for testing are based on whether there is known or suspected neurocognitive involvement or effects, or where neuropsychological testing will impact the management of the patient by confirmation or delineation of diagnosis, or otherwise providing substantive information regarding diagnosis, treatment planning, prognosis, or quality of life.

Neuropsychological testing is useful in persons with documented changes in cognitive function to differentiate neurologic diseases (i.e., one of the types of dementia) or injuries (e.g., traumatic brain injury, stroke) from depressive disorders or other psychiatric conditions (e.g., psychosis, schizophrenia) when the diagnosis is uncertain after complete neurological examination, mental status examination, and other neurodiagnostic studies (e.g., computed tomography (CT) scanning, magnetic resonance (MR) imaging). The clinician presented with complaints of memory impairment or slowness in thinking in a patient who is depressed or paranoid may be unsure of the possible contribution of neurological changes to the clinical picture. Neuropsychological testing may be particularly helpful when the findings of the neurological examination and ancillary procedures are either negative or equivocal. The differential diagnosis of incipient dementia from depression is a case in point, particularly when computed tomography (CT) fails to yield definitive results.

Neuropsychological testing may be indicated in persons with epilepsy. Neuropsychological testing is used in these patients to monitor the efficacy and possible cognitive side effects of drug therapy (e.g., new anti-convulsant drug therapy) by comparing baseline performance with subsequent testing performance. Neuropsychological testing is also used to assess post-surgical changes in cognitive functioning to guide further treatment services. Preferably, these tests should be administered by a psychiatrist or certified psychologist trained to conceptualize the neuro-anatomical and the neuro-behavioral implications of the diagnostic entities under consideration and who is capable of interpreting patterns of test scores in view of principles of lateralization and localization of cerebral function.

### **Covered Indications**

Neuropsychological testing is considered medically necessary for the following indications:

- When there are deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from other disease processes; or
- When neuropsychological data could provide clarification of clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, and the information will be useful in determining a prognosis or treatment

- planning by determining the rate of disease progression; or
- When there is a need for a pre-surgical or treatment-related cognitive evaluation to inform whether one might safely proceed with a medical or surgical procedure that may affect brain function (e.g., deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery) or significantly alter a patient's functional status; or
  - When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (e.g., radiation, chemotherapy, antiepileptic medications), and this information is utilized in treatment planning; or
  - When there is a need to assess progression, recovery, and response to changing treatments, in patients with CNS disorders, in order to determine the most effective plan of care; or
  - When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which directly impacts medical management by differentiating psychogenic from neurogenic syndromes (e.g., dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
  - When there is a need for treatment planning purposes of determining functional abilities/impairments in individuals with known or suspected CNS disorders (e.g., capacity for independent living or movement from a family home into an institutional setting); or
  - When there is a need to determine whether a patient can comprehend and participate effectively in complex treatment regimens and to determine functional capacity for health care decision-making, independent living, etc.; or
  - When there is a need to design, administer, and/or assess outcomes of cognitive rehabilitation procedures, often in collaboration with other specialists such as speech pathologists, occupational therapists, physiatrists, and rehabilitation psychologists; or
  - When there is a need for treatment planning of identification and assessment of neurocognitive sequelae of disease ; or
  - Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies for certain individuals with neuropsychiatric disorders; or
  - When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

The content of neuropsychological testing procedures differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.).

Psychological testing codes include the administration, interpretation, and scoring of the medically accepted tests for the evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Psychological tests are used to address a variety of questions about people's functioning, diagnostic classification, co-morbidity, and choice of treatment approach. For example, personality tests and inventories evaluate the thoughts, emotions, attitudes, and behavioral traits that contribute to an individual's interpersonal functioning. The results of these tests determine an individual's personality strengths and weaknesses and may identify certain disturbances in personality or psychopathology. One type of personality test is the projective personality assessment, which asks a subject to interpret some ambiguous stimuli, such as a series of inkblots. The subject's responses can provide insight into his or her thought processes and personality traits.

Examples of problems that might require psychological testing include:

1. Assessment of mental functioning for individuals with suspected or known mental disorders for purposes of differential diagnosis and/or treatment planning.
2. Assessment of patient strengths and disabilities for use in treatment planning or management when signs or symptoms of a mental disorder are present.
3. Assessment of patient capacity for decision-making when impairment is suspected that would affect patient care or management.
4. Assessment of mental function in certain chronic pain patients when indicated after psychological screening prior to surgical pain management intervention (e.g., implantable neurostimulator).
5. Assessment of mental function in a chronic pain patient with suspected somatization disorder.

When a psychiatric condition or the presence of dementia has already been diagnosed, there is value to the testing only if the information derived from the testing would be expected to have significant impact on the understanding and treatment of the patient. Examples include a significant change in the patient's condition, the need to evaluate a patient's capacity to function in a given situation or environment, and/or the need to specifically tailor therapeutic and/or compensatory techniques to particular aspects of the patient's pattern of strengths and disabilities.

### **Limitations**

Psychological and Neuropsychological testing is not considered reasonable and necessary when:

- the patient is not neurologically and cognitively able to participate in a meaningful way in the testing process;
- administered for educational or vocational purposes that do not establish medical management;
- performed when abnormalities of brain or emotional function are not suspected;
- used for self-administered or self-scored inventories or screening tests of cognitive function (paper-and-pencil or computerized), e.g., AIMS, Folstein Mini-Mental Status Examination;
- Repeated when not required for medical decision-making. Examples of medical decision making include: whether to start or continue a particular rehabilitative or pharmacologic therapy);
- Administered when the patient has a substance abuse background, and any of the following apply: the patient has ongoing substance abuse such that test results would be inaccurate, or the patient is currently intoxicated.

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.

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.

Psychological/neuropsychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home does not constitute medical necessity for testing. Testing of every patient upon entry to a nursing home would be considered a routine service and would not be covered. However, some individuals enter a nursing home at a time of physical and cognitive decline and may require psychological/neuropsychological testing to arrive at a diagnosis and plan of care. Decisions to test individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis.

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.

The psychological/neuropsychological testing codes should not be reported by the treating physician for only reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the

patient, such as evaluation and management services. Psychological and neuropsychological testing codes should be reported by the performing provider (i.e., clinical psychologist, neuropsychologist, or physician) who administered the test.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. 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.

For the formal evaluation of aphasia using a psychometric instrument such as the Boston Diagnostic Aphasia Examination, testing is typically performed once during treatment, and the medical necessity for such testing should be documented. Repeat testing should only be done if there is a significant change in the patient's aphasic condition.

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.

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

### **Summary of Evidence**

N/A

### **Analysis of Evidence (Rationale for Determination)**

N/A

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## **General Information**

### **Associated Information**

Documentation Requirements

Please refer to the Local Coverage Article: Billing and Coding: Psychological and Neuropsychological Tests (A57780) for documentation requirements that apply to the reasonable and necessary provisions outlined in this LCD.

### **Utilization Guidelines**

Please refer to the Local Coverage Article: Billing and Coding: Psychological and Neuropsychological Tests (A57780) for utilization guidelines that apply to the reasonable and necessary provisions outlined in this LCD.

### **Sources of Information**

American Academy of Clinical Neuropsychology (AACN), (October 2011) Neuropsychology Model LCD.

American Medical Association (2013) CPT® Professional Edition

Benedict RHB, (2011). Cognitive Dysfunction in Multiple Sclerosis. [A Clinical Bulletin]. From the Professional Resource Center of the National MS Society.

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Soderlund H, et.al. (2006). Cerebral changes on MRI and cognitive function: CASCADE study. *Neurobiology of Aging* 27: 16–23

Sumowski JF, Beneict r, Enzinger C, et al. (2018). Cognition in multiple sclerosis State of the field and priorities for the future. *Neurology*, 90 (6); 278-288.

Sumowski JF, Rocca MA, Leavitt VM, et al. (2014). Brain reserve and cognitive reserve protect against cognitive decline over 4.5 years in *MS Neurology* 82: 1776-1783.

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CGS Administrators, LLC LCD (L31887)

LCDs and policies from other Medicare contractors and private insurers

National Government Services, Inc. LCD (L26895)

Novitas Solutions, Inc. LCD (L32766)

Wisconsin Physicians Service Insurance Corporation LCD (L31990)

## Bibliography

N/A

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## Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
07/01/2020	R9	Revision Number: 8 Publication: June 2020 Connection LCR A/B2020-042  Explanation of Revision: Based on a CMS directive, the LCD was revised to remove language in	<ul style="list-style-type: none"><li>Other (Revision based on CMS directive)</li></ul>

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>the "Limitations" section regarding Alzheimer's disease. The effective date of this revision is based on date of service.</p>	

01/08/2019

R8

Revision Number 7  
 Publication November 2019  
 Connection  
 LCR AB2019-075

- Other (Revision based on CR 10901)

Explanation of Revision: Based on Change Request (CR) 10901, the LCD was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Social Security Act, Code of Federal Regulations, and IOM reference sections were

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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updated. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018.

At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.

01/01/2019	R7	<p>Revision Number: 6            Publication: December 2018            Connection            LCR A/B2019-001</p> <p>Explanation of Revision: Annual 2019 HCPCS Update. Descriptor revised for CPT code 96116. Deleted CPT codes 96101, 96102, 96103, 96111, 96118, 96119, and 96120. Added CPT codes 96112, 96113, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, and 96139. The effective date of this revision is based on date of service.</p>	<ul style="list-style-type: none"> <li>• Revisions Due To CPT/HCPCS Code Changes</li> </ul>
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Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>01/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.</p>	
11/28/2018	R6	<p>Revision Number: 5            Publication: December 2018            Connection            LCR A/B2018-088</p> <p>Explanation of Revision: Based on an LCD reconsideration request, the LCD was revised to add ICD-10-CM diagnosis codes B20 and G35 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT/HCPCS codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451. In addition, the “Sources of Information” section of the LCD was updated. The effective date of this revision is based on date of service.</p> <p>11/28/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires</p>	<ul style="list-style-type: none"> <li>• Reconsideration Request</li> </ul>

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.

10/01/2018	R5	<p>Revision Number: 4</p> <p>Explanation of Revision: Based on CR 10847 (Annual 2019 ICD-10-CM Update), the LCD was revised to indicate that diagnosis codes were added, deleted, and descriptors were revised within existing diagnosis code ranges. In addition, the LCD was revised to remove the duplicate paragraph in the "Revenue codes:" section of the LCD. The effective date of this revision is based on date of service.</p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
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10/31/2017

R4

Revision Number: 3

Publication: October 2017  
Connection

LCR A/B2017-042

Explanation of Revision: Based on an LCD reconsideration request, the LCD was revised to

- Reconsideration Request

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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add ICD-10-CM diagnosis codes G20, G40.001 - G40.319, G40.A01 - G40.B19, and G40.401 - G40.919 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT/HCPCS codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451. The effective date of this revision is based on date of service.

10/31/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.

10/01/2017	R3	<p><b>Revision Number: 2</b></p> <p>Publication: September 2017 Connection</p> <p>LCR A/B2017-038</p> <p><b>Explanation of Revision:</b> Based on CR 10153 (Annual 2018 ICD-10-CM Update) the LCD was revised. Added ICD-10-CM diagnosis code F10.11. The</p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
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Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>effective date of this revision is based on date of service.</p> <p>10/01/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	

10/01/2016

R2

Revision Number: 1  
 Publication: October 2016  
 Connection  
 LCR A/B2016-097

- Typographical Error

Explanation of Revision: Based on CR 9677 (Annual 2017 ICD-10-CM Update) the LCD was revised. Revised ICD-10-CM diagnosis code ranges from I69.01-I69.020 to I69.010 – I69.020, and I69.11-I69.122 to I69.110 – I69.122, and added new ICD-10-CM diagnosis ranges I69.210 – I69.219, I69.310 – I69.319, I69.810 – I69.819 and I69.910 – I69.919 in the “ICD-10 Codes that Support Medical Necessity” section of

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>the LCD. Also, deleted ICD-10-CM diagnosis codes I69.01, I69.11, I69.21, I69.31, I69.81 and I69.91 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD. The effective date of this revision is based on date of service.</p>	
10/01/2016	R1	<p>Revision Number: 1 Publication: October 2016 Connection LCR A/B2016-097</p> <p>Explanation of Revision: Based on CR 9677 (Annual 2017 ICD-10-CM Update) the LCD was revised. Revised ICD-10-CM diagnosis code ranges from I69.01-I69.020 to I69.010 – I69.020, and I69.11-I69.122 to I69.110 – I69.122, and added new ICD-10-CM diagnosis ranges I69.210 – I69.219, I69.310 – I69.319, I69.810 – I69.819 and I69.910 – I69.919 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD. Also, deleted ICD-10-CM diagnosis codes I69.01, I69.11, I69.21, I69.31, I69.81 and I69.91 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD. The effective date of this revision is based on date of service.</p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>

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## Associated Documents

### Attachments

N/A

### Related Local Coverage Documents

#### Articles

[A57780 - Billing and Coding: Psychological and Neuropsychological Tests](#) 


[A58256 - Psychological and neuropsychological tests - revision to the Part A and Part B LCD \(MCD Archive Site\)](#) 


### Related National Coverage Documents

#### NCDs

N/A

### Public Versions

Updated On	Effective Dates	Status	
06/19/2020	07/01/2020 - N/A	Currently in Effect	You are here

Some older versions have been archived. Please visit the [MCD Archive Site](#)  to retrieve them.

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## Keywords

N/A