

Effective: July 1, 2026

<p>Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax).</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>Notification Required</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>

Applies to:

- Tufts Health One Care
- Tufts Medicare Preferred HMO/PPO

We recommend submitting prior authorization [electronically](#). If you opt to submit prior authorization requests via fax, please refer to this [reference chart for the appropriate fax number](#) (varies by product). For details on all our products, please visit the [Our Plans page](#) on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our [Prior Authorization Resources](#) page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider [click here](#) to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® SmartSheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

Psychological testing and assessment is a technique performed by licensed psychologists in order to measure and evaluate behavior, cognition, mood, affect, and/or personality in order to improve understanding of capabilities and symptoms. It typically entails a combination of activities, measures, and tools including the use of norm-referenced psychometric instruments. Psychological testing and assessment are covered when performed as part of a medical or behavioral health evaluation, intended to address a specific clinical question that impacts clinical management of the member and criteria is met.

Neuropsychological testing and assessment provide information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning, and predict functional abilities across a variety of disorders. Neuropsychological testing and assessment are a covered benefit when specific cognitive impairments are suspected or have been identified, and when the testing is performed to address questions that have not been able to be answered after a medical or behavioral health evaluation.

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for Psychological and Neuropsychological Testing and Assessment:

1. Medicare: Behavioral Health Psychiatry and Psychology Services NGS

Limitations

The Plan considers Psychological and Neuropsychological Testing and Assessment as not reasonable or medically necessary for any of the following:

1. The testing is primarily for the purpose of qualifying for services that are covered under applicable state or federal special education laws.
2. The testing is being conducted primarily for educational (including learning disabilities), vocational or legal purposes.
3. Any other contraindication noted within criteria

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Procedure Code	Procedure 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)
96132	Neuropsychological 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
96133	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
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)
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only

References:

None

Approval And Revision History

November 16, 2023: Reviewed by the Medical Policy Approval Committee (MPAC), effective January 1, 2024

Subsequent changes and endorsements:

- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee, effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- September 19, 2024: Reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee, no changes
- September 19, 2024: Reviewed by MPAC, renewed without changes, effective November 1, 2024
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.