

## **Psychological Testing**

All psychological testing must be authorized prior to administering the tests.

Process:

- To initiate the authorization process the practitioner requesting the psychological testing and the practitioner who will perform the psychological testing must fill out a MCIC Request for Psychological Testing Form and fax to MCIC's Quality Health Management Team prior to the actual tests.
- MCIC's Behavioral Health Management team will review the request form and notify the requesting practitioner of the outcome (approval/denial) within two business days of receiving all requested materials/information.



# MERCYCARE HEALTH PLANS

MERCYCARE INSURANCE COMPANY • MERCYCARE HMO, INC.  
PO BOX 2770, JANESVILLE, WI 53547-2770  
PHONE (608) 752-3431 • (800) 752-3431 FAX (608) 752-3751

## Outpatient Neuro-Psychological Testing/Health & Behavioral Assessment Prior Authorization Request Form

### MEMBER IDENTIFICATION:

Member Name: \_\_\_\_\_  
Member #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Member Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

CPT Billing Code: \_\_\_\_\_  
Service Date(s): \_\_\_\_\_

### SERVICE REQUESTED:

**Neuro-Psychological Testing**

Member has had:

- a. A complete physical and history:  Yes  No
- b. Consultation from a Neurologist or Psychiatrist:  Yes  No  
Consultants Name: \_\_\_\_\_ Date: \_\_\_\_\_
- c. Received prior testing from \_\_\_\_\_

**Health & Behavioral Assessment:**

- a. Member diagnosed with mental illness:  Yes  No
- b. Medical condition impacting:
  - Treatment  Recovery/Disease
  - Progression  Symptom Management
  - Behavior Elimination  Prevention
- c. Medical Diagnosis: \_\_\_\_\_

### REQUIRED INFORMATION:

1. Presenting problem and reason for referral: \_\_\_\_\_
2. List specific questions that will be answered/biopsychosocial factors identified as a result of this testing/assessment: \_\_\_\_\_
3. Current mental status/symptoms: \_\_\_\_\_
4. Proposed treatment plan and differential diagnosis: \_\_\_\_\_
5. Expected outcome: \_\_\_\_\_

Below, please list the complete names of tests that will be used to answer the above questions, the administration/scoring/interpretation time for each (give a rationale that will be used for any that differ significantly from publisher recommended times), and its purpose.

	<u>Name of Test</u>	<u>Time in hours</u>	<u>Purpose</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

- \* -For neuro-psychological testing (90801) should be used for the evaluation prior to testing.
- Neuropsychological Testing (96117) is limited to 9 units per contract year.
- Health and Behavioral Assessment (96150 – 96154) is limited to 6 units per contract year.

Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Tax Id: \_\_\_\_\_

**Fax or mail this request to Quality Health Management (608) 758-7726**

### MCIC USE ONLY

Date Received \_\_\_\_\_ Received By: \_\_\_\_\_ Auth #: \_\_\_\_\_

Authorization approved?  Level: 1  2  3  # Units: \_\_\_\_\_ CPT Code: \_\_\_\_\_

Denied:  Reason: \_\_\_\_\_

Signature of Medical Director: \_\_\_\_\_ Date: \_\_\_\_\_



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## Request for Outpatient Psychological Testing

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date Received: \_\_\_\_\_ Billing Code: \_\_\_\_\_

Service Date(s): \_\_\_\_\_ Number of Units: \_\_\_\_\_

- Request must be medically necessary to evaluate or treat a mental disorder.
- Testing for educational purposes is not covered.
- Psychological tests should be standard, valid, and reliable tests. These tests should focus on the patient's problems and help clarify the diagnosis and also aid in the treatment outcome.
- Test must ask precise questions that can be answered by the tests administered. Organic or cognitive dysfunction due to substance abuse must be identified as results of tests may be altered.
- There must be uncertainty about the course of treatment, or the patient's lack of responses to treatment for testing to be authorized.

### Review Questions to be Completed by Therapist/Doctor

1. Test requested? \_\_\_\_\_
2. What questions are you trying to answer with the test? \_\_\_\_\_
3. Have the test been performed before? Yes \_\_\_\_\_ No \_\_\_\_\_ How long ago? \_\_\_\_\_
4. Is the diagnosis clear without testing (explain)? \_\_\_\_\_
5. Are stressors accounting for current level of patients functioning? \_\_\_\_\_
6. Are there any other sources of information beside the tests that can answer the questions? \_\_\_\_\_
7. Is the testing needed for a more comprehensive treatment plan? Please explain: \_\_\_\_\_
8. Is testing for educational purposes? Yes \_\_\_\_\_ No \_\_\_\_\_
9. How will the treatment outcome be improved? \_\_\_\_\_

Signature

Date

### Review Questions to be Completed by Psychologist

1. Tests required by psychologist? \_\_\_\_\_
2. Will the test answer the question? \_\_\_\_\_
3. Number of test sessions? \_\_\_\_\_
4. Number of hours to complete? \_\_\_\_\_
5. What time is required until results are ready? \_\_\_\_\_

Signature

Date

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#### MCIC USE ONLY

Date Received \_\_\_\_\_ Received By: \_\_\_\_\_ Auth #: \_\_\_\_\_  
 Authorization approved?  Level: 1  2  3  # Units: \_\_\_\_\_ CPT Code: \_\_\_\_\_  
 Denied:  Reason: \_\_\_\_\_  
 Signature of Medical Director: \_\_\_\_\_ Date: \_\_\_\_\_