

Medtronic

Psychological evaluation

2026 reimbursement guide

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Questions: email neuro.us.reimbursement@medtronic.com

Introduction

This document is intended to provide resources to support patient access as it relates to psychological evaluations. There are various types of mental health requirements for coverage. These requirements vary by therapy and payer type. As a result, it is essential to review the payer specific policy requirements for each patient to determine their specific mental health requirements.

Mental health requirements by therapy

Therapy	Payer	Mental health requirements
Spinal Cord Stimulation (SCS)	Medicare (National) Commercial payers (all)	Psychological evaluation
Targeted Drug Delivery (TDD)	Commercial payers (subset of payers for non-malignant pain)	Psychological evaluation
Basivertebral Nerve Ablation (BVNA)	CMS MAC Wellpoint CMS MAC Palmetto Commercial payers (subset of payers)	Psychological evaluation
	CMS MAC Noridian	Psychological assesment
	Commercial payers (subset of payers)	Mental health statement

Mental health requirement	Provider type	Example components
Psychological evaluation	Performed by a qualified mental health practitioner	Full evaluation, including assessment of the patient's psychological history, and current mental status.
Psychological assesment	Can be the same physician performing the Interventional/Implantable Pain procedure	Statement of the "patient's ability to tolerate and benefit from BVNA"; and the absence of untreated mental health conditions as the primary cause of chronic back pain.
Mental health statement	From a different HCP than the physician performing the Interventional/Implantable Pain procedure; but does not need to be a licenced mental health provider	Statement attesting to the absence of untreated mental health conditions as the primary cause of chronic back pain.



The remainder of this document is dedicated to **psychological evaluation** resources.

Psychological evaluation requirements

Common payer requirements

Evaluation Timing: Must be performed within the last 6-12 months.

Patient Condition Summary: Should include a summary of the patient's condition.

Behavior/Addiction Issues: Must indicate if there are treated or untreated behavior or addiction issues.

Psychosomatic Pain: Should state if the pain is or is not psychosomatic.

Clearance for procedure: Must indicate if the patient is or is not cleared for the requested procedure.

Practitioner Credentials: Must be signed and dated by a licensed mental health practitioner.

Medicare-specific requirements

Qualified Practitioners: Medicare requires the evaluation to be performed by a qualified mental health practitioner, which includes a Psychiatrist, Psychologist or a Licensed Clinical Social Worker.⁹ Evaluations conducted by licensed professional counselors, who are not considered qualified mental health practitioners, may not be accepted by Medicare.

Type of Evaluation: Medicare does not accept behavioral assessments (e.g., Pearson Assessment). They require a complete psychological evaluation from a qualified mental health practitioner.

Common denial reasons

Outdated Evaluation: The psychological evaluation was conducted too long ago.

Unqualified Practitioner: The evaluation was not conducted by a qualified mental health practitioner.

Incorrect Assessment Type: A behavioral assessment such as a Pearson evaluation was submitted instead of a full psychological evaluation.

Not Cleared: The psychological evaluation did not state the patient is cleared for treatment.

Psychological evaluation resources

Online telehealth evaluations

Medtronic does not endorse or promote the use of one company over the other. Any interactions with the companies listed below is at the discretion of the individual. Medtronic is not liable to any services provided or not provided.

To be included on the list, providers had to meet all of the following criteria:

- Offers telehealth capabilities
- Contracted with Medicare and at least 3 major commercial payers
- Offers services in at least 5 states
- Offers a self-pay option for patients whose insurance does not cover telehealth psych evals (with self-pay of < \$500).

WellBrain

707-410-0337

sales@wellbrain.io

<https://www.wellbrain.io/>

Advantage Point Behavioral

877-583-5633

support@advantagepointbehavioral.com

<https://advantagepointbehavioral.com/>

Medtronic provides this listing to support patient access as it relates to psychological evaluations for the on-label use of Medtronic SCS products. Medtronic has no vested interest in any specific psychological evaluation providers listed, nor do we provide any recommendation, assurance, or guarantee with respect to their service. Medtronic does not endorse or promote the use of one psychological evaluation provider over another. Medtronic is not liable for any services provided or not provided. Medtronic does not charge, and the psychological evaluation providers do not pay to be included on this list. The list of psychological evaluation providers may not include all the providers in your area who are qualified to provide care to you. The information provided should not be used as a substitute for talking with your doctor. Always talk with your doctor about diagnosis, treatment, and referral information.

If you are a telehealth provider that is interested in being included on this list,
please contact: neuro.us.reimbursement@medtronic.com.

Psychological evaluation

2026 coding and payment information

CPT codes for psychiatric evaluation

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Medicare RVUs and national average payment ^{†,2,3}					
CPT Code ⁴	Code description	Facility		Non-facility	
		Total RVUs	Natl avg payment	Total RVUs	Natl avg payment
90791 ^{b,c}	Psychiatric diagnostic evaluation	4.11	\$137	5.19	\$173
90792 ^{b,c}	Psychiatric diagnostic evaluation with medical services	4.77	\$159	6.05	\$202

CPT codes for psychological testing services

The psychological testing codes may be reported separately with the psychiatric evaluation codes 90791- 90792

- To report separately, the psychological testing must be distinct from the diagnostic assessment.^d
- Codes 96130-96146 may be assigned for specialized psychological tests only, not tests available in the public domain.^e
- It is important to note that testing is a supplement to the required psychiatric evaluation performed by a mental health professional, not a substitute for it.

Medicare RVUs and national average payment ^{†,2,3}					
CPT Code ⁴	Code description	Facility		Non-facility	
		Total RVUs	Natl avg payment	Total RVUs	Natl avg payment
Testing evaluation services					
96130 ^{f,g,h}	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test result 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	2.98	\$100	3.71	\$124
+96131 ^{f,g,h}	each additional hour	2.10	\$70	2.59	\$87

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

CPT codes for administration of psychological testing services

Medicare RVUs and national average payment ^{†,2,3}					
CPT Code ⁴	Code description	Facility		Non-facility	
		Total RVUs	Natl avg payment	Total RVUs	Natl avg payment
Test administration and scoring					
96136 ^{ij}	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes	0.64	\$21	1.31	\$44
+96137 ^{ij}	each additional 30 minutes	0.49	\$16	1.11	\$37
96138 ^{ij}	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes	N/A	N/A	1.13	\$38
+96139 ^{ij}	each additional 30 minutes	N/A	N/A	1.06	\$35

Medicare RVUs and national average payment ^{†,2,3}					
CPT Code ⁴	Code description	Facility		Non-facility	
		Total RVUs	Natl avg payment	Total RVUs	Natl avg payment
Automated testing and result					
96146	Psychological or neuropsychological test administration with single automated, standardized instrument via electronic platform, with automated result only	N/A	N/A	0.07	\$2

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Annual references

1. Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Section 160.7.B.2: Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators); Conditions of Coverage. Accessed January 9, 2026. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf
2. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-f> . Local physician rates will vary based on location specific factors not reflected in this document.
3. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. <https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip>
4. CPT Copyright © 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

Important information

- a. Medicare Learning Network (MLN1986542) booklet and Publication# 100-2, Chapter 15
- b. Code 90791 is generally used by psychologists while code 90792, because it is defined for medical services as well, is generally used by psychiatrists. These evaluation codes are commonly accepted by payers. However, some payers limit these codes to psychiatric conditions and instead require use of CPT E/M office consultation codes 99242- 99245. As the E/M consultation codes are not valid for Medicare, the regular office visit codes 99202-99215 are submitted to Medicare for consultations. However, this only applies to psychiatrists as psychologists are unable to bill E&M codes to Medicare. As always, providers should check with each payer to determine coverage, coding and reimbursement.
- c. In terms of documentation, the assessment must include a formal and explicit statement that recommends or clears the patient to proceed to spinal cord stimulation. Letters of support may not be accepted. Further, if the patient did not previously meet requirements, the re-assessment must include a formally identified ""Addendum"" with the new recommendation or clearance. The assessment must be signed by the practitioner, either physically or electronically. In the event of a name change, also ensure that the name on the assessment exactly matches the patient's current name.
- d. NCCI Policy Manual, 1/1/2022, Chapter XI, section M-2.
- e. NCCI Policy Manual, 1/1/2022, Chapter XI, section M-3.
- f. Codes 96130-96131 represent the psychiatrist or psychologist reviewing and integrating the patient history, interpreting the test results, making recommendations for treatment, and creating a report. By definition, interpretation of test results must be performed personally by a physician or psychologist. These codes are time- based and CPT manual instructions indicate that a minimum of 31 minutes must be provided to report per hour codes. Time includes face-to-face time with the patient and time spent integrating and interpreting data.
- g. Codes 96130-96131 do not include administering the tests, which is coded separately
- h. Psychological testing codes may be billed by physicians and psychologists, as well as NPs and PAs within their scope of practice. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 15, Section 80.2: Psychological Tests and Neuropsychological Tests. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- i. These codes represent actually administering and scoring the tests. At least two tests must be administered to report these codes. Per CPT manual instructions, codes 96136-96137 are for tests personally administered and scored by the psychiatrist or psychologist and codes 96138-96139 are for tests administered and scored by a technician. Tests may not be self- administered.⁶ Codes 96136-96139 are time-based, and CPT manual instructions indicate that a minimum of 16 minutes must be provided to report 30-minute codes.
- j. Although administering and scoring the tests is coded here, interpretation of the tests is a component of codes 96130-96

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