Clinical Policy Title: Neuropsychological testing

Clinical policy number: 09.01.08

Effective Date: Oct. 1, 2015
Initial Review Date: June 17, 2015
Most Recent Review Date: June 17, 2015
Next Review Date: June 2016

Related Policies:

CP# 09.01.02 — Immediate post-concussion assessment and cognition testing (ImPACT).
CP# 15.02.02 — Cognitive Rehab. Traumatic Brain Injury.
CP# 08.03.02 — Bariatric surgery/adults

ABOUT THIS POLICY: Arbor Health Plan has developed clinical policies to assist with making coverage determinations. Arbor Health Plan's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Arbor Health Plan when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Arbor Health Plan’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Arbor Health Plan’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Arbor Health Plan will update its clinical policies as necessary. Arbor Health Plan’s clinical policies are not guarantees of payment.

Coverage policy

Arbor Health Plan considers the use of neuropsychological testing (NT) to be clinically proven and, therefore, medically necessary to determine the functional consequences of known or suspected brain dysfunction when the following testing and clinical criteria are met:

<table>
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<tr>
<th>✓</th>
<th>Criteria For Neuropsychological Testing (ALL criteria must be met)</th>
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<tbody>
<tr>
<td></td>
<td>Standardized NT used is based on published national normative data with scoring that results in standardized or scaled scores.</td>
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You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services at 1-866-935-6760. For TTY, call 1-866-209-6421.

Criteria For Neuropsychological Testing  
(ALL criteria must be met)

| ✓ | NOTE: Brief rating scales and standardized questionnaires are **not** considered NT regardless of how administered. |
| ✓ | • NT is administered by an appropriately state licensed provider or by a trained technician who is under the direct supervision of the provider.  
**NOTE:** Provider must have professional training and expertise in the types of NT/assessments being requested (e.g., board certified neuropsychologist or neuro-behavioral psychiatrist). |
| ✓ | NT consists of:  
• Record review.  
• Neurobehavioral status exam (CPT 96116).  
• Test selection.  
• Test administration (CPT 96118, CPT 96119, or CPT 96120).  
• Feedback session (CPT 96118). |

---AND---

| ✓ | Clinical Criteria  
(Any of the following clinical indications are considered medically necessary) |
| ✓ | To assist in determining a diagnosis when neuropsychological data can provide a more comprehensive profile of cognitive function along with clinical, laboratory, and imaging data. |
| ✓ | To document cognitive impairment as a requirement of the diagnosis (e.g., post-concussion syndrome, Alzheimer’s disease or intellectual disability). |
| ✓ | To quantify cognitive or functional potential, particularly when the information will be useful in determining a prognosis (e.g., to predict recovery from medical or surgical treatment that may affect brain function or functional status). |
| ✓ | To determine the patient’s ability to comprehend and participate |
### Clinical Criteria

(Any of the following clinical indications are considered medically necessary)

- Effectively in complex treatment regimens (e.g., surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity).

- To assess 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.

- To assess the impact of medical therapies that may cause cognitive impairment (e.g., radiation, chemotherapy or antiepileptic medications).

- To characterize the cognitive strengths and weaknesses of an individual with a known or suspected central nervous system (CNS) disorder, as a guide to treatment or rehabilitation planning.

- To monitor the progression of cognitive impairment secondary to CNS disorders.

### Limitations:

All other uses of NT are not medically necessary.
- NT is not medically necessary for persons:
  - With medical indications (e.g., migraine headaches, myocardial infarction, chronic fatigue syndrome) without suspected cognitive dysfunction.
  - With uncomplicated cases of suspected attention deficit disorder with/without attention deficit hyperactivity disorder (ADHD). NPT may be considered medically necessary for neurologically complicated cases of ADHD (e.g., post head trauma and seizures).
  - With insufficient neurological and cognitive ability to participate in a meaningful way in the testing process.
  - With no clinical diagnosis or neurocognitive symptoms/behaviors suggestive of the need for this testing.
  - Who are actively abusing substances, are having acute withdrawal symptoms, or have recently entered recovery, because test results may be invalid.
• Up to 10 hours of NT is authorized for person with acute brain insult when brain damage is suspected; up to eight hours of NT is authorized for persons with other neurological conditions and suspected or demonstrated cognitive impairment (e.g., brain tumor in remission or slowly progressing, dementia, multiple sclerosis)

• The need for retesting will be reviewed on an individual case-by-case basis to determine medical necessity. Repeat testing is generally limited to one testing episode per 12 months, but may be performed earlier to evaluate unexpected changes in neurocognitive symptoms that have occurred within the last four months, to evaluate response to new treatment, or when retesting is planned as part of the treatment plan to reassess functioning.

• NT that will not directly contribute to or impact patient management is not medically necessary.

• NT used as screening tests for asymptomatic individuals (e.g. for Alzheimer’s disease and baseline testing for sport-related concussion) is not medically necessary.

• NT administered for non-medical purposes is not medically necessary (e.g., educational or vocational purposes that do not establish medical management, driving risk, forensic applications or to solely evaluate malingering).

• NT is generally not considered medically necessary for pre-surgical clearance. However, an evaluation by a psychologist or psychiatrist may be required in certain circumstances (see CP #08.03.02 Bariatric surgery/adults).

• NT requested for the evaluation of a mental health diagnosis (e.g., serious psychiatric illness, alcohol and/or drug abuse) is considered medically necessary through the mental health benefit. If NT or physical therapy (PT) is requested for evaluation of a medical diagnosis (e.g., traumatic brain injury, stroke, differentiation of brain damage from a depressive disorder, epilepsy, hydrocephalus, Alzheimer's disease, Parkinson disease, multiple sclerosis or AIDS), it is considered medically necessary under the medical benefit.

**NOTE:** The following CPT code is not included in the Medicaid fee schedule for Nebraska:.

96125 - Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

**Alternative covered services:**
• Psychological testing (CPT 96101, 96102, 96103).
• Assessment of aphasia (CPT 09105).
• Developmental screening (CPT 96110).
• Developmental testing (CPT 96111).

Background

According to the American Board of Professional Psychology, neuropsychology is a clinical field with specialized knowledge and training in the applied science of brain-behavior relationships (ABPP 2015). Clinical neuropsychologists employ psychological and behavioral methods to evaluate patients’ cognitive and emotional strengths and weaknesses and relate these findings to normal and abnormal central nervous system functioning. They use this knowledge in the assessment, diagnosis, treatment and rehabilitation of patients across the lifespan who have developmental, neurological, medical or psychiatric conditions.

Neuropsychological testing:

Critical to the neuropsychological assessment are a thorough clinical interview with the patient, a collateral interview with caregivers and family, and review of relevant medical records. Neuropsychological testing (NT), also called psychometric assessment, provides an objective assessment of the presence of brain damage, injury, or dysfunction and any associated functional deficits (Schwarz 2014). In other words, NT provides unique information on abilities, motivation, and potential for future outcomes. NTs are performance-based in that they are structured to require individuals to exercise their skills in the presence of an examiner/observer (Harvey 2012).

Neuropsychological evaluations vary in content depending on their purpose but typically assess multiple neurocognitive and emotional functions. NT comprises measures that can be standardized or targeted to the individual, scored objectively, and have established psychometric properties. The American Academy of Clinical Neuropsychology (AACN) lists the following primary cognitive domains (AACN 2007):

• Intelligence.
• Academic functioning (e.g. reading, writing and math).
• Receptive and expressive language skills (e.g. verbal comprehension, fluency, confrontation naming).
• Problem-solving and reasoning abilities.
• Simple and complex attention.
• Working memory.
• Speed of processing.
• Learning and memory (e.g. encoding, recall, recognition).
• Visuospatial skills.
• Fine motor skills.
• Executive functioning.

Ideally, assessments should also include measures designed to assess personality, social-emotional functioning and adaptive behavior (Harvey 2012). The Standards for Educational and Psychological Testing (2014) produced jointly by the American Psychological Association (APA), the American Educational Research Association, and the National Council on Measurement in Education provides additional guidelines for test selection.

Testing can be performed on an outpatient or inpatient basis; the duration of testing depends on the question for which the referring practitioner seeks an answer as well as clinical complexity. An evaluation generally takes between two and five hours to complete, but can take up to eight hours. Measures typically are administered by paper and pencil, although computer-based assessments are increasingly being employed. Because of the influence of demographic variables (age, sex, years of education and race), scores are compared with normative samples that resemble those of the patient’s background as closely as possible (Schwarz 2014).

Interpretation of test scores depends on expectations of how a patient should perform in the absence of neurologic or psychiatric illness (i.e., based on normative data and performance-based estimates of premorbid functioning). The overall pattern of intact scores and deficit scores can be used to form specific impressions about an individual’s diagnosis, cognitive strengths and weaknesses and strategies for intervention (Schwarz 2014).

**Searches**

Arbor Health Plan searched PubMed and the databases of:
• UK National Health Services Centre for Reviews and Dissemination.
• Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
• The Centers for Medicare & Medicaid Services.

Searches were conducted on May 18, 2015 using the terms "Neuropsychological Tests"[MeSH]. Included were:
• **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

• **Guidelines based on systematic reviews.**

• **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

NT is well-established for a range of mental health and medical conditions as reflected in the high volume of systematic reviews; therefore, search results were limited to evidence-based guidelines. Arbor Health Plan identified 22 evidence-based guidelines that address this policy, and their recommendations are summarized below.

• Guidelines support the use of standardized NT with established psychometric properties based published national normative data, with scoring resulting in standardized or scaled scores.

• Guidelines support the use of NT in patients: 1) with an illness or injury known to be associated with impairments in cognitive or brain development (e.g., degenerative dementias or traumatic brain injuries); 2) with reported impairments in cognitive functioning; 3) in whom evaluations of cognitive function are part of the standard of care for treatment selection and treatment outcome evaluations; and 3) in whom documentation of cognitive impairment is a requirement of the diagnosis (e.g., post-concussion syndrome, Alzheimer’s disease or intellectual disability). NT can also help distinguish between cognitive disorders and malingering or factitious disorders. Complex neuropsychiatric conditions that have the potential to induce changes in mood or motivational states can result in secondary impacts on cognitive functioning; these cognitive changes require a neuropsychological assessment that incorporates other factors that may be contributing to impaired cognitive functioning.

• Guidelines support the use of NT for a range of mental health and medical conditions. According to the American Psychiatric Association (2006), typical patterns of cognitive deficits have been identified in a variety of psychiatric disorders including Alzheimer’s disease, schizophrenia, bipolar disorder, major depressive disorder, and autism (APA 2006).
Other clinical conditions for which NT may be medically necessary include, but are not limited to:

- Cerebrovascular disease (in the recovery/rehabilitation phase following significant clinical recovery when there is still evidence of cognitive impairment or as a guide to rehabilitation and treatment planning).
- Other forms of dementia.
- Parkinson’s disease.
- Human immunodeficiency virus encephalopathy.
- Multiple sclerosis.
- Epilepsy (as part of presurgical treatment planning).
- Neurotoxic exposure.
- Hypoxic brain injury.
- Traumatic brain injury.
- Chronic pain (when used to assess personality and mood or to perform a cognitive assessment if symptoms indicate intellectual disturbances after discontinuation of pain-relieving or psychotropic medications);
- Neurologic disease (when used as an adjunctive personality assessment for identified or suspected brain disorders, such as brain tumors and hypoxic brain injury).

- Guidelines do not support the use of NT for:
  - Diagnosing uncomplicated attention deficit disorder (AD) with or without hyperactivity disorder (HD). Heterogeneous neuropsychological profiles of ADHD and lack of meaningful associations between ADHD symptoms and neuropsychological deficits limit the predictive value and diagnostic utility of NT. However, NT may be medically necessary for persons with emotional or behavioral (e.g., anxiety, depressive, oppositional defiant and conduct disorders), developmental (e.g., learning and language disorders or other neurodevelopmental disorders) and physical (e.g., tics, sleep apnea) conditions that may coexist with ADHD.
  - Screening for cognitive deficits in asymptomatic populations.
  - Assessing the functional importance of changes on advanced neuroimaging (e.g., detection of “silent” ischemic changes or degenerative changes) in the absence of neurocognitive dysfunction, as there is insufficient evidence to correlate any functional importance to these clinical changes.

Who may perform NT?
The widespread use of NT has led to questions about who should administer the tests and who should interpret the results. A licensed psychologist, who has explicit training in neuroscience and neurological bases of behavior in accordance with American Psychological Association standards of practice, typically conducts or supervises NT (AACN 2007). Clinical psychologists who perform NT must demonstrate their competence through board certification (e.g., the American Board of Clinical Neuropsychology). Alternatively, a neuro-behavioral psychiatrist with certification in neurology through the American Board of Psychiatry and Neurology, or accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association may provide NT when both of the following criteria are met (AACN 2007):

- The provider has professional training and expertise in the types of tests/assessment being requested.
- The provider can conduct test administration, scoring, and interpretation in accordance with currently prevailing national professional and ethical standards regarding provision of NT services.

The licensed psychologist or other qualified care provider must have face-to-face contact with the patient being tested, at a minimum at both an initial intake interview visit and at the testing feedback visit, and they must interpret the test and write (and sign) the report (Puente 2006, AACN 1999). However, an appropriately trained psychometrist or psychometrician may administer and score testing under their supervision (Puente 2006, AACN 1999).

**Summary of Clinical Evidence**

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<tr>
<th>Organization</th>
<th>Policy</th>
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<tr>
<td>CMS</td>
<td><strong>Neuropsychological Testing:</strong> CPT codes 96116, and 96118, 96119 and 96120</td>
</tr>
<tr>
<td>No NCDs found</td>
<td>Neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain dysfunction through testing of the neuro-cognitive domains responsible for language, perception, memory, learning, problem solving, adaptation, and constructional praxis. These evaluations are requested for patients with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning. The evaluations include a history of medical or neurological disorders 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</td>
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<td>Summary of LCDs</td>
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Neuropsychological assessment is considered medically necessary for the following indications:

1. When there are mild or questionable 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 changes that may occur with normal aging, or the expected progression of other disease processes.

2. When neuropsychological data can be combined with clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning.

3. When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression.

4. When there is a need for a pre-surgical or treatment-related cognitive evaluation to determine 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, stem cell transplant) or significantly alter a patient’s functional status.

5. 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), especially when this information is utilized to determine treatment planning.

6. When there is a need to monitor progression, recovery, and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care.

7. When there is a need for objective measurement of the patient’s subjective complaints about memory, attention, or other cognitive dysfunction, which serves to determine treatment by differentiating psychogenic from neurogenic syndromes (e.g., dementia vs. depression); or

8. When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders.

9. When there is a need to determine whether a patient can comprehend and participate effectively in complex treatment regimens (e.g., surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision-making, work, independent living, managing financial affairs, etc.; or

10. When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients.

11. When there is a need to establish treatment planning through identification and assessment of the neurocognitive sequelae of systemic disease (e.g., hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures).

12. Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.

13. 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.

Examples of problems that might lead to neuropsychological testing include:
1. Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries and AIDS dementia).
2. Differential diagnosis between psychogenic and neurogenic syndromes.
3. Delineation of the neurocognitive effects of CNS disorders.
4. Neurocognitive monitoring of recovery or progression of CNS disorders.
5. Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.
6. Determining the management of the patient by confirmation or delineation of diagnosis.

Limitations of Coverage:
Psychological and neuropsychological testing is not considered reasonable and necessary when:
1. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process.
2. Used as screening tests given to the individual or to general populations [Section 1862(a)(7) of the Social Security Act does not extend coverage to screening procedures].
3. Administered for educational or vocational purposes that do not establish medical management.
4. Performed when abnormalities of brain function are not suspected.
5. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS, Folstein Mini-Mental Status Examination, or
6. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy).
7. Administered when the patient has a substance abuse background and any of the following apply:
   a. the patient has ongoing substance abuse such that test results would be inaccurate.
   b. the patient is currently intoxicated.
8. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer’s diseases and there is no expectation that the testing would impact the patient’s medical management.
9. The test is being given solely as a screening test for Alzheimer’s disease - Medicare does not cover this screening for this diagnosis

Glossary

Central nervous system — The system in the body that regulates cognitive, voluntary and involuntary
activities. This includes the brain, the spinal cord, the peripheral nervous system and the autonomic nervous system.

**Cognitive** — Pertaining to the mental processes of perceiving, thinking and remembering; used loosely to refer to intellectual functions

**Factitious disorder** — A pattern of behavior centered on the exaggeration or outright falsifications of one’s own health problems or the health problems of others. This differs from malingering in that a person with a factitious disorder does not exaggerate or falsify for personal gain.

**Impairment** — A problem in body function or structure (e.g. a significant deviation or loss of muscle strength).

**Malingering** — A pattern of falsified or exaggerated behavior used to intentionally diminish or reduce capability and intentionally exaggerate symptom complaints for personal gain.

**Neurocognitive** — Of or relating to cognitive functions associated with particular areas of the brain.

**Neuropsychology** — A subspecialty of clinical psychology focused on understanding the brain–behavior relationship. Drawing information from multiple disciplines including psychiatry and neurology, neuropsychology seeks to uncover the cognitive, behavioral and emotional difficulties that can result from known or suspected brain dysfunction.

**Normative data** — Data that characterize what is usual in a defined population at a specific point or period of time (i.e. describe the “norm”). These data seek to describe rather than explain phenomena. Especially important in studies that seek normative data to precisely characterize a study population, provide a clear definition and measurement of phenomena, and appropriately interpret and generalize results.

**Psychometrics** — The field of study concerned with the theory and technique of psychological measurement of knowledge, abilities, attitudes, and personality traits. The field is primarily concerned with the study of differences between individuals. It involves two major research tasks: 1) the construction of instruments and procedures for measurement; and (ii) the development and refinement of theoretical approaches to measurement.

**Rehabilitation** — Health care services that help maintain, restore, or improve skills and functioning for daily living that have been lost or impaired because of illness, injury or disability.
These services include physical therapy, occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Related policies**
Caritas Utilization Management program description.

**References**

**Professional society guidelines/other:**


**Peer-reviewed references:**


**Clinical trials:**

Searched ClinicalTrials.gov on June 2, 2015 using terms neuropsychological test | Open Studies | intervention: "neuropsychological test" OR "neuropsychological assessment". 75 studies found.
Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCDs)
No NCDs found.

Local coverage determinations (LCDs)

Commonly submitted codes
Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

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<tr>
<th>CPT Code</th>
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<tr>
<td>96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.</td>
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<td>96118</td>
<td>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting test results.</td>
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<td>96119</td>
<td>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.</td>
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<tr>
<td>96120</td>
<td>Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report.</td>
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<tr>
<td>96125</td>
<td>Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.</td>
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