Digital Cognitive Assessments

Coding and Reimbursement Resource for Healthcare Professionals

GLOBAL CEOINITIATIVE
–ON ALZHEIMER'S DISEASE–

The Global CEO Initiative on Alzheimer's Disease (CEOi) provides this resource for informational purposes only. It does not constitute legal advice. CEOi has made a good faith effort to provide accurate information based on third-party sources, but information is subject to change. This guide is not an affirmative instruction or guarantee as to medical treatment protocol, medical benefit coverage, reimbursement, or any particular financial outcome. It is recommended to check with the billing and coding service of your practice or institution. CEOi does not make any recommendation or representation of use for any particular reimbursement code for any given service.

It is the provider's responsibility to determine the appropriate course of patient management, and the decision to perform a digital cognitive assessment should be based on the medical necessity of the service to the patient, without regard to any financial considerations. Moreover, it is the provider's responsibility to determine and submit the appropriate code(s) and applicable modifier(s) for any service, supply, procedure, or treatment rendered. Contact your local carrier/intermediary and payer organizations for specific coding guidelines.

With the growing number of individuals with mild cognitive impairment (MCI), many of whom will subsequently develop dementia, there has been an increased focus in the healthcare industry on the use of digital cognitive assessment (DCAs). DCAs offer the possibility of reducing variability and increasing accessibility compared to traditional tools.

CEOi convened a group of more than 200 experts to detail use cases and performance standards for DCAs in clinical practice, including how they can be used for (1) detecting cognitive impairment, (2) aiding in the diagnosis of MCI / dementia, or (3) cognitive profile characterization (to aid in determining etiology of dementia).

This resource seeks to provide information about how Medicare reimburses DCAs. CEOi and an expert consultant have reviewed the American Medical Association (AMA) 2025 CPT® Codebook for changes to the applicable codes and reporting instructions for these assessments. The current (CY 2025) Medicare Part B coverage and reimbursement policies was reviewed pertaining to the traditional fee-for-service Medicare program.

Because no specific codes exist for DCAs, and in many cases DCAs are used interchangeably with traditional brief cognitive assessments (BCAs), this resource provides examples of codes which could be applied to either category of test. Future efforts may look to develop specific codes for DCAs.

DCA Use Cases

DCAs can be used in different settings, for different uses, by different providers. Here we have tried to summarize these into three main categories: (1) detecting cognitive impairment during the annual wellness visit, (2) a standalone cognitive assessment, or (3) a full neuropsychological evaluation. Patients may enter the pathway at either step 1 or 2. Below we have summarized the codes that are often applicable in each of these stages and in which settings.

STEP	CARE SETTING	RELEVANT CODES
Annual Wellness Visit (AWV) (*e.g.*, Cognitive Impairment Detection)	Primary	G0438 G0439 96127 96146
Standalone Cognitive Assessment (*e.g.*, MCI/Dementia Diagnostic Aid)	Primary or Secondary	99483 99214 99215 G2211
Full Neuropyschological Evaluation (*e.g.*, Cognitive Profile Characterization)	Secondary	96116 96132 96136 96138 96146

Coding and Payment of the DCA

Under Medicare Part B, Current Procedural Terminology (CPT)® and/or Healthcare Common Procedure Coding System (HCPCS) codes are used to identify medical services. Potentially relevant codes for DCAs are listed below. Please note that the codes detailed below may not apply to all cognitive screening tools. The existence of codes does not guarantee coverage of the service and does not guarantee appropriate reimbursement

Physician services such as the ones noted below are billed to Part B and Medicare pays for these services based on the Medicare Physician Fee Schedule (MPFS). Payment for DCAs services under the MPFS is based on the CPT® code reported by providers and also dependent on:

- Where the service is rendered (facility (e.g., hospital) versus non-facility (clinic)
- Payment modifiers reported by the provider to provide more information about a procedure performed

The payment for these procedures is based on the allowed amount which is the lesser of the provider's charge or the Medicare Physician Fee Schedule (MPFS) amount. The national amounts for the 2025 Medicare Physician Fee Schedule are listed below. Note, MPFS rates vary by geographical location and providers should check their locality for geographic-specific rates. Please keep in mind there will be a deduction of 2% for MPFS claims due to on-going sequestration cuts that went into effect in 2022.

Important Note on Time Considerations:

Many codes noted below have a time requirement in order to be able to report the services. Under existing CPT time rules, a time-based CPT can be reported once the mid-point of the stated time requirement is passed (unless otherwise noted in coverage policies). As such for the 30-minute and 60-minute codes, a minimum of 16 and 31 minutes, respectively, must be met. Of note, many DCAs typically take only 5 – 10 minutes.

Current CPT® Coding and Payment Under Traditional Medicare

Code	Descriptor	MPFS Non-Facility CY 2025 Rate
Annual Wellness Visit		
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	$160.44
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	$126.47
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	$4.53
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	$2.26
Standalone Cognitive Assessment		
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.	$266.21
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	$125.18

99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection,40minutes must be met or exceeded.	$175.64
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	$15.53
Psychological and Neuropsychological Testing		
96116*	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$88.63
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	$125.18
96136*	Psychological or neuropsychological test administration and scoring by physician or other qualified healthcare professional, two or more tests, any method; first 30 minutes	$40.76
96138*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$33.64
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	$2.26

*There are add-on codes available for additional time of service (either a half hour or an hour).

Sources: CPT® 2025 Professional Edition & CY 2025 MPFS Final Rule Addendum B
Note: Local rates will vary based on geographic adjustments. Also, rates listed above do NOT reflect the 2% sequestration.
Note: Texts were underlined for emphasis purposes and are additive (not listed in the codebook).

Use Of Relevant CPT® Code By Medicare Population

The mere presence of the codes does not always translate into utilization of the codes. Anassessment was conducted by a consulting firm engaged with CEOi to evaluate which codes are being reported by which specialty types and in which locations. The table below outlines the volume of paid claims for the four codes with the highest volume in 2023 and the specialty with the highest percent of volume. It is important to note these codes are not utilized only for DCA administration.

CPT® Codes	96132	96116	96136	96138	99483
Total Claim Lines*	243,299	133,586	167,881	188,135	116,725
Top Provider Type	Clinical Psychologist (62.8%)	Clinical Psychologist (61.4%)	Clinical Psychologist (59.7%)	Clinical Psychologist (33.6%)	Nurse Practitioner (33.0%)
Place of Service	Physician office	Physician office	Physician office	Physician office	Physician office

*Paid claims in CY 2023

Sources:CY 2025 MPFS Final Rule Addendum B
Notes: Local rates will vary based on geographic adjustments. Also, rates listed above do NOT reflect the 2% sequestration.

Additional Information

For details regarding the Medicare coding and policies discussed in this resource, consult the "Manuals" pages of the CMS web site or contact your local Medicare contractor. To contact the Medicare Administrative Contractor in your specific locality, consult the CMS web site at: www.cms.gov.

Appendix

Limitations on other codes	Per CPT guidelines and consistent with the National Correct Coding Initiatives for Medicare, the test administration services (96136 – 96139) can be reported with the interpretation and results reporting services (96130 – 96133).
Coverage position	A few different Medicare Administrative Contractors (MACs)* have published local coverage determinations specific to psychological and/orneuropsychological testing. Some policies are silent specific to the noted codes or the digital/brief cognitive assessments but there are common themes across the policies: ▪ Services must be reasonable and necessary and documented in the medical record. ▪ Assessment tools are appropriate when mental illness or a behavioral health condition is suspected but not yet diagnosed. These tests should not be used for (population) screening purposes. ▪ Tests are not appropriate when the results are not expected to have an impact on treatment management. Absent a coverage policy in your geographic region, the MACs will adjudicate Medicare fee-for-service claims on case-by-case basis. *L39266 (Palmetto),L33632 (National Government Services), L35101 (Novitas), and L34646 (WPS). Last visited May 2025.