Psychological Testing Scoring Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A psychological testing scoring note records the professional evaluation side of testing: score verification, integration, interpretation, and the dated minutes behind CPT 96130 to 96133. The contents are payer policy and medical-necessity law; the titled note is convention. Most run 200 to 400 words plus the score summary and time log.

Episode header and referral one episode, one base code
Do: tie the note to the referral question, the ICD-10 linkage, and the episode span from first administration to feedback.
Pitfall: treating each sitting as its own encounter; the base code is reported once per episode with combined time.

Instruments and data integrated lists must reconcile
Do: name every test interpreted plus the collateral pulled in: interview, records, informant ratings, prior evaluations.
Pitfall: lists that drift between the administration record, this note, and the report read as work that may not have happened.

Score summary and validity exact values, exact names
Do: record exact raw and standard scores, validity indices, and every anomaly and correction; verify computer scoring first.
Pitfall: pasting the platform's narrative; one miskeyed age band corrupts everything downstream.

Evaluation time log dated minutes, named activity
Do: date each entry, name the activity, count the minutes; 31 minutes earns the base and add-ons accrue past each hour.
Pitfall: "approximately 1 to 2 hours"; vague time is a documented denial risk and matches no unit.

Interpretation and decision-making the clinician's own work
Do: synthesize verified scores against history and collateral in your own words; conclude and plan.
Pitfall: a trainee-drafted synthesis the psychologist merely signs; Medicare does not pay trainee-performed evaluation services.

Report, feedback, and sign-off close the episode
Do: file the report, give feedback, report the date of service as the day the episode concluded, sign with credentials.
Pitfall: an open-ended episode; no report status or conclusion date leaves the claim unsupported.

Before you sign

- [ ] Exact scores verified against the platform output
- [ ] Every instrument named, matching the administration record
- [ ] Dated minutes name the activity, never block time
- [ ] Evaluation time separated from administration minutes
- [ ] Units earned: 31 minutes for the base, once per episode
- [ ] Date of service is the day the episode concluded
- [ ] Report filed, feedback done, note signed with credentials

Drafting with AI

Give it the day's work: scores verified, anomalies, minutes per activity; it drafts the dated log, the score summary, and the sign-off block with the unit math shown.

"Draft a testing scoring note: WAIS-5 and CVLT-3 verified, one CAARS 2 rescore, 35 + 58 + 55 minutes over three dates, feedback today."

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

200 to 400 words	5 to 12 min by hand	Base code once	Payers · auditors · colleges
plus scores and time log	clinical team estimate	reported on the conclusion day	who reads it

Psychological Testing Scoring Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): DOB: Episode span:

Referring practitioner: ICD-10: Referral question:

Instruments interpreted and data integrated

Every test interpreted, by exact name · collateral pulled in: interview, records, informant ratings · the list must match the administration record

Score summary and validity

Exact raw and standard scores, percentiles · validity indices and response style · anomalies, corrections, and rescoring

Evaluation time log (interpreting clinician only)

Dated entries naming the activity and minutes · exclude administration and scoring time · total, units, and the base code once per episode

Interpretation and clinical decision-making

Findings integrated with history and presentation · diagnostic impression · next steps and treatment planning

Report, feedback, and date of service

Report completed and filed · feedback date · date of service reported as the episode conclusion

Completed by (name and credentials): Signature: Date: