Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Psychological and Neuropsychological Testing
PAGE: 1 of 10	**REPLACES:** NA
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PRODUCT TYPE: Medicare, Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff make psychological and neuropsychological testing pre-service decisions.

B. Policy

1. Clinical criteria for psychological testing services include:

1.1. A written pre-service request submitted by a practitioner detailing:

1.1.1. Evidence of a Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) disorder,

1.1.2. Evidence of symptoms requiring psychological or neuropsychological testing,

1.1.3. How testing will benefit the course of treatment, and

1.1.4. Clinical justification providing:

1.1.4.1. Current clinical presentation,

1.1.4.2. Behavioral health history,

1.1.4.3. Current physical health concerns affecting the patient's behavioral health,

1.1.4.4. Behavioral health treatment received, both currently and in the past,

1.1.4.5. Response to treatment, specifically changes in functioning and changes in symptoms, and

1.1.4.6. Identifying information about the requested licensed psychologist administering, scoring, and interpreting the test.

1.2. Evidence of DSM and ICD covered diagnosis(es):

1.2.1. Supported by comprehensive mental health assessment information completed within sixty (60) calendar days of the request, or

1.2.2. A pre-service determination based on:

1.2.2.1. Treatment history,

1.2.2.2. Degree of impairment,

1.2.2.3. Current symptoms,

1.2.2.4. Community supports, and

1.2.2.5. Medical appropriateness to support DSM and ICD covered diagnosis and need for psychological testing.

2. Psychological testing is used to assess a variety of mental abilities and attributes, including:

2.1. Central Nervous System (CNS) assessments such as:

2.1.1. Neuro-cognitive,

2.1.2. Mental status,

2.1.3. Achievement and ability,

2.1.4. Personality, and

2.1.5. Neurological functioning.

2.2. Differentiating between primary diagnoses that are the focus of treatment,

2.3. Ruling out cognitive impairment or organic component/etiology, and

2.4. Assisting in treatment planning, as long as treatment planning is not the sole purpose for testing.

3. Psychological testing:

3.1. Assists with diagnosis and management following clinical evaluation when a mental illness or psychological abnormality is suspected.

3.2. Provides a differential diagnosis from a range of neurological/psychological disorders that present with similar constellations of symptoms, e.g., differentiation between pseudo-dementia and depression.

3.3. Determines the clinical and functional significance of brain abnormality.

3.4. Delineates the specific cognitive bases of functional complaints.

4. Gender dysphoria:

4.1. When testing is requested as part of a psychosocial assessment of gender dysphoria, to occur prior to cross-hormonal therapy or gender re-assignment surgery, testing may be used to justify the following:

4.1.1. Having a persistent, well documented gender dysphoria,

4.1.2. Having the capacity to make a fully informed decision and to give consent for treatment, and

4.1.3. Having any significant medical or mental health concerns reasonably well controlled.

4.2. This policy does not address psychological testing which may be a part of other physical health pre-surgical or pre-procedure assessments.

5. Neuropsychological testing is used to evaluate patients with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning. Evaluations include:

5.1. A history of medical or neurological disorders compromising cognitive or behavioral functioning,

5.2. Congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development,

5.3. Reported impairments in cognitive functioning, and

5.4. Evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations.

6. Neuropsychological testing:

6.1. Neuropsychological assessment is considered medically necessary for the following indications:

6.1.1. 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,

6.1.2. 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,

6.1.3. 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,

6.1.4. 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,

6.1.5. 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,

6.1.6. 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,

6.1.7. 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),

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

6.1.9. 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.,

6.1.10. 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,

6.1.11. 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),

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

6.1.13. 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.

7. Psychological and Neuropsychological testing is not considered reasonable and necessary when:

7.1. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process,

7.2. 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],

7.3. Administered for educational or vocational purposes that do not establish medical management,

7.4. Performed when abnormalities of brain function are not suspected,

7.5. 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,

7.6. 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), or

7.7. Administered when the patient has a substance abuse background and any of the following apply:

7.7.1. The patient has ongoing substance abuse such that test results would be inaccurate, or

7.7.2. The patient is currently intoxicated.

7.8. 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.

7.9. The test is being given solely as a screening test for Alzheimer's disease - Medicare does not cover this screening for this diagnosis.

8. In addition, testing is not authorized for the sole purpose of the following:

8.1. Routine evaluations,

8.2. Establishing a baseline for future assessments,

8.3. Screening for level or type of placement,

8.4. Confirmation of a diagnosis,

8.5. Another agency's request (i.e., court mandate, state agency),

8.6. Educational testing or for educational purposes,

8.7. Forensic testing,

8.8. Disability or personal injury evaluation,

8.9. Competency testing,

8.10. Intelligence testing,

8.11. Research,

8.12. Risk assessment, or

8.13. Providing a standard assessment component at a residential program.

C. Procedure

1. Referrals:

1.1. Referred member must be enrolled in Trillium Community Health Plan.

1.2. Trillium members are able to access outpatient (OP) mental health assessments without referral.

1.3. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. Participating (Par) or non-participating (non-par) providers always require a prior authorization (PA) based on Authorization Required Qualifiers (ARQ), prior to the first date of service.

3. Par or non-par provider must submit:

3.2. PA request,

3.3. Updated medical records and assessment completed by Qualified Mental Health Professional (QMHP) or licensed medical professional (LMP) which includes the following information:

3.3.1. A DSM and ICD diagnosis, including member's current symptom presentation and any recent changes in presentation,

3.3.2. Relevant medical and/or behavioral health history, which may include:

3.3.2.1. Physical examination,

3.3.2.2. Medical diagnostic test/procedure results,

3.3.2.3. Behavioral diagnostic history, and

3.3.2.4. Behavioral and/or medical treatment history and member response to treatment already trialed.

3.3.3. Any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction,

3.3.4. The initial evaluation information that determines the need for testing, including specific clinical questions to be answered via testing and how testing results will specifically impact or inform the course of treatment:

3.3.4.1. The types of testing indicated, including the test(s) to be administered, along with the summary of planned scoring and interpretation hours,

3.3.4.2. The treatment recommendations,

3.3.4.3. The time involved and whether this is initial testing or follow-up, and

3.3.4.4. Previous testing by the same or different provider, and efforts to obtain previous test results performed.

3.4. More than eight (8) hours per patient per evaluation is considered excessive. If the requested hours exceed eight (8) hours, submitted clinical justification should address medical necessity of the extended testing above eight (8) hours.

3.4.1. While up to eight (8) hours is considered in the customary range, testing should be individualized to member evaluation needs and only diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services.

4. TBH Licensed UM staff:

4.1. Determine clinical appropriateness and medical necessity of requested services, indicated by:

4.1.1. Review of clinical information submitted, including behavioral health assessment and pertinent medical information, and

4.1.2. Refer to TBH Care Coordination (CC) staff when necessary to ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

5. Expected outcomes:

5.1. Stabilization/improvement of symptoms,

5.2. Stabilization/improvement of daily functioning,

5.3. Prevention of higher LOC services, or

5.4. Less restrictive LOC services are determined to be clinically appropriate.

6. When request is approved:

6.1. Initial (Certification) PA for Psychological and Neuropsychological services will not exceed six (6) months.

6.2. Concurrent (Recertification) authorization for additional codes or units within the current approved date range is based on additional clinical justification submitted.

6.2.1. A request for an extended or new date range will be treated as an initial PA request.

6.3. If no Servicing Provider was identified upon time of authorization request, TBH UM Staff will refer to a contracted practitioner who is able to provide the approved service.

7. When request is denied:

7.1. If the initial (Certification) or concurrent (Recertification) review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

7.2. When the decision is to deny request, practitioner may request an expedited appeal if he/she disagrees with the determination.

8. When request is returned to sender:

8.1. Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

8.1.1. Member identifying information,

8.1.2. Requesting Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:
8.1.2.1. Medicaid Provider/DMAP number for non-par OP PA requests.

8.1.3. Start date and end date for services,

8.1.4. ICD diagnostic code(s),

8.1.5. Billing code(s),

8.1.6. Number of units/visits/days for each billing code.

8.2. Upon review, no authorization is required per the ARQ for participating providers.

8.3. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

8.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

8.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster,

8.4.2. Mechanical or administrative delays or errors by the Contractor or State Office, or

8.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

8.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number,

8.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered, and

8.4.3.3. The provider submitted the request for authorization within sixty (60) days of the date the eligibility was discovered (excluding retro-eligibility).

8.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

8.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. Definitions

Word / Term	Definition
ARQ	Authorization Required Qualifier.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling

Word / Term	Definition
	assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Clinical Exception	When a Trillium Medicaid member has an identified mental health treatment issue that indicates a need to deviate from the standard formulary of Trillium Behavioral Health (TBH) approved mental health services and/or indicates the need for an off-panel licensed professional to provide the needed mental health service(s).
Diagnostic and Statistical Manual of Mental Disorders (DSM)	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
ICD	The International Classification of Diseases.
Licensed Behavioral Health Practitioner (LBHP)	Doctoral-level clinical psychologist or psychiatrist.
Licensed UM Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Mental Health Assessment	The process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.
Neuropsychological Test	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.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State ofOregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Review	Any non-urgent care or service Trillium must approve, in whole or in part, in advance of the member obtaining medical care or services. Pre-authorization and pre-certification are pre-service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Psychological Test	Tests used to assess a variety of mental abilities and attributes, including Central Nervous System (CNS) Assessments such as neuro-cognitive, mental status, achievement and ability, personality, and neurological functioning.
Qualified Mental Health Professional (QMHP)	An LMP or any other individual meeting the minimum qualifications as authorized by the Licensing Mental Health Authority or designee. Person demonstrating the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, conducting a mental status examination, complete a DSM diagnosis; conducting best

Word / Term	Definition
	practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a Service Plan; and providing individual, family or group therapy within the scope of their training. (a) QMHPs shall meet the following minimum qualifications: (A) Bachelor's degree in nursing and licensed by the State or Oregon; (B) Bachelor's degree in occupational therapy and licensed by the State of Oregon; (C) Graduate degree in psychology; (D) Graduate degree in social work; (E) Graduate degree in recreational, art, or music therapy; or (F) Graduate degree in a behavioral science field; or (G) A qualified Mental Health Intern.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	B.2.3.b.c.e
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity
	E.23.
Code of Federal Regulations	422.101(b)(1)-(5)
	422.566
Centers for Medicare and Medicaid Services	Local Coverage Determination L34646
Medicare Managed Care Manual	Chapter 13 (40.1)
Current NCQA Health Plan Standards and Guidelines	UM 2:C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
	UM 5: C,D Timeliness of UM Decisions
	UM 6: BRelevant Information for Behavioral Health Decisions

Health Evidence Review Commission	Guideline note 127
Oregon Administrative Rules	410.120.0000(145)(146)
	410.120.1295
	410.141.0480(3)
	410.141.0500(1)(f)(2)(a,b,c)
	410.172.0630
Oregon Regulatory Statutes	430.630

F. Related Material

Name	Location
Behavioral Health/Medical Management Prior Authorization Process	TBH Database
Use of Out-of-Network Providers and Steerage Policy	Trillium Database
World Professional Association for Transgender Health	WPATH Standards

G. Revision Log

Type	Date
Merged Policy and Procedure into one document	2-23-18
Updated Definition List	2-23-18
Added Return to Sender Language	2-23-18
Content update based on LCD	2-23-18
Updated Definitions	2-4-19
Updated OARS	2-4-19
Updated Related Material	2-4-19