Comments
L31990 Psychological and Neuropsychological Testing PSYCH-017

Wisconsin Physicians Service (WPS) would like to address some issues before responding to the specific comments we received regarding this Draft Local Coverage Determination (LCD). First we would like to thank the people who sent the many comments with supporting documentation.

We also would like to thank the *Neuropsychology Model LCD Taskforce*, a national workgroup representing The American Academy of Clinical Neuropsychology (AACN), the American Psychological Association (APA) Division of Clinical Neuropsychology, and the National Academy of Neuropsychology (NAN) for sending WPS the NEUROPSYCHOLOGY MODEL LCD and the comments received from Marshfield Clinic.

WPS separated draft LCD L31990 **Psychological and Neuropsychological Testing** from the current LCD L30489 Psychiatry and Psychology Services - PSYCH-014 to separate the psychiatric therapy services from Psychological and Neuropsychological Testing issues. During this process WPS received many comments regarding the need for testing for different medical conditions. It is not the intent of this policy to speak about coverage of medical conditions for these tests either prior to a surgical procedure or as part of the evaluation of a specific medical condition. As for all Medicare services, documentation in the medical record must support the medical necessity (reason) for tests.

However, since WPS has had multiple questions regarding Alzheimer's disease this has been included in the billing and coding guidelines. Medicare has a national regulation that says it does not cover screening tests. Therefore screening for Alzheimer's disease is not covered. Providers who want to have any of tests covered as screening tests should address their concerns to either Congress or the Centers of Medicare and Medicaid (CMS). Comments received about screening issue are not relevant to this LCD and have not been addressed.

Comment:
I urge WPS to avoid restricting the availability of neuropsychological evaluations and consultations under Medicare to the narrow range of patients and service types currently proposed in PSYCH-017. I wish to support and encourage your collaboration with the AACN Neuropsychology Task force to discuss and develop an alternative LCD that maintains access to neuropsychological evaluations, consultations, and post-test feedback in order to optimize patient care. This issue is especially important at this time in our history, given the need to provide accurate medical management for a growing population of older adults who frequently have overlapping, co morbid conditions in which differential diagnosis and treatment planning is uniquely informed by neuropsychological testing.

Response:
WPS received the AACN *Neuropsychology Model LCD Taskforce* LCD and used it to finalize L31990. While their LCD was much more detailed than WPS needed, we appreciated their comments and used many of them in the development of the policy.

After discussion with Clinical Psychologists, it was agreed that part of testing is informing the patient and /or family the result of the test(s). The time this normally takes does not exceed 60 minutes. To acknowledge this, the wording of the paragraph below changed from seven hours to eight hours.

4. If the total time for the tests exceeds eight hours, a report may be requested asking for the medical necessity of the extended testing. The explanation of the test to the patient/family is considered part of this time and should not exceed 60 minutes. If more than one hour is required to establish a plan of care based on the results of the test, this service should be billed with another CPT code as it is not part of the testing service.
5. The time spent with the interpretation and the preparation of the report, and explanation of the report to the patient and/family are billed with the same CPT code used to perform the test.
6. The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report that will be given to the referring provider

Comment:
I encourage you to review the model neuropsychological LCD proposed by the National Academy of Neuropsychology (NAN) and consider NAN's proposed model.

Response:
Thank you, WPS did receive, review and consider the *Neuropsychology Model LCD Taskforce*, written by a national workgroup representing The American Academy of Clinical Neuropsychology (AACN), the American Psychological Association (APA) Division of Clinical Neuropsychology, and the National Academy of Neuropsychology (NAN) while finalizing this LCD.

Comment:
I am a neurologist and run the Center for Dementia and Alzheimer's Care. Our mission is to improve the quality of care, while improving service and doing so at an affordable cost. We are constantly striving to deliver best care at the lowest cost possible. For patients with dementia, this often includes the judicious use of neuropsychological testing. It would be a huge detriment to the care of our increasing population of dementia patients if we were unable to be appropriately reimbursed for appropriately used neuropsychological testing.

Response:
This LCD does not limit the coverage of medically necessary testing of patients with dementia.

Comment:
1. Excluding neuropsychological evaluations for patients with a FAST level of 3 or greater will prohibit results that would have been extremely clinically useful in determining etiology and treatment.
2. It is unclear if this functional level exclusion applies only to patients with diagnosed Alzheimer's disease, or for patients with any kind of a dementia, or for patients with problems of any etiology. The etiology of deficits at FAST stages 3 and 4 is still often unknown, and this remains a clinically useful question that a neuropsychological evaluation can answer. The typical rule-outs of Alzheimer's disease will still occur at high levels at these stages (depression/anxiety, vascular causes, other dementia syndrome, normal aging, medication side effects), and neuropsychological testing is still sensitive and specific at these stages in terms of suggesting the most appropriate diagnosis. Results will help understand the prognosis and most importantly, direct the referring provider to medications and other treatments that are beneficial rather than hurtful.

Response:
WPS felt that since this test is listed under "Alzheimer's disease" and is for the "Functional Assessment Staging of Alzheimer's Disease" it would be more obvious that the test was to be for the evaluation of Alzheimer disease. However this information has been removed from the LCD.

Comment:
If the current proposal to greatly restrict neuropsychological testing for Medicare recipients passes, there will be serious negative consequences. Patients and their families will not have access to standard of care evaluations, which lead to proper medical and psychiatric treatment. Primary care doctors will not have the expert safety net they (and their patients) need. There will be greater costs to the community with poorer outcomes prompting more hospitalizations for behavioral symptoms and due to more acute care needs in the community.

Response:
The intent of separating psychological testing from psychiatric services it to avoid the problem of denying services based on mental health diagnosis. The restrictions in this LCD are the same as for all diagnostic tests: the services have to be ordered by the attending physician must be medically necessary and screening exams are not covered under the Medicare program.

Comment:
I am attaching guidance from the Emory Healthcare Compliance office that outlines what neuropsychology and cognitive neurology are permitted to bill. As you can see, the professional component to neuropsychological testing is essentially eliminated. I am also attaching information that I assembled from a variety of CPT sources that describes inconsistencies in CPT code application. It would be very helpful if any future revision from WPS contains explicit language stating that 96118 can be billed for test integration and report writing when testing is done by a technician (96119) or computer (96120). If any ambiguity exists, our compliance office will "round down" over audit concerns.

Without being compensated to write a report stating what the individual neuropsychological test findings mean (e.g., subcortical dementia, MCI and their functional and prognostic implications), neuropsychology will be force to operative it will be as if an MRI scan were performed, but sent to the referring physician without interpretation.

Response:
The AMA definition of these codes is:

96118	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 these test results and preparing the report
96119	Neuropsychological testing (ie, Halsted-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.

CMS, the LCD and the AMA states:
The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be

paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.

“96118 cannot be used “for interpretation and report of 96119 or 96120,” which refer to individual test findings, the time for integration of previously completed and reported technician- and computer-administered tests is the process of integrating “separate interpretations and written reports for each of these tests into a comprehensive report,” and is not contradicted anywhere on the CMS website.

Any inconsistencies in CPT code application should be discussed with the American Medical Association (AMA). CPT codes are the intellectual property of the AMA and thus only the AMA can change the definition of any CPT codes, or create new codes. .

Comment:
Neuropsychological evaluation (96118/96119) should be billed using ICD codes that reflect the patients' medical condition -- a disease or injury that impacts brain function. To code and bill appropriately, the neuropsychological diagnoses should reflect the ICD codes assigned (or questioned) by the referring physicians. Citizens would be harmed by inappropriately excluding neurologic conditions and symptoms for which neuropsychological testing is medically indicated.

Response:
There are no ICD-9 codes used in this LCD. Medical conditions are recognized as appropriate indications for these tests. The medical record must contain documentation that supports the reason the test is necessary to treat the signs and symptoms presented by the beneficiary.

Comment:
Neuropsychological testing may be medically indicated for neurologically stable patients whose life circumstances undergo significant change. Often, a physician needs advice about how to help a medically stable patient adapt to sudden change in his or her social or physical environment, and that question will trigger neuropsychological re-evaluation -- the patient's functional abilities are not an "absolute" but may need different levels of support and rehabilitation, depending upon the demands and supports that are present in their lives. For example, a neuropsychologist may be asked to assess the patients' abilities and needs for medication management or rehabilitative therapies when a care giving spouse dies; when the person is considering whether to return to work, to retire, or to take on a more challenging job. Without such information, a physician often will not know what to recommend, and citizens may be placed into dangerous situations (if they are not warned of neuropsychological impairments that might impede their ability to work safely). Also, they might have their civil rights violated if they are restrained from engaging in work or leisure activities of which they are neuropsychologically capable.

Response:
The medical record must document direct correlation between the test and the use of the result of the test by the treating provider to demonstration that this is not being performed as a screening tool. There is no restriction in this LCD on testing based on medical conditions.

Comment:
The neuropsychological findings and treatment recommendations should be shared by the treating neuropsychologist with the patient (and, usually, with his or her family). We could not expect a primary care physician to effectively, ethically convey the information obtained by an orthopedic surgeon or clinical oncologist -- when patients need to see highly trained specialists, the expectation is that those specialists will explain their tests, findings, diagnoses, and

recommendations directly to the patient and family, as well as communicate that information to the referring and other treating physicians. Similarly, when a neuropsychological evaluation is completed, results are shared with the patient and family in a treatment planning conference (sometimes referred to as a "feedback session"), as well as with the referring physician and other relevant providers (with proper consents). Most of the time, the recommended interventions will require clear understanding, acceptance, and participation from the patient and collateral family members. Physicians are not trained to conduct, interpret, or integrate neuropsychological assessment into the treatment of their patients (a training process that typically requires 4 to 5 years of graduate study in psychology, with an additional 2 years of post-doctoral study of neuropsychology, before the neuropsychologist is considered eligible to sit for board certification by the American Board of Clinical Neuropsychology.)

Response:
The AMA definition of these codes is:

"xxxxx, per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report". There is nothing in the description of the CPT codes in this range that says "feedback session". However, WPS is willing to allow 60 minutes of time for the testing provider to explain the results of the test to the patient/and or family.

The LCD now reads:
"4. If the total time for the tests exceeds eight hours, a report may be requested asking for the medical necessity of the extended testing. The explanation of the test to the patient/family is considered part of this time and should not exceed 60 minutes. If more than one hour is required to establish a plan of care based on the results of the test, this service should be billed with another CPT code as it is not part of the testing service.

7. The time spent with the interpretation and the preparation of the report, and explanation of the report to the patient and/family are billed with the code used to perform the test. "

Comment:
The proposed LCD states that feedback of test results is not billable and should be the domain of the referring provider.

Response:
The draft LCD said:

c. There is no "feedback" billed by the person who performed psychological and neuropsychological testing. Medicare payment for the test includes the test and the report. The report goes to the person who ordered the test. The feedback of the test to the beneficiary should come from the provider who ordered the test. If the person who ordered the test is the same person who performed the test the feedback is a separate service. The feedback of the test(s) is included in the appropriate therapy service.
d. When a provider and a technician administer different medically necessary tests, the interpretation must be allocated to the appropriate CPT code. Computerized tests are billed once and include the interpretation and report.
e. Typically, the total time for all tests (regardless who performs them) will be 5-7 hours including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and

The final LCD says:

4. If the total time for the tests exceeds eight hours, a report may be requested asking for the medical necessity of the extended testing. The explanation of the test to the patient/family is considered part of this time and should not exceed 60 minutes. If more than one hour is required to establish a plan of care based on the results of the test, this service should be billed with another CPT code as it is not part of the testing service.
8. The time spent with the interpretation and the preparation of the report, and explanation of the report to the patient and/family are billed with the code used to perform the test.
9. The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report that will be given to the referring provider

Comment
Neuropsychology should be allowed to use ICD-9 neurological diagnostic codes to bill for our services. Neuropsychological assessment is a standard part of medical care for a number of neurological conditions. If the individual with the neurological disorder is cognitively intact,

Response
Neuropsychologists are allowed to use ICD-9 neurological diagnostic codes to bill for services. There are no ICD-9 codes in this LCD. ICD-9 codes are required by CMS to define the reason the service is rendered. Any appropriately used ICD-9 code that fills this definition is thus allowed.

Comment:
Neuropsychological assessment is useful for individuals with mild cognitive impairment and dementia, and the use of a FAST stage 3 as a cut-off for neuropsychological assessment limits access of patients that could benefit from neuropsychological assessment. Neuropsychological testing is goes beyond simply detecting the presence or absence of dementia. It is useful in providing differential diagnostic information for providers caring for patients with dementia. Neuropsychological assessment can be useful in distinguishing between various dementing conditions (see Manning, 2004). Differential diagnosis of dementia can assist physicians in care for their patients. Use of antipsychotic medication in an individual with Alzheimer's may be a reasonable consideration, while the physician may be more hesitant to try antipsychotic medication on an individual with Lewy Body Dementia. Moreover, the physician might focus more aggressively on cerebrovascular risk factors on an individual with vascular dementia versus a patient with frontotemporal dementia. Neuropsychology is uniquely positioned to provide physicians, patients, and families with information regarding the etiology of cognitive deficits. Neuropsychological assessment is also useful in determining the subtype of Mild Cognitive Impairment. MCI increases risk for dementia, but the subtype of MCI is important. Individuals with amnestic MCI are much more likely to progress to dementia versus individuals with non-amnestic MCI show a significantly lower rate of progression to dementia. Neuropsychological assessment can be useful in helping to determine those individuals who are at high risk for progression to dementia versus those who are at relatively lower risk. With this information, physicians may opt to put individuals in the high-risk group on memory enhancing medication, while opting to follow low-risk patients without initiating medication intervention.

Response:
Medicare covers medically necessary tests. Medicare regulations does not allow for payment of screening tests. While WPS agrees the information above is useful, when it involves screening, it is not covered by Medicare.

Comment:

1. The feedback session is a valuable clinical intervention and should be preserved as a key component of neuropsychological evaluation.
2. The requirement for medical providers to make a "neuropsychological diagnosis" before referring a patient for neuropsychological testing will be a barrier to treatment.
3. For many patients at FAST Stages 3 and higher, the etiology and implications of cognitive deficits are unknown, and a neuropsychological evaluation is invaluable in determining the most appropriate treatment and recommendations.

Response:

1. Feedback is a term that is not used in this LCD however; the provider may give the results of the test to the patient/family as part of the testing procedure.
2. There is no requirement for medical providers to make a neurophysiological diagnosis before referring a patient for neuropsychological test. Like all diagnostic tests there has to be an ICD-9 code that is placed on the test when it is submitted for payment to Medicare.
3. While the FAST test has been removed from the LCD – stage three "3. Decreased job function evident to co-workers; difficulty in traveling to new locations, decreased organizational capacity" was the point the patient was showing obvious disease.

Comment:

I have also been highly concerned about the elimination of payable diagnostic codes. If transparency is desired about the indication for neuropsychological services to address medical necessity (which presumably it would be), we should be able to bill with appropriate medical diagnoses for services, such as stroke, TBI, Alzheimer's disease, Parkinson's disease, and other neurologic and medical conditions. We are essentially forced to use generic, non-specific (psychiatric) diagnoses as the only payable diagnoses for care for our evaluation and services. Please consider transparency of condition for which the patient is being seen, when looking at what diagnostic codes are payable for neuropsychological services.

Response:

The ICD-9 codes have not been eliminated they are still required on the claim. However, listing ICD-9 codes in the LCD limits the diagnosis that are payable to the ones listed. By not listing ICD-9 codes all medically necessary diagnosis are covered. **However, per national law, s**creening tests are not covered.

Comment:

I am writing in response to some aspects of the policy that are not in keeping with laws, good science, and best practice of clinical neuropsychology. Conflicts between state law and the provision of neuropsychological testing by non-psychologists. Several state laws are inconsistent with the following language contained in the draft policy (Billing and Coding Guidelines, p. 2):

> "…nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the general supervision of a physician or a CP. Rather, NPs and CNSs must perform such tests under the requirements of their respective benefit instead of the requirements for diagnostic psychological and neuropsychological tests."

Most states restrict the use of psychological tests, some limit use to qualified mental health professionals and a few only allow access by licensed clinical psychologists. None of the scopes of practice of non-psychologist licensure laws in WPS states comment on the restricted use of psychological tests. It is my hope that the LCD will be modified to recognize psychologists'

scope of practice and comply with state law and strong public policy of test security as described by the U.S. Supreme Court in Detroit Edison v. NLRB (1979) and its progeny.

Comment
The proposal to allow non-physician health care providers such as nurse practitioners, clinical nurse specialists, and physician assistants to provide neuropsychological assessments independently of practitioners with specialized training in neuropsychology fails to recognize the level of expertise needed to administer and interpret these assessments and also jeopardizes their utility. Neuropsychological assessment measures by persons with little if any knowledge of their proper use and without the involvement of professionals trained in these methods, is likely to lead to both inappropriate applications of the measures and to faulty interpretations of the findings obtained from them. Lessening restrictions on the use of these methods is also likely to make the tests less secure, diminishing their sensitivity to clinical disorder and altering normative standards in ways that would make results more difficult to interpret.

Response
This is a direct quote from the CMS manual:
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

Comment:
My colleagues and I recommend that, prior to neuropsychological testing, patients score at or above the following cut-offs on screening tests:

MoCA: 19	SLUMS: 18
MMSE: 18	Kokmen: 18

Shorter screens (e.g., the Mini-Cog) do not provide adequate range to recommend a cut-off. For repeat neuropsych testing (no sooner than one year), in addition to the restriction criteria above, the diagnosis must still be in question and/or there must be evidence of unexpected change in cognition. Additionally, we recommend that administering formal neuropsychological testing be restricted to licensed neuropsychologists. The more difficult but practical question in persons with dementia is not in limiting neuropsychological testing for diagnosis and management, but in limiting other procedures, such as routine screening with colonoscopy, PSA, PAPs, or mammograms, and various cardiology, oncology, orthopedic, etc. evaluations and interventions.

Response:
Thank you for this comment however it will not be included in this LCD

Comment:
We respectfully request that the use of the FAST Scale be reconsidered. FAST Scale Stages 1 and 2 reflect normal functioning and no referral to neuropsychology would be made. FAST Scale Stage 3 is the initial onset of dementia and likely the first time the patient or family would consult a physician or a neuropsychology evaluation would be considered. However, the policy states on page 11 first paragraph that "Patients with FAST Scale of Stage Three or more Alzheimer's disease would not benefit from Psychological or Neuropsychological Testing." If we understand this correctly, there doesn't appear to be a circumstance under which a patient with Alzheimer's would meet medical necessity for referral to neuropsychology.

Response:
This has been removed from the LCD. Thank you