Massachusetts
Neuropsychological
Society

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Dear Drs. Haug and Cunningham:

The (list associations here) are writing to thank you for your swift response to our request to revise language in the National Governmental Services (NGS) Local Coverage Determination for Psychiatry and Psychology Services (LCD L26895). The changes you made will significantly improve access to high quality psychological and neuropsychological assessment and therapy.

We believe there was an error in one of the revisions that changed the meaning of the passage in a way NGS did not intend. We request that you revise the language. Also, we would like to request additional consideration regarding the issue of hours allowed for assessment and the conditions under which patients with dementia are able to access psychotherapy services.

I. Presumed error in revision:

In our October letter, we noted that the NGS LCD (Section VII, B) states:

> Neuropsychological testing does not rely on self report measures such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT).

We requested the following language change, noting that brain damage or degenerative disease processes (e.g. right hemisphere stroke, traumatic brain injury, frontotemporal dementia) commonly affect emotional expression and behavioral control, and likewise, mood disorder may produce or mimic cognitive impairment, and neuropsychologists routinely utilize mood and personality measurements as an integral component of their neuropsychological evaluations.

> Neuropsychological testing may include self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT), when questions of how brain damage or degenerative disease processes (e.g. right hemisphere CVA) may be affecting emotional expression or how significant emotional distress or mood impairment might be affecting cognitive function (e.g. question of presence of "pseudodementia") arise.

NGS added the language, but left out the words “may include.” The current sentences still uses the original phrase, “does not rely on” therefore fundamentally changing the meaning of the language change.

II. Hours for assessment

The NGS LCD (Section VII, Limitations) stated:

> Typically, psychological testing/neuropsychological testing may require four (4) to six (6) hours to perform (including administration, scoring, and interpretation). If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

We applaud the inclusion of the language we suggested:

> Supporting documentation in the medical record must be present to justify greater than 8 hours per patient per evaluation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, medical necessity for extended time should be documented in the report.

We also requested that the following phrase be deleted:

> Typically, psychological testing/neuropsychological testing may require four (4) to six (6) hours to perform (including administration, scoring, and interpretation).

We continue to be concerned that this language remains in the LCD. While four to six hours of neuropsychological testing is adequate for many evaluations for Medicare policyholders, it is not for many others. Some referral questions for patients require longer or more extensive testing, for example younger patients who have been disabled by moderate to severe traumatic brain injury and are seen for assessment for neurological rehabilitation planning purposes. More

generally, the length of evaluation can vary because of a wide range of uncontrollable factors, including neurologic, emotional, and other factors in the patient's history and current medical status, such as motor slowing, setting of the evaluation (inpatient versus outpatient), timing of the evaluation (acute versus subacute versus more long-standing conditions), or even patient fatigue.

The inclusion of the "4-6 hours" phrase is likely to confuse clinicians regarding covered services and may lead to a restriction of access to medically necessary services for Medicare patients.

We also suggest that, when a claim for more than 8 hours is rejected, there be an accessible mechanism for appeal and peer review of the supporting documentation that would enable a subscriber to be covered for more than 8 hours, where appropriate. We would welcome the chance to work with you to create an effective mechanism for accessing needed services for these patients, and we would like to discuss this further with you when we meet.

III. Psychotherapy patients with dementia

The NGS LCD (Section VII, Limitations) stated that

> Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia be mild and that they retain their capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

We recommend the including mild and moderate stages of dementia in the groups which may access psychotherapy services. This was in line with the NHIC LCD, and most consistent with the variability present in individuals with dementia. Some patients with moderate dementia may benefit from psychotherapy, depending on the nature of their dementia presentation. Practitioners would bear the burden of documenting in their medical record that the dementia has not produced a severe enough cognitive defect to prevent psychotherapy from being effective. We therefore request that you add the phrase "or moderate" to this section.

IV: Psychotherapy with dementia patients, more restrictive definition of "mild dementia."

Additionally, language was included in the revised LCD that creates a more restrictive definition of mild dementia than the previous LCD: "(MMSE >15)" was added after "mild dementia." While an MMSE score is one possible metric for classifying dementia stage, it is only one of many possible sources of information in the staging process (e.g. Marcel 2011). For example, the Clinical Dementia Rating Scale, one of the most widely used dementia rating systems, relies on functional status and not on any single psychometric score. Including this narrow definition in the LCD 1) is not based on standard of care, and 2) creates an overly restrictive definition that

will result in less access to care. As it is our understanding that more restrictive LCD language requires a draft process, we respectfully suggest that this be removed.

Respectfully submitted,

On behalf of the (List associations and signers here) Massachusetts Psychological Association (MPA), the Massachusetts Neuropsychological Society (MNS), and the New York State Association of Neuropsychology (NYSAN):

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Additional references:

Rikkert MG, Tona KD, Janssen L, Burns A, Lobo A, Robert P, Sartorius N, Stoppe G, & Waldemar G. (2011). Validity, reliability, and feasibility of clinical staging scales in dementia: a systematic review**.** *American Journal of Alzheimers Disease and Other Dementias.* 26(5):357-65.