



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION



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Cigna
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October __, 2014

Re: Cigna Medical Coverage Policy on Neuropsychological Testing

Dear Dr. Kessel:

Thank you for your letter dated August 4, 2014 responding to the Inter Organizational Practice Committee, National Academy of Neurology, and Brain Injury Association of America's concerns regarding the Cigna medical coverage policy on neuropsychological testing. After reviewing your letter, we would like to ask for clarification on issues you responded to, and also ask for responses to sections of our letter that were not addressed by Cigna.

1. We believe your August 4th letter indicates that Cigna will cover neuropsychological testing in cases of MCI, concussion, and other conditions as long as there is a suspected change in mental status, behavior, or memory. If we are reading this correctly, we would like you to clearly state this in an update of your medical coverage policy.

We would not have understood this from the policy or letter if a member of our group had not been in meetings with Cigna where this approach had been discussed. It is important that your policy be written so that any neuropsychologist can understand them without the need for inside information.

2. **Psychiatric conditions** (e.g. psychotic disorders, anxiety disorders, substance abuse, personality disorders, mood disorders).

Your letter fails to address our parity violation concern in any real way. Your policy's exclusion for psychiatric conditions discriminates against all mental health patients protected by the federal parity law, the Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA). Cigna's defense is the bald assertion that "non-coverage of behavioral health diagnoses is based on medical necessity." You make this assertion without any further explanation, without citing any research, and without responding to our prior example of how neuropsychological assessment is medically necessary for the management of schizophrenia. That still looks to us like a blatant parity violation.

It is widely accepted in the health care field that neuropsychological assessment is necessary to guide the treatment of consumers with many psychiatric conditions. For example, schizophrenia carries common and frequently severe cognitive impairments that act as barriers to patients' ability to communicate effectively with their treating professionals, understand, remember, and execute treatment protocols, and benefit from therapeutic interventions. While neuropsychological assessment is not necessary to *diagnose* schizophrenia, neuropsychological assessment is often critical to understanding the unique and potentially disabling cognitive deficits associated with the disease process that interfere with effective treatment. Without that understanding those barriers to treatment cannot be addressed. Due to the common, cognitively-based deficits of insight for patients with schizophrenia less expensive methods for making this determination, such as a clinical interview, are not available. This is also true for many other psychiatric conditions, depending on the severity and specific expression of the disease course.

As another example, Bipolar disease likewise carries common cognitive impairments that interfere with patients' ability to manage their illness, communicate effectively with clinicians, and respond to therapeutic interventions. As with schizophrenia, neuropsychological assessment is not medically necessary to diagnose Bipolar disease, but it is often necessary to understanding (and thereby reducing) cognitive barriers to effective disease management. As with schizophrenia, less costly methods of making this determination, such as a clinical interview, are not available.

In this letter, we cite research in further support of neuropsychological assessment as medically necessary for certain psychiatric disorders that fall under your blanket exclusion. We challenge Cigna to explain those studies away.

- 3. Autistic Spectrum Disorders/ PDD.** Autism has been firmly established over the past 40 years as a neurological and therefore a medical disorder. Your letter of August 4, 2014 did not address Cigna's strange statement that neuropsychological assessment is not medically necessary in cases of Autism.

As we noted previously, specific cognitive profiles and deficits are strongly associated with autism. Language impairments are widespread, sometimes resulting in significant overall language delay and sometimes preferentially affecting semantics and pragmatics while sparing syntax and phonology. Memory, especially verbal memory, is frequently impaired. Social cognition is usually impaired. A variety of attentional deficits are common. Executive function deficits are almost universal. Intellectual disability is a frequent comorbid condition, as are sensory and motor dysfunction. Neuropsychological assessment focusing on these areas of frequent impairment will dictate whether the patient's condition warrants, and his/her mental status allows benefit from speech/language therapy, cognitive-behavioral therapy, behavioral

management, social skills training, occupational therapy and physical therapy, and whether a referral for psychopharmacological consultation is warranted, and therefore is needed to make recommendations for a program of care specific to the patient's needs. Follow-up evaluation of these areas of functioning will determine the success of treatment and the rate of improvement, if any, and dictate appropriate adjustments to treatment. In addition, individuals with ASD are at risk for other medical complications, such as seizure disorders, and neuropsychological assessment is sometimes requested by physicians to determine whether mental status is undergoing a decline. Having access to intervention of the appropriate type and intensity can make an extremely significant difference to treatment response and ultimate outcome (Orinstein et al, 2014).

On behalf of the American Academy of Clinical Neuropsychology, National Academy of Neuropsychology, Division 40 (Neuropsychology) of the American Psychological Association Practice Organization, and the American Board of Professional Neuropsychology, we look forward to your response. (Please respond to Karen Postal, Ph.D., APBB-CN 166 North Main Street Suite 3B Andover, MA 01810, karenpostal@comcast.net; 978-475-2025).

Thank you for your time and consideration.

Respectfully submitted,



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References

Psychiatric Disorders:

Lewandowski K, Cohen B, & Ongur D. (2011). Evolution of neuropsychological dysfunction during the course of schizophrenia and bipolar disorder. *Psychological Medicine*. 41:225-241.

Nuechterlein K, Barch, D, Gold T, et. al. (2004). Identification of separable cognitive factors in schizophrenia. *Schizophrenia Research* 72:29-39.

Heinrichs R, & Zakzanis K. (1998). Neurocognitive deficits in schizophrenia: a quantitative review of the evidence. *Neuropsychology*. 12: 426-445.

Mann-Wrobel M., Carreno, J & Dickinson D. (2011). Meta-analysis of neuropsychological functioning in euthymic bipolar disorder: an update and investigation of moderator variables. *Bipolar Disorder*. 13: 334-342.

MCI:

Albert M, DeKosky S, Dickson D, et al. (2011) The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association

workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & dementia : the journal of the Alzheimer's Association*, 7:270-9.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual, Fifth Edition*. American Psychiatric Association, Washington DC.

Belleville, S., Gilbert, B., Fontaine, F., Gagnon, L., Menard, E., & Gauthier, S. (2006). Improvement of episodic memory in persons with mild cognitive impairment and healthy older adults: evidence from a cognitive intervention program. *Dementia, Geriatrics, & Cognitive Disorders*, 22(5-6), 486-499. doi: 00096316

Fields, J., Ferman, T., Boeve, B., & Smith, G. (2011). Neuropsychological assessment of patients with dementing illness. *Nature Reviews. Neurology*. doi: 10.1038/nrneuro.2011.173

Giza, C. C., Kutcher, J. S., Ashwal, S., Barth, J., Getchius, T. S., Gioia, G. A., . . . Zafonte, R. (2013). Summary of evidence-based guideline update: Evaluation and management of concussion in sports: Report of the guideline development subcommittee of the American Academy of Neurology. *Neurology*, 80, 2250-2257. doi:10.1212/WNL.0b013e31828d57dd

Gomar, J., Bobes-Bascaran, M., Conejero-Goldberg, C., Davies, P., Goldberg, T., & for the Alzheimer's Disease Neuroimaging Initiative. (2011). Utility of combinations of biomarkers, cognitive markers, and risk factors to predict conversion from mild cognitive impairment to Alzheimer disease in the Alzheimer's Disease Neuroimaging Initiative. *Archives of General Psychiatry*, 68, 961-969.

Greenaway, M. C., Duncan, N. L., & Smith, G. E. (2013). The memory support system for mild cognitive impairment: randomized trial of a cognitive rehabilitation intervention. *Int J Geriatr Psychiatry*, 28(4), 402-409. doi: 10.1002/gps.3838

Heister, D., Brewer, J., Magda, S., Blennow, K., McEvoy, L., & for the Alzheimer's Disease Neuroimaging Initiative. (2011). Predicting MCI outcome with clinically available MRI and CSF biomarkers. *Neurology*, 77, 1619-1628.

Jedynak, B. M., Lang, A., Liu, B., Katz, E., Zhang, Y., Wyman, B. T., . . . Prince, J. L. (2012). A computational neurodegenerative disease progression score: method and results with the Alzheimer's disease Neuroimaging Initiative cohort. *Neuroimage*, 63(3), 1478-1486. doi: 10.1016/j

Landau, S., Harvey, D., Madison, C., Reiman, E., Foster, N., Aisen, P., . . . Jagust, W. (2010). Comparing predictors of conversion and decline in mild cognitive impairment. *Neurology*, 75(3), 230-238. doi: WNL.0b013e3181e8e8b8 [pii]

Concussion:

Belanger, H. G., Spiegel, E., & Vanderploeg, R. D. (2010). Neuropsychological performance following a history of multiple self-reported concussions: A meta-analysis. *Journal of the International Neuropsychological Society*, 16, 262-267.

Bijur, P. E., Haslum, M., & Golding, J. (1990). Cognitive and behavioral sequelae of mild head injury in children. *Pediatrics*, 86, 337-344.

Bush, S. (Ed.). (2012). *Neuropsychological practice with veterans*. New York, NY: Springer Publishing Company, LLC.

Carone, D. & Bush, S. S. (Eds.). (2013). *Mild traumatic brain injury: Symptom validity assessment and malingering*. New York, NY: Springer Publishing Company, LLC.

Carroll, L. J., Cassidy, J. D., Cancelliere, C., Co[^]te', P., Hincapie', C. A., Kristman, V. L., . . . Hartvigsen, J. (2014). Systematic review of the prognosis after mild traumatic brain injury in adults: Cognitive, psychiatric, and mortality outcomes: Results of the international collaboration on mild traumatic brain injury prognosis. *Archives of Physical Medicine and Rehabilitation*, 95, 152-173.

Cernich, A. N., Chandler, L., Scherdell, T., & Kurtz, S. (2012). Assessment of co-occurring disorders in veterans diagnosed with traumatic brain injury. *Journal of Head Trauma and Rehabilitation*, 27, 253-260.

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (2011). *Indications and conditions for in-theater post injury neurocognitive assessment tool (NCAT) testing*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://www.dcoe.mil>

Harmon, K. G., Drezner, J., Gammons, M., Guskiewicz, K., Halstead, M., Herring, S., & Kutcher, J. (2013). American Medical Society for Sports Medicine Position Statement: Concussion in Sport. *Clinical Journal of Sports Medicine*, 23, 1-18.

Echemendia, R. J., Iverson, G. L., McCrea, M., Broshek, D. K., Gioia, G. A., Sautter, S. W., . . . Barr, W. B. (2011) Role of neuropsychologists in the evaluation and management of sport-related concussion: An inter-organization position statement. *The Clinical Neuropsychologist*, 25, 1289-1294.

Faul, M., Xu, L., Wald, M. M., & Coronado, V. (2010). Traumatic brain injury in the United States: Emergency department visits, hospitalizations and deaths, 2002–2006. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Iverson, G. L. (2006). Misdiagnosis of the persistent postconcussion syndrome in patients with depression. *Archives of Clinical Neuropsychology*, 21, 303-310.

Kelly, J. C., Amerson, E. H., & Barth, J. T. (2012). Mild traumatic brain injury: Lessons learned from clinical, sports, and combat concussions. *Rehabilitation Research and Practice*, doi:[10.1155/2012/371970](https://doi.org/10.1155/2012/371970)

Kennedy, C. H., & Moore, J. L. (Eds.). (2010). *Military neuropsychology*. New York, NY: Springer Publishing Company, LLC.

Leininger, S., Strong, C. A. H., & Donders, J. (2014). Predictors of outcome after treatment of mild traumatic brain injury: A pilot study. *Journal of Head Trauma Rehabilitation*, 29, 109-116.

McCrory, P., Meeuwisse, W. H., Aubry, M., Cantu, B., Dvorák, J., Echemendia, R. J., . . . Turner, M. (2012). Consensus statement on concussion in sport: The 4th international conference on concussion in sport held in Zurich, November, 2012. *British Journal of Sports Medicine*, 47, 250-258.

Sweet, J.J., & Guidotti Breting, L.M. (2013). Symptom validity test research: status and clinical applications. *Journal of Experimental Psychopathology*, 4, 6-19.

Webbe, F. (Ed.). (2011). *The handbook of sport neuropsychology*. New York, NY: Springer Publishing Company, LLC.

Autism:

Orinstein, A., Helt, M., Troyb, E., Tyson, K., Barton, M., Eigsti, E., Naigles, L. and Fein, D. (2014) Intervention for Optimal Outcome in Children and Adolescents with a History of Autism. *Journal of Developmental and Behavioral Pediatrics*.

Rich Stoner, Ph.D., Maggie L. Chow, Ph.D., Maureen P. Boyle, Ph.D., Susan M. Sunkin, Ph.D., Peter R. Mouton, Ph.D., Subhojit Roy, M.D., Ph.D., Anthony Wynshaw-Boris, M.D., Ph.D., Sophia A. Colamarino, Ph.D., Ed S. Lein, Ph.D., and Eric Courchesne, Ph.D. (2014). Patches of Disorganization in the Neocortex of Children with Autism. *N Engl J Med* 2014;370:1209-19

Appendix A – Highlights of the American Academy of Neurology and American Medical Society for Sports Medicine Studies/Recommendations

AMS Sports Medicine Guideline

Neuropsychological Testing

- Neuropsychological tests are an objective measure of brain-behavior relationships and are more sensitive for subtle cognitive impairment than clinical exam.
- Most concussions can be managed appropriately without the use of neuropsychological testing.
- Computerized neuropsychological testing should be interpreted by healthcare professionals trained and familiar with the type of test and the individual test limitations, including a knowledgeable assessment of the reliable change index, baseline variability, and false positive and false negative rates.
- Paper and pencil neuropsychological tests can be more comprehensive, test different domains, and assess for other conditions that may masquerade as or complicate assessment of concussion.
- Neuropsychological testing should be used only as part of a comprehensive concussion management strategy and should not be used in isolation.
- The ideal timing, frequency, and type of neuropsychological testing have not been determined.
- In some cases, properly administered and interpreted neuropsychological testing provides added value to assess cognitive function and recovery in the management of sports concussions.
- It is unknown if use of neuropsychological testing in the management of sports concussion helps prevent recurrent concussion, catastrophic injury, or long-term complications.

AAN Guideline

ABSTRACT Results: Specific risk factors can increase or decrease concussion risk. Diagnostic tools to help identify individuals with concussion include graded symptom checklists, the Standardized Assessment of Concussion, neuropsychological assessments, and the Balance Error Scoring System.

ANALYSIS OF EVIDENCE

Neuropsychological testing. Instruments for neuropsychological testing are divided into 2 types on the basis of their method of administration: paper-and-pencil and computer.

Both types generally require a neuropsychologist for accurate interpretation, although they may be administered by a non-neuropsychologist. It is likely that neuropsychological testing of memory performance, reaction

time, and speed of cognitive processing, regardless of whether administered by paper-and-pencil or computerized method, is useful in identifying the presence of concussion (sensitivity 71%–88% of athletes with concussion) (1 Class II study, 38 multiple Class III studies^{25,26,39,40, e12e6}). There is insufficient evidence to support conclusions about the use of neuropsychological testing in identifying concussion in preadolescent age groups.

Studies relevant to the prediction of early postconcussion impairments provided moderate to strong evidence that elevated postconcussive symptoms (1 Class I⁴⁰ study, multiple Class II and Class III studies^{28,230,33,e10}), lower SAC scores (2 Class I studies^{25,26}), neuropsychological testing score reductions (3 Class I^{e4,e11,e12} and 3 Class II^{28,e13,e14} studies), and deficits on BESS (1 Class I study²⁶) and SOT (1 Class I study,³² 1 Class II study^{e9}) are likely to be associated with more severe or prolonged early postconcussive cognitive impairments.

PRACTICE RECOMMENDATIONS

Retirement from play: Counseling.

2. LHCPs caring for professional contact sport athletes who show objective evidence for chronic/persistent neurologic/cognitive deficits (such as seen on formal neuropsychological testing) should recommend retirement from the contact sport to minimize risk for and severity of chronic neurobehavioral impairments (Level B).