SECTION XVI – PSYCHOLOGICAL TESTING SERVICES

All psychological testing services administered by network providers requires the completion of a *Psychological Testing Request* (PTR) form (Attachment I). The Local Mental Health Plan (LMHP) will facilitate a request for psychological testing and review the psychological testing report to promote and ensure report quality acceptability. Network Providers performing Psychological Testing are not required to obtain a pre-authorization for services after August 31, 2020 (MHSUDS Information Notice No.: 19-026). When Specialty Mental Health Services (SMHS) are medically necessary, Network Providers are not required to go to the Provider Connect Application and submit a Psychological Testing request.

The Los Angeles County Department of Mental Health (LACDMH) requires an authorization for all services and Fee-For-Service (FFS) Network Providers shall input only one authorization on a claim line. Funding Source Authorizations will be used by FFS providers for Specialty Mental Health and Medication Support services. The Funding Source Authorizations are given by LACDMH according to the disciplines of the providers Funding Source Authorizations begin with an 'F', followed by a number.

GOALS OF THE PSYCHOLOGICAL TESTING PROCESS

- Ensure the timely delivery of psychological testing to clients;
- Ensure the quality of psychological test reports by using standardized quality control procedures;
- Increase interdisciplinary access to psychological testing;
- Improve the process of determining the need for psychological evaluations;
- Facilitate access by clients to appropriate mental health services;
- Facilitate the coordinated delivery of mental health services between service providers; and
- Promote case consultation to improve mental health outcomes for clients.

RESPONSIBILITIES OF THE CENTRAL AUTHORIZATION UNIT

- Refer and facilitate service coordination between network providers, local community mental health centers, and protective services for clients requiring psychological testing;
- Consult, train and support network providers, community mental health centers and referral sources to establish and maintain practices relevant to psychological testing, assessment and service planning for clients; and
- Promote community wide practice guidelines and standards for psychological testing consistent with the California Board of Psychology.

CRITERIA FOR PSYCHOLOGICAL TESTING

One of more of the following criteria must be met for psychological testing:

1. The client must meet medical necessity criteria in order to be considered for psychological testing;
2. Psychological testing must be an adjunct to ongoing mental health treatment;
3. There is a need to clarify the client's diagnosis in order to further the treatment process;
4. An intervention or multiple interventions have failed;

5. A non-verbal client must be assessed in the absence of historical data;
6. To evaluate the client's capacity for informed consent, to emancipate successfully, and/or to ascertain benefits for Supplemental Security Income (SSI);
7. There is an unaccountable decline in the client's functioning;
8. The client presents with an unusual or high-risk behavior;
9. The client presents with a risk of non-emergency harm to self or others that is denied by the client; or
10. Other special circumstances.

The CAU does not reimburse psychological testing for:

- General assessments unrelated to psychological treatment;
- Learning disabilities;
- Intellectual Disability;
- Pre-adoption studies;
- General intelligence testing;
- Diagnosing Attention-Deficit/Hyperactivity Disorder (ADHD);
- Court ordered testing;
- Ruling out dementias or other neurologically-based disorders prior to an evaluation by an appropriate medical specialist; and
- Determining if medication is warranted.

GUIDELINES FOR REVIEW OF PSYCHOLOGICAL TESTING

The CAU psychologists utilize the following guidelines in facilitating requests for psychological testing:

1. The PTR form must include information that provides a compelling rationale for psychological testing;
2. The client must meet medical necessity criteria in order to be considered for psychological testing;
3. Psychological testing must be an adjunct to ongoing mental health treatment;
4. Neuropsychological testing requires a referral from a physician;
5. Psychological testing is not to be performed during a crisis;
6. Psychological testing shall not be performed to make decisions as to whether the client is to be on medication;
7. Referral questions are specific, relevant and individualized to the client and the treatment plan;
8. The request for psychological testing must clearly demonstrate that testing is necessary at this time;
9. Children and adolescents seven years and older, have not been tested within the last two years; and
10. Children six years and younger have not been tested within the last year.

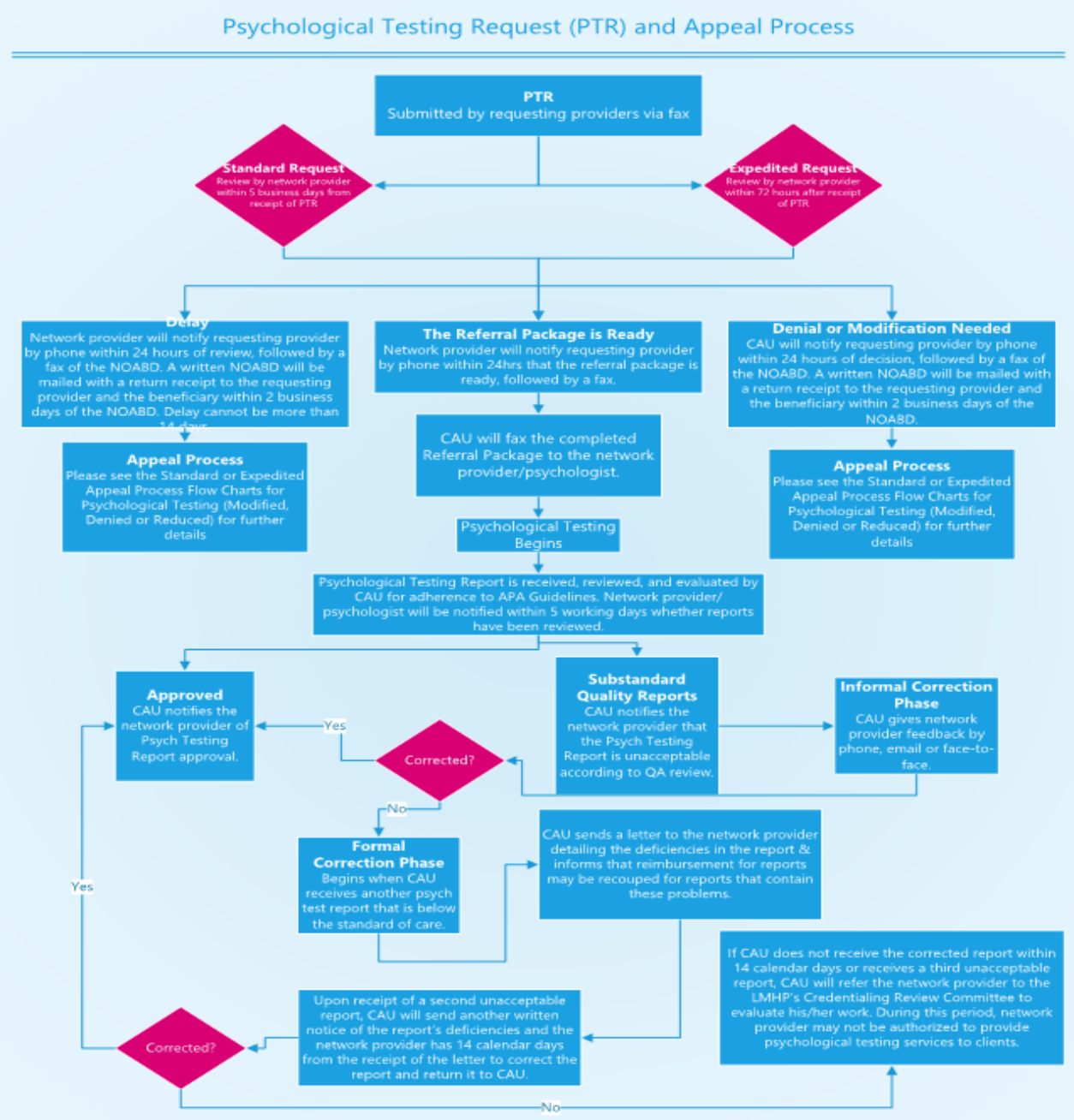
All requests to test minors under the supervision of the Department of Children and Family Services (DCFS) should be initiated by the Children's Social Worker (CSW) using DCFS form 5005. The form is completed by the CSW and then faxed directly to the CAU. The 5005 form must also be signed by the CSW's Supervising Children's Social Worker (SCSW).

FACILITATING PSYCHOLOGICAL TESTING

In order to facilitate a request for Psychological Testing, the requesting provider for the client must submit the PTR by faxing the completed PTR to CAU at (213) 738-4412. The CAU will forward the PTR to a network provider who will make the decision to approve, modify, delay, or deny PTRs (Refer to Figure A).

The CAU psychologist can advise the requesting provider if they need additional information/paperwork to complete the request, or whether the request is for a service that is not a covered benefit. Once the referral package is ready, the CAU psychologists will send it to a network provider. However, the referring party may suggest a network provider.

FIGURE A



The network psychologists must make decisions in a timely fashion, appropriate for the nature of the beneficiary's condition, and not to exceed five (5) business days from the receipt of the request for psychological testing. For cases in which a requesting provider indicates, or the network psychologists determine, this standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the network psychologists must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. The MHP may extend the timeline regarding an extension under two conditions: The beneficiary requests the extension or the MHP demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest (Reference Title 42, CFR, Section 438.408 (c) (1) (i). In no event shall the event extend beyond the 14 calendar day extension (Refer to Psychological Testing Authorization Process Policy and Procedure No. 313.42).

Decisions to approve, modify, delay, or deny provider requests for authorization prior to the provision of services to beneficiaries must be communicated initially by telephone to the requesting provider within 24 hours of the decision, followed by a fax. Decisions resulting in denial or delay of all or part of the requested service shall be communicated to the beneficiary and the requesting provider, in writing and must be mailed to the beneficiary and the requesting provider within two (2) business days of the decision.

When testing or the referral package is ready, the referral package must be communicated to the requesting provider initially by telephone within 24 hours of the decision, followed by a fax. CAU Psychologist will monitor the type of psychological testing that should be administered, based upon the needs of the Medi-Cal beneficiary. Then, a *Psychological Testing Request – Response* (PTR-R) form (Attachment II) is electronically transmitted via facsimile to the network provider. The PTR-R is formal notification of the network provider accepting the case and agreeing to do the testing.

When psychological testing services are denied or modified, the requesting provider will be notified initially by a telephone call within 24 hours, followed by a fax of the Notice of Adverse Benefit Determination (NOABD). In addition, a written NOABD notice will be mailed with a return receipt within two (2) business days of the adverse benefit notice for psychological testing to the provider and the beneficiary. The NOABD letter must include the enclosures: *NOABD Your Rights, Nondiscrimination Notice, and Language Assistance*. These enclosures are required to ensure that the beneficiary is informed of civil rights laws and the right to appeal a NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43 & Section XVII: Notice of Adverse Benefit Determination).

When psychological testing services are delayed, the requesting provider and beneficiaries will be notified initially by telephone within 24 hours of the decision followed by a fax of the NOABD letter. In addition, a written NOABD notice will be mailed with a returned receipt within two business days of the adverse benefit notice for psychological testing to the provider and the beneficiary. The Provider and beneficiary will be mailed with a return receipt within two (2) business days of a written Notice of Adverse Benefit Determination Authorization Delay. This is when a decision about the Psychological Testing Request (PTR) has not been made because there is a need for additional information and the delay is in the beneficiary's best interest. The NOABD Authorization Delay notice is an apology to the Provider for the delay in processing the request for services in a timely manner, including the reason for the delay. As a result, the network psychologist has not completed reviewing the request, and the decision is delayed.

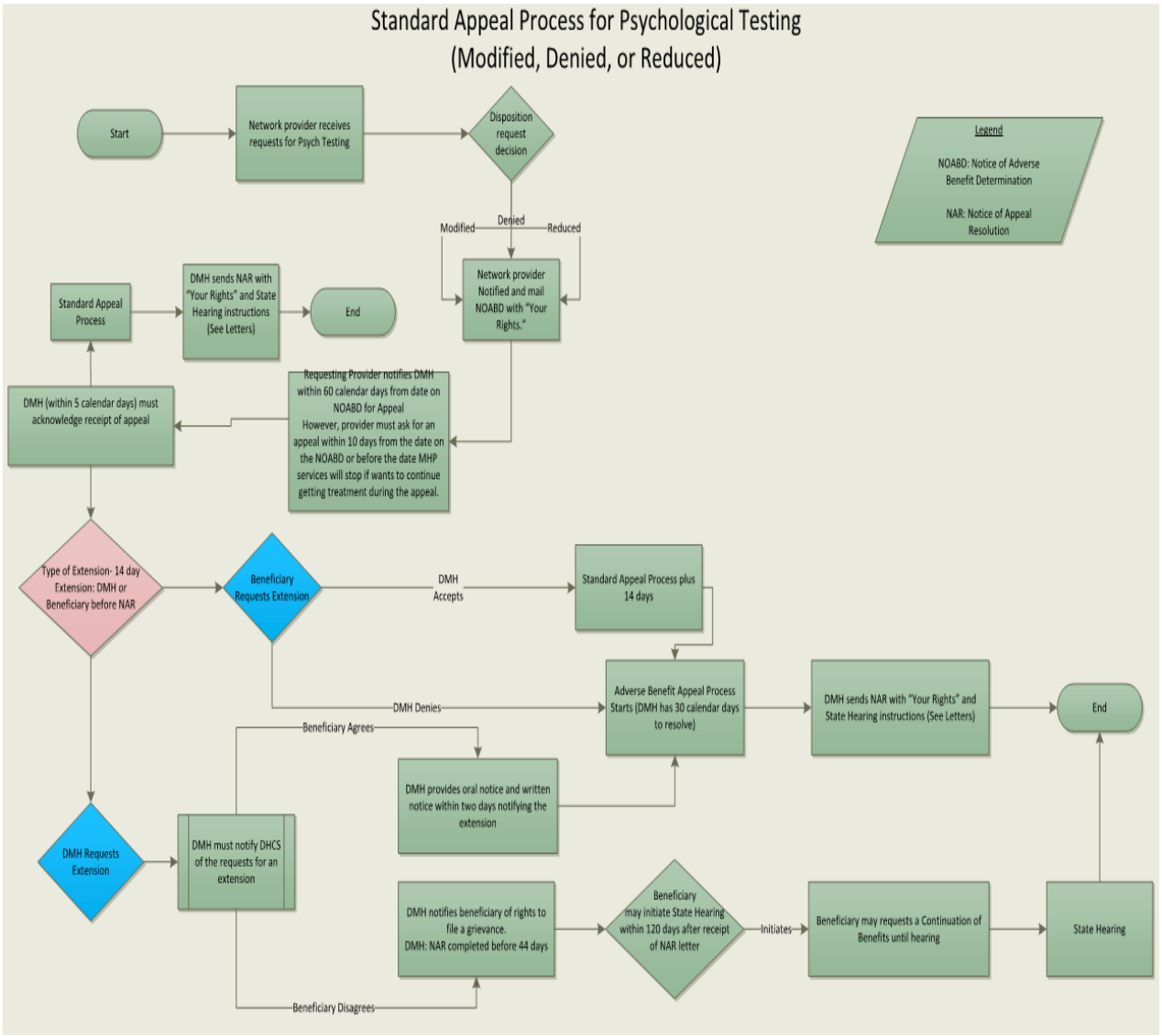
Note: Effective 9/1/2020, the IBHIS/ Provider Connect Psychological Testing Authorization screen will no longer indicate the status of a PTR (e.g., pending status).

In no event shall the event extend beyond the 14 calendar day extension. The CAU Psychologist shall include with the NOABD Authorization Delay notice the enclosure: "*NOABD Your Rights*" notice which tells the requesting provider and beneficiary about the right to an appeal and timelines to follow to file an appeal if the beneficiary disagrees with the extension regarding the *NOABD Authorization Delay* (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

APPEALS PROCESS

The referring party or requesting provider may ask for reconsideration of a denied or modified request for psychological testing referral and/or payment reimbursement within 60 calendar days of the date from the date on the NOABD letter. The request for reconsideration may be initiated through an internal MHP Appeal process (Refer to Figure B).

FIGURE B



Internal MHP Appeal Process for Beneficiary, Provider or Beneficiary Representative After Receipt of a Notice of Adverse Benefit Determination (NOABD) (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

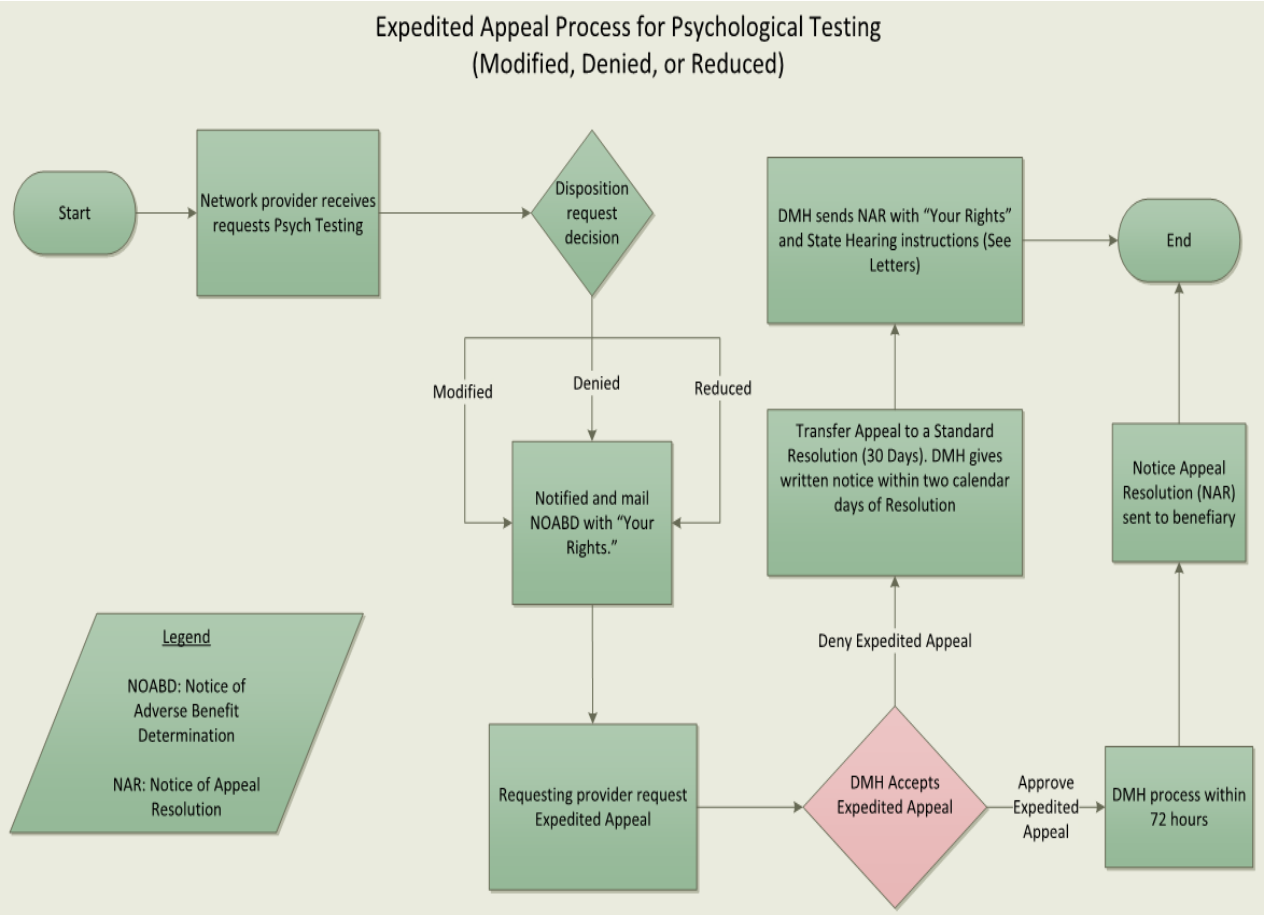
Beneficiaries must exhaust the MHP's appeal process prior to requesting a State Hearing. A beneficiary has the right to request a State Hearing only after receiving notice that the Plan is upholding an adverse benefit determination or the MHP's initial decision remains (Refer to Psychological Testing Policy and Procedure NOABD No. 313.43).

After receipt of the NOABD letter, the beneficiary may request an internal appeal with the MHP. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

The providers and authorized representatives cannot request continuation of benefits during the appeal. However, the beneficiary must state in the appeal request that he or she wants to continue getting treatment during the appeal. In this event, the beneficiary must ask for an appeal within 10 days from the date on the NOABD letter or before the date MHP services will stop.

The beneficiary's standard appeal request must be submitted within 60 calendar days from the date on the NOABD letter. An oral appeal shall be followed by a written appeal signed by the beneficiary, unless the beneficiary or provider have requested an Expedited Appeal (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43) (Refer to Figure C).

FIGURE C



The MHP/CAU must send a written Acknowledgment of Receipt of the appeal of the beneficiary's request postmarked within five (5) calendar days of receipt of the appeal.

The MHP/CAU shall maintain a log of oral appeals made by the provider or the beneficiary. The oral appeal is the filing date for the appeal. In the event the MHP/CAU does not receive a written appeal from the beneficiary, the MHP must neither dismiss nor delay resolution of the appeal and must send a Notice of Appeal Resolution (NAR) to the beneficiary).

Notice of Appeal Resolution (NAR) After Receipt of a Notice of Adverse Benefit Determination (NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43)

The Notice of Appeal Resolution (NAR) is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. Beneficiaries must exhaust the MHP's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination.

The NAR review process is not completed by the initial network psychologist. The NAR review process is conducted by a different an impartial CAU Clinical Reviewer to determine a resolution.

The Notice of Appeal Resolution (NAR), letter must include the enclosures "NAR Your Rights", "Nondiscrimination Notice" and "Language Assistance Notice". The NAR letter must include the criteria, clinical guidelines, or policies used in reaching the determination, the right to request a State hearing and how to request it, the right to request and receive benefits while the hearing is pending, how to make the request and notification that the beneficiary may be held liable to the cost of those benefits if the hearing decision upholds the MHP's benefit determination.

The MHP/CAU Clinical Reviewer must adhere to the 30 calendar day timeline; if the MHP fails to resolve the appeal within the 30 calendar day timeline then the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State hearing. The CAU Clinical Reviewer shall determine whether an Adverse Benefit Determination has been overturned or upheld. Refer to Definitions under section 1.6 in this policy.

THE MHP/CAU Clinical Reviewer has determined that a resolution has been made, and it is not resolved wholly in favor of the beneficiary. The result is that an Adverse Benefit Determination NAR, Upheld, is final. The request is still denied.

The *NAR Adverse Benefit Decision Upheld*, shall include: the results of the resolution and the date it was completed, including the reasons for the MHP's determination, the criteria, clinical guidelines, or policies used in reaching the determination, the right to request a State hearing, no later than 120 calendar days from the date on NAR and how to request it, the right to request and receive benefits while the hearing is pending, (including the timeframe in which the request shall be made, within ten (10) from the date the letter was post-marked and delivered to the beneficiary), how to make the request and notification that the beneficiary may be held liable to the cost of those benefits if the hearing decision upholds the MHP's benefit determination.

THE MHP/CAU Clinical Reviewer has determined that a resolution has been made, and it is resolved wholly in favor of the beneficiary. Appeals resolved wholly in favor of the beneficiary are *NAR Adverse Benefit Decision Overturned* The NAR Adverse Benefit Decision Overturned reads: The MHP/CAU has reviewed the appeal and has decided to overturn the original decision. The request is now approved. Other providers who conduct psychological testing and are not a MHP

Network Provider will receive the NAR Overturned decision within 72 hours by telephone, fax and by mail with a return receipt.

The NAR shall include the results of the resolution with a clear and concise explanation of the reasons, including why the decision was overturned and the date it was completed. The MHP/CAU must authorize the disputed services promptly and as expeditiously as the beneficiary's condition requires if the MHP reverses the decision to deny Psychological Testing services that were not furnished while the appeal was pending.

MHP/CAU shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Beneficiary, Provider or Beneficiary Representative May Request an Expedited Resolution of an Appeal After Receipt of a Notice of Adverse Benefit Determination (NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43)

The MHP Internal Appeal Process includes an Expedited Resolution of an Appeal.

An Expedited Resolution Appeal is available to the beneficiary if the beneficiary thinks waiting 30 days will hurt their health. The beneficiary may request or the provider may indicate that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health or substance use disorder condition and/or the beneficiary's ability to attain, maintain, or regain maximum function.

The provider or beneficiary representative may request an Expedited Resolution, after receipt of a Notice of Adverse Benefit Determination (NOABD).

The MHP/CAU must resolve the appeal within 72 hours from receipt of the appeal. The CAU Psychologist must log the time and date of the appeal receipt when an expedited resolution is requested, as this specific time of receipt drives the timeframe for resolution.

The MHP/CAU denial of the request for an Expedited Appeal requires reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution should be made by the MHP. The MHP shall provide written notice within two (2) calendar days of making this decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with extension.

The MHP/CAU can extend the standard resolution timeframes for resolving Expedited Appeals by up to 14 calendar days.

For an extension not requested by the beneficiary, but the MHP has requested the extension then the MHP is required to provide the beneficiary with written notice of the reason for the delay including: make reasonable efforts to provide the beneficiary with prompt oral notice of the extension; to provide written notice of the extension within two (2) calendar days of making the decision to extend the timeframe; and to notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

If there is no grievance from the beneficiary regarding the MHP's request for an extension of the timeline, then the MHP shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14 calendar day extension.

If the beneficiary does not receive a notice from the MHP within the timeline of 30 days, then the Plan has failed to adhere to the federal timeline and the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State Hearing (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

The MHP must inform the beneficiary that a request for a State Hearing must be made within 120 days from the date of the Notice of Appeal Resolution (NAR), and only after the MHP has notified the beneficiary that the MHP has decided to "Uphold" the adverse benefit determination decision). The NAR ABD Upheld letter will include the attachment NAR "Your Rights, Nondiscrimination Notice and Language Assistance Notice. The MHP shall notify the beneficiary that to continue treatment during the appeal for a State Hearing, a request for a State hearing must be made within 10 days from the date that the NAR was postmarked or delivered to the beneficiary or before the date the MHP reported that services will be stopped or reduced. The State must reach its decision on the hearing within 90 calendars of the date of the request for the hearing (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

The parties to State hearings include the MHP, as well as the beneficiary and his or her authorized representative or the representative of a deceased beneficiary's estate.

NOABD, Appeals, and Grievances on NOABD and any other Communications should be mailed to:

Intensive Care Division/ Psychological Testing Requests
Los Angeles Department of Mental Health
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020
Fax (213) 738-4412

PSYCHOLOGICAL TESTING REPORT

The network provider must send all completed psychological testing reports to the CAU at:

Intensive Care Division/ Psychological Testing Requests
Los Angeles Department of Mental Health
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020
Fax (213) 738-4412

Reports must be completed in a timely manner as specified in the PTR-R. This will generally be within 42 days of receiving the referral package. The CAU psychologists will perform a standardized review of the test reports to promote and ensure report quality acceptability. Within five working days, the CAU will notify the network provider whether reports have been reviewed. Reimbursement for reports not meeting quality standard may be recouped. (MHSUDS IN No.: 19-026 page 11).

The CAU psychologists may obtain consultation and/or peer review of selected reports from members of the psychological community. *The Quality Assurance: The Clinical Evaluation* form (Attachment III) may be used to evaluate psychological test reports.

Note: Reimbursement for psychological testing reports completed in an untimely manner, or of substandard quality may be recouped. Psychological testing reports must be sent to the CAU as well as to the referring party.

All testing must be:

1. Per American Psychological Association (APA) guidelines;
2. Clinically adequate; and
3. Placed in the Medi-Cal beneficiary's clinical record.

QUALITY ASSURANCE PROCESS FOR PSYCHOLOGICAL TESTING REPORTS

The CAU expects that network providers will comply with the Ethical Principles and Code of Conduct (June 2003 with amendments effective June 1, 2010 and January 1, 2017) of the *American Psychological Association* (APA). Network providers who conduct psychological testing and prepare psychological test reports should be familiar with the *Standards for Educational and Psychological Testing* (2014) adopted by the APA, in particular, Chapter 12 *Psychological Testing and Assessment* [American Educational Research Association (2014) *Standard for Educational and Psychological Testing* Washington, DC: APA].

The CAU also expects that network providers who conduct psychological testing and prepare psychological testing reports for minors who are dependents (WIC300) of the Juvenile Court, will be familiar with the *Guidelines For Psychological Evaluations In Child Protection Matters* (2011) approved by the Council of Representatives of the APA [American Psychological Association Committee on Professional Practice and Standards (2011). *Guidelines for Psychological Evaluations in Child Protection Matters* Washington, DC: APA].

For these reasons, the CAU expects that network providers will answer referral questions that are within the scope of practice for a licensed psychologist. Furthermore, the CAU expects network providers not to answer referral questions that are outside the particular field or fields of competence as established by his or her education, training and experience.

The CAU will not accept or recommend payment for psychological test reports that:

1. Do not answer or address the reason(s) for referral;
2. Do not make clear whether the client's test-taking behavior did or did not allow the psychologist to arrive at a valid assessment of the client's functioning;
3. Do not offer a coherent psychological explanation for the behavior(s) of the client and how best to treat the behavior(s);
4. Do not employ a norm-referenced measure of adaptive behavior to assess the role of a still active developmental delay in the client's Axis I diagnosis;
5. Do not use age-related norms to describe test behavior when such norms are available;
6. Do not include a norm-referenced measure of cognitive functioning without an explanation as to why the use of such a measure would not be in the best interests of the client;
7. Do not include appropriate measures of academic achievement when school-related placement decisions are part of the referral process;
8. Do not offer diagnoses consistent with ICD-10 CM Codes criteria, or, offer diagnoses that do not meet the definition of mental disorders found in the ICD-10 CM manual.

This is especially relevant to the severe and incapacitating developmental/behavioral deficits typically associated with the criteria that define the diagnosis of "Other Specified Early Childhood Psychoses" in the manual;

9. Do not consider diagnoses other than Oppositional Defiant Disorder for minors under the age of three years, or reports that offer a diagnosis of Oppositional Defiant Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
10. Do not consider diagnoses other than Attention-Deficit /Hyperactivity Disorder for children under the age of three years, or reports that offer a diagnosis of Attention-Deficit/ Hyperactivity Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
11. Do not offer new understandings about the functioning of the client beyond what could be achieved without the use of psychological tests;
12. Do not use the most recent edition of a specific test;
13. Do not offer a diagnosis of Intellectual disability using norm-referenced instruments that address ICD-10 CM Code and DSM V criteria. (A. Deficits in intellectual functions, such as, reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing. B. Deficits in adaptive functioning that result in failure to developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily living, such as communication, social preparation, and independent living, across multiple environments such as home, school, work, and community. C. Onset of intellectual and adaptive deficits during the developmental period); and
14. Does not report test results consistent with the administration of a full test battery, whether a development inventory, a measure of cognitive functioning, or other psychological measure.

COMMUNICATION TO NETWORK PROVIDERS CONCERNING QUALITY OF REPORTS

The CAU will review all psychological testing reports conducted by network providers on behalf of clients, including those that are not submitted to the LHMP for payment.

Informal Correction Phase

On receiving a report considered unacceptable according to the *Quality Assurance: The Clinical Evaluation* form, the network provider will receive informal feedback from the professional staff of the CAU prior to any formal notice. This informal consultation, usually performed by telephone or email, is designed to explore those areas within the test report that need improvement and how best to accomplish the correction. A face-to-face conference with the network provider to review problem areas in more detail may also be suggested.

Formal Correction Phase

This phase begins when the CAU receives another test report from a previously counseled network provider that is again below the standard of care. Step one of this three step process is a letter to the network provider that details the deficiencies in the test report and informs the network provider that, in the future, reimbursement for reports that contain these problems may be recouped.

Upon receipt of a second unacceptable report, the network provider again receives written notice of the report's deficiencies and that he/she will have 14 calendar days from receipt of the letter to correct the report and return it to the CAU. Until a corrected report is received, reimbursement for the psychological testing services to clients may be recouped.

When the CAU does not receive a corrected report within 14 calendar days, receives a corrected report that remains unacceptable, or receives a third unacceptable report thereafter. The network provider will be referred to the LMHP's Credentialing Review Committee to evaluate his/her work with respect to quality of care. During this period, the network provider may not be authorized to provide psychological testing services to clients. (Refer to Policies and Procedures 313.52, 313.53, and 313.54).