MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Instructions For Completion Of Neuropsychological Testing Request Form

1. Completion and submission of this form is required for authorization for reimbursement for neuropsychological testing for:
   - Members of our HMO plans
   - Members of our POS plan utilizing in-network services

   Authorization is not required for members of our PPO, Federal Employees Program (FEP), Medicare PPO Blue®, or indemnity products. Medicare HMO Blue® requires a referral from a primary care physician but no authorization.

2. Please make sure the information you provide is accurate and complete. Blue Cross Blue Shield of Massachusetts (BCBSMA*) will use this as the sole source of clinical information to make the initial determination of medical necessity for the requested neuropsychological testing as well as to determine the number of hours of testing authorized when medical necessity is met.

3. Please type or print legibly in completing the form. This will enable us to process the request in a timely fashion.

4. While much of the form is set up with check boxes, the "Additional Clinical Information to Support Request" narrative section at the bottom of page 2 is your opportunity to describe more fully the clinical situation that you believe necessitates the requested neuropsychological testing.

5. You may attach additional written information to the form if appropriate.

6. The conditions listed on the Request Form are **not** intended to be an exhaustive list of clinical situations for which reimbursement for neuropsychological testing will be authorized. If your patient's clinical situation is not included or specifically described by these conditions, the Additional Clinical Information narrative section at the bottom of page 2 provides an opportunity to amplify and clarify the rationale for the request.

7. The list of tests you intend to use (page 1) will help us understand the extent and complexity of the evaluation requested. At the time of the actual testing, you can perform other tests if appropriate.

8. We will notify you by phone and letter of the results of the medical necessity review. Depending on the clinical circumstances, the testing may be:
   - authorized for the number of hours requested
   - authorized, but for fewer hours than requested
   - denied

   Appeal rights will be communicated in the letter in the event of a denial of the request as submitted. For authorizations, the hours authorized are intended to cover testing, scoring, interpreting, report writing and discussion with the member and the referral source.

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Neuropsychological Testing Request Form

*Required for all members **except** for the Federal Employee Program, Medicare, Indemnity, PPO, and out-of-network care for POS plans*

Fax to: 1-888-641-5199

For BCBSMA/EDS Employees & Dependents, fax to: 1-888-608-3693

Note: **No coverage is provided for exams, evaluations or services that are performed solely for educational or vocational purposes.**

Either the referring clinician or the clinician performing the service may submit the request.
Complete all fields on both pages. The medical necessity review will be based on the information you supply.

Member Information (Verify eligibility before rendering services)

Today's date: _____ Patient Name: _____

BCBSMA Member ID: _____ Date of Birth (mm/dd/yyyy) _____

Provider Information

Testing Provider		Requesting Provider	
Clinician name:		Clinician name:	
Clinician discipline		Clinician discipline	
NPI		NPI	
TIN if not contracted		TIN if not contracted	
Group name:		Group name:	
Group address:		Group address:	
Phone:		Phone:	
Fax:		Fax:	

Our policy requires us to handle PHI in accordance with HIPAA. Is this fax number 'secure' for the receipt/ transmission of PHI? ☐ Yes ☐ No

Our policy requires us to handle PHI in accordance with HIPAA. Is this fax number 'secure' for the receipt/ transmission of PHI? ☐ Yes ☐ No

Request Information

Is this an out-of-network request? ☐ Yes* ☐ No

Number of hours requested: _____

* If yes, reason: ☐ geoaccess ☐ language ☐ Other (explain in "additional Information" section)

List tests you intend to use (attach list if necessary):

☐ By checking this box, I attest that this testing is not solely for educational/vocational purposes

Prior Clinical Evaluation

What clinical evaluation has already occurred, and why was it not sufficient to shape the current treatment plan?

How will neuropsychological testing contribute to the member's treatment?

Testing History

Has neuropsychological testing been performed previously? ☐ Yes* ☐ No

***If yes, testing was within prior:**

☐ 6 months ☐ 12 months ☐ 36 months

☐ Other: _____

Reason for prior testing episode(s)

☐ Brain tumor, dementia, mild cognitive impairment, or epilepsy

☐ Multiple sclerosis

☐ Other:

Number of lifetime testing episodes: _____

Based on previous testing, is cognitive impairment suspected/evident? ☐ Yes ☐ No

Has previous testing confirmed neurological deficit? ☐ Yes ☐ No

Reason for requested episode of retesting:

☐ Unexpected change in symptoms

☐ Retesting to evaluate response to new treatment

☐ Retesting to assess functioning

☐ Other (specify): _____

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Today's date: _____ Patient Name: _____

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ICD-9/DSM-IV Diagnosis

	Primary	Co-occurring
Axis I:	☐☐☐-☐☐	☐☐☐-☐☐
		☐☐☐-☐☐
Axis II:	☐☐☐-☐☐	☐☐☐-☐☐

Axis III: _____

Is medical condition(s) relevant to treatment? ☐ Yes ☐ No

Neurological Conditions, Suspected or Confirmed (check all that apply)

☐ Traumatic brain injury:
- ☐ Confirmed by imaging
- ☐ Head injury w/ loss or alteration of consciousness/ amnesia

☐ History of intracranial surgery

☐ Anoxic/ hypoxic brain injury

☐ Confirmed neurotoxin exposure

☐ Encephalitis/Meningitis

☐ Pervasive developmental disorder

☐ Cerebrovascular accident

☐ Brain tumor in remission or with slow progression

☐ Epilepsy with cognitive impairment suspected / demonstrated
- ☐ Seizures at least 1x/mo on optimal medication
- ☐ Neurosurgery planned for epilepsy control

☐ Multiple sclerosis and suspected/ demonstrated cognitive impairment

☐ Dementia/ mild cognitive impairment suspected/diagnosed

☐ Other: _____

Child/adolescent:

☐ Prematurity/low birth weight

☐ Genetic/chromosomal condition affecting brain function

☐ Language disorder suspected/diagnosed

☐ Structural malformation

☐ Pervasive developmental disorder

☐ Cerebral palsy

☐ Static encephalopathy (specify): _____

☐ Hydrocephalus
- ☐ With shunt placement

Medication/Substance Abuse

Have medication effects been ruled out as cause of cognitive impairment? ☐ Yes ☐ No*

* If no, describe rationale for testing despite this info

_____

If substance abuse/ dependence diagnosed, patient has at least 10 days sobriety ☐ Yes ☐ No

Additional Clinical Information to Support Request (submit additional pages if necessary)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____