Professional Psychology: Research and Practice
2000, Vol. 31, No. 2, 131–140

0735-7028/00/$5.00 DOI: 10.1037//0735-7028.31.2.131

Problems and Limitations in Using Psychological Assessment in the Contemporary Health Care Delivery System

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Psychologists report limitations on psychological assessment services and problems gaining authorizations and reimbursement for these services from third-party payers. Documentation and categorization of these problems and limitations is based on responses from well over 500 psychologists responding to a broad solicitation for feedback. This article explores the barriers to access for assessment services, including resistance to psychological assessment, difficulties in the preauthorization process, problems with reimbursement, the clinical decision-making process, and larger systems issues. The authors make recommendations for redress of these problems through work with the profession, other mental health professionals, managed care, and patients–consumers and through political action.

Psychological and neuropsychological assessment services are under assault from organized health care delivery systems, managed mental health care organizations, and health care payers. As a profession, psychology must respond to this attack with advocacy and a credible explanation of the value and usefulness of assessment if it is to survive as a covered health care service. This article reviews issues in the current applications of psychological assessment in health care settings and recommends appropriate responses.

The message from health care delivery systems is clear. Critics argue that psychological assessment is time consuming, expensive,

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THE OPINIONS EXPRESSED IN THIS ARTICLE are those of the authors and do not necessarily reflect the official policy of the U.S. Office of Personnel Management.

THIS ARTICLE IS DEDICATED to the memory of Kevin L. Moreland, who died tragically in an automobile accident August 31, 1999.

A VERSION OF THIS ARTICLE was initially prepared by the Psychological Assessment Work Group organized by the Board of Professional Psychology. The work group was chaired by Stephen E. Finn. We are grateful to the following American Psychological Association staff members for their support and assistance: Geoffrey M. Reed, Christopher J. McLaughlin, Mary Ann Wilson, and Russ Newman of the Practice Directorate; and Dianne C. Brown of the Science Directorate. We also thank Georgia Sargeant for her editorial assistance.

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and of limited utility in the context of current patterns of care. Unfortunately, past episodes of indiscriminate use of costly psychological evaluations (Griffith, 1997) may have contributed to this reaction. The practice of routine psychological assessments for all patients, an issue cited by managed care as a factor in skyrocketing health care costs, has all but been eliminated and is no longer an issue. However, the profession's lack of advocacy in encouraging, implementing, and disseminating research that demonstrates the efficacy and utility of assessment in treatment planning has allowed the pendulum to swing too far in the other direction.

There are several reasons why this devaluation of psychological assessment did not come to the attention of the American Psychological Association (APA) much sooner. At first, psychologists performing assessments dealt with such challenges as reduced time allocations for their services by donating (through not billing) their time to complete their assessments. In addition, the perceptions of leading psychologists conflicted, with some proposing that psychological assessment was flourishing whereas others maintained that it was a dwindling clinical activity. Neither perspective is valid, according to a recent APA Practice Directorate practitioner survey that shows that psychological assessments represent the second most frequent service provided by psychologists across practice settings, and that all aspects of practice have been adversely affected by managed care (Phelps, Eisman, & Kohout, 1998). Furthermore, the Practice Directorate's Office for Managed Care has been consulted about many issues related to the role of psychological assessment in managed care. Interestingly, in a report on the legal and ethical issues of practice in managed care based on the work of this APA office, three out of six case scenarios cited as problems encountered by practicing psychologists had to do with issues of clinical assessment (Higuchi & Hinnefeld, 1996).

In 1995, the APA's Board of Professional Affairs (BPA) charged the Psychological Assessment Work Group (PAWG) with two tasks: (a) to assess the scope of the threat to psychological and neuropsychological assessment services in the current health care delivery system and (b) to identify research studies that document the efficacy of psychological assessment in clinical practice. This article is derived from the PAWG report that addressed the first task concerning threats and barriers to assessment services. The other PAWG report, which reviewed research on the efficacy of assessment, is available from BPA (Meyer et al., 1998; also see Kubiszyn et al., 2000; Meyer et al., 2000).

When PAWG began its work for BPA, committee chairman Stephen Finn issued a broad solicitation for information related to marketplace and regulatory changes that have compromised the use of psychological assessment in clinical practice. Psychologists were contacted through E-mail list-servers, letters to state and regional psychological associations, practice divisions, newsletter articles, and presentations at professional associations of psychologists involved in assessment. PAWG received more than 400 written responses and hundreds of verbal communications from psychologists and mental health professionals throughout the country. These responses and others culled from the psychological literature provide the foundation for the present article. It must be noted that the conclusions in this article were based on a preponderance of anecdotal data collected from respondents, and frequency counts of complaints were not done. Therefore, it is impossible to determine the specific magnitude or prevalence of each problem identified.

Although this article is focused on problems, there are many psychologists employed within organizations (managed care organizations [MCOs]) who provide credible services through policies and authorization procedures that adhere to the highest professional standards. Advocacy with some MCOs has produced marked improvement in the attitudes of policymakers at those organizations. Some of these agencies have even become proactive in reaching out to clinicians when new policy issues emerge that are related to psychological assessment. Nevertheless, the present article focuses on the remaining problems because we believe that these difficulties require continued advocacy. Throughout this article, the phrase "psychological assessment" is intended to refer to both psychological and neuropsychological evaluations in health care settings.

Problems Encountered by Practicing Psychologists

Resistance to Psychological Assessment

More and more frequently, psychologists report that assessment is neither authorized nor reimbursed by third-party payers even when it is indicated for ethical clinical practice and sound risk management. These payers often argue that diagnostic interviews are sufficient for many, if not most, of the conditions previously evaluated through the use of psychological assessment. One provider manual states:

> However . . . [the MCO] cannot support the use of tests for behavioral health diagnostic purposes since the *DSM–IV* [*Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 1994] makes no reference to psychological or neurological testing for diagnostic purposes. Instead to make behavioral health diagnoses the *DSM–IV* emphasizes clinical interviews and obtaining information from persons who have observed the patient.

Psychologists counter that the application of diagnostic interviews as the sole criterion for such decisions as differential diagnoses, treatment dispositions, and disability determinations is fraught with situational and examiner effects that limit reliability and validity. These arguments typically fall on deaf ears, despite extensive evidence that distressed children and adults often are not dependable reporters during a clinical interview because of their limited verbal skills, defensiveness, or deceptiveness or because they lack insight into their own behavior. Although a skilled interviewer may be able to circumvent some of these confounds, psychological assessment is often the best way to learn about the patient's symptoms and current concerns. Documentation of some shortcomings associated with diagnostic interviews is summarized in the aforementioned article by Meyer and his colleagues (1998).

Many of the decision makers in MCOs are not psychologists. When they are psychologists, often they are not proficient in psychological assessment. In addition, the allocation of budgets and staff responsibilities in MCOs may lead to situations in which the person authorizing psychological evaluations often has no knowledge of the assessment process and little information about, or investment in, the overall outcome of the case.

> A state department, which determined disability, decided to eliminate most psychological assessment as a way to reduce expenses. Psychologists argued that a diagnostic interview alone was inadequate for assessing psychiatric disability, especially when patients stood to gain significant financial support, often for life, if they were determined to

be disabled. It was emphasized that if psychological assessment identified even one person as a malingerer, the long-term cost savings to the state would more than pay for all of the psychological evaluations that year. The administrator stated that his job was not to save the state money but only to determine disability and have his department come in on budget.

A related threat to psychological assessment is the policy of many MCOs to encourage providers to make differential diagnoses through medication trials. An example is the expectation that conditions such as attention-deficit hyperactivity disorder (ADHD) can be differentiated from normal personality characteristics or problems such as conduct disorder, mood or anxiety disorder, language processing difficulties, or psychosis through the patient's response to stimulant drugs such as Ritalin.

With Ritalin, however, even children without ADHD show increased attending behavior, leading to situations where depression, psychotic disorders, and other conditions (Forness, Kavale, King, & Kasari, 1994) may go undetected for long periods of time. Such assessment and treatment failures can lead to discouragement and despair in clients and jeopardize their subsequent treatment and recovery. Delays lead to higher treatment costs for MCOs and patients if the working diagnosis is erroneous and leads to implementation of a faulty treatment protocol. Finally, the "medication first" approach treats prescription drugs as benign and may overlook such problematic side effects as behavioral problems, somatic toxicity, and increased substance abuse potential. In some cases, the ADHD diagnosis from childhood has a lifelong effect on adult diagnostic impressions and treatment. According to Gene R. Haslip of the Drug Enforcement Administration (DEA),

> medical experts agree that these drugs [stimulants for the treatment of ADHD] do help a small percentage of children who need them. But there is also strong evidence that the drugs have been greatly overprescribed in some parts of the country as a panacea for behavior problems. . . . This constitutes a potential health threat to many children and has also created a new source of drug abuse and illicit traffic. . . . I do want to emphasize that medical authorities do believe that ADHD is a distinct health problem affecting some children who can be helped by these drugs **when prescribed after careful diagnosis** [emphasis added]. (DEA, 1996)

The use of medication for diagnostic purposes is a problem not only with ADHD but also with suspected bipolar disorder, anxiety, and depression.

> The Health and Human Service's Agency for Healthcare Policy and Research's Guidelines for the Treatment of Depression in a Primary Care Setting (U.S. Department of Health and Human Services, 1996) stated that primary care providers should first treat depression diagnosed through a clinical interview in their office by giving a medication trial of 3 weeks. This is to be followed, if there is no positive response, by another medication trial of 3 weeks; followed, if still no positive response, by referral to a mental health professional.

Beyond the exposure to potential adverse side effects, this "diagnosis through medication" approach can limit patient access to mental health professionals. Under this guideline, mental health treatment will be initiated only after two treatment failures have occurred. This may compromise a depressed patient's capacity to marshal dwindling internal resources for the tasks of management and recovery from a potentially life-threatening disorder.

Two other issues are significant. The first is that the proper use of psychological assessment is ethically mandated for psychologists. For example, when test instruments have been revised, the clinical judgment of the psychologist should be used to determine which form of the instrument to administer on the basis of current professional standards and the psychometric qualities for the particular test. Yet, some psychologists report being required by MCOs to use outdated forms of assessment instruments because they yield numbers with which the MCOs are familiar or because newer versions of the measures are somewhat longer and hence more costly. When compliance with such requests compromises patient care, the psychologist faces ethical and professional dilemmas. In addition, when psychologists decide to administer more costly test versions, some are informed that there will be no corresponding increase in reimbursement for the additional time it takes to administer, score, or interpret the revised edition.

> One psychologist was denied reimbursement for an MMPI-2 (Minnesota Multiphasic Personality Inventory–2nd Edition) that had been administered to a patient and was told by the MCO staff person that this test was considered "experimental" because it was published in 1989 and "all the scientific literature relates to the earlier MMPI."

Many clinicians report that they believe a psychological assessment is indicated to elucidate fully the client's problems. The insurer sometimes disagrees because it does not recognize the value of having the entire client profile or does not intend to authorize treatment based on it. Current mental health delivery systems view their role as acute care providers and are therefore not interested in identifying more chronic or characterological problems because they do not intend to underwrite the cost of their treatment. The psychologist feels professionally compelled to conduct as comprehensive an assessment as possible but is barred from doing so. Even if the psychologist would be willing to assess the patient pro bono, this decision may be interpreted by the managed care organization as behavior that is "managed care unfriendly." This is a euphemism for stating that the provider is focusing more on long-term issues or is resisting the short-term, problem-focused treatment approach demanded by MCOs. In cases like this, it is never clear what psychologists should do. Their dilemma is that they are guided by ethics, standards of care, and federal laws such as the Americans With Disabilities Act to do the fullest job possible, yet fear the loss of provider network membership if they challenge the MCO's policies.

A final issue concerns risk management. In some cases it is sound risk-management policy to conduct a psychological assessment, especially in cases such as potential suicidality, dangerousness, or complicated diagnostic questions that may lead to invasive treatment approaches or interventions that restrict a patient's freedom. Again, psychological assessment is not reliably approved in these situations by MCOs. Such denials deprive the provider of an important source of support to defend any malpractice actions related to adverse treatment or questionable diagnostic decisions. Thus, the refusal to authorize assessment can have important ethical and legal implications to the provider. MCOs counter that they have no ethical or legal liability related to assessment or treatment denials because they are managing benefits, not making clinical decisions. However, there exists case law such as *Wickline v. State of California* (1987) and legislation enacted in 1997 in Texas that refute this contention and now identify treatment authorization and utilization review as a clinical care activity.

The appropriate and skilled use of psychological assessment can substantially reduce many of the potential legal liabilities involved in the provision of health care services (Bennett, Bryant, VandenBos, & Greenwald, 1990). For example, service providers who perform standard baseline assessments of their clients' initial levels of psychological distress and functioning (e.g., with the MMPI-2) can use those assessments as reference points should a client later claim that he or she was misdiagnosed or damaged by the treatment provided. In addition, the courts have tended to look favorably on psychological tests as a kind of "outside opinion" that can be used by clinicians in determining appropriate treatment (Schultz, 1982).

Difficulties in the Preauthorization Process

One substantial problem in the authorization process is that reviewers often work from standardized authorization protocols that prescribe appropriate clinical criteria needed to authorize psychological assessment, including standardized time or service units within which to accomplish the service. This authorization is often determined without regard to confounding variables in the assessment situation that might indicate, even before the testing session, that this particular evaluation will require more time to complete. Moreover, in many MCOs the actual protocols for authorization of psychological assessment are not only inflexible but also seldom communicated to the psychologist requesting the authorization. The clinician must guess what personal client information to furnish to obtain the authorization.

Patients are often required to obtain a referral for assessment from their primary care provider (PCP). Many PCPs are poorly informed about the use and value of psychological assessment or when and how to make these referrals. Many PCPs also feel strong pressure from MCOs to try medication first and limit referrals to specialists for services such as psychological assessment.

Once a request for authorization for psychological assessment reaches the MCO, there can be other problems. Psychologists report dealing with MCOs that have no psychologists either in authorization review positions or even available for appeal of a denial (appellate review). Federal and state advocacy to encourage appellate review by a "like licensed" provider is increasing in consumer protection legislative initiatives. Passage of these initiatives would ensure that appeals of assessment and treatment denials would be heard by professionals with expertise in the service being requested.

Completion of preauthorization forms is another problematic area for the provider. Information requested on the preauthorization form may constitute the reason for the assessment (e.g., determining a diagnosis). Psychologists are placed in a catch-22 situation: Authorizations are denied if all requested information is not provided before the assessment is begun, but some or all of the required information will not be available until the assessment is completed. To compound this problem, some companies will not pay for a preliminary interview with the patient yet request information for the authorization that can be acquired only through such initial contact. Finally, when the initial interviews are conducted by professionals other than psychologists, the other professionals might not be skilled in the appropriate terminology to convince the reviewer to preauthorize an assessment.

Authorization is often test specific. This does not allow the psychologist to tailor the psychological assessment battery to meet the unique needs and characteristics of the patient when these are not evident at the outset but emerge over the course of the assessment process. As a result, psychologists are professionally bound to perform the tests necessary to investigate questions as they surface, without any assurance that they will be reimbursed by the MCO. Payment is even less likely if there is no pathological finding on the additional tests, even though they were indicated by the initial clinical findings.

> A psychologist received preauthorization to administer only the MMPI-2 to a patient with a diagnosis of borderline personality disorder to assess her level of depression. When the MMPI-2 strongly suggested the possibility of a significant thought disorder in the patient, the psychologist requested permission to do a follow-up Rorschach, noting that this instrument was more sensitive in diagnosing major psychopathology. He was denied authorization and told that "enough assessment had already been done on this patient."

Some psychologists also report that authorization or reimbursement is based on fixed test batteries that may not be necessary or appropriate. Over the past 20 years, neuropsychologists have been moving toward individualized or flexible batteries consisting of a core of neuropsychological tests in combination with instruments selected to address the referral question for the specific patient. To illustrate, a broad survey of cognitive functions may be completed initially, using reliable measures of intermediate difficulty. Then, as deficits are encountered, the focus of the examination can be narrowed to explore the specific problem areas in much greater detail, with test selection dictated by the patient's level of functioning. The requirement of many MCOs to specify tests before the clinician evaluates the patient runs counter to this specific clinical practice and limits the flexibility that is essential in many other assessment situations.

Psychologists also report that the authorization process takes too long and that, particularly with at-risk adolescents, some of their patients have deteriorated, moved, or run away before the authorization request is reviewed. Similar problems arise with hospitalized patients because of shorter treatment stays. Moreover, reimbursement for speciality services, including psychological assessment, is often included in a hospital's fixed per diem, or daily rate. This provides inpatient units and treatment teams with a financial disincentive to order psychological assessment because its cost will reduce the funds available for other services.

Network membership is also a problem for psychological assessment specialists. Because the field of assessment can be highly specialized, psychologists who conduct assessments as a central activity are often willing to travel to the patient's location for an evaluation. However, many health care delivery systems are arranged according to catchment areas and zip codes, because they are mostly based on a clinical delivery model where the patient regularly receives their treatment at the provider's office. This often leads to unnecessary restrictions on referrals to the most appropriate assessment provider when this clinician's office is outside the patient's catchment area.

Ethnic and linguistic minority assessment providers can be confronted with unrealistic and ethically challenging referrals under managed care. There are reports of managed care companies that hire staff as if they believe that, if a provider speaks a language other than English, that provider should be able to do all forms of therapy as well as perform all types of psychological assessments with patients of all ages who happen to speak that language.

Compounding the problem of limited access to appropriately trained and culturally competent providers, many insurance plans offer limited or no out-of-network benefits.

Another issue with the authorization process has to do with the application of postaudit reviews (reviewing the appropriateness of the psychological assessment after it has been performed). This type of procedure is often used with high-volume providers or those who have a track record of high-quality and responsible assessment services within a managed care network. Although this cuts down on the hassles and delays that are part of the preauthorization process, it leaves the provider vulnerable to nonpayment for services that are determined after the fact to be unnecessary.

The last issue to be discussed in this section has to do with the interface between authorization and reimbursement. The problem arises when an MCO appropriately authorizes an assessment service based on a rule-out diagnostic question but then cannot pay the provider for the authorized services because the final diagnosis is one not covered under the MCO's contract.

> A psychologist was requested to conduct a psychological assessment to determine a differential diagnosis between two mental disorders that were covered by the insurer. The diagnosis found was one not covered by the insurer. Despite prior authorization for the testing, the psychologist was told that "the computer" could not pay him for a noncovered diagnosis. When the psychologist sought advice, he was directed to change the diagnosis to one of the covered ones to get paid, despite the fact that this would constitute insurance fraud.

The problems outlined above stem from the fact that many preauthorization decisions are driven by economics rather than by a sound clinical rationale. In part, this is an understandable reaction to some past practices of administering a full psychological test battery to every patient admitted to the hospital. This approach was very costly, and though it undoubtedly helped many patients, it was often not essential. MCOs blame those early situations for the tight rein they have placed on psychological assessment, but the reality is that the rein has become a noose, choking off appropriate as well as inappropriate uses of this service.

Problems With Reimbursement

The most frequently cited problems have to do with the low levels of reimbursement. Despite the fact that psychological assessment may require specialized and advanced training and experience, some national MCOs pay less per hour for psychological assessment than for individual therapy.

By far the most prevalent and indirect way of lowering reimbursement levels without cutting hourly fees is to allocate an insufficient number of hours for an assessment while still requiring its completion. Recent large-scale studies on test use (e.g., Ball, Archer, & Imhoff, 1994; Camara, Nathan, & Puente, 1998) demonstrate that the time allocated by many MCOs to administer, score, and interpret tests and to write the report is less than it would take just to administer the specific test(s).

Time estimates for administration, scoring and interpretation that appear in manuals developed by test publishers are used by some MCOs to determine reimbursement. These estimates are realistic in some cases. In others, particularly when the tests have been revised over time and additional items and procedures have been added, MCO policy for time allocations may remain based on the earlier, shorter versions of the test even though it would be expected that the new version would be used.

The psychotherapy provider often tailors the treatment to the number of sessions authorized, but the psychological assessor is seldom able to do so and still produce a valid and complete assessment. This means that often the psychologist will provide the remainder of the assessment as a pro bono service.

> One national MCO allows only 1 hr for administering, scoring, and interpreting a Wechsler Adult Intelligence Scale—Revised. Ball et al. (1994) reported that the mean time for these activities is 75.6, 21.6, and 25.0 min, respectively, and even longer for more difficult patients.

Problems as to which aspects of the assessment process are reimbursable have been reported. Psychologists say that, despite the fact that the current APA "Ethical Principles of Psychologists and Code of Conduct" (APA, 1992) require that there be a feedback session for patients, families, or referral sources after an evaluation, MCOs often do not pay for this service. In addition to the ethical reason for conducting feedback sessions, it has been shown to be sound clinical practice by Eyde et al. (1993), who identified lack of feedback to be one of the common test misuse factors in their study. Similarly, Finn and Bunner (1993) found that clients who did not receive feedback about their assessments reported being dissatisfied with their assessments, whereas all of those who reported being very satisfied were in the group that received assessment feedback. In addition, research has shown that such feedback can have a therapeutic effect in that it can alleviate symptomatic distress and increase hope, and it can positively affect the course of treatment for patients and their families (Finn & Tonsager, 1992, 1997; Newman & Greenway, 1997; Pollak, 1988).

Again, the psychologist is often forced either to offer the feedback session at no cost or to ignore professional ethics. The third option, billing the patient for the session, is often prohibited by the provider's contract with the MCO.

Reimbursement may also be denied for other potentially necessary parts of the assessment, such as time for preliminary interviews and collateral interviews. Typically, psychologists are not reimbursed at all for time spent writing reports. If such activity is reimbursed, compensation is not commensurate with the level of detail and specificity that was once considered the standard of practice. Psychologists have been told by some MCOs to write brief reports similar to radiology reports, even when a comprehensive report has been requested by the referring professional. However, psychological assessment bears little resemblance to radiology, which simply looks for signs of pathology on a single assessment instrument (e.g., magnetic resonance imaging; MRI). In contrast, psychological assessment is designed to provide information that can identify not only pathology but also personality resources, coping skills, and appropriate targets for treatment intervention. The assessment process and resulting report typically integrate a variety of information sources, including client history, clinical observations, test scores, and interpretations, all incorporated into a comprehensive clinical formulation.

One alarming set of incidents reported in our survey showed that requests for psychological assessments may be declining because the cost of the assessment depletes a patient's benefit for treatment of the condition identified.

> One nonpsychologist mental health provider wrote that she had "regularly referred patients for psychological assessment in the past but could no longer do so" because insurance companies routinely deduct assessment sessions from the total mental health benefit for the

> patient's subsequent treatment. This provider said that she "greatly missed the consultation I had received from colleagues who did psychological assessment," but she was now put in the unfortunate position of having to "compete with them for shrinking insurance dollars."

The medical community would never tolerate being told that a patient could not have treatment for a brain tumor because the MRI scan cost so much. Yet, routinely neurology patients are informed that there is no money left in their benefit for treatment related to the emotional effect of having cerebral impairment because the neuropsychological assessment depleted their mental health benefit for the year.

A problem that is becoming more prevalent, especially for neuropsychological assessment providers, is the prohibition against retesting a patient who has been evaluated within the past year or 2. Although in many cases this is reasonable, a significant use of assessment is for progress checks and posttherapy outcome evaluations. Retesting can help track clinical improvement in response to drugs or other clinical interventions. At times, it is virtually the only way that these interventions can be monitored. For example, one cannot claim that someone has a progressive dementia unless he or she has been tested twice. Other clinically acceptable reasons for repeat testing that are not approved by some MCOs are to assess medical and surgical intervention and failure to respond to these interventions and to evaluate changes in geriatric or demented patients.

One cost-effective way to provide assessment services is by increasing the use of brief screenings, which at times can be the best way to determine whether a more complete psychological assessment is warranted and in which areas to focus that evaluation. When performing more than one patient assessment within each calendar year is prohibited, the conservative approach would be to conduct only full assessments, because a limited screening would rule out further evaluations for the entire year. This prohibition is neither cost effective nor in the best interests of the patient.

Some MCOs refuse to reimburse for technicians to administer tests. Although use of technicians is a contested issue in psychology at present, it has been viewed in the neuropsychological community for years as cost effective, safe, and reliable. The APA's Division of Neuropsychology (APA Division 40, 1989) developed guidelines for the use of technicians in neuropsychological assessment. Insurers that prohibit this practice serve to keep psychology differentiated from other health care professions such as medicine and nursing, which regularly use assistants. A related issue is the refusal to pay for the cost of computer scoring, even though it is more accurate for some tests than hand scoring.

Psychologists also report that some companies refuse to pay for instruments that are self-administered and computer scored because of the belief that these should be seen as part of the clinical interview. These companies do not reimburse for self-report instruments such as the Beck Depression Inventory or MMPI-2, even though they may be useful clinically and the psychologist must pay for materials, scoring, interpretation, and feedback (Update on Psychological Testing, 1996). Likewise, there is no reimbursement for the professional time spent in evaluating information gathered by others that require the psychologist's time and expertise for scoring and interpretation, such as ADD (attention deficit disorder), anxiety, or depression rating forms.

Clinical Decision Making in Psychological Assessment

Decisions about which tests are acceptable or optimal in a particular assessment situation are often made by the MCO rather than the psychologist. The problem that then arises is demonstrated by the authorization of predetermined testing protocols. Decisions regarding which tests are appropriate is a clinical issue and should not be made according to a company protocol interpreted by a utilization manager who has no psychological expertise and who is not present during the assessment. So long as there is a sound rationale, a psychologist should be free to adapt the protocol that fits the needs of the client on the basis of accepted clinical indicators.

An illustration of MCOs forbidding clinically accepted practice is demonstrated by statements that "administration of two tests of the same type is rarely if ever indicated." This policy prohibits important cross-checks; for example, it restricts the use of two self-report tests even when they measure different attributes (Wise, 1994). When a certain MCO was asked how this policy was developed, no underlying research or clinical rationale could be provided. Such policies are problematic, as they may limit the optimal diagnostic efficiency of the assessment and force providers to operate outside accepted clinical practice, thereby increasing their liability exposure if there is an adverse clinical result.

MCOs are particularly reluctant to underwrite the costs of an assessment battery, even when the psychologist has carefully selected and limited the number of instruments. In this era of cost containment, the objective is to severely restrict the amount of time devoted to the evaluation process. There is often little understanding in these organizations of how distinct assessment methods can furnish unique information (Meyer et al., 1998) that facilitates differential diagnosis and treatment planning. This is especially true for individuals who have limited verbal facility, limited self-awareness, or motives to deceive the clinician by presenting an overly favorable impression or one that exaggerates the suffering experienced.

Whole categories of tests are proscribed or automatically ruled out because they are not identified as mental health instruments. These include cognitive–educational tests, occupational–vocational tests, and measures of normal personality traits. At times these tests may be crucial in determining treatment interventions for people with serious mental illness, but providers find their hands tied by the restrictions on their use. This is not to say that these instruments should be used routinely, but rather that a procedure for authorizing their use should be implemented when appropriate.

> In the face of limited treatment progress, a nurse practitioner referred an 11-year-old to a psychologist for evaluation of the child's cognitive abilities, processing skills, and capacity to understand therapeutic interventions. Despite arguments that the Wechsler Intelligence Scale for Children—3rd Edition would provide invaluable information to facilitate treatment, precertification for testing was denied on the basis that "psychoeducational testing is done by the schools."

Occupational and vocational testing can be very useful in treatment planning for many clinical diagnoses, but, again, these instruments are often rejected on the basis of not being mental health tests and not reimbursable under health insurance. The benefits of these tests for conditions such as identity disorders, brain injury or disease, or other medical problems affecting cognitive functioning

make it clear they are useful within the health care system. Providing a therapist with information about occupational and vocational possibilities for a patient despondent about his or her ability to live independently may be an important mental health intervention.

Moreover, many normal-range personality traits (e.g., introversion–extroversion) are highly relevant to mental health treatment assignments (e.g., group vs. individual therapy), and evaluating such traits promotes efficient and cost-effective treatments (Harkness & Lilienfeld, 1997; Sanderson & Clarkin, 1994).

Other issues of clinical significance result from restrictions of services due to a patient's route of referral. MCOs have strict prohibitions about paying for assessments if the issue is related to problems other than mental health. Unfortunately, they sometimes implement this policy by not authorizing psychological assessment except when the request comes from a mental health provider. Providers in the educational, juvenile justice, and social service systems are well aware that, especially with adolescents, mental health problems can first become manifest through a wide range of behavior such as criminality, truancy, running away, and failing in school. At times, the best way to determine the optimal disposition and intervention for multiply involved adolescents is through psychological assessment. The question of whether an adolescent should be sent to a facility that primarily treats her substance abuse or one that treats his or her mental illness is important and should be answered before he or she is sent to either. It can be important to assess impulse control and dangerousness in teens before they are admitted to a ward with other children. In many MCOs, this cannot be implemented until after the disposition.

Larger Systems Issues

There remain several issues that deserve attention. The first concerns the failure of most national companies to reimburse for appropriately trained and supervised students, interns, or unlicensed postdoctoral psychologists to conduct assessments. When these evaluations are done under the close supervision of a licensed psychologist as part of an organized training program, they should count for reimbursement purposes as being conducted by that licensed psychologist. The supervising psychologist devotes the training and supervision time (often hours per battery) necessary to meet the professional, ethical, and legal requirements for signing off on the report. The refusal to reimburse for any of that time places these training programs at risk of closure and thus is a threat to the field of psychological assessment. If there is no support for training the next generation of clinicians in psychological and neuropsychological assessment, the value of this service will be further diluted and ultimately may be lost to the health care field.

Many psychologists complain that managed care provider panels in their areas are closed to them. Some of these clinicians were highly experienced and had considerable expertise in psychological assessment. However, despite their impressive credentials, they were denied access to patients in their communities who might benefit from their specialized skill because, the psychologists were told, "We have enough psychologists on our panel." Efforts to reason with those in executive positions in the company that not all psychologists have equal expertise in assessment usually met with little success.

MCOs also need guidance from the psychological community and consumer advocates about the confidentiality of test protocols and raw data. Requests from MCOs for entire clinical records, including raw test data, for the purpose of quality assurance or utilization reviews are increasingly common. Psychologists are concerned about responding to these requests because it is not clear which ethical and professional standards apply. This is because they are not given information such as whether a psychologist is conducting the review, who else has access to the data, and whether this type of disclosure is covered by a blanket release-of-information form.

The last large-systems issue, the potential for conflict of interest in the authorization reviewer, is one that also comes up on other areas of managed care. The obvious fact that reviewers are paid by their companies to monitor inappropriate utilization may at times put them in the position of feeling pressure to deny requests on behalf of their employers. This is not to imply that all requests for psychological assessment are valid and worthy of authorization or that psychologists' applications for authorization are not also vulnerable to financially driven decision making about test use in the first place. However, the best arrangement for these requests may be impartial evaluation by third parties who work independently as reviewers without feeling committed to the MCO for their salary and who are thoroughly trained in the service they are reviewing.

Psychologists who work as reviewers, formulate policy, or conduct assessments need more guidance from the profession about the appropriate way to address the questions that arise at the interface of practice and managed care. There are many dedicated psychologists working in MCOs who strive to render credible judgments but who have no professional guidance for resolving the ethical and professional dilemmas outlined herein.

The issues outlined above represent a synthesis of the feedback psychologists communicated regarding their struggles when doing assessment in the current health care environment. Many of these issues have proven to be amenable to modification through appropriate, respectful advocacy. As psychologists, we need to be aware that we contribute to the problem. Without proper scientific demonstration of the efficacy and relevance of assessment to quality of care, assessment is vulnerable to elimination, reduction, and misuse by third party payers.

Finally, researchers and practitioners must communicate so that future research designs address the relevant issues and questions in the current health care climate. Particularly needed is more investigation of the utility of psychological assessment in improving treatment for some of the more difficult, intractable, and costly-to-treat client populations found in today's health care system. Collaboration between science and practice will serve the best interests of both the profession and the public.

Recommendations

In this final section, we present recommendations to remedy the issues raised earlier within five arenas: (a) the profession, (b) managed care, (c) other mental health professionals, (d) patients–consumers, and (e) political action. We conclude with a call for all psychologists to work together to support and strengthen the role of psychological assessment in health care delivery.

The recent Practice Directorate Practitioner Survey (Phelps et al., 1998), as well as the reports from clinicians across the country (PAWG report), reveal that psychological assessment continues to

be a frequent and valued activity for psychologists and that the effect of managed care on assessment has been decidedly negative. Piotrowski, Belter, and Keller (1998) reported findings from their survey of members of the National Register of Health Service Providers in Psychology that show that managed care has diminished assessment practices and shifted the focus primarily to quick and inexpensive measures. Our perspective is that the field of psychological assessment faces enormous obstacles in the current health care delivery system. These include outright refusal to endorse assessment as a worthwhile clinical activity, difficulties in gaining preauthorization for testing, substantial problems with reimbursement, and interference in assessment decisions that are appropriately the purview of the psychologist who provides this service.

MCO assessment policies are not solely responsible for the decline in psychological assessment. An increased emphasis on short-term treatment, the use of psychoactive agents to arrive at diagnoses, the lack of studies directly measuring the cost effectiveness and value of assessment in treatment planning and outcome, and general pressures to streamline interventions and contain costs all prompt questions about the role of psychological assessment in today's health care marketplace. To address the current crisis, we offer the following recommendations to encourage critical self-reflection by psychologists regarding their own contributions to the problem. Moreover, we suggest constructive steps that psychologists can take as they interface with managed care, other health care professionals, consumers, and policymakers.

Working Within the Profession

Psychologists must evaluate how our professional activities in practice, training, and research affect psychological assessment. Psychologists must provide competent and comprehensive evaluations grounded in the latest scientific research. Psychologists need to (a) support each other to recognize strengths and limitations associated with testing and assessment and (b) collaborate to provide a scientific foundation that can inform practice and to formulate research questions that are guided by practice. We must shift our attention to the critical evaluation of assessment measures in treatment planning.

Our training programs must address central problems; for example, frequently, what is taught does not match what is demanded in practice, students get minimal exposure to actual work with patients, and courses on assessment are not well integrated with courses on treatment. The gap between research and practice in this field continues. As described in detail in Meyer et al. (1998), we need studies that directly examine the cost effectiveness and value of assessment for treatment planning, the relationship of evaluation to treatment outcome, and the therapeutic value of clinical assessment as an intervention in its own right.

In terms of practice, we recommend the development of a set of criteria to help psychologists, the public, and decision makers to recognize those situations and conditions for which psychological assessment is most helpful and appropriate. Moreover, psychologists should formulate criteria and guidelines for the selection of appropriate assessment instruments to use in response to the referral question, clinical indicators, and stage of treatment. Psychology must take this task into its own hands or run the risk of having managed care rush into the vacuum and create its own guidelines designed to address their criticisms of psychology's indiscriminate use of the most costly and comprehensive assessments.

Expanded and upgraded continuing education offerings should be made available for psychologists who provide assessment services to improve their skills and awareness of practice standards and ethical requirements. Collaboration between relevant professional groups (e.g., the Society for Personality Assessment and APA) should explore the development of competency criteria for individual tests and assessment approaches as well as guidelines for the health care delivery system on appropriate reasons for referral for psychological assessment.

Working With Managed Care

Many people who work in managed care and other health care delivery systems appear to have developed biases or mindsets that devalue psychological assessment. More constructive interactions with the health care delivery system are needed to reduce some of the misunderstandings and prejudices outlined in this article and to counter the critical attacks on its value in treatment planning. We suggest that this may be accomplished through the creation of a nationwide network of assessment-minded psychologists to work with managed care and other health care delivery systems. This group would disseminate research findings supportive of the "best practices" use of psychological assessment.

This network could also establish a dialogue with the health care system to (a) help define the concept of "medical necessity" as it relates to assessment, (b) educate MCO leaders about assessment, (c) exert some pressure against such unwarranted restrictions on assessments as arbitrary "rule-outs" and unreasonable time constraints, and (d) establish guidelines for how we can help third-party payers to appreciate and monitor the appropriate use of tests by psychologists.

In addition, information flow to purchasers of insurance and policy makers at MCOs should include data about the potential cost savings that can be realized by appropriate psychological assessment. We must provide them with research findings that clarify how assessment facilitates treatment and reduces their costs.

The state psychological associations and the APA Practice Directorate have implemented programs to help member psychologists work with managed care in resolving these problems. They provide a clearinghouse for policy interpretation, complaints, and potential solutions to the problems outlined earlier, such as the need to appeal adverse authorization decisions. They provide advocacy for psychologists with MCOs at the local as well as the national, policy-setting level.

Working With Other Mental Health Professionals

Interprofessional tensions between psychologists and other groups (i.e., psychiatrists, social workers, and mental health counselors) have been noted over the years. The sources of this dissension have included misunderstandings about the contribution of psychological assessment to treatment planning and patient care, the quality of assessment reports, the lack of constructive dialogue regarding assessment findings, and competition for limited mental health benefits.

We believe that the image of psychological assessment could be enhanced and the demand for diagnostic and treatment-planning

evaluations could be increased through improved interprofessional communication. Workshops on the appropriate use of psychological assessment at meetings for psychiatrists, social workers, nurse practitioners, and other relevant groups would be invaluable, as would effort to ensure that the indications for and benefits of assessment were adequately covered in their professional literature. For example, the value of psychological testing is mentioned only once in *DSM–IV* and that is in the diagnosis of mental retardation. Certainly, the potential contributions of assessment to such areas as differential diagnosis, detection of malingering, targeting appropriate treatment goals, and risk factors (e.g., suicidality, neurological impairment) could be highlighted at annual conferences and in relevant texts, professional journals, and wherever protocols for defining and determining diagnoses exist.

Working With Patients–Consumers

Most members of the public are unaware of the potential value of psychological assessment. Although many patients are assessed in the course of their treatment in both inpatient and outpatient settings, most receive little feedback about the clinician's findings. At times, only fragments of the assessment results may be shared with patients by the treating psychiatrist. Psychologists should do more to educate patients and the public about the merits of psychological assessment. An occasional inkblot may appear in a made-for-TV movie or in a soap opera, but psychologists have not launched a concerted public education campaign to promote psychological assessment or to correct the faulty impressions conveyed by such programs.

Working Through Political Action

Finally, an enhanced legislative and regulatory agenda on behalf of psychological assessment at national and state levels is needed. To this end, we propose a variety of strategies. These include (a) educating mental health lobbyists about assessment benefits, research, ethics, and practice; (b) arguing for more consistency in benefits for assessment; (c) lobbying for reimbursement for neuropsychological assessment from medical–surgical benefits; and (d) working with the Social Security Administration and the workers' compensation system to promote psychological assessment as an overall cost-saving mechanism.

Final Comment and Recommendation

This article reflects a synthesis of problems and recommendations to address concerns voiced by more than 400 APA members regarding threats to the viability of psychological assessment in the health care marketplace. We hope that it serves to illustrate both the complexity of our mission to promote psychological assessment and the need to protect it as a vital component of psychological practice, science, and training. All psychologists, regardless of their professional interests, stand to lose if the stature of psychological assessment is further eroded in the health care marketplace. We offer this review to suggest ways in which psychology as a whole can counter the threats to psychological testing and assessment in the rapidly changing health care delivery system. This goal is well within the spirit of the recent APA Council of Representatives resolution, which identified addressing the effect of the changing health care environment as one of the top priorities of the APA (APA Council of Representatives, 1999).

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Received April 5, 1999
Revision received November 8, 1999
Accepted December 2, 1999 ■