360 Degree Advocacy: A Model for High Impact Advocacy In a Rapidly Changing Healthcare Marketplace

Karen S. Postal[1,2], Timothy F. Wynkoop[1,3], Beth Caillouet[1,4], Randi Most[1,5], Tresa Roebuck-Spencer[1,5] , Michael Westerveld[1,6], Antonio Puente[7], Neil H. Pliskin[8]

[1] Delegate to the Inter Organizational Practice Committee
[2] Harvard Medical School, Department of Psychiatry
[3] University of Toledo School of Medicine, Department of Psychiatry
[4] Western State Hospital; University of Virginia School of Medicine, Department of Psychiatry and Behavioral Sciences
[5] Private Practice
[6] Florida Hospital for Children, Pediatric Neuropsychology
[7] University of North Carolina - Wilmington, Department of Psychology
[8]University of Illinois at Chicago Medical School, Department of Psychiatry

Address correspondence to Dr. Karen Postal, 166 North Main Street Suite 3B, Andover, Massachusetts 01810. Office (978) 475-2025. Email Karenpostal@comcast.net

Abstract

In an era of rapid changes in the healthcare marketplace the specialty of clinical neuropsychology faces substantial challenges. These include maintaining both *access to services* and a *favorable practice climate* as new healthcare structures and payment models evolve. The issue of regional variability complicates an effective response to these challenges from national professional organizations. One response to the challenge of regional variability is to strengthen our national organizations' capacity to engage in coordinated and effective advocacy, and to partner with state and regional neuro/psychological associations. The Inter-Organizational Practice Committee (IOPC) was formed in 2012 to meet this need. The IOPC has developed a model of *360 Degree Advocacy* that coordinates local, regional and national resources for high impact, efficient advocacy. This paper describes the *360 Degree Advocacy* model, and walks readers through an example of the model in action, successfully responding to a threat to patient access and practice climate with a regional Medicare carrier.

Key words: Advocacy, Neuropsychology, Healthcare Reform

360 Degree Advocacy: A model for high impact advocacy In a rapidly changing healthcare marketplace

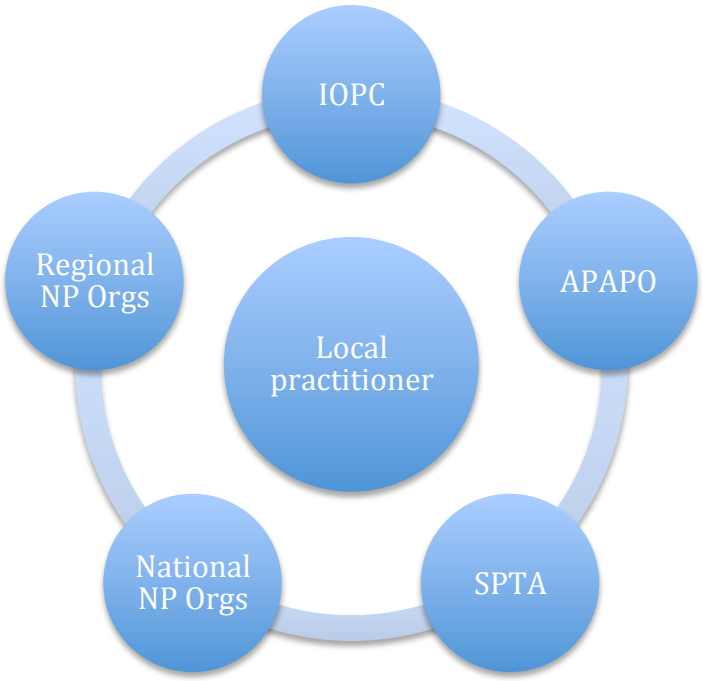
In an era of rapid changes in the healthcare market, the specialty of clinical neuropsychology faces substantial advocacy challenges. These include maintaining both *access to services* and a *favorable practice climate* as new healthcare structures and payment models continue to evolve. Access issues include insuring high quality neuropsychological and psychological services are incorporated into coverage plans and integrated structures. Practice climate issues include defending and advancing the scope of practice, ensuring reimbursement aligns appropriately with services, and ensuring services reflect the training received. However, the complex web of national (e.g., federal regulation, nation wide insurance carriers), regional (e.g., Medicare intermediaries), and state (e.g., state and territorial regulations, local insurance carriers including Medicaid) healthcare funding and regulation complicates an effective response to these challenges from national professional organizations. One response to the challenge of regional and state variability is to strengthen neuropsychology's national organizations' capacity to engage in effective advocacy. The Inter-Organizational Practice Committee (IOPC) was formed in 2012 for this reason. The group has been successful in achieving its mandate of coordinating advocacy responses by all of the major national neuropsychology organizations to increase impact and avoid inefficient duplication.

Another very important response to the problem of regional and state variability is to more effectively coordinate the existing network of regional neuropsychological

societies and State, Provincial and Territorial Psychological Associations (SPTAs). The IOPC proposes a model of *360 Degree Advocacy* that can be used as a roadmap to coordinate local, regional and national resources for high impact, efficient advocacy. This paper will describe the *360 Degree Advocacy* model, and present an example of the model in action,

[Insert figure 1, 360 Degree Advocacy Model, about here]

Figure 1. 360 Degree Advocacy Model



Legend: IOPC= the Inter Organizational Practice Committee; SPTA= State, Provincial, or Territorial Association; National Neuropsychological Organizations include the American Academy of Clinical Neuropsychology, the National Academy of Neuropsychology, The Society for Clinical Neuropsychology (Division 40 of the American Psychological Association), the American Board of Professional Neuropsychology; APAPO= the American Psychological Association Practice Organization

Key players in the 360 degree advocacy model

Inter Organizational Practice Committee (IOPC)

Each of the IOPC member organizations have well-seasoned, active volunteer practice advocacy committees that advocate for good patient care and fair treatment of practitioners. The IOPC is a committee of the practice and advocacy chairs of the American Academy of Clinical Neuropsychology (AACN; the academy of the American Board of Clinical Neuropsychology), the National Academy of Neuropsychology (NAN), The Society for Clinical Neuropsychology (Division 40 of the American Psychological Association), and the American Board of Professional Neuropsychology (ABN)[9]. These organizations formed the IOPC in 2012 in order to coordinate national practice advocacy efforts. Each national neuropsychology organization that had an active practice and advocacy committee sent the chair of that committee as a delegate to the IOPC. Organizational leaders acknowledged that each of the member organizations has overlapping, but not completely redundant interests and organizational structures that shape their stance on, and approach to, important issues. Thus, the multi-organizational structure allowed for coordination of advocacy efforts on topics of mutual concern, while retaining the individual organizations' autonomy in determining the direction of their own organizational priorities. This formula for collaboration has led to a spirit of cooperation among the member organizations, which is noteworthy given the history of perceptions that neuropsychology organizations often worked at odds with one another and lacked a unified voice.

[9] The American Psychological Association Practice Organization has recently also formally joined the IOPC.

At the time the IOPC was founded, practice and advocacy chairs of the national neuropsychology organizations recognized that while the advocacy needs of the field were rapidly increasing in the context of healthcare reform and consolidation of the healthcare industry, advocacy resources were being used inefficiently. For example, AACN might create a work group to address an advocacy issue, only to find after several months of work that NAN already had a well-established work group that had put considerable time into the issue. Similarly, ABN's practice committee might devise an advocacy strategy only to discover that Division 40 had tried that strategy, found that it was ineffective, and succeeded in an alternative strategy. Organizations were not replicating others' successful advocacy efforts, thus wasting scarce volunteer resources. Fractured advocacy efforts may also have been signaling to policy makers and external organizations that the field of neuropsychology was divided.

Additionally, IOPC practice and advocacy chairs recognized that most national advocacy efforts were reactive rather than proactive. Insurance, legislative, or regulatory crises would emerge, and practice and advocacy chairs would mobilize resources to try to affect a favorable outcome. This response left few resources for pro-active advocacy work. In the first several meetings, IOPC delegates asked the question, "What are the practice and advocacy needs of the neuropsychology community, and how can our national organizations work in concert to proactively achieve those goals?" Creation of the Neuropsychology and Healthcare Reform Web Toolkit (neuropsychologytoolkit.com) is one example of the IOPC's proactive advocacy agenda.

State, Provincial and Territorial Psychological Associations (SPTAs)

State legislators and regulatory bodies often create, re-interpret and revise existing laws and regulations that govern healthcare. Lawmakers and administrators look to state level provider organizations for input when considering changes in laws and regulations. In some cases, not consulting with or not entertaining input from state provider organizations might place state legislators and bureaucrats in an uncomfortable political position. This is one reason that SPTAs are powerful advocacy partners for clinical neuropsychologists. Additionally, SPTAs typically have paid staff such as directors of professional affairs and lobbyists who are familiar with the state level governmental and industry decision makers, and who groom interpersonal relationships with them. SPTAs are often the single voice that state regulators and legislators respond to, due to their long history of providing a unified voice for the profession within the state.

Many neuropsychologists do not belong to their SPTAs, considering it an organization for "clinical psychologists" rather than neuropsychologists. They may also not belong to the American Psychological Association (or the APAPO) for similar reasons, feeling more comfortable within a national organization that more narrowly addresses their specialty. However, due to size and resources, the State Psychological Association is typically neuropsychologists' most powerful ally for effecting legislative and organizational change in their state

Some neuropsychologists have expressed frustration with their SPTAs, feeling that the organization does not appropriately focus on the concerns of the neuropsychology community and, in some cases, actually worked contrary to the interests of neuropsychologists. This may be an accurate appraisal of their SPTA's current strategic plan or activities. However, becoming active constituents of the SPTA by

paying member dues, joining advocacy committees, and running for the board of directors is a highly effective way to change their SPTA's focus to include the needs of the neuropsychology community and remains the most effective way to effect change in most cases. It is difficult, if not impossible, to impact change as outsiders.

State/regional neuropsychology societies

Many states have active neuropsychology societies (visit neuropsychologytoolkit.com for a list compiled by the IOPC). Some of these have formal ties to SPTAs. Others were formed when neuropsychologists broke off from their SPTA in order to focus more clearly on the interests and advocacy needs of neuropsychologists. This was the case recently with the New York State Association of Neuropsychologists (NYSAN) and decades ago with the Massachusetts Neuropsychological Society (MNS).

Some state/ regional neuropsychology groups have pursued policy change without collaboration with the state societies, partially because of substantial differences in interpretations of the scope of practice. For example, in New York the state psychological association did not support the use of testing technicians.

In contrast, other state associations have been very responsive to neuropsychology. For example, North Carolina neuropsychologists partnered with the North Carolina Psychological Association (NCPA) to open up and revise state law to allow for engagement of "organic" disorders. The North Carolina Neuropsychological Society, was formed on the anniversary of NCPA 50th anniversary to move fast on specific subjects and the two groups frequently work together on issues of mutual concern.

The degree to which regional neuropsychological societies focus on advocacy varies. Many of the societies initially organized around education or research interests and may or may not have evolved their mission to include professional affairs. Some of the societies have well-developed professional affairs committees and have hired lobbyists to further their legislative and regulatory agendas. Typically, though, the relatively small size of the societies, dictated by the number of neuropsychologists in a state, means that the regional neuropsychology societies are limited in their advocacy resources. For this reason, SPTAs and regional neuropsychological societies frequently work closely together when common advocacy issues arise. For example, the Massachusetts Neuropsychological society has a formal joint advocacy committee with the Massachusetts Psychological Association that has been effective in addressing state level issues. Successfully adding language to Massachusetts' healthcare reform law compelling insurance companies to make medical necessity criteria sets transparent was a recent win for both the state psychological association and neuropsychological society.

Joining a state or regional neuropsychology society is an effective way for neuropsychologists to stay informed about and take action on local practice and advocacy issues.

The American Psychological Association Practice Organization (APAPO)

The APA created the APAPO in order to legally engage in advocacy on behalf of the professional practice of psychology without IRS restrictions. This means that the APAPO can use its resources to directly promote the professional interests of psychologists in legislative and regulatory arenas, and the healthcare marketplace. The APAPO full time, multi staffed legal team, government relations department, and public

relations department actively identify and advocate for federal level practice issues. They also consult with SPTAs in order to bring national caliber advocacy and resources to state level efforts. None of the national neuropsychology organizations come close to having the advocacy resources of the APAPO.

Being a member of APA does not automatically include membership in the APAPO. A separate practice assessment, based on practice income, is levied to join APAPO. As members of Division 40 pay their practice assessment in greater numbers than any other APA division, the needs and concerns of neuropsychologists are squarely in the radar of the APAPO. In addition, the current executive director of the APAPO spent three decades as a private practitioner in child psychology and neuropsychology. APAPO leadership therefore understands the needs of the neuropsychology community, and neuropsychologists who pay their practice assessment benefit from APA's advocacy resources.

The role that APAPO and APA have had in the CPT coding system is an excellent example of the critical nature of the groups' activities on behalf of the practice of neuropsychology. The Current Procedural Terminology (CPT®) coding system was developed by the American Medical Association (AMA) in 1996 and is under contract with the Center for Medicare and Medicaid Services (CMS). The CPT process is maintained by the 17 member CPT Editorial Panel, which meets three times a year to discuss issues associated with new and emerging technologies as well as difficulties encountered with procedures and services and their relation to CPT codes. There are over 120 medical and allied health specialties that attend the meetings as observers/participants. The APA/ APAPO facilitated a neuropsychologist, Dr. Antonio

E. Puente, working on the panel in 1992. Additionally, 11 nonmedical specialties (including the APA) comprise a *Health Care Professionals Advisory Committee* (HCPAC) which provides two voting members of the Editorial Panel. Dr. Puente was elected from this group to sit on the 11 member editorial panel. More recently, Dr. Neil Pliskin, another neuropsychologist, serves as a representative for the APA.

The CPT process becomes vitally important for any specialty seeking third party reimbursement for new or existing services and procedures. In order to obtain new codes, the clinical efficacy of that service must be established and documented in peer-reviewed scientific/professional literature. Each of the 120 plus societies has a distinct role in helping other group representatives understand the role of their professional members. Further, as part of CPT process, they study, research and put large number of hours, staff and volunteer, as well as financial resources to ensure that the service proposed by the professional community is empirically supported. Though clearly behind the scenes, the APAPO analyzes each issue at the micro and macroscopic levels to make sure not only that psychology is well represented in the coding process but that health care appreciates the importance of behavioral health in the larger health care scenario.

The CPT process gives health care providers and their specialty societies a voice in shaping the future of healthcare delivery. Indeed, new healthcare trends envisioned by the Affordable Care Act (i.e., integrated/embedded services) will be actualized through the AMA/CPT process. However, it can take anywhere from 2 to 12 years for new codes to be developed and approved, making the AMA/CPT process critical to the future of healthcare and for specialties like neuropsychology.

Coordinating Local and National Efforts

State level government agencies are often mandated to receive input from local provider communities. The presence of state level provider organizations (SPTAs and state/regional neuropsychology societies) reassures the agencies that they are hearing the voice of local providers, whereas input of national organizations in a vacuum can raise hackles and have unfavorable outcomes. Input from state level provider organizations, *in combination* with input from national organizations, reassures state agencies that they are hearing legitimate local provider concerns, and impresses them with the backing and support of major national organizations. However, there are clearly times when both local and national efforts need to be blended to achieve a desired goal. The recent IOPC effort, via all four IOPC member organizations, to encourage neuropsychologists to contact their federal senators and representatives in support of the proposed change of Medicare language including psychologists in the definition of physician is one example of this.

360 Degree Advocacy Model

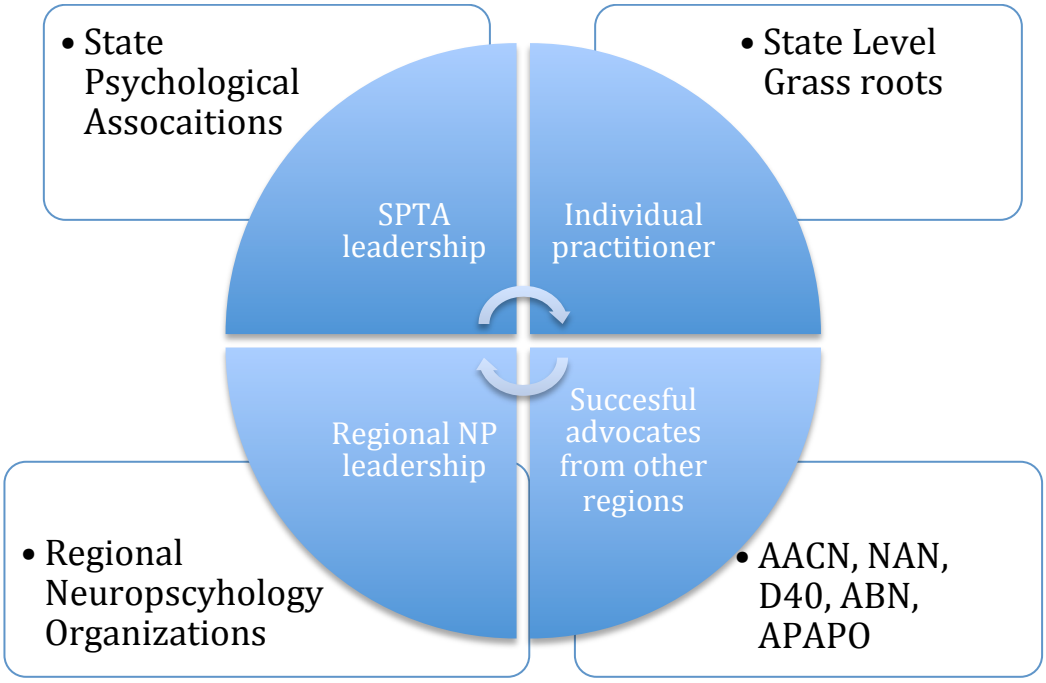
The *360 Degree Advocacy* model is activated when a neuropsychologist learns of a critical practice or advocacy issue. The neuropsychologist informs the practice and advocacy committee of his/her national neuropsychology organization (e.g. AACN or NAN). The matter is discussed in committee and if appropriate the practice and advocacy chair (who is also a delegate to the IOPC) refers the issue to the IOPC.

IOPC delegates share information about current or past advocacy efforts in the area of concern. In this way, the IOPC identifies previously successful advocacy efforts carried out in parallel circumstances in other areas of the country. The IOPC recruits

neuropsychologists who participated in other advocacy efforts to participate on a *360 Degree Advocacy* team, along with local neuropsychologists and SPTA/ regional neuropsychology leaders. Where appropriate, in the IOPC also contacts the APAPO for consultation and resources. State level providers carry out action with input from the *360 Degree Advocacy* team. The result is a rapid advocacy response, using best national practices, with buy in and "boots on the ground resources" from local clinicians and state level leaders. The model can also be triggered when a SPTA, regional neuropsychology association, or national neuropsychology organization learns of a practice, access, or legislative threat or opportunity.

[Insert figure 2, 360 Degree Advocacy Team, about here]

Figure 2. 360 Degree Advocacy Team



Legend: SPTA= State, Provincial, or Territorial Association; AACN= the American Academy of Clinical Neuropsychology; NAN= the National Academy of Neuropsychology; D40= Division 40 (Society for Clinical Neuropsychology) of the

American Psychological Association; ABN= the American Board of Professional Neuropsychology; APAPO= the American Psychological Association Practice Organization

360 Degree Model in action: Medicare patients' access to neuropsychological services

Though several examples of the *360 Degree Advocacy* model could be provided, one in particular, the IOPC's advocacy for adequate Medicare coverage of neuropsychological services in Florida, will be highlighted due to its potential national impact, the rapidity of the coordinated efforts and the eventual impact of the collaboration.

Statement of the Problem

In June of 2013, First Coast Services, Inc., the regional Medicare carrier for Florida, Puerto Rico, and the Virgin Islands, announced that it was revising its local coverage determination (LCD) for neuropsychological services. Alterations to the number of hours considered typical for neuropsychological assessment, which ICD-9 codes would demonstrate medical necessity, and the scope of neuropsychology services, were among the proposed changes in the draft that was released.

Medicare coverage determination is a regional rather than national, issue. Although Medicare is a national program, federal law requires the national Center for Medicare and Medicaid Services (CMS) to contract with regional carriers to handle claims and determine how services will be covered at local levels. Each regional carrier has a medical director who sets coverage policies, assisted by a regional Clinical Advisory Committee (CAC) made up of physicians and other practitioners. They

regularly review LCDs and solicit input at the local level to determine the local standard of care. The LCDs are announced regionally and affect only practitioners in the specific region covered by the regional carrier.

Trigger of the 360 Degree Advocacy model

Announcements from First Coast alerted several local neuropsychologists covered in the First Coast region to the proposed changes in local coverage of neuropsychological services. The local clinicians notified their national neuropsychology organizations. In this case, they alerted all of the national neuropsychology organizations, including AACN, NAN, Division 40, and ABN.

Referral to the IOPC

Alerts of the proposed First Coast restriction of access to neuropsychology services came to the IOPC through the practice and advocacy committees of all four of the member organizations. The IOPC determined that this was an issue of considerable significance to the Neuropsychology communities of Florida, the U.S. Virgin Islands, Puerto Rico. And, as one region's local coverage determinations are frequently cited in drafts of other region's LCDs, the IOPC determined that the issue might have national consequences, were an unfavorable LCD draft accepted by First Coast.

Review of previously successful efforts

One of the benefits of the IOPC is the opportunity to share information about whether previous advocacy efforts have been carried out in other regions of the country, and to clarify which of those advocacy strategies have been effective. Discussion among IOPC members revealed that two other regional Medicare carriers had recently revised their Neuropsychology LCDs: National Heritage Insurance Company (NHIC), the carrier

for five Northeast states, and Wisconsin Physicians Service (WPS), the carrier for Illinois, Wisconsin, and Michigan. In both cases, neuropsychologists successfully advocated for more favorable LCD language, improving *access* and *practice climate* issues. The WPS experience involved active input from AACN, NAN, and Division 40, and led to the creation of a model national neuropsychology LCD (Braun et. al., 2011) .

The IOPC identified individuals who had experience successfully advocating for favorable neuropsychology LCDs, the question became, "how can we assemble a team to help neuropsychologists in the First Coast region replicate that success?"

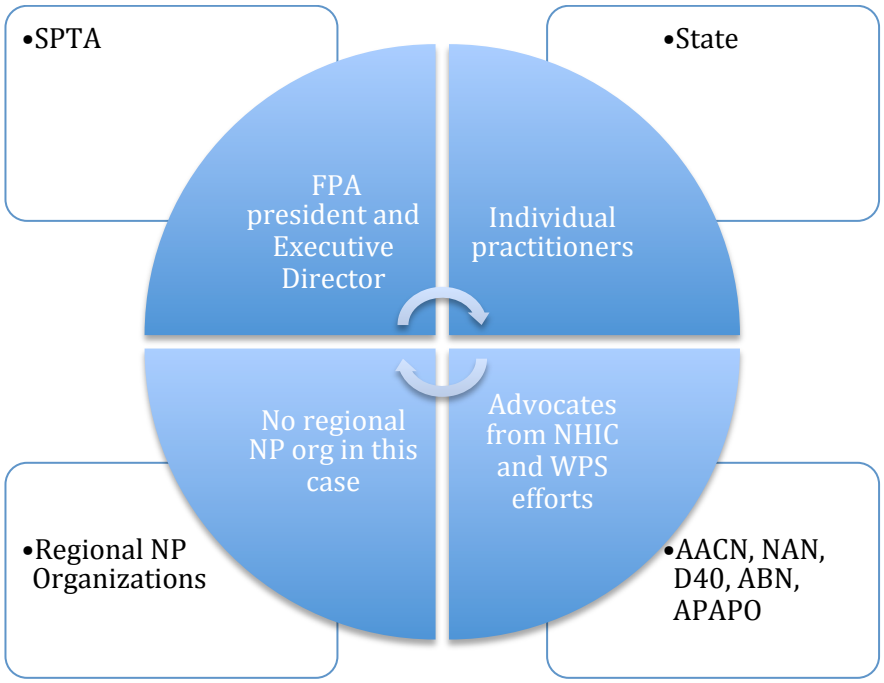
Creation of the 360 Degree Advocacy Team and coordination between groups

With both the NHIC and WPS regional Medicare carriers, the presence of local psychology and neuropsychology state leaders was critical to the success in revising their draft neuropsychology LCDs. Therefore, a goal of the IOPC advocacy strategy was to assemble a team that included state leaders from the First Coast Region, as well as individuals with experience in the issue from the national level who played a role in the WPS and NHIC LCD drafts. The IOPC also asked the individual practitioners from Florida who originally contacted their national neuropsychology organizations to participate in the *360 Degree Advocacy team*. In addition, the IOPC asked the executive director of the Florida Psychological Association (FPA) and its President to join the effort. Neither the executive director, nor the president of the Florida Psychological Association were neuropsychologists. However, both immediately embraced the opportunity to participate in the First Coast LCD workgroup.

The workgroup[10] also included neuropsychologists who participated in the WPS, NHIC, and National Model LCD for Neuropsychology efforts, as well as members of the IOPC. The workgroup contacted the APAPO to help them establish contact with the SPTAs for Puerto Rico and the Virgin Islands.

[Insert figure 3, 360 degree advocacy team, First Coast about here]

Figure 3. 360 Degree advocacy team, First Coast



Legend: SPTA= State, Provincial, or Territorial Association; AACN= the American Academy of Clinical Neuropsychology; NAN= the National Academy of Neuropsychology; D40= Division 40 (Society for Clinical Neuropsychology) of the American Psychological Association; ABN= the American Board of Professional

[10] The workgroup included Dr. Robert Porter, President of Florida Psychological Association, Ms. Connie Galleti, Executive Director of Florida Psychological Association, as well as neuropsychologists Dr. Michelle Braun, Dr. Teresa Deer, Dr. Seema Elcher, Dr. Randi Most, Dr. Karen Postal, Dr. Tresa Roebuck- Spencer, Dr. Michael Schoenberg and Dr. Michael Westerveld.

Neuropsychology; APAPO= the American Psychological Association Practice Organization

Resolution of the First Coast advocacy effort

Utilizing the Model National Neuropsychology LCD, and WPS and NHIC LCDs as a template, members of the First Coast *360 Degree Advocacy* team drafted language changes to the First Coast LCD. The changes were directly informed by team members' experiences in the state with First Coast, and the advocacy process with other Medicare carriers. The IOPC sent a letter signed by each member organization to First Coast outlining the new language as well as an explanation of the rationale for the changes. The Florida Psychological Association sent a similar letter to First Coast. The workgroup also drafted a grass roots letter and sent it to psychologists in the three states/territories covered by First Coast via SPTA listserv and local neuropsychology networks. This resulted in over 60 individual letters sent by neuropsychologists in Florida to First Coast.

Outcome of First Coast Advocacy Effort

The IOPC *360 Degree Advocacy* team efforts resulted in substantial improvement in the LCD for practicing clinicians. First Coast published a comment summary, which began with an acknowledgement of the input from the IOPC and grassroots letter writing campaign. "Comments 1-11 address the considerable input to various sections of the LCD received from the Inter Organizational Practice Committee (IOPC), a coalition of representatives of various entities tasked with coordinating national neuropsychology advocacy efforts. Regarding the IOPC recommendations received, the contractor acknowledges (First Coast, 2013) that an extensive number of letters and emails from various stakeholders across Florida were received in support of the IOPC's suggested

changes to the policy." Eight out of the 11 comments suggesting changes to LCD draft language that the *360 Degree Advocacy* team submitted to First Coast were incorporated into the final LCD draft. Where comments were not incorporated, explanations that would be helpful to clinicians and their billing departments in clarifying billing procedures were offered in the published comments summary document. Accepted suggestions to the LCD included language that more accurately described psychological and neuropsychological assessments and the difference between the two, clarification that time integrating self report measures into neuropsychological evaluations is considered a covered service, clarification that feedback sessions by neuropsychologists, psychologists, or the performing provider are considered covered services, and increase in the number of codes considered medically necessary for neuropsychological assessment.

While First Coast did not add suggested clarifying language to the LCD about the number of hours typically required to perform a neuropsychological assessment, they published the following comment in response to the advocacy teams' concerns that their draft language describing "4-6 hours as typical and more than 8 requiring extra documentation" was confusing. Their published comments will be helpful in addressing potential post service audits. "When the contractor states that typically psychological testing/neuropsychological testing may require four to six hours to perform (including administration, scoring, and interpretation), it's just indicating that this is the most common length of time for these tests. The contractor recognizes that tests could last up to eight hours and sometimes extended time is necessary. The emphasis intended is that for testing time exceeding eight hours, medical necessity for the extended testing should

be documented in the report, since the provider could fall under medical review."[10]

Summary of the 360 Degree Advocacy model in action

In the First Coast advocacy effort, the *360 Degree Advocacy* model was triggered by individual practitioners who learned of a critical practice issue in their state. Those individuals alerted national neuropsychology organizations, who referred the issue to the IOPC. The IOPC identified previously successful advocacy efforts carried out in parallel circumstances in other areas of the country. Neuropsychologists who participated in those other advocacy efforts were pulled in to participate on a *360 Degree Advocacy team*, along with local neuropsychologists and SPTA leaders. The result was a rapid response, with buy in from local clinicians and leaders, and a work product signed by national neuropsychology organizations as well as the state psychological association. The advocacy effort resulted in substantial changes to the LCD, and therefore to the practice climate of neuropsychologists in the region.

Conclusions

Increasing clinical neuropsychology's capacity for effective advocacy as a field is particularly important during this time of rapid changes in the health care marketplace. In an era of rapid changes in the healthcare market, decisions affecting *access to neuropsychological services and the neuropsychology practice climate* may have long lasting implications as new delivery structures and payment models are solidified. However, state-by-state variability in regulations and healthcare marketplaces makes it difficult for national professional organizations to recognize critical advocacy issues as they emerge, and to mobilize finite resources effectively. The *360 Degree Advocacy*

model allows national neuropsychology organizations to identify and address practice threats and advocacy opportunities with maximal impact and efficiency by sharing best practices and activating the existing network of state psychological associations and regional neuropsychological societies.

We encourage neuropsychologists to become active participants in the *360 Degree Advocacy* model by reporting practice and advocacy issues to their regional and national neuropsychology organizations, with the intention of participating in the advocacy and solution process. In addition, the *360 Degree Advocacy* model only works to the extent that practicing neuropsychologists are active in not only neuropsychology organizations but organizations that more broadly represent psychologists as a whole (SPTAs and APAPO). Paying dues, joining advocacy committees, and running for leadership positions in SPTAs and APA will ensure that those organizations will be active participants in coordinated, state level advocacy efforts on behalf of neuropsychology.

References

Braun, M., Deer, T., Kaufmann, P., Postal, K., Tupper, D., Westerveld, M., Wills, K. (2011) Neuropsychology Model LCD [Position paper] Retrieved from https://www.theaacn.org/userdocuments/neuropsychology_model_lcd-1.pdf

Frst Coast (2013). Psychological and Neuropsychological Tests: Medicare Part A/B local coverage determination (LCD) comment summary. Retrieved from http://medicare.fcso.com/Draft_comments/259074.asp