CHAPTER 2

Reviewing Referrals

Managing Clinical Consults That Contain Forensic Elements

For most clinicians, clinical work begins before the initial face-to-face encounter with a patient. Typically, the first step is reviewing insurance information, referral letters, and/or medical notes to ensure that referrals are appropriate for evaluation by the clinician. For example, the clinician might consider the patient's age, reason or condition leading to referral, primary language, and potential for a dual relationship (e.g., if the clinician knows the patient personally).

In addition to screening for issues such as those discussed above, clinicians should also consider whether referrals are appropriate for clinical evaluations. If billing the patient's health insurance, this means that the clinician must determine whether the evaluation is medically necessary, as evaluations that are not considered medically necessary (i.e., they are not expected to affect medical/health care management of the patient) are typically not reimbursed by health insurance (Schroeder, Martin, & Walling, 2019a). Even if an evaluation is to be paid in cash, it is necessary to consider whether a clinical evaluation, which entails the development of a doctor–patient relationship, or a forensic evaluation, in which no doctor–patient relationship is established (Binder, 2019), is most appropriate. Within the context of validity assessment, two of the more common types of referrals requiring careful consideration are clinical referrals to document neuropsychological dysfunction to aide in seeking disability benefits and clinical referrals of individuals involved with or considering litigation. From our perspective, there are instances where such referrals are appropriate to accept clinically but also instances where such referrals should be declined. In the following sections, we discuss factors to consider when screening such cases, and we also provide guidance for communicating the advantages and disadvantages of

proceeding with a clinical versus forensic evaluation when discussing the case with referral sources and potential patients.

CASES WITH DISABILITY INVOLVED OR POTENTIALLY INVOLVED

When patients are clinically referred for an evaluation, but disability pursuit is also present, the clinician will need to determine whether a clinical or nonclinical evaluation would be most appropriate. For many clinicians, deciding how to move forward will likely vary on a case-by-case basis. We discuss three types of cases where the presenting issues are all related to disability pursuit but other background factors are different. We then discuss how each case might be handled within a clinical setting.

Cases Where Disability Is the Sole Referral Question

When patients are referred to document cognitive and/or psychological functioning for the *sole purpose* of assisting in an application for SSDI benefits, it would likely be inappropriate to accept the patient for a clinical evaluation and bill that patient's health insurance. This is because accepting the case as a clinical one would establish a doctor–patient relationship when there is no intent of truly having such a relationship. Additionally, health insurance might not reimburse for the evaluation because determining disability is not a medically necessary question. In cases where it is clear that the only referral question is regarding assistance for SSDI, potential patients might instead be directed to contact a Disability Determination Services (DDS) case worker. The potential patient can then obtain a referral for a psychological consultative examination if deemed necessary by DDS. A psychological consultative examination is a fairly condensed and structured evaluation done by a psychologist who is credentialled with and paid by DDS for the evaluation (Schroeder & Chafetz, 2022). Within these evaluations, the examinee is not paying any money for the evaluation (DDS is paying the agreed-upon contracted cost) and the examinee's health insurance is not billed. The individual, however, is unlikely to get a thorough neuropsychological evaluation, and he or she is unlikely to obtain feedback from the clinician on the results.

As an alternative to directing the potential patient to DDS, the clinician could accept the individual for a quasi-forensic evaluation and require that the evaluation be self-pay instead of billed through health insurance. While this would be appropriate (and in some instances, maybe preferable for the examinee as it would likely be a more thorough evaluation with feedback on the results), it would obviously cost the individual money whereas obtaining an evaluation through a DDS contracted psychological consultant would not cost him or her money. For this reason, it would be ethically appropriate to discuss potentially obtaining a DDS referred evaluation prior to agreeing to see the potential patient for a self-pay evaluation. A discussion on this topic with the potential patient could be structured in a manner similar to following:

"Dr. Smith referred you for a neuropsychological evaluation, indicating that the evaluation is for assessment of your cognitive functioning to potentially aide in obtaining SSDI benefits. While I would be happy to conduct the evaluation, I do need to provide you with some information on this topic that might alter whether you want to move forward with the evaluation. Since the evaluation is not for health care purposes, but for potential disability attainment, it is not what health insurance companies consider medically necessary. Consequently, health insurance companies generally refuse to pay for these evaluations. To move forward, there are a couple of options that I would suggest. If you would like, I could perform this evaluation for you but without billing insurance, meaning that there would be an out-of-pocket expense for you. I would estimate that your expense for the evaluation would be around $1,000 (or whatever the estimated expense would be), but my billing specialist could provide you with a more precise estimate. Another option would be to contact an SSDI case manager to ask if they could refer you to one of their contracted psychologists to get an exam. If they believe it would be necessary to help determine whether you have a disability, they would refer you for an evaluation, and they would likely pay all of the associated costs. The evaluation would probably be less comprehensive, solely conducted to help determine whether you meet their standards for disability, and you probably won't directly get feedback on the results, but it would help to achieve the goal of obtaining documentation for disability pursuit."

Cases Where Disability Is Present and Medical Necessity Might Be Present

Unlike when it is clear that the evaluation is solely for disability-related purposes, there are times when a referring provider documents the presence of symptoms, presumably in need of diagnosis and treatment planning, but then only states in the referral note something along the lines of "Patient would like to pursue disability and we discussed referral for formal neuropsychometric evaluation." In some of these cases, the medical necessity for a neuropsychological evaluation could perhaps be inferred; however, there is also the possibility that the patient's health insurance will reject reimbursement given that disability is the stated reason for referral. In cases of poor or unclear documentation on the part of the referring provider, one might consider contacting the referring provider to (1) ensure that a medically necessary question exists and (2) document the medically necessary question in the referral information to reduce the likelihood of insurance rejection. If medical necessity is established via this contact, it could be appropriate to move forward with a clinical evaluation. In such cases, it would still be important to discuss with the potential patient the possible advantages and limitations of continuing with a clinical evaluation (potentially using one of the scripts in this chapter) since the individual appears primarily interested in assistance with their disability application.

Cases Where Disability and Medical Necessity Are Both Clearly Present

Finally, outside of those types of cases previously discussed, we have seen a number of referrals that are made where disability pursuit is present (or likely present) but there are also clear clinical questions that would impact medical management. In this instance, there would likely be medical necessity, and health insurance could reasonably be billed. Consider, for example, the following case which was an actual referral that one of the authors received. The referral was from a local neurologist; the patient was a 61-year-old female who was reporting depressive symptoms, cognitive decline, difficulties with completing instrumental activities of daily living, and problems with completing activities at work. The referral note from the neurologist read "Please evaluate to help plan treatment. Differential diagnosis is pseudodementia due to depression versus emerging dementia. Patient is also pursuing disability and would like documentation for this." In this case, it is clear that the referral is for two purposes: differential diagnosis which would impact medical management (which makes the referral medically necessary) and documentation for disability pursuit (which is not a medically necessary reason for an evaluation).

In a case such as that which was just described, we tend to discuss the dual referral question with the patient either before the appointment is scheduled or at the very beginning of the clinical interview. A statement similar to the following might be provided:

> "Dr. Doe referred you for an evaluation of your cognitive functioning. He stated that the evaluation would help to direct your medical care, and he also noted that you would like documentation for pursuing disability. Health insurance policies typically indicate that they will only cover costs associated with evaluations that will directly impact your health care treatment. For that reason, the evaluation that I would provide to you would be geared toward achieving that objective—providing you with a diagnosis and treatment recommendations. It would not specifically be conducted to provide documentation for SSDI, as health insurance companies do not consider that need to be medically necessary, and they would not cover the cost of this. At the same time, many patients send their medical notes to Disability Determination Services for review, which Disability Determination Services often considers sufficient for documentation. Now, I cannot guarantee the outcome of the evaluation, I cannot guarantee that the results will be viewed favorably or will get you disability benefits, and I must emphasize that Disability Determination Services makes that ultimate determination of whether you get disability benefits, not me. But, if you would like to move forward, I would be happy to conduct the clinical evaluation and, after we discuss the findings, you can decide if you want to send the findings to Disability Determination Services in addition to your referring provider. Would you like to move forward with the clinical evaluation?"

In our experience, nearly all patients agree to the clinical evaluation, and we proceed to conduct the evaluation as a clinical one, billing health insurance.

Conclusions

Like us, most neuropsychologists appear not to view the presence of disability questions as exclusionary in the context of clinical evaluations so long as there are also clinically appropriate questions regarding diagnosis or treatment planning. In a recent survey (data previously unpublished but collected as part of the survey described in Martin & Schroeder, 2020) we asked neuropsychologists the question: "A patient is clinically referred to determine degree of cognitive impairment and need for intervention. At the outset of the neuropsychological evaluation, the patient states that he hopes the evaluation will contribute to his treatment planning, but his primary goal is to use the clinical report in support of applying for disability. How likely are you to accept this patient as a clinical patient?" The most frequent response (i.e., the mode response), which was endorsed by approximately 30% of neuropsychologists, was that the patient would be accepted as a clinical patient 100% of the time. Additionally, the median response from all surveyed neuropsychologists was that the case would be seen as a clinical case 80% of the time. These data suggest that, even in cases where the patient's primary reason for the evaluation is to support a disability application, so long as there are medically necessary questions that can be answered, most neuropsychologists will proceed with the clinical evaluation in most cases.

CASES WITH LITIGATION INVOLVED OR POTENTIALLY INVOLVED

When individuals are clinically referred for an evaluation, yet are simultaneously involved in or considering litigation, the neuropsychologist must determine whether a clinical or forensic evaluation would be most appropriate. Even when such cases are appropriate to be seen clinically, they can present with a set of unique challenges that clinicians must consider. For one, when lawsuits occur, data and opinions from clinical evaluations can lose confidentiality and become part of a public record (Schroeder & Martin, 2022b). Furthermore, lawsuits are adversarial in nature, which means that the patient's neuropsychological report is likely to be scrutinized by attorneys and retained experts from both sides. Given this, as well as the increased likelihood for noncredible symptom report in the context of possible or active litigation, such cases often encourage a more thorough investigation of other sources and materials to corroborate the individual's reported history and symptoms. In some cases, this can include reviewing an increased quantity of medical records and/or reviewing records that one might not generally review within the context of standard clinical practice (e.g., accident reports that are not readily available in the medical record or scholastic records). Moreover, the clinician might consider utilizing more thorough and/or time-consuming testing when there is knowledge that the patient might look

to introduce the exam findings into his or her lawsuit. While clinicians can (and should) bill for all of the time that is required to conduct accurate and skillful evaluations, time limit caps are sometimes provided by health care insurance (e.g., not allowing payment for more than 8 hours of the clinician's time). In these cases, health insurance might not pay for all of the activities and, even if a clinician were to do these activities for reduced fees or free, these activities might sometimes be so time consuming that doing them could cause clinicians to have less time to see other clinical patients who need care.

Given the considerations noted above, clinicians will need to determine their own willingness to engage in a mixed clinical/forensic case. In addition to this, though, other factors should also be considered. In discussing this topic further, we present three types of mixed clinical/forensic referrals that we believe are likely the most common scenarios seen within clinical neuropsychology.

Cases Where Future Legal Issues Could Be Pending in the Background

Sometimes clinical referrals of patients are made without any mention of future litigation. Consider, for example, the following case. A 63-year-old male was referred by his primary care physician after suffering a stroke following an orthopedic surgery. The referral note from the primary care physician read "Evaluate and treat. Patient had stroke and would like to get a cognitive baseline to help direct speech therapy." Upon meeting with the patient for the clinical interview, the patient described that he was considering suing the physician who performed the surgery. He stated that he was considering litigation because he had a known history of stroke, yet his surgeon did not discuss the possibility that another stroke could occur as a result of his elective surgery. The patient stated that, if he had known that another stroke was possible, he would not have undergone the surgery. In this case, the referral was for treatment planning purposes (which makes the referral medically necessary) but there was also a clear possibility of litigation, which could have resulted in the neuropsychological report being submitted as legal evidence if litigation were to be pursued.

In cases such as the one just described, where a patient is clinically referred for an evaluation to address a clinically relevant question, it is our perspective that such patients should not be denied care just because there is a stated potential for future litigation. During the clinical interview, however, we discuss with the patient that the evaluation is being completed for health care purposes and not for the purpose of pursuing litigation because doing the evaluation for litigation purposes and billing health care would not be permissible and could even potentially be considered health care fraud. We also note that, if the patient were to pursue litigation and request the neuropsychologist's work be involved, patient–doctor confidentiality would no longer apply, and information obtained from the evaluation could become part of a public record. It is our experience that patients generally agree to pursue this type of evaluation as a clinical one, and follow-up litigation does not always occur. Our specific discussion is often along the lines of the following:

"Before moving forward with the evaluation, I want to make sure that we are on the same page regarding a couple of issues that you brought up. First, if this evaluation is to be billed to health insurance, which I believe was our original plan, it has to be completed for a medical reason, not a litigation-related reason, as litigation-related matters are typically not considered medically necessary reasons for health insurance to pay for evaluations. If you decide to move forward with a lawsuit and you want to use findings from our clinical evaluation after the fact, you would be able to do so, but this evaluation would, again, be done to address your health care needs, not to address litigation-related matters if we bill health insurance. Would you be in agreement with that or would you prefer to obtain an evaluation to better address litigation-related matters? (Pause here to obtain the patient's response.) Next, I need to inform you that if you were to pursue litigation and request information from this appointment be used in litigation, all of the information obtained during the evaluation could lose patient–doctor confidentiality and become part of a public record related to your lawsuit. Do you understand that, and do you still want to continue with this evaluation as is?"

Cases Where Legal Issues Are Co-Occurring

Sometimes clinical referrals are made with an indication that the evaluation request is clinical in nature but there is co-occurring litigation. Consider the following referral: A neurologist referred a 42-year-old male who was involved in a motor vehicle accident 5 months earlier. Available medical records suggested that the patient sustained a mild traumatic brain injury. The patient complained to the neurologist of headaches, periodic dizziness, cognitive dysfunction, and mood lability. The referral note from the neurologist read "Patient hit head in MVA. Evaluate to determine if cognitive symptoms are due to brain injury and/or depression. Lawsuit is pending." In this case, it is clear that the referral is for differential diagnosis which would impact medical management, but there are also clear signs of active litigation related to the injury in question. In this type of case, we tend to have discussions with patients (ideally before seeing the patient for a clinical interview) to ensure that a clinical evaluation is warranted and wanted by the patient and to also ensure that patients understand the limitations of using a clinical evaluation in litigation. This discussion may be similar to the following:

"Dr. Smith referred you for an evaluation of your cognitive functioning. She stated that the evaluation would help to direct your medical care, and she also noted that you are pursuing litigation. Health insurance policies, however, typically indicate that they will only cover costs associated with evaluations that will directly impact your health care treatment. We cannot conduct an evaluation solely for litigation-related reasons and then bill your health insurance for it because that could be considered health care fraud. Additionally, there are

other differences between a health care-related evaluation and a litigation-related evaluation that I want you to be aware of.

"If we were to move forward with a health care-related evaluation, the goal of the evaluation would be focused on achieving a diagnosis and health care-related treatment recommendations, not necessarily on determining whether your accident was the cause of any of your symptoms and whether any ongoing care needs are directly related to issues stemming from the accident. Therefore, the evaluation report will likely be insufficient in addressing questions of causation, so it may not be of great help in your lawsuit. Further, there is always the possibility that findings from the evaluation do not support claims made in the lawsuit. If that were to be the case, the evaluation could still be discoverable by either attorney, and it could be introduced into court. Finally, if we were to move forward with an evaluation and you later request the results be included in your lawsuit, all of the information obtained during the evaluation could lose patient–doctor confidentiality and become part of a public record related to your lawsuit.

"For all of these reasons, if your goal is to use this evaluation in litigation, I would suggest that you first talk to your lawyer. He or she might then contact us or another neuropsychologist to schedule a forensic evaluation. The goals of a forensic evaluation would be somewhat different as the focus would be on not only identifying the nature and severity of your symptoms but also determining their relation to your injury. In a forensic evaluation there would be a focus on documenting diagnoses, determining how those diagnoses relate to your accident, documenting functional issues that might result from those diagnoses, and making recommendations for treatment and other care or needs related to litigation. If pursuing this route, the neuropsychologist involved in the case would likely need to review additional records, which your attorney would help to obtain. Additionally, with this type of evaluation, you and your attorney decide what happens with the report—for example, if you want to use it in the lawsuit or if you want to keep it private. This litigation-related evaluation would likely be more helpful for your lawsuit, but the cost would not be covered by health insurance; it would need to be paid out of pocket, and it can be quite expensive."

After having this discussion with the patient, it is recommended that the clinician ask the patient which type of evaluation they believe would be most fitting (clinical or forensic). It is then recommended that they speak with their attorney to get the attorney's input as well.

After having the discussion outlined above, both the patient and the clinician need to decide which evaluation to pursue, with the ultimate decision of whether to accept the case as a clinical evaluation being determined by the clinician. We tend to accept the patient as a clinical patient if that is the patient's preference *and* if there appears to be a genuine need and desire for clinical care. Conversely, if (1) the patient and his or her attorney desire a forensic evaluation *or* (2) it is stated that they still want a clinical evaluation but there does not appear to be a genuine need or desire

for clinical care, we will decline the clinical evaluation but offer a forensic evaluation or a referral for a forensic evaluation. If the patient and/or his or her attorney wants the clinical evaluation but we feel a clinical evaluation is inappropriate, we state that, while we understand they are asking for a clinical evaluation, we don't feel a clinical evaluation is suitable for the purpose, we are concerned about the possibility of committing health care fraud, and, consequently, we are going to have to decline the referral.

Cases Where Legal Issues Are Clearly the Impetus for the Evaluation

Sometimes clinical referrals are made when the evaluation is clearly intended to be forensic in nature. Consider the following referral: A primary care physician referred a 34-year-old female who was involved in a motor vehicle accident and diagnosed with a concussion. The referral note from the primary care physician read "Patient is involved in a lawsuit and is requesting a referral for neuropsychological testing." Within the medical records from the physician, there was no documentation of concerns about cognitive or psychological functioning. The clinician called the referring physician and asked about the medical necessity of the case. The physician indicated that he was referring the patient because the patient requested the referral (not seeming to realize that the lack of medical necessity would result in a likely rejection of health insurance coverage), and the physician did not think that the results would likely change his treatment plan. Consequently, our office contacted the referred patient and discussed that there was no medical necessity for completing the evaluation; thus, billing health insurance could not be ethically or legally done. The patient indicated that she asked her primary care physician for the referral at the request of her attorney, and she didn't realize it would be inappropriate to bill health insurance. She was directed to talk to her attorney about undergoing a forensic neuropsychological evaluation, which she stated that she would do.

In the previous case, it seems likely that the referring physician simply did not realize that the referral was not an appropriate clinical referral. Conversely, it seems possible that the patient's attorney, who directed the patient to ask for the referral, might have been intentionally trying to deceive the health care providers with the referral. When there is intention to deceive others with the purpose of the referral, we refer to these deceptive referrals as stealth referrals. Specifically, we define a *stealth referral* as the following: a stealth referral for a forensic evaluation is a referral that is *intentionally* deceptive in the sense that the referral was initiated with the goal of obtaining data for forensic purposes, but that goal is hidden under the guise of a clinical referral. The purpose of a stealth referral for a forensic evaluation is typically to have the evaluation billed to a party (e.g., health insurance) that is not involved in the forensic proceeding in an attempt to save money within the forensic proceeding.

As an example of a stealth referral, consider the following referral that one of us has received: An attorney contacted the clinician and indicated that the attorney's client was in a lawsuit related to a brain injury. The attorney indicated that his client

is struggling with apathy, and it was not clear if the apathy was due to the brain injury or depression. The attorney indicated that the client is a very nice gentleman and throughout his work with the attorney, the attorney has become more and more concerned about his well-being. The attorney adamantly stated that he did not want a forensic evaluation of the client; instead, he was looking for a doctor to determine whether the client is experiencing increasing depression so that the client can receive help if that is the issue. While the attorney indicated (when asked) that he does not yet have an expert neuropsychologist retained, he "reassure(d)" the clinician that the clinical evaluation would not be used as part of the legal case.

While it is possible that the attorney was being genuine in his request for a clinical evaluation, this was very possibly an attempt at a stealth forensic evaluation. In this case, the clinician communicated to the attorney that it seemed quite possible that the report could be used in a legal manner and discussed the limitations of the evaluation and resultant report if they were to be relied on as evidence in the case. The clinician then described the advantages of obtaining a forensic evaluation, which could still include recommendations for treatment of depression, if present. The attorney stated that he would discuss this with his client and then follow up; no follow up ever occurred.

While the two cases just described are different, they share an important commonality: the intended goal of the evaluation was seemingly forensic. In these situations, we tend not to accept the referrals as clinical referrals. Surveyed neuropsychologists also indicate that they tend to decline referrals for clinical patients who plan to *primarily* utilize the evaluation for forensic purposes. Specifically, neuropsychologists were asked: "A patient is clinically referred to determine degree of cognitive impairment and need for intervention. At the outset of the neuropsychological evaluation, the patient states that he hopes the evaluation will contribute to his treatment planning, but his primary goal is to use the clinical report in support of pursuing personal injury litigation. How likely are you to accept this patient as a clinical patient?" The most frequent response (i.e., the mode), which was endorsed by approximately 25% of neuropsychologists, was that the patient would be accepted as a clinical patient 0% of the time. The median response from all surveyed neuropsychologists was that the case would be seen as a clinical case 25% of the time (data previously unpublished but collected as part of the survey described in Martin & Schroeder, 2020).

Conclusions

In conclusion, it is our perspective that, in most instances, it is not appropriate to conduct a clinical evaluation when patients pursue the evaluation for the *primary purpose* of supporting a lawsuit. In such cases, education can be provided about why referrals are not accepted as clinical referrals, and recommendations for appropriate forensic referrals can be made. However, in cases where appropriate clinical questions co-exist, a clinical evaluation might still be appropriate at the discretion of the neuropsychologist so long as there is a mutual understanding between the patient and

clinician that (1) the goal of the evaluation will be to address a medically necessary question (e.g., treatment planning), and (2) topics pertinent to the lawsuit will likely not be adequately addressed by a clinical evaluation.

FACTORS ASSOCIATED WITH INCREASED POTENTIAL FOR NONCREDIBLE SYMPTOMATOLOGY

In addition to ensuring that referred cases are appropriate for clinical evaluations, it is recommended that clinicians be aware of factors that are associated with an increased potential for noncredible symptomatology when reviewing referral records. Factors that suggest the potential for noncredible symptomatology are listed in Table 2.1. Identifying that such factors are present can help to ensure that appropriate questions are asked during the clinical interview, including those questions that might "pull out" clearer indications of pursuits of external incentives.

In many cases, the factors listed in Table 2.1 are associated with an increased likelihood of noncredibility because they either represent or suggest the possibility of external incentives (e.g., Ardolf, Denney, & Houston, 2007; Bianchini et al., 2006; Marshall et al., 2010; Shura et al., 2022; Suhr et al., 2022). For example, indications of problems at work could suggest that the examinee might be considering leaving the workforce, which could mean they might be seeking documentation to support

TABLE 2.1. Factors That Could Suggest an Increased Risk of Noncredible Symptomatology

- Indications of problems at work
- Disability might be or is being pursued
- Workers' Compensation is involved
- Veteran status, particularly when a diagnosis could be linked to military service
- A note of an accident occurring in the medical record
- Litigation might be or is being pursued
- Patient has legal or criminal issues pending
- Indications of problems at school
- Somatoform presentations are suspected or known
- Mild traumatic brain injury with persistent cognitive complaints
- Adult attention-deficit/hyperactivity disorder is a diagnostic consideration
- There are prominent psychiatric or mental health issues potentially contributing
- Severe cognitive complaints without medical conditions expected to cause dysfunction
- Other health care providers use terms presented in Table 2.2.

TABLE 2.2. Terms That Physicians Sometimes Use to Signal Possible Poor Effort, Feigning, or Nonorganic/Somatoform Presentations

Term	Possible suggestion
Nonorganic or nonphysiological	Terms suggestive of non-neurological etiologies, possible somatoform issues or feigning
Functional disorder	A non-neurologic disorder, likely somatoform in etiology
Psychogenic symptoms	Symptoms that are likely somatoform in nature
Supratentorial issues	Symptoms are likely psychological in nature, possibly somatoform related
Collapsing weakness/give-away weakness	A finding suggestive of poor effort, feigning, or weakness related to nonorganic issues
Improvement with distraction	A sign that suggests somatoform issues or feigning
Hoover's sign	A sign suggestive of a somatoform presentation
Waddell signs	Signs suggestive of possible somatoform issues or feigning

a disability application. Other examples listed in Table 2.1 pertain to medical issues where persisting cognitive dysfunction is not anticipated (e.g., mTBI), which could suggest that the patient's report is influenced by an undisclosed external incentive or possible somatization. It is important to keep in mind that the presence of such factors is neither necessary nor sufficient to determine noncredibility; however, identifying such issues prior to evaluating the patient is helpful when planning the clinical interview, as will be discussed in Chapter 3.

Finally, referring providers will sometimes alert the neuropsychologist to the possibility of noncredible or invalid presentations. Davis (2022) provides an excellent discussion of terms that physicians and other health care providers sometimes use to signal the possibility that a patient might be providing poor effort, feigning, or have psychological or somatoform features contributing to their neurological complaints. We summarize these terms in Table 2.2 and refer the reader to Davis's work if additional detail is desired. If a clinician were to identify one or more of these terms in referral notes, it would likely be wise to consider this information when approaching the clinical interview.

CLOSING REMARKS

As discussed throughout the chapter, it is important to screen referrals and ensure that they are appropriate for clinical evaluations. If billing health insurance, it is essential that there is documentation indicating that the evaluation is medically necessary. Even if the evaluation is to be paid in cash, though, it is important to consider

whether a clinical evaluation will be appropriate given the evaluation context and needs. When disability or litigation pursuit are noted in the consult or become evident after meeting with the patient, a clinician can still potentially perform a clinical evaluation, but the clinician will need to consider the appropriateness of and their comfort with moving forward in this manner. When such cases are accepted as clinical evaluations, the clinician should consider the increased risk for noncredible symptomatology given the presence of an external incentive, and the clinician should be aware that the evaluation results might be introduced into administrative or legal cases at a later date. Considering all of these factors and having clear discussions with the patient (and potentially other pertinent parties such as the patient's attorney), should increase the likelihood that the evaluation will be carried out in an ethical, legally appropriate, and clinically helpful manner.