Attention-Deficit / Hyperactivity Disorder (ADHD)

OBJECTIVE

To provide evidence-based recommendations for the management of Attention Deficit Hyperactivity Disorder (ADHD).

INTRODUCTION

Attention Deficit Hyperactivity Disorder is a neurobehavioral disorder of children, adolescents and adults characterized by persistent pattern of difficulty paying attention, excessive activity, and impulsivity that interferes with or reduces the quality of cognitive, academic, social, emotional, behavioral or occupational functioning. The percentage of children estimated to have ADHD has changed over time. The American Psychiatric Association states in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that 5% of children have ADHD. On the other hand, Center of Disease Control and Prevention's surveys studies estimated the prevalence of children 4-17 years of age diagnosed with ADHD in 2011 as approximately 11% (6.4 million).

CO-MORBID CONDITIONS

Disorders that commonly co-exist with ADHD in children and adolescents include:

1. **Emotional and Behavioral Disorders** such as conduct disorders, anxiety disorders, depression, bipolar affective disorder, disruptive behavior disorders and oppositional defiant disorders.
2. **Developmental Disorders** such as learning disabilities, speech and language disorders or other neurodevelopmental disorders.
3. **Physical Disorders** such as tics and sleep apnea.
4. **Substance Abuse** such as higher incident in adolescents and adults.

CORE SYMPTOMS OF ADHD

Inattention Dimension	***Hyperactivity-Impulsivity Dimension***	
	Hyperactivity	*Impulsivity*
Careless mistakes Difficulty sustaining attention Seems not to listen Fails to finish tasks Difficulty organizing Avoid tasks that require sustained attention Loses things Easily distracted Forgetful	Fidgety Unable to stay seated Moves excessively (restless) "On the go" Talks excessively Difficulty engaging in leisure activities quietly	Blurts answers before questions are completed Difficulty awaiting turn Interrupts on others

PRESENTATIONS OF ADHD

Based on the types of symptoms, three presentations of ADHD can occur:

1. Predominantly inattentive presentation
2. Predominantly hyperactive-impulsive presentation
3. Combined presentation

Presentation of ADHD in a given patient can change from one to another, depending on symptom changes over time.

Original Effective Date: 6/16/2011 Revised:12/1/2011, 10/3/2013, 6/17/2014, 2/5/2015, 5/7/2015, 1/7/2016

EVALUATION OF ADHD

The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.

The evaluation for possible ADHD includes comprehensive medical, developmental, educational, psychosocial, and ancillary evaluation. Comprehensive evaluation is necessary to confirm the presence, persistence, pervasiveness, and functional compliance of core symptoms.

The evaluation should include review of the medical, social, and family histories; clinical interviews with the parent and patient; review of information about functioning in school or day care; and evaluation for coexisting emotional or behavioral disorders. Regular vital signs with height and weight are indicated at first visit and regularly at follow-up. Electrocardiogram and cardiology consults are recommended if cardiac history is known or suspected. The necessary information may be obtained through in-person discussions, questionnaires, and web-based tools.

ADHD rating scales are recommended at diagnosis and for follow-up to track treatment response. These include the Conners Parent and Teacher Rating Scales or the equivalent and may also include the Continuous Performance Test. Neither Psychological Testing nor Neuropsychological Testing is considered medically necessary to establish the diagnosis of ADHD.

GUIDELINE HIERARCHY

CPGs are updated every two years or as necessary due to updates made by the American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to ADHD, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites.

NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the APA and the AAP on the topic of ADHD. The following are highlights from the organizations.

DIAGNOSIS OF ADHD

WellCare adheres to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)*, published in 2013 by the American Psychiatric Association (APA) to make diagnosis of ADHD. Primary care physicians and behavioral health practitioners should adhere to the DSM-5 criteria when diagnosing ADHD. Adherence to the DSM-5 criteria can help to minimize over- and underdiagnoses of ADHD. The DSM-5 diagnosis of ADHD requires:

- For children <17 years: ≥6 symptoms of hyperactivity and impulsivity or ≥6 symptoms of inattention.
- For adolescents ≥17 years and adults: ≥5 symptoms of hyperactivity and impulsivity or ≥5 symptoms of inattention

- Symptoms of hyperactivity/impulsivity or inattention must:
  - Be present before the age of 12 years
  - Be persistent for at least 6 months
  - Be present in two or more settings (e.g., at home, school or work)
  - Have clear evidence that the symptoms interfere with, or reduce the quality of, academic, social, or occupational activities

  - Show a persistent pattern that interferes with functioning or development
  - Other physical, situational, or mental health conditions that could account for the symptoms must be excluded (e.g., mood disorder, anxiety disorder, dissociative disorder, a personality disorder)

- Specify ADHD presentations that have been present for the past 6 months.
- Specify if in partial remission; when full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

- Specify current symptom severity:
  - **Mild.** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
  - **Moderate.** Symptoms or functional impairment between "mild" and "severe" are present.
  - **Severe.** Symptoms are in excess of those required to make a diagnosis; or several particularly severe symptoms are present; or symptoms result in marked impairment in social or occupational functioning.

TREATMENT OF ADHD

WellCare adheres to 2011 clinical practice guidelines on ADHD by American Academy of Pediatrics (AAP) regarding treatment of ADHD in children and adolescents which vary depending on the patient's age:

- **For preschool-aged children (4–5 years of age),** the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment. Methylphenidate may also be prescribed if the behavior interventions do not provide significant improvement and there is moderate to severe continuing disturbance in the child's function. Medication should only be prescribed to preschool aged children with moderate-to-severe ADHD. In areas where evidence-based behavioral treatments are not available, the clinician should weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment.

  NOTE: Although the AAP recommends Methylphenidate for preschool aged children, Methylphenidate is not FDA approved for this age group. Dextroamphetamine is the only FDA approved product for preschool-aged children and is available on the WellCare Preferred Drug List; however, the AAP does not suggest as first-line therapy.

- **For elementary school–aged children (6–11 years of age),** the primary care clinician should prescribe FDA approved medications for ADHD and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD (preferably both). Evidence is particularly strong for stimulant medications and sufficient however, evidence is less favorable for atomoxetine, extended-release guanfacine, and extended-release clonidine, respectively. The child's school environment, program, or placement is a part of any treatment plan.

- **For adolescents (12–18 years of age),** the primary care clinician should prescribe FDA approved medications for ADHD with the agreement of the adolescent and may prescribe behavior therapy as treatment for ADHD (quality of evidence /recommendation) (preferably both).

The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects. Treatment progress can be assessed by clinical observations and interviews, as well as rating scales completed by parents and teachers. The hallmark of treatment planning in children is a firm alliance with the parents, patient and teachers to make sure that consistent, coordinated efforts are applied across settings.

The primary care physician should also stress the importance of a weekend "holiday" with methylphenidate, when appropriate, to treat ADHD. A randomized clinical trial showed significant reduction in side effects of insomnia and appetite suppression without a significant increase in symptoms, either on weekends or on the next school day, in the 5-day per week MPH regimen with weekend holidays compared to the 7-day per week MPH regimen.

PSYCHOSOCIAL INTERVENTIONS FOR ADHD

Psychosocial interventions should be implemented to offset the debilitating effects of the condition on academic/vocational performance as well as interpersonal relationships. It is indicated for all patients/families. Parental education and social skills training should be addressed with parents who are dealing with a child who repeatedly fails

to meet expectations. Collaboration with schools is critical for children with academic and interpersonal difficulties which should be accessed at each visit for all students. Cognitive-Behavioral Therapy (CBT) and/or coaching by a specific ADHD coach can be very useful for college students and adults. It is appropriate to encourage an Individualized Educational Plan (IEP) or to support informal school modifications. Appropriate documentation, including crucial details, is required from the health care provider to the school system.

INDICATIONS FOR REFERRAL

Evaluation by a pediatric specialist (e.g., psychologist, psychiatrist, neurologist, educational specialist, or developmental-behavioral pediatrician) is indicated for children in whom the following diagnoses are of concern:

- Intellectual disability (mental retardation)
- Developmental disorder (e.g., speech or motor delay)
- Learning disability
- Visual or hearing impairment
- History of abuse
- Severe aggression
- Seizure disorder
- Coexisting learning and/or emotional problems
- Chronic illness that requires treatment with a medication that interferes with learning
- Children who continue to have problems in functioning despite ADHD treatment

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the Healthcare Effectiveness Data and Information Set (HEDIS), a set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). The following HEIDS measurements are used to assess practitioner compliance with this guideline.

Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measure

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

The following measures are used to assess compliance during Medical Record Review (MRR):

- Developmental history
- Physical exam during visits
- Rating scale (e.g., Conners, Vanderbilt or equivalent)
- Parent and member education
- Medication management

RELATED CLINICAL PRACTICE GUIDELINES

For the Georgia market, please reference the CPG *ADHD: HS-1020GA.*

REFERENCES

1. Wolraich M, et al. Subcommittee on Attention-Deficit/Hyperactivity Disorder; Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. American Academic of Pediatrics. 2011;128(5):1007-1022. Retrieved from http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf. Accessed March 12, 2015.
2. American Psychiatric Association. Attention-deficit/hyperactivity disorder. In: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) American Psychiatric Association, Arlington, VA 2013. p.59. Accessed March 12, 2015.
3. Martins S, Tramontina S, et al. Weekend Holidays During Methylphenidate Use in ADHD Children: A Randomized Clinical Trial. Journal of Child and Adolescent Psychopharmacology. 2004;14: 195-205. Accessed March 12, 2015.
4. Krull K, Augustyn M, et al. Attention deficit hyperactivity disorder in children and adolescents: clinical features and evaluation. Up To Date. 2015; 624. Accessed March 14, 2015.

LEGAL DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Note: Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Easy Choice Health Plan, Inc. ~ Exactus Pharmacy Solutions, Inc. ~ Harmony Health Plan of Illinois, Inc. ~ Missouri Care, Incorporated
WellCare Health Insurance of Arizona, Inc., operating in Hawai'i as 'Ohana Health Plan, Inc. ~ WellCare Health Plans of Kentucky, Inc.
WellCare Health Plans of New Jersey, Inc. ~ WellCare of Connecticut, Inc. ~ WellCare of Florida, Inc., operating in Florida as Staywell
WellCare of Kentucky, Inc. ~ WellCare of Georgia, Inc. ~ WellCare of Louisiana, Inc. ~ WellCare of New York, Inc.
WellCare of South Carolina, Inc. ~ WellCare of Texas, Inc. ~ WellCare Prescription Insurance, Inc. ~ Windsor Health Plan, Inc.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	History and Revisions by the Medical Policy Committee
1/7/2016	• Approved by MPC. Cross referenced Georgia specific CPG on Asthma. Inclusion of CPG Hierarchy.
5/7/2015	• Approved by MPC. Revised CPG to include items needed for NCQA accreditation purposes.
2/5/2015	• Approved by MPC. Added Background information and Member Education section.
6/17/2014	• Updated CPG with American Academy of Pediatrics guideline on ADHD.
10/3/2013	• Enhanced policy with highlights from AACAP document.
12/1/2011	• New template design approved by MPC.
6/16/2011	• Approved by MPC.