

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Clinical Pathway: Attention Deficit Hyperactivity Disorder	Utilization Management
Date: 9-98 Reviewed by QI Committee: 9-06, 9-07 Revised by QI Committee: 9-06	Page: 1 of 5 Policy Number: UM-8.3

Purpose: The purpose of this policy is to provide guidance to Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) staff and providers when providing clinical services to patients with Attention Deficit/Hyperactivity Disorder (ADHD). This policy provides suggestions and recommended practices but does not prescribe treatment. The provider should consider these guidelines in the treatment of a patient but may depart from them when clinically indicated.

Policy:

1.0 Intake and Triage

- 1.1 When a parent/legal guardian requests evaluation for their child or adolescent related to ADHD, the patient should be referred to a licensed clinician who specializes in the assessment of ADHD.
- 1.2 When an adult patient requests evaluation for himself related to ADHD, the patient should be referred to a psychiatrist who has experience treating adult ADHD.

2.0 Assessment

- 2.1 Initial evaluation should include a complete biopsychosocial and psychiatric assessment.
 - 2.1.1 Childhood History
 - 2.1.1.1 Developmental history
 - 2.1.1.2 DSM-IV symptoms of ADHD: (1) Presence or absence, (2) Development and context of symptoms and resulting impairment, including school (e.g., learning, academic productivity, and behavior), family and peers.
 - 2.1.1.3 DSM-IV symptoms of possible alternate or comorbid psychiatric diagnosis.
 - 2.1.1.4 History of psychiatric, psychological, pediatric, or neurological treatment for ADHD; details of medication trials.
 - 2.1.1.5 Areas of relative strength (e.g. talents and abilities)
 - 2.1.1.6 Medical history: (1) Medical or neurological primary diagnosis (e.g. fetal alcohol syndrome, lead intoxication, thyroid disease, seizure disorder, migraine, head trauma, genetic or metabolic disorder, primary sleep disorder). (2) Medications that could cause symptoms (e.g. Phenobarbital, antihistamines, theophylline, sympathomimetics, steroids).
 - 2.1.2 Family History

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- 2.1.2.1 ADHD, tic disorders, substance-use disorders, personality disorders, mood disorders, obsessive-compulsive disorder, and other anxiety disorders, schizophrenia.
- 2.1.2.2 Developmental and learning disorders.
- 2.1.2.3 Family coping style, level of organization, and resources.
- 2.1.2.4 Past and present family stressors, crises, changes in family constellation.
- 2.1.2.5 Abuse or neglect.
- 2.2 Standardized rating scales completed by parents/legal guardians such as:
 - 2.2.1 Child Behavior Check List
 - 2.2.2 Conner's Rating Scale
 - 2.2.3 The Attention Deficit Disorders Evaluation Scale
- 2.3 School information from as many current and past teachers as possible.
 - 2.3.1 Use of standardized rating scales such as those listed in 2.2.
 - 2.3.2 Test reports including standardized test results and assessments by a school psychologist.
 - 2.3.3 Grade and attendance records.
 - 2.3.4 Individual educational plan (IEP), if applicable.
- 2.4 Diagnostic interview: history and mental status examination.
 - 2.4.1 Symptoms of ADHD (note: may not be observable during interview and may be denied by child)
 - 2.4.2 Oppositional behavior
 - 2.4.3 Aggressive behavior
 - 2.4.4 Mood and affect
 - 2.4.5 Anxiety
 - 2.4.6 Obsessions or compulsions
 - 2.4.7 Form, content, and logic of thinking and perception
 - 2.4.8 Fine and gross motor coordination
 - 2.4.9 Tics, stereotypes, or mannerisms
 - 2.4.10 Speech and language abilities
 - 2.4.11 Clinical estimate of intelligence
- 2.5 Physical evaluation:
 - 2.5.1 Medical history and examination within past 12 months or more recently if the clinical condition has changed
 - 2.5.2 Documentation of health history, immunizations, screening for lead level, etc.
 - 2.5.3 Measurement of lead level (if not already done) only if history suggests, pica or environmental exposure
 - 2.5.4 Documentation or evaluation of visual acuity
 - 2.5.5 Documentation or evaluation of hearing acuity

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- 2.5.6 Further medical or neurological evaluation as indicated
- 2.5.7 In preparation for pharmacotherapy: (1) Baseline documentation of height, weight, vital signs, and abnormal movements. (2) EKG before TCA or clonidine. (3) Consider EKG before TCA or bupropion, if indicated. (4) Liver function studied before pemoline.
- 2.6 Referral for additional evaluations if indicated.
 - 2.6.1 Psychological Testing usually is not needed to make a diagnosis. If testing would aide in making the diagnosis, a Continuous Performance Test such as the TOVA, IVA or Conner's CPT can be used (One hour of testing) in addition to the checklists used in 2.2.
 - 2.6.2 Psychological Testing solely to rule out learning disabilities is not a covered mental health benefit. This testing should be provided by the local school district under a request for Individualized Education Plan (IEP). Note that children attending a private school are entitled to a psychological assessment and speech/language assessment by their local public school district. Parents/legal guardians may need to be instructed on how to obtain the assessment. A written request from the psychiatrist may be beneficial. Students already participating in special education are also entitled to a complete mental health evaluation from their local county mental health agency upon referral from the public school district.
 - 2.6.3 Speech/language assessment may also be requested from the local school district and may be useful in making a diagnosis or in treatment planning.
- 3.0 Psychiatric differential diagnosis
 - 3.1 Oppositional Defiant Disorder
 - 3.2 Conduct Disorder
 - 3.3 Mood disorders - Major Depression or Bioplar
 - 3.4 Anxiety disorders
 - 3.5 Tic disorder (including Tourette's disorder)
 - 3.6 Pica
 - 3.7 Substance use disorder
 - 3.8 Learning disorder
 - 3.9 Pervasive developmental disorder
 - 3.10 Mental retardation or borderline intellectual functioning
- 4.0 Treatment planning
 - 4.1 Establish target symptoms and baseline impairment (rating scales such as the Conner's may be useful).
 - 4.2 Consider treatment for comorbid conditions.

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- 4.3 Prioritize modalities to fit target symptoms and available resources: (1) Education about ADHD, (2) Classroom placement and resources, (3) Medication, (4) Other modalities may assist with remaining target symptoms such as behavior modification.
- 4.4 Monitor multiple domains of functioning: (1) Learning in key subjects (e.g., achievement tests, classroom tests, homework, classwork), (2) Academic productivity (homework, classwork), (3) Emotional functioning, (4) Family interactions, (5) Peer relationships. (6) If on medication, appropriate monitoring of height, weight, vital signs, and relevant laboratory parameters.
- 4.5 Reevaluate efficacy and need for additional interventions.

5.0 Treatment

- 5.1 Education of parents, child and significant adults.
- 5.2 School interventions: (1) Ensure appropriate class placement and availability of needed resources. (2) Consult or collaborate with teachers and other school personnel including information about ADHD, educational techniques and behavior management. (3) Direct behavior modification program when possible and if problems are severe in school setting.
- 5.3 Medication:
 - 5.3.1 Stimulant medications have proven to be beneficial for 60% to 80% of children meeting the criteria for ADHD diagnosis. These medications produce a rapid response and are easy to titrate. They have relatively few side effects.
 - 5.3.1.1 Patients who fail to respond to one psycho stimulant drug may have a positive response to the other.
 - 5.3.1.2 An afternoon dose can be beneficial for behavioral control.
 - 5.3.1.3 Rebound effect, consisting of increased excitability activity, talkativeness, irritability beginning 4 to 15 hours after a dose, may be seen as the last dose of the day wears off. Management strategies include increased structure after school, a dose of medication in the afternoon that is smaller than the morning and midday doses, use of a long-acting formulation, and the addition of clonidine or guanfacine to the regimen.
- 5.4 Psychosocial interventions.
 - 5.4.1 Parent behavior modification training.
 - 5.4.2 Psychoeducational training to improve social skills, problem solving skills and anger management.
 - 5.4.3 Referral to parent support group, such as CHADD.
 - 5.4.4 Family psychotherapy if family dysfunction is present.
 - 5.4.5 Individual psychotherapy for comorbid problems, not core ADHD.

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Reference: *Practice Parameter for the Assessment and Treatment of Children, Adolescents, and Adults With Attention-Deficit/Hyperactivity Disorder*. Journal American Academy of Child and Adolescent Psychiatry, 36:10 Supplement, October 1997.

URAC Standard

UM 1 – Review Criteria Requirements