



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Attention-Deficit/Hyperactivity Disorder (ADHD): Assessment and Treatment

Effective Date 11/15/2010
Next Review Date 11/15/2011
Coverage Policy Number 0231

Table of Contents

Coverage Policy	1
General Background	3
Coding/Billing Information	10
References	13
Policy History	17

Hyperlink to Related Coverage Policies

Biofeedback
 Chemical Hair Analysis
 Cognitive Rehabilitation
 Comparative Genomic Hybridization Testing (Chromosomal Microarray Analysis)
 Complementary and Alternative Medicine
 Genetic Counseling
 Genetic Testing of Heritable Disorders
 Neuropsychological Testing
 Nuclear Imaging including Single-Photon Emission Computed Tomography (SPECT)
 Quantitative Electroencephalography (QEEG)
 Sensory and Auditory Integration Therapy - Facilitated Communication
 Speech/Language Therapy
 Transcranial Magnetic Stimulation
 Vision Therapy/Orthoptics

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2010 CIGNA

Coverage Policy

Services provided by a psychiatrist, psychologist or other behavioral health professionals are may be subject to the provisions of the applicable behavioral health benefit.

Assessment and treatment for comorbid behavioral health and/or medical diagnoses and associated symptoms and/or conditions may be covered under applicable medical and behavioral health benefit plans.

Services for the assessment or treatment of attention-deficit/hyperactivity disorder (ADHD) that are considered primarily educational or training in nature or related to improving academic or work performance are not covered under many benefit plans.

When not otherwise excluded, CIGNA covers medically necessary services for the treatment of ADHD when the criteria of the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR) are met.

Coverage of medications related to the treatment of ADHD is subject to the pharmacy benefit of the applicable benefit plan.

CIGNA does not cover any of the following services, because each is considered educational in nature and not medically necessary for the assessment and/or treatment of ADHD (this list may not be all-inclusive):

- Intelligence Quotient (IQ) testing
- education and achievement testing
- educational intervention (e.g., classroom environmental manipulation, academic skills training, and parental training)
- neuropsychological testing

CIGNA does not cover the following procedures/services, because each is considered experimental, investigational or unproven for the assessment and/or treatment of ADHD (these lists may not be all-inclusive):

Assessment:

- actometer
- computerized electroencephalogram (EEG) (e.g., brain mapping, neurometrics, or quantitative electroencephalography [QEEG])
- computerized tests of attention and vigilance
- event-related potentials (i.e., evoked potential studies)
- hair analysis
- neuroimaging (e.g., computerized tomography [CT], magnetic resonance imaging [MRI], positron emission tomography [PET] and single-photon emission computerized tomography [SPECT])

Treatment:

- anti-candida albicans and antifungal medications
- anti-motion sickness medication
- auditory integration therapy
- chiropractic manipulation
- cognitive rehabilitation
- dietary treatments
- Dore program/Dyslexia Dyspraxia Attention Treatment (DDAT)
- EEG biofeedback/neurofeedback
- herbal remedies
- intensive intervention programs (e.g., early intensive behavior intervention [EIBI] intensive behavior intervention [IBI], Lovaas therapy, applied behavior analysis [ABA])
- megavitamin therapy
- metronome training
- movement therapy
- Neuro-Emotional Technique (NET)
- sensory integration therapy
- transcranial magnetic stimulation/cranial electrical stimulation
- vision therapy

General Background

Attention-deficit/hyperactivity disorder (ADHD) is a common disorder of childhood and adolescence that is characterized by symptoms of inattention and/or hyperactivity/impulsivity. In this disorder, the symptoms have persisted for at least six months, to a degree that is maladaptive and inconsistent with developmental level. The hyperactive-impulsive or inattention symptoms that cause impairment are present before age seven, although many individuals are diagnosed after the symptoms have been present for a number of years. Some impairment from the symptoms is present in two or more settings (e.g., at home and at school).

Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome interpersonal relationships with family members and peers, and low self-esteem. Individuals with a history of untreated childhood ADHD are more likely to experience conduct disorder, substance abuse, antisocial behavior and injuries later in life (National Institute of Health [NIH], 1998). Early recognition, assessment and management of this condition can redirect the educational and psychosocial development of most children with ADHD.

The Diagnostic and Statistical Manual of Mental disorders, Fourth edition, Text Revision (DSM-IV-TR) notes that there are three subtypes of ADHD (American Psychiatric Association [APA]), 2000):

- ADHD, combined type: This subtype is used when six or more symptoms of inattention and six or more symptoms of hyperactivity/impulsivity have persisted for at least six months. Most children and adolescents with the disorder have the combined type.
- ADHD, predominantly inattentive: This subtype is used when six or more symptoms of inattention (but fewer than six symptoms of hyperactivity/impulsivity) have persisted for at least six months.
- ADHD, predominantly hyperactive/impulsive: This subtype is used when six or more symptoms of hyperactivity/impulsivity (but fewer than six symptoms of inattention) have persisted for at least six months.

Diagnostic Criteria from Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) for:

314.00 Attention-Deficit/Hyperactivity Disorder, predominantly inattentive type

314.01 Attention-Deficit/Hyperactivity Disorder, predominantly hyperactive-impulsive type

314.01 Attention-Deficit/Hyperactivity Disorder, combined type

A. Either 1 or 2:

1) Inattention: six (or more) of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

- often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- often has difficulty organizing tasks and

2) Hyperactivity-impulsivity: six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:

- often fidgets with hands or feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

<p>activities</p> <p>f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)</p> <p>g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)</p> <p>h) is often easily distracted by extraneous stimuli</p> <p>i) is often forgetful in daily activities</p>	<p>Impulsivity:</p> <p>g) often blurts out answers before questions have been completed</p> <p>h) often has difficulty awaiting turn</p> <p>i) often interrupts or intrudes on others (e.g., butts into conversations or games)</p>
--	---

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorders, or a Personality Disorder).

In addition, the DSM-IV-TR notes that the designation of “not otherwise specified” (NOS) (DSM-IV-TR code 314.9) may be used for disorders with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet the above criteria for ADHD. Examples of this may include (APA, 2000):

- individuals whose symptoms and impairment meet the criteria for attention-deficit disorder, predominantly inattentive type but the age of onset is seven years or after
- individuals with clinically significant impairment who present with inattention and whose symptom pattern does not meet the full criteria for the disorder but have a behavioral pattern marked by sluggishness, daydreaming, and hypoactivity

While there is ongoing research as to the etiology of ADHD, it is thought by some experts that both genetic and developmental factors are strong causes of this condition. There is evidence that ADHD is a highly heritable condition with the rates of inheritance between 0.85 and 0.90 (Katragadda and Schubiner, 2007). Recent studies suggest that the genetic cause of ADHD may be complex with an association noted with markers at chromosomes 4, 5, 6, 8, 11, 16, and 17 (Pliszka, et al., 2007). In addition, it has been proposed that there are nongenetic causes of ADHD that are considered neurobiological in nature—these causes include such factors as prenatal stress and low birth weight, traumatic brain injury, maternal smoking during pregnancy, and severe early deprivation (Pliszka, et al., 2007).

Assessment

The diagnosis is clinical, based on findings that are derived from the history, physical and patient/family interviews. There are no specific diagnostic tests for ADHD. The established diagnostic tools used in the assessment of ADHD include:

- parent/child interview (to rule out other psychiatric or environmental causes of symptoms)
- medical evaluation with a complete medical history and physical examination (to assess for co-existing conditions)
- electroencephalogram (EEG) or neurological consult when the presence of focal signs or clinical findings is suggestive of a seizure disorder or a degenerative neurological condition

In general, no other form of testing has been established to be of benefit in assessing ADHD. The DSM-IV-TR, notes that, “There are no laboratory tests, neurological assessments, or attentional assessments that have been established as diagnostic in the clinical assessment of Attention-Deficit/Hyperactivity Disorder” (APA, 2000).

The American Academy of Pediatrics (AAP) developed a clinical practice guideline for the assessment and diagnosis of ADHD among school-age children who are evaluated by primary care clinicians. The significant components of the diagnostic guideline include (AAP, 2000):

- use of the DSM-IV-TR criteria for the diagnosis
- the importance of obtaining information about the child's symptoms in more than one setting (especially from schools)
- the search for coexisting conditions that may make the diagnosis more difficult or complicate treatment planning

The use of the DSM-IV-TR criteria is a standard of care for practitioners of all types (e.g., primary care, subspecialty, psychiatry and non-physician mental health providers) to use in the assessment and diagnosis of ADHD. Diagnosis usually requires several steps, and clinicians will generally need to carry out the evaluation in more than one visit, often two to three visits.

Children who meet diagnostic criteria for the behavioral symptoms of ADHD but who do not demonstrate functional impairment do not meet the diagnostic criteria for ADHD (AAP, 2000). The behaviors must adversely affect functioning in school or in a social setting. Information obtained from the parent and school can assist the physician in assessing the effects that the symptoms are having on classroom performance, self-esteem, and family and social relationships.

Other psychological and developmental disorders, including oppositional defiant disorder, conduct disorder, depression, anxiety disorder, and learning disabilities, frequently coexist in children who are evaluated for ADHD. Assessment and examination for such coexisting disorders are an integral part of the evaluation process for ADHD patients. Evidence for most of these coexisting disorders may be readily detected by the primary care clinician. For example, a family history of anxiety disorders, coupled with a patient's history of frequent fears and difficulties with separation from caregivers, may suggest the presence of anxiety disorder either as the primary diagnosis or as a comorbid diagnosis to ADHD. Several screening tests are available that can detect areas of concern for many of the mental health disorders that coexist with ADHD. Although these scales have not been tested for use in primary care settings and are not diagnostic tests for either ADHD or associated mental health conditions, some clinicians may use them to establish high risk for coexisting psychological conditions.

According to the literature, several medical screening tests and laboratory measures have been used to evaluate children with suspected ADHD. These include blood lead levels, neuroimaging (e.g., computerized tomography [CT], magnetic resonance imaging [MRI]), EEG, and neurological screening exams, as well as other miscellaneous laboratory assessments (Brown, et al., 2001). The association between elevated lead levels and impairments in cognitive functioning, including attention problems, has been consistently reported in the literature. Brown et al. (2001) reviewed six studies and found no statistically significant associations in three of them. One study reported a positive association between lead level and behavioral problems. Two studies examined children screened for disruptive behavioral problems and found associations between elevated lead levels and behavioral problems. Since these studies did not assess ADHD, however, the extent to which their findings may apply to children with this disorder is unknown (Brown, et al., 2001). The studies' findings suggest an association between elevated lead levels and a range of behavioral problems, including inattention, but do not support the routine use of lead screening as a diagnostic indicator for ADHD. Only when clinical or environmental factors are present is the measurement of blood lead levels appropriate.

There is insufficient evidence in the medical literature to support the use of computerized methods of EEG (e.g., quantitative electroencephalography [QEEG]) brain mapping, neurometrics) in the assessment of ADHD. When another condition is present along with ADHD, genetic testing may be considered. While there is ongoing research into the genetic causes of ADHD, it is preliminary and currently there is no established role for genetic testing, including microarray testing, in the assessment of this condition.

Neuropsychological testing for educational reasons is generally considered not medically necessary for the assessment of ADHD. Educational testing is usually provided by school systems under applicable state and federal rules. Neuropsychological testing may be medically necessary in neurologically complicated cases of ADHD (e.g., post-head trauma, seizures). Children with uncomplicated ADHD do not require neuropsychological testing.

The AAP clinical practice guidelines (2000) made the following statements regarding the diagnosis and evaluation of patients with ADHD:

- Regular screening of children for high lead levels does not aid in the diagnosis of ADHD.
- Current literature does not support the routine use of EEG in the diagnosis of ADHD.
- Available evidence does not support routine screening of thyroid function as part of the effort to diagnose ADHD.
- Neuroimaging studies should not be used as a screening or diagnostic tool for children with ADHD because they are associated with high rates of false-positives and false-negatives.
- Current data do not support the use of any available continuous performance tests in the diagnosis of ADHD.

The Agency for Healthcare Research and Quality (AHRQ) sponsored the development of a systematic technical review to summarize current scientific evidence from the literature on the prevalence of ADHD and on the value of various evaluation methods. Data from 97 accepted articles and manuals were abstracted, tabulated systematically, and subjected to statistical analysis. The AHRQ (1999) made the following statements, based on the findings, regarding medical screening tests:

- Analysis of six studies on the relation between elevated lead levels and ADHD showed that lead levels are not useful as a general diagnostic tool for ADHD. This is strengthened by the fact that ADHD prevalence appears to be increasing even as lead levels in the population appear to be decreasing.
- Analysis of four studies showed no relation between abnormal thyroid function and ADHD. Thus, the evidence does not support the use of tests of thyroid function to screen for ADHD.
- Analysis of seven imaging studies of the brain (e.g., computerized axial tomography [CAT] and magnetic resonance imaging [MRI]) that were performed to detect morphologic differences in brain structures of children with ADHD yielded sparse and diverse evidence. Thus, none of the imaging procedures analyzed are considered useful as a screening or diagnostic tool for ADHD.
- Eight studies of electroencephalogram (EEG) patterns and ADHD found no serious EEG abnormalities in ADHD children, although many studies found significant differences in brain wave activity between ADHD children and normal controls. The heterogeneity of results across studies indicates that the EEG should not be routinely used as a screening tool for ADHD.
- Evidence from studies of neurological screening tests did not yield any clues to the etiology of ADHD. Thus, these tests are not deemed effective for screening ADHD.
- Continuous performance tests (CPT) measure impulsivity, inattention, and vigilance. Statistical analysis of studies using these tests indicated that CPTs would not serve as useful screening tools for ADHD.

The American Academy of Child and Adolescent Psychiatry (AACAP) published updated evidenced-based practice parameters for the assessment and treatment of children and adolescents with ADHD (Pliszka, et al., 2007). The guidelines include the following recommendations regarding evaluation of ADHD:

- Screening for ADHD should be part of every patients' mental health assessment: if a patient or the parent reports that the patient suffers from any symptom of ADHD that induce impairment or if the patient scores in the clinical range for ADHD symptoms on a rating scale, then a full evaluation is indicated
- Evaluation of preschooler, child or adolescent for ADHD should consist of clinical interviews with the parent and patient, obtaining information about the patient's school or day care functioning, evaluation for comorbid psychiatric disorders and review of patient's medical, social and family histories.
- If the patient's medical history is unremarkable, laboratory or neurological testing is not indicated. The guidelines note that there are few medical conditions that pose as ADHD, and the vast majority of patients with ADHD will have an unremarkable medical history. The parameters note that, "Unless there is strong evidence of such factors in the medical history, neurological studies (electroencephalography [EEG], magnetic resonance imaging, single-photon emission computed tomography [SPECT], or positron emission tomography [PET]) are not indicated for the evaluation of ADHD." They note that the American Psychiatric Association Council on Children, Adolescents and Their Families in their report of brain imaging and child and adolescent psychiatry have warned against

the exposure of children to intravenous radioactive nucleotides as part of the diagnosis or treatment of childhood psychiatric disorders, citing both a lack of evidence of validity and safety issues.

- Psychological and neuropsychological tests are not mandatory for the diagnosis for ADHD, but should be performed if the patient's history suggests low general cognitive ability or low achievement in language or mathematics relative to the patient's intellectual ability. The guidelines note that, "Psychological testing of the ADHD patient usually consists of a standardized assessment of intellectual ability (IQ) to determine any contribution of low general cognitive ability to the academic impairment, and academic achievement. Neuropsychological testing, speech-language assessments, and computerized testing of attention or inhibitory control are not required as part of a routine assessment for ADHD, but may be indicated by the findings of the standard psychological assessment."
- The clinician must evaluate the patient with ADHD for the presence of comorbid psychiatric disorders. The guidelines note that it should be determined if the patient meets criteria for separate comorbid disorder in addition to ADHD, the comorbid disorder is the primary disorder and ADHD is caused by it, or the comorbid symptoms do not meet criteria for separate disorder but rather represent secondary symptoms that are caused by the ADHD.

Treatment

The most widely researched and commonly prescribed treatments for ADHD are psychostimulant medications, including methylphenidate and other amphetamines (NIH, 1998). The U.S. Food and Drug Administration (FDA) approved Stattera[®] (atomoxetine) (Eli Lilly and Co., Indianapolis, IN) in November 2002 as a new non-stimulant treatment for ADHD. Studies with atomoxetine have thus far compared it only to a placebo. Until head-to-head studies are available comparing the efficacy and safety of atomoxetine with those of stimulants, its role in the treatment of ADHD remains limited. It can be recommended for those patients who are unable to tolerate stimulants or cannot take stimulants because of a clinical reason (Corman, et al., 2004).

Many studies have documented the efficacy of stimulants in reducing the core symptoms of ADHD. Numerous short-term studies have established the safety and efficacy of stimulants and psychosocial treatments for alleviating the symptoms of ADHD, as well as for improving function in a number of domains. Most studies of stimulants have been short-term, demonstrating efficacy over several days or weeks. The National Institute of Mental Health (NIMH) Multimodal Treatment Study (MTA) of ADHD extended the demonstrated efficacy to 14 months (MTA, 2004). The NIMH research indicates that the two most effective treatment modalities for elementary school children with ADHD are a closely monitored medication treatment and a treatment that combines medication with intensive behavioral interventions. The study involved 579 elementary school children with ADHD (ages 7.0–9.9 years) across multiple sites. The participants were randomized to four treatment groups: medication management alone; medication management and behavior treatment; behavior treatment alone; and standard community care. The results showed that nine out of ten children with ADHD showed marked reduction in core ADHD symptoms over a 14-month period when treated with medication management alone or a combination of medication and behavior treatment. While the medications were extremely beneficial to most children, MTA findings indicated that medications alone may not necessarily be the best strategy for many children. For example, children who had accompanying problems (e.g., anxiety, stressful home circumstances, social skills deficits) over and above the ADHD symptoms appeared to obtain maximal benefit from the combined treatment.

In April 2004, the MTA group published an evaluation of the persistence of the beneficial effects of medication management and the combination of medication and behavior treatment for 10 months beyond the 14 months previously reported. Ninety-three per cent of the original group participated in the follow-up. It was noted that the medication management strategy showed persisting significant superiority over the behavior treatment and community comparison, although not as great as at 14 months (MTA, 2004).

In August 2007, a three-year follow-up of the MTA study was published with 83.8% participating (Jensen, et al., 2007). Once the delivery of randomly assigned treatments by MTA staff ended at 14 months, the MTA became an observational study in which the subjects and their parents were able to choose their own treatment in the context of availability and barriers to care existing in their communities. It was noted that in contrast to the significant advantage of medication management and combination treatment over behavior treatment and community comparison for ADHD symptoms at 14 and 24 months, treatment groups did not differ significantly on any measure at 36 months. The percentage of children taking medication > 50% of the time changed between 14 and 36 months across the initial treatment groups: Behavior therapy significantly increased (14% to

45%), combination of medication and behavior treatment significantly decreased (91% to 71%), and community care remained relatively constant (60%–62%). The report indicated that regardless of their treatment use changes, all of the groups showed symptom improvement over baseline. The authors theorized that the results may be due to age-related decline in ADHD symptoms, changes in the medication management intensity, starting or stopping medications altogether, or other factors that have not been evaluated.

Molina et al. (2009) reported on long-term effects of this study six and eight years after childhood enrollment of the MTA study. In nearly every analysis, it was found that the originally randomized treatment groups did not differ significantly on repeated measures or newly analyzed variables (e.g., grades earned in school, arrests, psychiatric hospitalizations, other clinically relevant outcomes). The medication use decreased by 62% after the 14-month controlled trial, but adjusting for this did not change the results. The ADHD symptom trajectory in the first three years predicted 55% of the outcomes. The MTA participants fared worse than the local normative comparison group on 91% of the variables tested. The results indicated that the type or intensity of 14 months of treatment for ADHD in childhood does not predict functioning six to eight years later, but rather the early ADHD symptom trajectory regardless of treatment type is prognostic. The researchers noted that the finding implies that children with behavioral and sociodemographic advantage, with the best response to any treatment, will have the best long-term prognosis.

The AACAP guidelines (Pliszka, et al., 2007) contain the following recommendations regarding treatment of ADHD:

- A well-thought-out and comprehensive treatment plan should be developed for the patient with ADHD. The treatment plan may consist of pharmacological and/or behavior therapy. The plan should consider the most recent evidence concerning effective therapies as well as family preferences and concerns. The treatment plan should be reviewed on a regular basis and modified if the patient is not responding.
- The initial psychopharmacological treatment of ADHD should be a trial with an agent approved by the FDA for treatment of ADHD. These medications include dextroamphetamine (DEX), D, L-methylphenidate (MPH), mixed salts amphetamine and atomoxetine. The guidelines also include typical dosing of medications. Regarding selection of which agent, the guidelines note that it is the sole choice of the family and the clinician as to which agent should be used, and each patient's treatment must be individualized.
- If none of the FDA approved agents results in satisfactory treatment of the patient with ADHD, the clinician should undertake a careful review of the diagnosis and then consider behavior therapy and/or use of medications not approved by the FDA for treatment of ADHD. As part of the review of diagnosis, it should be examined whether any undetected comorbid conditions are present, such as affective disorders, anxiety disorders, or subtle developmental disorders. Among the medications that may be used at this time are bupropion, tricyclic antidepressants (TCAs), and alpha-antagonists. The guidelines note that the evidence base for these medications is far weaker than for the FDA-approved agents.
- While receiving psychopharmacological interventions, the patient should be monitored for treatment-emergent side effects. This assessment may necessitate the use of a different stimulant or a nonstimulant medication.
- If there is a robust response to psychopharmacological treatment and subsequently normative functioning in academic, family and social functioning, the psychopharmacological treatment of the ADHD alone is satisfactory. The guidelines note that it is not mandatory that behavior therapy be added to the regimen, although parental preferences should be taken into account.
- When there is a less than optimal response to medication, the patient has a comorbid disorder, or experiences stressors in their family life, then psychosocial treatment in conjunction with medication is often beneficial.
- The patient should be assessed at regular intervals to determine whether there is continued need for treatment or if symptoms have been decreased. The treatment should continue as long as symptoms remain present and cause impairment. The guidelines note that signs that ADHD has diminished include: lack of any need to adjust despite robust growth, lack of deterioration when a dose of stimulant medication is missed, or newfound abilities to concentrate during drug holidays.
- While treated with medication, height and weight should be monitored.

A Cochrane review was performed (Bjornstad and Montgomery, 2005) to address the question of whether family therapy without medication can reduce the core symptoms of ADHD as compared to no treatment or standard

treatment. The review involved two studies that met the criteria for quality of research method. It was noted that one found no difference in children's symptoms of ADHD after either family therapy or normal treatment in the community. The second study found that family therapy was more effective than a medication placebo. The reviewers concluded that further research examining the effectiveness of family therapy versus a non-treatment control condition is needed to determine whether family therapy is an effective intervention for children with ADHD.

In an effort to support and empower parents of children age 12 and under who are diagnosed with ADHD, CIGNA Behavioral Health has implemented a preventive health program for improving the management of ADHD (<http://www.cignabehavioral.com/web/basic/site/consumer/educationAndResourceCenter/adhd.jsp>). The program went into effect on October 1, 2003. Automated algorithms within the Care Advocacy Program of CIGNA Behavioral Health identify the first claim for a service to a child age 12 or under who carries the diagnosis of ADHD. An information packet is then mailed to the child's parents, and resources are made available to treating practitioners. The ability of parents to effectively understand and report information to those involved with their child is critical to care planning and to evaluating treatment response for ADHD. Early recognition, assessment, and management of this condition can redirect the educational and psychosocial development of most children with ADHD.

A variety of nonpharmacological treatments for ADHD other than behavior therapy were reviewed by the AACAP in developing their practice parameters (Pliszka, et al., 2007). These include cognitive-behavioral therapy and dietary modifications. It was found that there was no evidence to support these interventions

It was also noted in the AACAP guidelines that the efficacy of EEG feedback (e.g., neurofeedback), either as primary treatment or an adjunct to medications, has not been established (Pliszka, et al., 2007). A systematic review and meta-analysis was published by ECRI (2007) on the effectiveness of neurofeedback for treatment of ADHD. Eight studies met inclusion criteria. Five studies (n=167) compared neurofeedback to a waitlist or placebo, and four studies (n=242) compared neurofeedback to stimulant medication. Most of the studies were nonrandomized, small and in some studies patients were also on medication. ECRI stated that neurofeedback is comparable to standard medical care for improving attention in ADHD patients, but that the evidence was weak (based on four studies) and was insufficient to allow a precise, quantitative estimate of the effect of neurofeedback on this outcome. ECRI also stated that due to insufficient evidence, it could not be determined if neurofeedback was comparable to standard medical care for other ADHD symptoms (i.e., hyperactivity, impulsivity and aggression). The evidence was insufficient to determine if neurofeedback improved patient function and quality of life.

Other alternative interventions have been proposed for treatment of ADHD. These include the use of anti-candida albicans, antifungal medications and anti-motion sickness medication, chiropractic manipulation, herbal remedies, megavitamin therapy, vision therapy, sensory (auditory) integration therapy, transcranial magnetic stimulation/cranial electrical stimulation, metronome training, movement therapy or cognitive rehabilitation. There is insufficient evidence in the medical literature to support the use of these interventions for ADHD.

Dore Program/Dore Program for Attention Deficit Disorder: The Dore program, also known as Dore Program for Attention Deficit Disorder, or Dyslexia Dyspraxia Attention Treatment (DDAT), is an exercise-based program that was originally developed to treat dyslexia. The program is aimed at treating dyslexia, ADHD, dyspraxia and Asperger's Syndrome. The program consists of a specialized neurological evaluation and series of patient-specific exercises designed to simulate the cerebellum or "hind brain." The proponents of this program theorize that cerebellar size and function are related to a constellation of learning disorders that are referred to as cerebellar developmental delay (CDD). At the Dore USA website, it notes that the exercises incorporated in the program "stimulate the cerebellum to function more rapidly and to enable the development of previously poor motor and cognitive skills. The exercise program directly impacts motor skills while cognitive skills slowly improve through the exercises' stimulatory effects." A review of this treatment (Bishop, 2007) notes that published studies regarding this program "are seriously flawed." The review notes that two studies were published regarding this treatment for children with dyslexia. Regarding the use of the Dore program for ADHD, the review notes that, "There is nothing here to justify the claims made that the Dore Programme is more effective than state-of-the-art medication for ADHD, especially in view of the fact that only one child in the study had an ADHD diagnosis." There is insufficient evidence to support the efficacy of the Dore program for treatment of ADHD.

Intensive Intervention Programs: Intensive intervention programs, also known as early intensive behavior intervention (EIBI) intensive behavior intervention (IBI), Lovaas therapy, and applied behavior analysis {ABA}. These programs incorporate behavior modification and applied behavior analysis. The programs were developed initially to treat children with autism spectrum disorders (ASD) and have recently been proposed to treat children with learning disabilities and ADHD. These programs may be prescribed by school systems as an intervention that is part of the individualized educational plan (IEP). The program is intensive and usually involves hours of treatment (usually more than 15 hours per week) delivered over a long period of time (ECRI, 2009). There is a lack of scientific evidence to support the efficacy of the programs for ADHD.

Neuro Emotional Technique (NET): NET has been described as methodology of finding and removing Neuro Emotional Complexes (NECs) which are defined as a subjective maladaptation syndrome adopted by the organism in response to a real or perceived threat to any aspect of its survival (Karpouzis, et al., 2009). NET has been proposed as a treatment designed to address negative distressing stimuli, by removing these patterns by accessing the nervous system via stimulation of the spine. It was first developed as a branch of chiropractic care, but is now being provided by other practitioners such as psychologists and licensed acupuncturists to treat many other disorders including ADHD. It is purported that there is a mind-body connection with these conditions that can be corrected with NET. There is insufficient evidence in published peer-reviewed scientific literature to support the efficacy of this treatment for ADHD.

Adult ADHD

It was previously thought that ADHD did not continue beyond adolescence, but long-term, controlled, follow-up studies have shown that the disorder persists in a sizable number of adults who were diagnosed with ADHD in childhood. ADHD occurs in approximately 4% of adults, and the condition can impair work and social functioning (Goroll, 2009). The clinical features are highly reminiscent of the pediatric form of the disorder. The condition frequently coexists with anxiety, depression and substance abuse. ADHD can be diagnosed reliably in adults who currently have symptoms of ADHD as defined in the DSM-IV-TR and who, on careful questioning, give a history of such symptoms since childhood.

Unlike treatment for childhood ADHD, treatment for adult ADHD has not been well-established by randomized, controlled trials, nor are there any published treatment guidelines (Goroll, 2009). Modalities include cognitive-behavioral therapy and pharmacotherapy. Support groups, such as Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) assist newly diagnosed adults by providing information about ADHD and available resources, including peer support groups. Coaching and training in organizational skills appear useful but remain unstudied.

The benefit of pharmacotherapy for the treatment of ADHD in children has been established, but the usefulness of medication as a treatment for adults with ADHD has not been well-established. To date, the FDA has approved the following agents for adult use: mixed amphetamine compounds, the noradrenergic-specific reuptake inhibitor, Strattera. In May 2005, the FDA approved Focalin XR[®] (dexmethylphenidate HCl) (Novartis, East Hanover, NJ) for treatment of ADHD in adults, adolescents and children. One review article notes that the stimulants, methylphenidate and amphetamine, are the most commonly used and are highly effective in a dose-dependent manner for adults with ADHD (Wilens, 2004). Other available medication shown to be effective for adults with ADHD includes bupropion, desipramine and pemoline (Wilens, 2004).

Summary

Attention-deficit/hyperactivity disorder (ADHD) is a common neurobehavioral disorder of childhood and adolescents that is characterized by symptoms of inattention and/or hyperactivity/impulsivity that have persisted for at least six months. There is evidence to support that a combination of certain medical and behavioral interventions can be effective in the treatment of ADHD in children.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Experimental, investigational or unproven and not covered when used to report the assessment and/or treatment of ADHD:

CPT* Codes	Description
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
76390	Magnetic resonance spectroscopy
78600	Brain imaging, less than 4 static views;
78601	Brain imaging, less than 4 static views; with vascular flow
78605	Brain imaging, minimum 4 static views;
78606	Brain imaging, minimum 4 static views; with vascular flow
78607	Brain imaging, tomographic (SPECT)
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
90901	Biofeedback training by any modality
92065	Orthoptic and/or pleoptic training with continuing medical direction and Evaluation
92548	Computerized dynamic posturography
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) (QEEG)
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions
0160T	Therapeutic repetitive transcranial magnetic stimulation treatment planning
0161T	Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session

HCPCS Codes	Description
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
P2031 [†]	Hair analysis (excluding arsenic)
S8035 [†]	Magnetic source imaging
S8040 [†]	Topographic brain mapping

Educational in nature, not medically necessary and not covered for the assessment and/or treatment of ADHD:

CPT* Codes	Description
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report

HCPCS Codes	Description
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session
S9446	Patient education, not otherwise classified, nonphysician provider, group, per session
T1018	School-based individualized education program (IEP) services, bundled

ICD-9-CM Diagnosis Codes	Description
314.00	Attention deficit disorder without mention of hyperactivity
314.01	Attention deficit disorder with hyperactivity

References

1. Agency for Healthcare Research and Quality (AHRQ) (formerly Agency for Health Care Policy and Research) diagnosis of attention-deficit/hyperactivity disorder. Summary, Technical Review: Number 3, August 1999. Accessed October 5, 2010. Available at URL address: <http://www.ahrq.gov/clinic/epcsums/adhdsutr.htm>
2. American Academy of Child and Adolescent Psychiatry (AACAP). ADHD - A Guide for Families. Attention deficit/hyperactivity. Accessed October 5, 2010. Available at URL address: http://www.aacap.org/cs/adhd_a_guide_for_families/resources_for_families_adhd_a_guide_for_families
3. American Academy of Pediatrics (AAP). Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics*. 2000 May;105(5):200-24.
4. American Academy of Pediatrics (AAP). Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. *Pediatrics*. 2001 Oct;108(4):110-20.
5. American Psychiatric Association (APA). Diagnostic and statistical manual for mental disorders text revision. DSM-IV-TR. 4th ed. Arlington, VA; 2000.
6. American Psychiatric Association Council on Children, Adolescents and Their Families. Clinical Use for Single Photon Emission Computed Tomography (SPECT). Brain Imaging and Child and Adolescent Psychiatry with Special Emphasis on SPECT. January 2005. Accessed October 5, 2010. Available at URL address: <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/ResourceDocuments/200501.aspx>
7. Bishop DV. Curing dyslexia and attention-deficit hyperactivity disorder by training motor co-ordination: Miracle or myth? *J Paediatr Child Health*. 2007 Oct;43(10):653-5.
8. Bjornstad G, Montgomery P. Family therapy for attention-deficit disorder or attention-deficit/hyperactivity disorder in children and adolescents. *Cochrane Database Syst Rev*. 2005 Apr 18;(2):CD005042.
9. Brown RT, Freeman WS, Perrin JM, Stein MT, Amler RW, Feldman HM, et al. American Academy of Pediatrics. Prevalence and assessment of attention-deficit/hyperactivity disorder in primary care settings. *Pediatrics*. 2001 Mar;107(3):1-11.
10. Brown RT, Amler RW, Freeman WS, Perrin JM, Stein MT, Feldman HM, et al.; American Academy of Pediatrics Committee on Quality Improvement; American Academy of Pediatrics Subcommittee on Attention-Deficit/Hyperactivity Disorder. Treatment of attention-deficit/hyperactivity disorder: overview of the evidence. *Pediatrics*. 2005 Jun;115(6):e749-57.
11. CIGNA Behavioral Health. Preventive health program description for: improving management of attention-deficit/hyperactivity disorder. Accessed October 5, 2010. Available at URL address: <http://www.cignabehavioral.com/web/basic/site/consumer/educationAndResourceCenter/adhd.jsp>
12. Corman SL, Fedutes BA, Culley CM. Atomoxetine: the first nonstimulant for the management of attention-deficit/hyperactivity disorder. *Am J Health Syst Pharm*. 2004 Nov 15;61(22):2391-9.
13. Coulter MK, Dean ME. Homeopathy for attention deficit/hyperactivity disorder or hyperkinetic disorder. *Cochrane Database Syst Rev*. 2007 Oct 17;(4):CD005648.
14. Dodson WW. Pharmacotherapy of adult ADHD. *J Clin Psychol*. 2005 May;61(5):589-606.

15. Dore program website. Accessed October 5, 2010. Available at URL address: <http://www.doreusa.com/>
16. ECRI Institute. Neurofeedback for Treatment of Attention Deficit Hyperactivity Disorder. Plymouth Meeting (PA): ECRI Institute Health Technology Assessment Information Service; 2007 Feb. 87 p. (Evidence Report; no. 144). Available at URL address: <http://www.ecri.org>.
17. ECRI Institute. Comprehensive Educational and Behavioral Interventions for Autism Spectrum Disorders. Plymouth Meeting (PA): ECRI Institute Health Technology Assessment Information Service; 2009 Feb. 187 p. (Evidence Report; no. 167). Available at URL address: <http://www.ecri.org>.
18. Fabiano GA, Pelham WE Jr, Coles EK, Gnagy EM, Chronis-Tuscano A, O'Connor BC. A meta-analysis of behavioral treatments for attention-deficit/hyperactivity disorder. *Clin Psychol Rev*. 2009 Mar;29(2):129-40.
19. Gevensleben H, Holl B, Albrecht B, Vogel C, Schlamp D, Kratz O, et al. Is neurofeedback an efficacious treatment for ADHD? A randomised controlled clinical trial. *J Child Psychol Psychiatry*. 2009 Jul;50(7):780-9.
20. Goroll AH, Mulley AG editors. Primary care medicine 6th edition. Philadelphia, PA: Lippincott Williams & Wilkins; 2009.
21. Greenhill LL, Hechtman L. Attention-Deficit/Hyperactivity Disorder. In: Sadock, BJ, Sadock, VA, Ruiz P, editors. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry* 9th edition. Philadelphia: Lippincott Williams; 2009.
22. Greydanus DE, Pratt HD, Patel DR. Attention deficit hyperactivity disorder across the lifespan: the child, adolescent, and adult. *Dis Mon*. 2007 Feb;53(2):70-131.
23. Institute for Clinical Systems Improvement (ICSI). ADHD, Attention Deficit Hyperactivity Disorder in Primary Care for Children and Adolescents (Guideline). Eighth Edition. Released March 2010. Accessed October 5, 2010. Available at URL address: <http://www.icsi.org/search.aspx?searchFor=adhd>
24. Jadad AR, Boyle M, Cunningham C, et al. Treatment of Attention-Deficit/Hyperactivity Disorder. Evidence Report/Technology Assessment No. 11 (Prepared by McMaster University under Contract No. 290-97-0017). AHRQ Publication No. 00-E005. Rockville, MD: Agency for Healthcare Research and Quality. November 1999. Accessed October 5, 2010. Available at URL address: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1.chapter.14677>
25. Jensen PS, Arnold LE, Swanson JM, Vitiello B, Abikoff HB, Greenhill LL, et al. 3-year follow-up of the NIMH MTA study. *J Am Acad Child Adolesc Psychiatry*. 2007 Aug;46(8):989-1002.
26. Karpouzis F, Bonello R, Pollard H. Chiropractic care for paediatric and adolescent Attention-Deficit/Hyperactivity Disorder: A systematic review. *Chiropr Osteopat*. 2010 Jun 2;18:13.
27. Karpouzis F, Pollard H, Bonello R. A randomised controlled trial of the Neuro Emotional Technique (NET) for childhood Attention Deficit Hyperactivity Disorder (ADHD): a protocol. *Trials*. 2009 Jan 27;10:6.
28. King S, Griffin S, Hodges Z, Weatherly H, Asseburg C, Richardson G, et al. A systematic review and economic model of the effectiveness and cost-effectiveness of methylphenidate, dexamfetamine and atomoxetine for the treatment of attention deficit hyperactivity disorder in children and adolescents. *Health Technol Assess*. 2006 Jul;10(23):iii-iv, xiii-146.
29. Knouse LE, Safren SA. Current status of cognitive behavioral therapy for adult attention-deficit hyperactivity disorder. *Psychiatr Clin North Am*. 2010 Sep;33(3):497-509.
30. Krisanaprakornkit T, Ngamjarus C, Witoonchart C, Piyavhatkul N. Meditation therapies for attention-deficit/hyperactivity disorder (ADHD). *Cochrane Database Syst Rev*. 2010 Jun 16;6:CD006507.

31. Majewicz-Hefley A, Carlson JS. A meta-analysis of combined treatments for children diagnosed with ADHD. *J Atten Disord.* 2007 Feb;10(3):239-50.
32. Molina BS, Hinshaw SP, Swanson JM, Arnold LE, Vitiello B, Jensen PS, et al.; MTA Cooperative Group. The MTA at 8 years: prospective follow-up of children treated for combined-type ADHD in a multisite study. *J Am Acad Child Adolesc Psychiatry.* 2009 May;48(5):484-500.
33. Monastra VJ, Lynn S, Linden M, Lubar JF, Gruzelier J, LaVaque TJ. Electroencephalographic biofeedback in the treatment of attention-deficit/hyperactivity disorder. *Appl Psychophysiol Biofeedback.* 2005 Jun;30(2):95-114.
34. MTA Cooperative Group. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry.* 1999 Jun;56:1073-86.
35. MTA Cooperative Group. National Institute of Mental Health Multimodal Treatment Study of ADHD follow-up: changes in effectiveness and growth after the end of treatment. *Pediatrics.* 2004 Apr;113(4):762-9.
36. MTA Cooperative Group. National Institute of Mental Health Multimodal Treatment Study of ADHD follow-up: 24-month outcomes of treatment strategies for attention-deficit/hyperactivity disorder. *Pediatrics.* 2004 Apr;113(4):754-61.
37. National Alliance for Mental Illness (NAMI). Attention-deficit/hyperactivity disorder (ADHD). 5/2003. Accessed October 5, 2010. Available at URL address: http://www.nami.org/Content/Microsites138/NAMI_Fort_Wayne_Indiana/Home128/Resources_for_Educators/ADHD_facts.pdf
38. National Institute for Health and Clinical Excellence (NICE). NICE clinical guideline 72. Developed by the National Collaborating Centre for Mental Health. Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults. September 2008. Accessed October 5, 2010. Available at URL address: <http://guidance.nice.org.uk/CG72>
39. National Institute of Health (NIH). Attention deficit hyperactivity disorder (ADHD). Last reviewed: October 4, 2010. Accessed October 5, 2010. Available at URL address: <http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml>
40. National Resource Center on AD/HD (NRC): A Program of Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). Complementary and alternative treatments. January 2008. Accessed October 5, 2010. Available at URL address: <http://www.help4adhd.org/treatment/complementary/WWK6>
41. National Resource Center on AD/HD (NRC): Complementary and Alternative Treatments: Neurofeedback (EEG Biofeedback) and AD/HD. January 2008. Accessed October 5, 2010. Available at URL address: <http://help4adhd.org/en/treatment/complementary/WWK6A>
42. NETmindbody. Accessed October 8, 2010. Available at URL address: http://www.netmindbody.com/index_2.html
43. Nutt DJ, Fone K, Asherson P, Bramble D, Hill P, Matthews K, et al.; British Association for Psychopharmacology. Evidence-based guidelines for management of attention-deficit/hyperactivity disorder in adolescents in transition to adult services and in adults: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol.* 2007 Jan;21(1):10-41.
44. Pineda DA, Puerta IC, Aguirre DC, Garcia-Barrera MA, Kamphaus RW. The role of neuropsychologic tests in the diagnosis of attention deficit hyperactivity disorder. *Pediatr Neurol.* 2007 Jun;36(6):373-81.

45. Pliszka S; AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry*. 2007 Jul;46(7):894-921.
46. Pliszka SR. Pharmacologic treatment of attention-deficit/hyperactivity disorder: efficacy, safety and mechanisms of action. *Neuropsychol Rev*. 2007 Mar;17(1):61-72.
47. Rappley MD. Clinical practice. Attention deficit-hyperactivity disorder. *N Engl J Med*. 2005 Jan 13;352(2):165-73.
48. Raishevich N, Jensen P. Attention-deficit/Hyperactivity Disorder. In: Kliegman RM, Behrman RE, Jenson HB, Stanton BF editors. *Nelson Textbook of Pediatrics*, 18th ed. Philadelphia: Saunders; 2007. ch 31.
49. Rostain AL, Ramsay JR. A combined treatment approach for adults with ADHD--results of an open study of 43 patients. *J Atten Disord*. 2006 Nov;10(2):150-9.
50. Schachar R, Jadad AR, Gauld M, Boyle M, Booker L, Snider A, et al. Attention-deficit hyperactivity disorder: critical appraisal of extended treatment studies. *Can J Psychiatry*. 2002 May;47(4):337-48.
51. Shaffer RJ, Jacokes LE, Cassily JF, Greenspan SI, Tuchman RF, Stemmer PJ Jr. Effect of interactive metronome training on children with ADHD. *Am J Occup Ther*. 2001 Mar-Apr;55(2):155-62.
52. Sinha D, Efron D. Complementary and alternative medicine use in children with attention deficit hyperactivity disorder. *J Paediatr Child Health*. 2005 Jan-Feb;41(1-2):23-6.
53. Snyder SM, Hall JR. A Meta-analysis of Quantitative EEG Power Associated with Attention-Deficit Hyperactivity Disorder. *J Clin Neurophysiol*. 2006 Oct;23(5):441-56.
54. U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health (CDRH). Search for recorder, attention task performance, product code LQD. Accessed October 5, 2010. Available at URL address: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>
55. U.S. Food and Drug Administration (FDA). FDA Alert for Healthcare Professionals for Atomoxetine (marketed as Strattera). September 2005. Accessed October 5, 2010. Available at URL address: <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124391.htm>
56. Weber W, Newmark S. Complementary and alternative medical therapies for attention-deficit/hyperactivity disorder and autism. *Pediatr Clin North Am*. 2007 Dec;54(6):983-1006; xii.
57. Weiss M, Murray C. Assessment and management of attention-deficit hyperactivity disorder in adults. *CMAJ*. 2003 Mar 18;168(6):715-22.
58. Wilens TE. Drug therapy for adults with attention-deficit hyperactivity disorder. *Drugs*. 2003 Aug;63(22):2395-411.
59. Wilens TE, Faraone SV, Biederman J. Attention-deficit/hyperactivity disorder in adults. *JAMA*. 2004 Aug;292(5):619-23.

Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	11/15/2008	0231	Attention-Deficit/Hyperactivity Disorder (ADHD): Assessment and Treatment

“CIGNA” and the “Tree of Life” logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA’s subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.