Clinical Policy: Attention Deficit Hyperactivity Disorder Assessment and Treatment

Reference Number: LA.CP.BH.124

Coding Implications

Date of Last Revision: 5/23 **Revision Log**

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders in children, with an increasing prevalence of diagnosis in adults. ADHD affects the cognitive, academic, emotional, and social well-being of individuals and can persist throughout life. While there is no single test to diagnose ADHD, a clinical assessment based on defined clinical parameters establishes criteria for diagnosis in children and adults.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that the following services are medically necessary when requested for the assessment and treatment of attention deficit hyperactivity disorder (ADHD):

A. Assessment

1. **Complete medical evaluation with history and physical examination;**
2. **Parent(s)/Family/child interview or patient interview, if adult, to obtain information listed in Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5 TR);**
3. **Collection of collateral information, if available, such as the Vanderbilt or Conners assessment;**
4. **Complete psychiatric evaluation or other services provided by a psychiatrist, psychologist, or other behavioral health professional;**
5. **Laboratory evaluation prior to stimulant medication therapy, including any of the following:**
   a. **Complete blood count;**
   b. **Liver function tests;**
   c. **Toxicology screen, if drug use is suspected;**
   d. **Cardiac evaluation and screening. Electrocardiogram (ECG), if clinically indicated (e.g., family or personal history of cardiovascular disease or those with congenital heart disease);**
6. **Measurement of thyroid hormone levels, if patient exhibits clinical manifestations of hyperthyroidism;**
7. **Assessment of comorbid behavioral health and/or medical diagnoses and associated symptoms;**
8. **When not otherwise excluded, other services for the assessment of ADHD to meet the DSM-5 TR criteria.**

B. Treatment:

1. **Pharmacotherapy;**

2. **Behavioral modification;**
3. **Treatment of comorbid behavioral health and/or medical diagnoses and associated symptoms;**
4. **When not otherwise excluded, other services for the treatment of ADHD;**
5. **Ongoing assessment and application of standardized scales to assess treatment benefit; and**
6. **Treatment of family, guardian(s) and/or custodian. Also, parenting therapy has been shown to be an effective treatment in addressing family issues in children with ADHD. Evaluations should be conducted on family members who appear to be contributing to family disorder or on family members negatively impacted by the member's ADHD.**

II. It is the policy of Louisiana Healthcare Connections that there is insufficient evidence to support the following for the assessment or treatment of ADHD (may not be all-inclusive):

A. Assessment:

1. **Actigraphy;**
2. **Acoustic reflex testing;**
3. **AFF2 gene testing;**
4. **Assessment of serum lipid profiles;**
5. **Computerized electroencephalogram (EEG);**
6. **Computerized tests of attention and vigilance;**
7. **Education and achievement testing;**
8. **Electronystagmography in the absence of symptoms of vertigo or balance dysfunction;**
9. **Evaluation of iron status (e.g. measurement of serum iron and ferritin levels);**
10. **Event-related potentials;**
11. **Functional near-infrared spectroscopy;**
12. **Hair analysis;**
13. **IgG blood tests;**
14. **Measurement of peripheral brain-derived neurotrophic factor;**
15. **Measurement of zinc;**
16. **Neuroimaging (e.g., CT [computed tomography], CAT [computerized axial tomography], MRI [magnetic resonance imaging], including diffusion tensor imaging), MRS (magnetic resonance spectroscopy), PET (positron emission tomography), and SPECT (single-photon emission computerized tomography), functional brain mapping;**
17. **Neuropsychiatric EEG-based assessment aid system;**
18. **Pharmacogenetic tools (vascular flow brain imaging);**
19. **Otoacoustic emissions in the absence of signs of hearing loss;**
20. **Quotient ADHD system / test;**
21. **Synaptosomal-associated protein (SNAP) 25 gene polymorphisms testing;**
22. **Transcranial magnetic stimulation – evoked measures (e.g., short-interval cortical inhibition in motor cortex) as a marker of ADHD symptoms;**
23. **Measures of thyroid hormones unless the individual exhibits clinical manifestations of hyperthyroidism (e.g. (modest acceleration of linear growth**

andepiphyseal maturation, weight loss or failure to gain weight, excessive retraction of the eyelids causing lid lag and stare, diffuse goiter, tachycardia and increased cardiac output, increased gastrointestinal motility, tremor, hyperreflexia);
24. Tympanometry in the absence of hearing loss.

B. Treatment:
1. Acupuncture/acupressure;
2. Application of: hot or cold packs, traction, mechanical, electrical stimulation (unattended), vasopneumatic devices, paraffin bath, whirlpool, diathermy (eg, microwave), infrared, ultraviolet, electrical stimulation (manual), iontophoresis, contrast baths, ultrasound, hubbard tank;
3. Anti-*candida albicans* medication;
4. Anti-fungal medication;
5. Anti-motion sickness medication;
6. Auditory Integration Therapy;
7. Applied kinesiology;
8. Brain integration;
9. Cannabidiol oil;
10. Chelation;
11. Chiropractic manipulation;
12. Cognitive behavior modification;
13. Cognitive rehabilitation;
14. Cognitive training;
15. Computerized training on working memory;
16. Deep pressure sensory vest;
17. Dietary counseling and treatments, i.e., Feingold diet;
18. Dore program / dyslexia – dyspraxia attention treatment (DDAT);
19. EndeavorRx® ;
20. EEG Biofeedback/Neuro Biofeedback;
21. External trigeminal nerve stimulation (eTNS);
22. Herbal remedies;
23. Homeopathy;
24. Intensive behavioral intervention programs;
25. Megavitamin therapy;
26. Metronome training;
27. Mindfulness;
28. Mineral supplementation;
29. Music therapy;
30. Optometric vision training;
31. Psychopharmaceuticals (lithium, benzodiazepines, and selective serotonin reuptake inhibitors, unless the patient also exhibits anxiety and depression);
32. Reboxetine;
33. Sensory integration therapy;

34. **Supportive counseling;**
35. **The Good Vibrations device;**
36. **The Neuro Emotional Technique;**
37. **Therapeutic eurythmy (movement therapy);**
38. **Transcranial magnetic stimulation / cranial electric stimulation;**
39. **Vayarin;**
40. **Vision therapy;**
41. **Yoga.**

III. **It is the policy of Louisiana Healthcare Connections that interventions that are strictly educational in nature (e.g., classroom environmental manipulation, academic skills training) are not medically necessary as they are not considered medical interventions.**

Background

ADHD (Attention Deficit Hyperactivity Disorder) is one of the most commonly diagnosed neurodevelopmental disorders in children and adolescents and is increasingly being diagnosed in adults.[5] The main characteristics of ADHD are symptoms of inattention, hyperactivity, and impulsivity that have continued for at least six months and are maladaptive and inconsistent with development level.[1] There is no single genetic or behavioral test to diagnose ADHD. Instead, a clinical diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders-5* (DSM-5) criteria is applicable for both children and adults.[2] The prevalence of adult ADHD has been estimated to be around 4.4% in the United States and 3.4% internationally. National survey data estimates the prevalence of ADHD in children and adolescents in the United States is 9.4% and a recent meta-analysis indicates worldwide prevalence in children and adolescents to be 7.2%, with some community-based samples indicating rates of 8.7% - 15.5%. [2,3,5] Due to the prevalence of children and adolescents with this diagnosis, the treatment of ADHD is often managed in the primary care setting, and evidence supports that appropriate diagnosis can be accomplished in this setting.[5] However, primary care providers should refer children to a specialist for complex ADHD symptoms.[16] Some of the more common comorbid disorders include anxiety, autism spectrum disorder, depression, disruptive behavior disorders, substance use disorders and Tic disorders.[3,16] Suggested first line treatment for adults with ADHD is medication rather than cognitive-behavioral therapy (CBT).[18]

In 2011, the American Academy of Pediatrics (AAP) published a clinical practice guideline to clarify the diagnosis, evaluation, and treatment parameters of ADHD and this guideline was updated in 2019.[4] This guideline expanded the age range of children to include preschool aged children (4 to 6 years of age) and adolescents (12 to 18 years of age), and suggests an expanded scope for behavioral interventions.[4] The evaluation of comorbid conditions, including behavioral, emotional, developmental, and physical, that might coexist with ADHD must also be considered.[4,5] Most children and adolescents diagnosed with ADHD also meet diagnostic criteria for other behavioral health conditions. In some situations, the presence of a comorbid diagnosis will alter the course of ADHD treatment. Additionally, when an adolescent receives a new diagnosis of ADHD, an assessment for substance use, anxiety, depression, and learning disorders should also be conducted, as these are common comorbid conditions that may alter the treatment approach of the

adolescent population.[5] Similar clinical recommendations have been made by various organizations for adults, including the Canadian ADHD Resource Alliance, the American Academy of the Child and Adolescent Psychiatry, the National Institutes of Health, and the British Association for Psyschopharmacology.[5] Pharmacotherapy can provide a way to manage ADHD symptoms and improve quality of life.

In 2020, The Society for Developmental and Behavioral Pediatrics (SDBP) published Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder and Process of Care Algorithms (POCA) that are meant to be used as companion documents to the published guidelines. The algorithms include suggested steps in the treatment of complex ADHD and key concepts include focus on functional impairment to improve long-term outcomes, psychosocial treatment as foundational in the treatment of complex ADHD, shared decision making, interprofessional care, using mental health diagnostic assessment and testing appropriately, identifying and treating impairments caused by coexisting conditions, and a lifelong perspective. These algorithms are based on expert consensus, and review of existing publications and practice guidelines and are meant to improve the care that children and adolescents with complex ADHD receive.

Stimulants and non-stimulants are common examples of medications prescribed to treat ADHD. A systemic review of sixteen randomized clinical trials and one meta-analysis that involved 2668 participants and evaluated pharmacological and psychosocial treatments of ADHD in adolescents 12 to 18 years of age was completed.[7] The findings demonstrated that extended-release methylphenidate and amphetamine formulations, atomoxetine, and extended-release guanfacine led to clinically significant symptom reduction.[7] Nonstimulants are not approved by the FDA for use in preschool-aged children. There is strong evidence for stimulant medications and significant evidence, but less strong, for atomoxetine, extended release guanfacine, and extended-release clonidine. Due to the lack of significant studies in school-aged children for nonstimulant medication and dextroamphetamine, methylphenidate is recommended as the first line of pharmacologic treatment for this population.[5] Findings from clinical trials studying adults with noncomorbid ADHD suggest amphetamines as first-line treatment when compared to other medications or cognitive-behavioral therapy (CBT).[18] Methylphenidate is noted as the first option of treatment for adults with moderate or severe ADHD; however, the evidence on the effects of immediate-release (IR) methylphenidate is limited and controversial in the treatment of the adult population.[17]

The AAP (American Academy of Pediatrics) has established recommendations regarding treatment modalities based on age. It is recommended that preschool children (4 to 6 years of age) are first prescribed evidence-based behavioral Parent Training in Behavior Management (PTBM) and/or classroom interventions. If these methods are not effective, Methylphenidate can be considered. For elementary and middle school children (6 to 12 years of age), a combination of FDA approved medications for ADHD and PTBM and classroom interventions should be prescribed. Educational interventions and supports, including an Individualized Education Program (IEP) are a vital part of treatment. Adolescents (12 to 18 years of age) should be treated with FDA approved medications in

conjunction with evidence-based training or behavioral interventions. Educational interventions and supports are also an important aspect of treatment in this age group and can include an IEP or 504 plan. Additionally, planning for adulthood is an important component of the chronic care model for ADHD.[5]

The AAP also recognizes psychosocial treatments as effective for the treatment of ADHD. These treatments may include behavioral therapy and training interventions. Behavioral therapy can help adults (parents and school staff) to learn how to respond effectively and prevent certain behaviors, such as interrupting, aggression, non-compliance with requests, and non-completion of tasks. Skill development is targeted in training interventions and include repeated practice and performance feedback. The effectiveness of certain training interventions, such as social skills training, is not supported by research.[5]

While the pathogenesis of ADHD is unknown, the clinical impairments in neurobehavioral and neurodevelopmental functioning pathways elicit deficiencies in vigilance, perceptual-motor speed, working memory, verbal learning, and response inhibition.[2] Consequently, ADHD affects the cognitive, academic, emotional, and social wellbeing of individuals and can persist throughout life. ADHD is a chronic condition and children and adolescents with ADHD should be managed in the same way those with special health care needs would be managed. Principles of the chronic care model and the medical home should be followed.[5]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes considered not medically necessary when billed with a sole diagnosis 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
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
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)

CPT® Codes	Description
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
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation.
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78610	Brain imaging, vascular flow only
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis
82365	Calculus; Infrared spectroscopy
82465	Cholesterol, serum or whole blood, total
82728	Ferritin
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
82787	Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each
83540	Iron
83550	Iron binding capacity

CPT® Codes	Description
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	Lipoprotein, direct measurement; VLDL cholesterol
83721	Lipoprotein, direct measurement; LDL cholesterol
83722	Lipoprotein, direct measurement; small dense LDL cholesterol
84436	Thyroxine; total
84437	Thyroxine; requiring elution (eg, neonatal)
84439	Thyroxine; free
84442	Thyroxine binding globulin (TBG)
84443	Thyroid stimulating hormone (TSH)
84445	Thyroid stimulating immune globulins (TSI)
84478	Triglycerides
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84481	Triiodothyronine T3; free
84630	Zinc
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
92065	Orthoptic training performed by a physician or other qualified health care professional
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
90901	Biofeedback training by any modality
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92547	Use of vertical electrodes (List separately in addition to code for primary procedure)
92550	Tympanometry and reflex threshold measurements

CPT® Codes	Description
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing, threshold
92569	Acoustic reflex testing; decay
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3 to 6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
95803	Actigraphy testing recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95812	Electroencephalogram (EEG) extended monitoring; 41 to 60 minutes
95813	Electroencephalogram (EEG) extended monitoring; 61 to 119 minutes
95816	Electroencephalogram (EEG); including recording awake and drowsy
95819	Electroencephalogram (EEG); including recording awake and asleep
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2 to 12 hours; unmonitored
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2 to 12 hours; with intermittent monitoring and maintenance

CPT® Codes	Description
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2 to 12 hours; with continuous, real-time monitoring and maintenance
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12 to 26 hours; unmonitored
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12 to 26 hours; with intermittent monitoring and maintenance
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12 to 26 hours; with continuous, real-time monitoring and maintenance
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2 to 12 hours; unmonitored
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2 to 12 hours; with intermittent monitoring and maintenance
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2 to 12 hours; with continuous, real-time monitoring and maintenance
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12 to 26 hours; with continuous, real-time monitoring and maintenance
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12 to 26 hours; with intermittent monitoring and maintenance
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12 to 26 hours; with continuous, real-time monitoring and maintenance
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2 to 12 hours of EEG recording; without video
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2 to 12 hours of EEG recording; with video (VEEG)
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24 hour period; without video
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of

CPT® Codes	Description
	spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24 hour period; with video (VEEG)
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs

CPT® Codes	Description
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs
95930	Visual evoked potential (VEP), checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95937	Neuromuscular junction testing (repetitive stimulation paired stimuli), each nerve, any 1 method
95938	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report
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), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
97010	Application of a modality to 1 or more areas; hot or cold packs

CPT® Codes	Description
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97810	Acupuncture, one or more needles, w/o electric stimulation; initial 15 minutes of personal one-one contact with the patient
97811	Acupuncture, one or more needles, w/o electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of

CPT® Codes	Description
	needles (s)
97813	Acupuncture, one or more needles, with electric stimulation; initial 15 minutes of personal one-one contact with the patient
97814	Acupuncture, one or more needles, with electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of the needle(s) (List separately in addition to code for primary procedure)
98940	Chiropractic manipulative treatment (CMT); spinal, 1 to 2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3 to 4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

HCPCS codes considered not medically necessary when billed with a sole diagnosis of ADHD

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)
S8040	Topographic brain mapping

ICD-10-CM Diagnosis Codes that Support Medical Necessity

ICD-10-CM Code	Description
F90.0 through F90.9	Attention-deficit hyperactivity disorders

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Rebranded from corporate policy	5/24	

References

1. Post RE, Kurlansik SL. Diagnosis and management of adult attention-deficit/hyperactivity disorder. *Am Fam Physician*. 2012;85(9):890-896.

2. **Bukstein O. Attention deficit hyperactivity disorder in adults: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis. UpToDate. www.uptodate.com. Updated April 7, 2022. Accessed February 17, 2023.**
3. **Krull KR. Attention deficit hyperactivity disorder in children and adolescents: Epidemiology and pathogenesis. UpToDate. www.uptodate.com. Updated May 16, 2022. Accessed February 17, 2023.**
4. **Krull KR. Attention deficit hyperactivity disorder in children and adolescents: Overview of treatment and prognosis. UpToDate. www.uptodate.com. Updated June 6, 2022. Accessed February 17, 2023.**
5. **Wolraich ML, Hagan JF Jr, Allan C, et al. Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents [published correction appears in Pediatrics. 2020 Mar;145(3):]. *Pediatrics*. 2019;144(4):e20192528. doi:10.1542/peds.2019-2528**
6. **Gibbins C, Weiss M. Clinical recommendations in current practice guidelines for diagnosis and treatment of ADHD in adults. *Curr Psychiatry Rep*. 2007;9(5):420-426. doi:10.1007/s11920-007-0055-1**
7. **Chan E, Fogler JM, Hammerness PG. Treatment of Attention-Deficit/Hyperactivity Disorder in Adolescents: A Systematic Review. *JAMA*. 2016;315(18):1997-2008. doi:10.1001/jama.2016.5453**
8. **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;46(7):894-921. doi:10.1097/chi.0b013e318054e724**
9. **Gloss D, Varma JK, Pringsheim T, Nuwer MR. Practice advisory: The utility of EEG theta/beta power ratio in ADHD diagnosis: Report of the guideline development, dissemination, and implementation subcommittee of the american academy of neurology. *Neurology*. 2016;87(22):2375-2379. doi:10.1212/WNL.0000000000003265**
10. **Tseng PT, Cheng YS, Yen CF, et al. Peripheral iron levels in children with attention-deficit hyperactivity disorder: a systematic review and meta-analysis. *Sci Rep*. 2018;8(1):788. Published 2018 Jan 15. doi:10.1038/s41598-017-19096-x**
11. **Wang Y, Huang L, Zhang L, Qu Y, Mu D. Iron Status in Attention-Deficit/Hyperactivity Disorder: A Systematic Review and Meta-Analysis. *PLoS One*. 2017;12(1):e0169145. Published 2017 Jan 3. doi:10.1371/journal.pone.0169145**
12. **Krull KR. Attention deficit hyperactivity disorder in children and adolescents: Clinical features and diagnosis. UpToDate. www.uptodate.com. Updated May 31, 2022. Accessed February 17, 2023.**
13. **Dalrymple RA, McKenna Maxwell L, Russell S, Duthie J. NICE guideline review: Attention deficit hyperactivity disorder: diagnosis and management (NG87). *Arch Dis Child Educ Pract Ed*. 2020;105(5):289-293. doi:10.1136/archdischild-2019-316928**
14. **Barbaresi WJ, Campbell L, Diekroger EA, et al. Society for Developmental and Behavioral Pediatrics Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder. *J Dev Behav Pediatr*. 2020;41 Suppl 2S:S35-S57. doi:10.1097/DBP.0000000000000770**
15. **Berger S. Cardiac evaluation of patients receiving pharmacotherapy for attention deficit hyperactivity disorder. UpToDate. www.uptodate.com. Updated October 20, 2022. Accessed February 17, 2023.**

16. Not just ADHD? Helping children with multiple concerns. Centers for Disease Control and Prevention. Updated August 9, 2022. Accessed February 17, 2023.
17. Cândido RCF, Menezes de Padua CA, Golder S, Junqueira DR. Immediate-release methylphenidate for attention deficit hyperactivity disorder (ADHD) in adults. *Cochrane Database Syst Rev*. 2021;1(1):CD013011. Published 2021 Jan 18. doi:10.1002/14651858.CD013011.pub2
18. Brent D, Bukstein O, Solanto MV. Management of attention deficit hyperactivity disorder in adults. UpToDate. www.uptodate.com. Updated February 1, 2023. Accessed February 17, 2023..
19. Young S, Hollingdale J, Absoud M, et al. Guidance for identification and treatment of individuals with attention deficit/hyperactivity disorder and autism spectrum disorder based upon expert consensus. *BMC Med*. 2020;18(1):146. doi:10.1186/s12916-020-01585-y
20. National Institute for Mental Health. Attention Deficit Hyperactivity Disorder. https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd. Updated September 2022. Accessed February 17, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.