Clinical Policy: Attention Deficit Hyperactivity Disorder Assessment and Treatment

Reference Number: TX.CP.MP.124 Coding Implications
Effective Date: 08/16
Last Review Date: 05/20 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 and also occurs 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 health plans affiliated with Centene Corporation® that the following services are **medically necessary** when requested for the assessment and treatment of ADHD:

A. Assessment

1. Complete medical evaluation with history and physical examination;
2. Parent/child interview or patient interview, if adult, to obtain information listed in Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5);
3. Collection of collateral information if available, such as such as the Vanderbilt or Conners assessments;
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 incorporating an electrocardiogram (ECG);
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 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.

II. It is the policy of health plans affiliated with Centene Corporation that the following services for the assessment and treatment of ADHD are **investigational or unproven** (may not be all-inclusive):

A. Assessment:

1. Actimeter
2. AFF2 gene testing
3. Computerized electroencephalogram (EEG)
4. Computerized Tests of Attention and Vigilance
5. Education and achievement testing
6. Electronystagmography in the absence of symptoms of vertigo or balance dysfunction
7. Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)
8. Event-related potentials
9. Functional near-infrared spectroscopy
10. Hair analysis
11. IgG blood tests
12. Measurement of peripheral brain-derived neurotrophic factor
13. Measurement of zinc
14. 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)
15. Neuropsychiatric EEG-based assessment aid system
16. Neuropsychological testing for suspected uncomplicated cases of ADHD (without history of head trauma, seizures)
17. Pharmacogenetic tools
18. Otoacoustic emissions in the absence of signs of hearing loss
19. Quotient ADHD system / test
20. Synaptosomal-associated protein (SNAP) 25 gene polymorphisms testing
21. Transcranial magnetic stimulation – evoked measures (e.g., short-interval cortical inhibition in motor cortex) as a marker of ADHD symptoms
22. Tympanometry in the absence of hearing loss.

B. Treatment:

1. Acupuncture/acupressure
2. Anti-*candida albicans* medication
3. Anti-fungal medication
4. Anti-motion sickness medication
5. Auditory Integration Therapy
6. Applied kinesiology
7. Brain integration
8. Cannabidiol oil
9. Chelation

10. Chiropractic manipulation
11. Cognitive behavior modification
12. Cognitive rehabilitation
13. Cognitive training
14. Computerized training on working memory
15. Deep pressure sensory vest
16. Dietary counseling and treatments, i.e., Feingold diet
17. Dore program / dyslexia – dyspraxia attention treatment (DDAT)
18. Educational intervention (e.g., classroom environmental manipulation, academic skills training, and parental training)
19. Neuro Biofeedback/EEG Biofeedback
20. External trigeminal nerve stimulation (eTNS)
21. Herbal remedies
22. Homeopathy
23. Intensive behavioral intervention programs
24. Megavitamin therapy
25. Metronome training
26. Mindfulness
27. Mineral supplementation
28. Music therapy
29. Optometric vision training
30. Psychopharmaceuticals (lithium, benzodiazepines, and selective serotonin reuptake inhibitors, unless the patient also exhibits anxiety and depression)
31. Reboxetine
32. Self-care management training
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. Yayarin
40. Vision therapy
41. Yoga.

Background

ADHD is among the most commonly diagnosed neurodevelopmental disorders in children and adolescents and is increasingly being diagnosed in adults. 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%. [2,3,14] 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.[14]

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 – 6 years of age) and adolescents (age 12 – 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.[4,14] 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.[14] 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. Chan, *et al*, performed 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 aged 12 years to 18 years. They found that extended-release methylphenidate and amphetamine formulations, atomoxetine, and extended-release guanfacine led to clinically significant symptom reduction.[6] Nonstimulants are not approved by the FDA for use in preschool-aged children. There is strong evidence for stimulant medications and significant evidence, but evidence is 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.[14]

The AAP has established recommendations regarding treatment modalities based on age. It is recommended that preschool children (4 – 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 (6 – 12 years of age), a combination of FDA approved medications for ADHD and PTBM and classroom intervention should be prescribed. Educational interventions and supports, including an Individualized Education Program (IEP) are vital part of treatment. Adolescents (12 -18 years of age) should be treated with FDA approved medications for the treatment of ADHD and it is encouraged that evidence-based training or behavioral interventions are prescribed, as well. Educational interventions and supports are also an important aspect of treatment in this age group, and can included an IEP or 504 plan. Additionally, planning for adulthood is an important component of the chronic care model for ADHD.[14]

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.[14]

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.[14]

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 2019, 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. 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

CPT® Codes	Description
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
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
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
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	Cytogenetic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
82365	Calculus; Infrared spectroscopy
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
84630	Zinc
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
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

CPT® Codes	Description
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
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 recordings
92545	Oscillating tracking test, with recording
92547	Use of vertical electrodes (List separately in addition to code for primary procedure)
92548	Computerized dynamic posturography
92550	Tympanometry and reflex threshold measurements
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis
92567	Tympanometry (impedance testing)
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 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
95803	Actigraphy testing recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	Electroencephalogram (EEG) extended monitoring; 61-119 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, 2-12 hours; unmonitored
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance

CPT® Codes	Description
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 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, 2-12 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, 2-12 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 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

CPT® Codes	Description
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
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
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

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), 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
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
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
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour
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

CPT® Codes	Description
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97750	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one 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 needles.
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).
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 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 – F90.9	Attention-deficit hyperactivity disorders

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	08/16	08/16
Added 92540, 92545, 92548, 97535, 97750 as not medically necessary per Texas Medicaid Guidelines	12/16	

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	07/17	08/17
Assessment: Added "Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)" as not medically necessary. References and Codes reviewed and updated. Added the following codes as not medically necessary: 70460, 70470, 70552, 78600, 78601, 78605, 78606, 82728, 83540, 83550, 95827	05/18	05/18
Added AFF2 gene testing and measurement of peripheral brain-derived neurotrophic factor as investigational to II.A. Code updates-deleted CPT 96101, 96102, 96103, 96118, 96119, 96120, and 97532. Added CPT-96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, and 97127. References reviewed and updated. Specialist reviewed.	04/19	05/19
Revised description for CPT-96116	05/19	
Removed the following codes from the list of CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD: 96136, 96137, 96138, 96139, 96146.	12/19	
Clarified in the medical necessity statement in I. that the following services are medically necessary *when requested.* Removed the following codes from the list of CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD: 96130, 96131.	01/20	
Policy reviewed. References reviewed and updated. Updated Section I.A. to include "collection of collateral information" and "toxicology screen." Updated Section I.B. to include "ongoing assessment and application of standardized scales to assess treatment benefit." Updated Section II. "investigational or unproven" assessments and treatments with the following: pharmacogenetic tools; Cannabidiol oil; cognitive training; external trigeminal nerve stimulation (eTNS); mindfulness; and supportive counseling, to reflect the 2019 version of American Academy of Pediatrics (AAP) Clinical Practice Guidelines. Edited Section II.A.19. to read "Neuro Biofeedback/EEG Biofeedback." Updated AAP recommended treatment modalities. Added information regarding The Society for Developmental and Behavioral Pediatrics (SDBP) Clinical Practice Guidelines and Process of Care Algorithms for Assessment and Treatment of Children and Adolescents with Complex ADHD. Updated Background section to include most recent prevalent statistics and the necessity of treatment by Primary Care Providers. CPT Code Updates: Removed 78607, 95827, 97127. Added 78803, 81171, 81172, 92065, 92547, 95705, 95706, 95707, 95708, 95709, 95710, 95711, 95712, 95713, 95714, 95715, 95716, 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726, 96121, 97129, 97130. HCPCS Code Updates: Added G0176.	04/20	5/20

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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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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. This clinical policy is not intended to recommend treatment for members. Members 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.

Providers, members 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.