

Health Benchmarks[®] Program

Clinical Quality Indicator Specification 2011

Measure Title	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION THERAPY: INITIATION PHASE		
Disease State	Attention Deficit Hyperactivity Disorder	Indicator Classification¹	Disease Management
Strength of Recommendation²	B		
Organizations Providing Recommendation	American Academy of Pediatrics American Society of Child and Adolescent Psychiatry		
Clinical Intent	To ensure that children who are initiated on medication for ADHD receive at least 1 follow-up visit with a prescribing practitioner within 1 month of prescription fill.		
Background	<p>Disease Burden</p> <ul style="list-style-type: none"> ADHD is one of the most common disorders of childhood with an estimated prevalence of 9.5% or 5.4 million in school-aged children between 4 to 17 years of age[1], and 4.3% of children had ADHD and were on medication.[2] According to data from the National Survey of Children's Health, the prevalence of ADHD increases with increasing age (4.1 percent versus 9.7 percent among those <9 years and ≥9 years, respectively). Among those with reported ADHD, 56 percent were being treated with medication at the time of the survey.[3] <p>Reason for Indicated Intervention or Treatment</p> <ul style="list-style-type: none"> Regular monitoring of children who are receiving pharmacological treatment for ADHD is necessary to review progress, adjust the dose if necessary, monitor adverse effects of therapy and review the child's understanding of the medication as he or she develops.[4] According to a study published in 2004, researchers who observed the therapy outcomes of 579 children with combined-type ADHD concluded that those who were closely monitored showed the greatest improvement in their symptoms. [5] <p>Evidence Supporting Intervention or Treatment</p> <ul style="list-style-type: none"> Some side effects of stimulant medication include appetite disturbances, sleep disturbances, weight loss, increased heart rate and blood pressure, headache, social withdrawal, nervousness, and irritability.[4, 6] Other more serious side effects may include liver toxicity and sudden unexpected death.[7, 8] A 2004 survey of physicians evaluating adherence to the AAP Guidelines 		

found that only half (53%) reported routine monitoring and follow-up (3-4 visits per year) of children with ADHD and taking medication after a month into treatment.[9]

Clinical Recommendations

- The American Academy of Pediatrics strongly recommends periodically providing systematic follow-up in children with ADHD.[10]
- The 2007 American Academy of Child and Adolescent Psychiatry Practice Parameters for the Assessment and Treatment of Children and Adolescents with ADHD recommends follow-up and periodic monitoring of patients placed on psychopharmacological therapy to ensure proper dosage, assess side-effects, and resolution of symptoms at least several times a year. In addition, for patients newly started on medication for ADHD “the physician may titrate upward every 1 to 3 weeks until the maximum dose for the stimulant is reached, symptoms of ADHD remit, or side effects prevent further titration, whichever occurs first. Contact with physician or trained office staff during titrations is recommended.”[4]

Source Healthcare Effectiveness Data and Information Set (HEDIS®) 2011 Technical Specification for Physician Measurement

Denominator

Denominator Definition Continuously enrolled members aged 6-12 who were prescribed ADHD medication during the 1 year period starting 10 months prior to the start of the measurement year.

Denominator Index Date First instance of members who had a prescription for an ADHD medication during the 1 year period starting 10 months prior to the start of the measurement year.

Denominator Encounters/Claims Criteria Drug list: amphetamine-dextroamphetamine, atomoxetine, dexamethylphenidate, dextroamphetamine, guanfacine, lisdexamfetamine, methamphetamine, methylphenidate

Denominator Exclusion

Denominator Exclusion Definition Members who were prescribed ADHD medication in the 1-120 days prior to the index date (exclusive of the index date), members who had an acute mental health or substance abuse inpatient stay in the 1-30 days after the index date (exclusive of the index date), or members diagnosed with narcolepsy any time in history.

Denominator Exclusion Claims Criteria CPT-4 code(s): 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261*-99263*, 99291-99300, 99356-99357, 99431*-99440*, 99460-99465, 99468-99476, 99477-99480

ICD-9 diagnosis code(s): 290.xx, 291.xx-292.xx, 293.xx-302.xx, 303.xx-305.xx, 306.xx-316.xx, 317.xx-319.xx, 347.xx, 535.3x, 571.1x, 960.xx-979.xx

MS-DRG code(s): 876, 880-887

UB revenue code(s): 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987

Drug list: amphetamine-dextroamphetamine, atomoxetine, dexamethylphenidate, dextroamphetamine, guanfacine, lisdexamfetamine, methamphetamine, methylphenidate

*Code range was retired but is appropriate for retrospective analysis.

Numerator

Numerator Definition

Members with at least 1 follow up visit with a prescribing practitioner** during the 1-30 days after the index date (exclusive of the index date).

***A practitioner with any prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.*

Numerator Claims Criteria

CPT-4 code(s): 90801, 90802, 90804-90815, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99341-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510

HCPCS code(s): G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

Place of service code(s): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

UB revenue code(s): 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

Physician Attribution

Physician Attribution Description

If client data contains prescribing provider:

Score the physician who prescribed the ADHD medication on the index date.

If client data does not contain prescribing provider:

Score all physicians who saw the member 0-3 days prior to the index date (inclusive of the index date).

References

1. CDC. *Attention-Deficit / Hyperactivity Disorder (ADHD): Data and Statistics*. 2010 Nov 10 [cited 2011 Jan 7]; Available from: <http://www.cdc.gov/ncbddd/adhd/data.html>.
2. Visser, S.N., C.A. Lesesne, and R. Perou, *National estimates and factors associated with medication treatment for childhood attention-deficit/hyperactivity disorder*. *Pediatrics*, 2007. **119 Suppl 1**: p. S99-106.
3. *Mental health in the United States. Prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder--United States, 2003*. *MMWR Morb Mortal Wkly Rep*, 2005. **54**(34): p. 842-7.
4. Pliszka, S., *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): p. 894-921.
5. *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. **113**(4): p. 754-61.
6. Findling, R.L., *Evolution of the treatment of attention-deficit/hyperactivity disorder in children: a review*. *Clin Ther*, 2008. **30**(5): p. 942-57.
7. Safer, D.J., J.M. Zito, and J.E. Gardner, *Pemoline hepatotoxicity and postmarketing surveillance*. *J Am Acad Child Adolesc Psychiatry*, 2001. **40**(6): p. 622-9.
8. Cooper, R.J., et al., *Principles of appropriate antibiotic use for acute pharyngitis in adults: background*. *Ann Intern Med*, 2001. **134**(6): p. 509-17.
9. Rushton, J.L., K.E. Fant, and S.J. Clark, *Use of practice guidelines in the primary care of children with attention-deficit/hyperactivity disorder*. *Pediatrics*, 2004. **114**(1): p. e23-8.
10. *Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder*. *Pediatrics*, 2001. **108**(4): p. 1033-44.

¹ **Indicator Classification** (Adapted from HEDIS® technical specifications)

Diagnosis	Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g., evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain).
Effectiveness of Care	
Prevention	Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g., immunizations).
Screening	Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g., pap smears; screening for elevated blood pressure).
Disease Management	Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g., cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).
Medication Monitoring	Measures applicable to patients taking medications with narrow therapeutic windows and / or potential preventable significant side effects or adverse reactions (e.g., thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy).
Medication Adherence	Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g., adherence to lipid lowering medication).
Utilization	Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g., conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).

2 Strength of Recommendation

Strength of Recommendation Based on a Body of Evidence

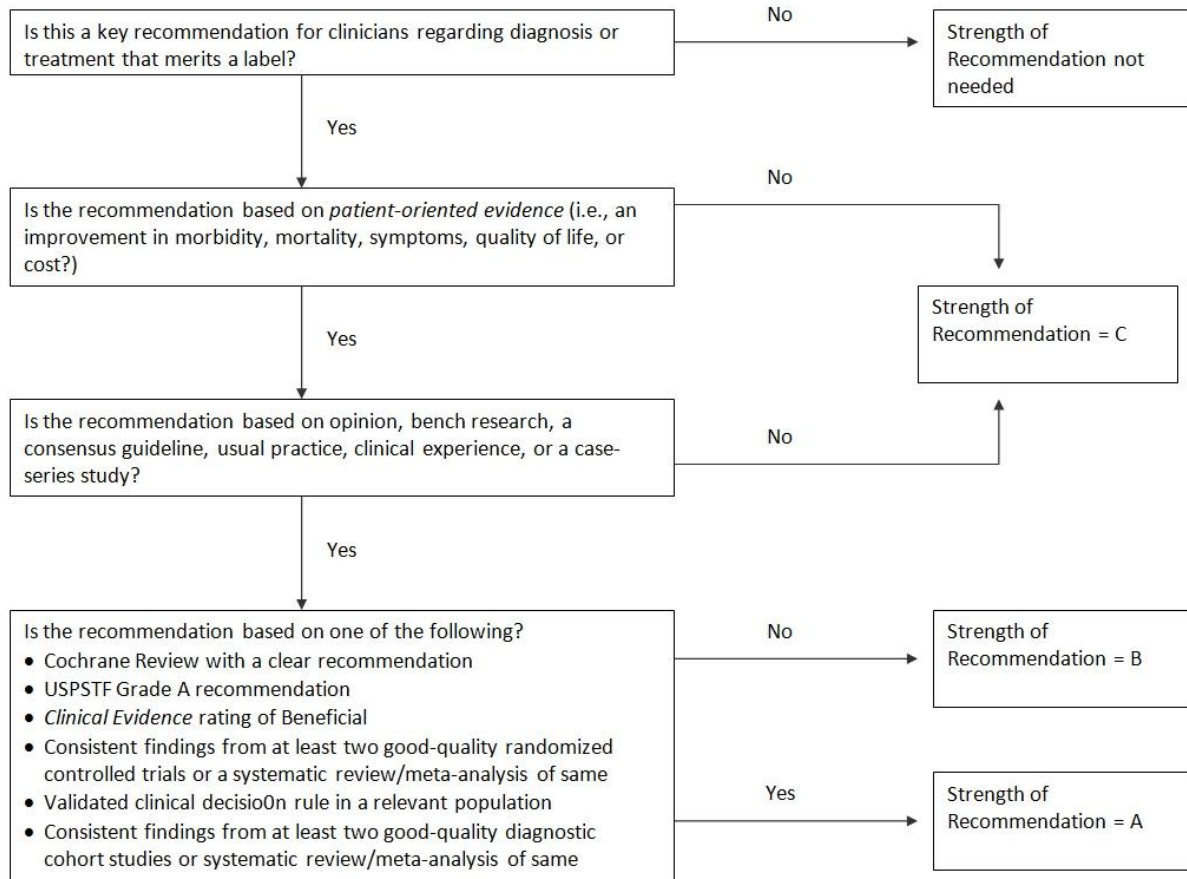


FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)