BEHAVIORAL HEALTHCARE PROVIDERS

BHP CLINICAL ACTIVITIES GUIDELINE

ADHD/ADD Assessment and Treatment Guideline

The following guidelines are not intended to be inclusive of all proper aspects of care. The clinician is the ultimate synthesizer of information and its impact upon treatment. We do ask, however, that you meet the five basic criteria for assessment. This is intended for children and adolescents, ages 5-17.

I. A thorough and comprehensive diagnostic assessment of the patient including:

   a. Completion of a **Parent Rating Scale** (Conners Parent Rating Scale, CBCL, Brown, etc., a "short version" scale is acceptable).
   b. Completion of a **Teacher Rating Scale** (Conners Teacher Rating Scale, Academic Performance Rating Scale, Vanderbilt ADHD Diagnostic Teacher Scale, etc., short version scales are acceptable). Review of school report cards or work samples may be reviewed if the teacher is unable to complete a rating scale.
   c. A **Medical Evaluation** (to rule out rare but possible causes of ADHD/ADD-like symptoms).**
   d. The **application and analysis of DSM criteria** indicating frequency, duration and severity of each symptom, presence of psychiatric disorder comorbid to ADHD, and evaluation of the setting in which impairment occurs should also be noted.
   e. Interview with the patient and parent/guardian in which the following information is obtained: assessment of **family history and family functioning, history of trauma, psychosocial stressors, developmental and medical history.**

II. Create a comprehensive treatment plan in collaboration with the patient and parent/legal guardian.

III. Maintain long-term supportive contact with patient, family and school.

IV. Provide psychoeducation for patient, parents/guardian, and significant adults about the impact of ADHD/ADD.

V. Suggest school interventions such as:
   a. appropriate classroom placement
   b. collaboration with teachers and other school personnel about ADHD/ADD, educational techniques and behavior management
   c. Parent contact with 504 Plan coordinator

Copyright ©2016 Behavioral Healthcare Providers. All Rights Reserved.

VI. If medications are not already part of the treatment plan, consider referral for psychiatric evaluation and monitor use of appropriate medications.

VII. Advocate for psychosocial and behavioral interventions such as:
   a. Parent behavior modification training
   b. Parent Support Group
   c. Referral to CHADD
   d. Family psychotherapy if indicated

- If patient is an adolescent, consider co-morbidity with: medication misuse, CD, substance abuse, suicidality, unreliable teacher reports. Also consider a greater need for vocational evaluation, counseling, safe driving practices and active participation in treatment.

Exceptions to BHP Guidelines
Exceptions to this guideline need to be documented specifically.

- If a practitioner determines that major aspects of the guideline criteria are not appropriate for the member he/she is treating, or, **if any aspect of the assessment portion of the guideline is not appropriate for the member**, **the practitioner must clearly document this in writing.** The following documentation should exist in the treatment plans for the member:

  1. Identify which of the 7 numbered aspects of the criteria is being addressed.

  2. State clearly the reason why the suggested guideline criteria is not appropriate.

  3. State your alternative assessment or treatment plans.

BHP reviewers will pay close attention to assessment criteria.

**Acceptable evidence of Medical Evaluation
The following are acceptable means of evidence that the recommendation and/or occurrence of a medical evaluation were taken into account. *We do not require or believe that it is the job of the practitioner is to ensure that they sought care by a medical physician but only that this was taken into account during the assessment.* **We do require that the practitioner ask about this, make a referral as indicated and document this in the chart.** A medical physician may be a PCP, pediatrician, psychiatrist, physician assistant or other independent medical physician, as appropriate to the age and issue of the patient.

1) The presence of a medical write up, labs, other medical reports.
2) Documentation that patient was referred to/from a physician.
3) Co-existing charts between therapist and psychiatrist.
4) Documentation of refusal to see a physician
5) Evidence of exchange of information with a physician.

Copyright ©2016 Behavioral Healthcare Providers. All Rights Reserved.

Regulatory / External Resources: NCQA2014: QI 10.0; Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder, J.AM. Acad. Child Adolesc. Psychiatry, 46:7, July 2007.

Internal References:

Date Revised: November, 2014

Date Reviewed by Clinical/QIC Team: March 1, 2000, December 2002, December 2004, July 20, 2005, July 19, 2006, July 18, 2007, July 16, 2008, July 22, 2009, July 14, 2010, July 20, 2011, July 18, 2012; July, 2013; November 2014; November 2015

Copyright ©2016 Behavioral Healthcare Providers. All Rights Reserved.