Behavioral Health Provider Toolkit

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Table of Contents

Welcome:

Thank you for being part of the Molina Healthcare network of providers.

We designed this Behavioral Health Provider Toolkit to provide tools and guidance around management of common behavioral health conditions. Included in the toolkit are chapters addressing:

- Assessment and Diagnosis of Behavioral Health Conditions including:
  - Depression
  - Alcohol and Substance Use Disorders
  - Bipolar Disorder
  - Schizophrenia
  - ADHD

- HEDIS Tips including:
  - Antidepressant Medication Management
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Follow-Up After Hospitalization for Mental Illness
  - Follow-Up Care for Children Prescribed ADHD Medication
  - Schizophrenia Management including:
    - Diabetes Screening
    - Diabetes Monitoring
    - Cardiovascular Monitoring
    - Antipsychotic Medication Adherence

- Risk Adjustment education for:
  - Major Depression
  - Alcohol and Substance Use Disorders
  - Bipolar Disorder
  - Schizophrenia

We hope the information in this toolkit helps support your clinical practice.

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Vice President, Behavioral Health

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Assessment and Diagnosis of Behavioral Health Conditions

Depression Screening

Molina Healthcare recommends the use of the ***PHQ-9 Depression Assessment Tool*** to assess depression.

- A component of the longer *Patient Health Questionnaire,* the *PHQ-9* is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- The tool is a ***diagnostic measure*** for Major Depression as well as for recognizing subthreshold depressive disorders.
- It can be administered repeatedly – reflecting improvement or worsening of depression in response to treatment.
- Refer to Molina's ***Depression Clinical Guidelines Quick Reference Guide (QRG)*** included in this guide for recommended treatment interventions based on the results of the *PHQ-9*.
- For claims billing confirmation:
  - Use HCPCS G8431 if positive screen for clinical depression and follow-up plan is documented
  - Use HCPCS G8510 if negative screen for clinical depression.
  - Use the codes indicated above only if appropriate for the service/s rendered.

Over the last 2 weeks, how often has the patient been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself and/or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way	0	1	2	3
Scoring:	0	+ _____	+ _____	+ _____
TOTAL SCORE :	_____			

10. If the patient checked off any problems, how difficult have those problems made it for him/her to do work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

Consider total score as possible indicator of level of depression. Circle the appropriate score/severity indicator	
	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression
Q.10 – non-scored question used to assign weight to the degree to which depressive problems have affected the patient's level of function.	

NOTE: The clinician should rule out physical causes of depression, normal bereavement and a history of manic/hypomanic episode

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

- Kroenke K, Spitzer RL, and Williams JBW. *The PHQ-9: validity of a brief depression severity measure.* J Gen Intern Med. 200 Sep; 16(9): 606–613.

DSM-5 Diagnostic Criteria – Diagnosing Depression

Complete diagnostic criteria for *Depressive Disorders* can be found in the DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Major Depressive Disorder (adapted from DSM-5)

Single Episode: 296.2x/F32.x; Recurrent Episode: 296.3x/F33.x

A. Five (or more) of the following symptoms have been present during the same 2- week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Additional Provider Resource

- **The MacArthur Foundation Initiative o Depression and Primary Care's** *Depression Management Tool Kit* can be found at http://otgateway.com/articles/13macarthurtoolkit.pdf

Depression Clinical Guidelines QRG

To ensure that Molina Member care providers are using a standardized and, effective model for managing the of quality of care for members with Depression. For the purposes of this process, the member's score on the Patient Health Questionaire (PHQ-9) will be a determinant on frequency and scope of interventions provided.

The PHQ-9, scoring instructions, and description of the depression risk levels (low/maintenance level, moderate, high/severe) can be
found on the SAMHSA website at *http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf*

NOTE: If member answers YES to question #9 no matter what the overall scoring is, crisis protocols should be followed. At all levels, crisis policies for the practice should be followed.

LOW/MAINTENANCE (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 0-9
- A member may also have a diagnosis of depression, but symptoms are managed by medication, therapy, or a combination of both and is maintaining self advocacy through community supports – the member is in what is considered the maintenance phase of treatment.

Interventions that can be provided at this Level:

- Provide health education/coaching on Wellness Self-Management
- Identification of and recognition of triggers
- Review with member self-identified healthy coping management techniques
- Provide medication education (if member is currently on anti-depressant medications) to ensure adherence.
- Provide service coordination including transportation coordination and appointment scheduling
- Provide additional community based referrals based on member identified needs for psychosocial support needs such as: AA/Alanon, Consumer Credit Counseling, Food Assistance, Victim Assistance

MODERATE RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score between 10-19
- A member may also have identified one or more moderate risk depression items on the PHQ-9 but none in the severe range but still has a score of 9 or below
- Member has had recent hospitalization for depression (within last 6 months)

Interventions that can be provided at this Level:

- All interventions listed for LOW RISK
- Conduct medication review and education on efficacy, side effects, and proper administration to ensure adherence to treatment plans
- If member is not currently on anti-depressant medication, member should be evaluated for medication needs
- Have member identify internal and external supports – including social supports, providers, social service agency involvement, cultural supports, family as well as self identified strengths.
- Rule-out potential medical disorders that may be mimicking, masking, or affecting symptoms
- Consider referral to Molina Case Management Team for additional support

Depression Clinical Guidelines QRG

MODERATE INTERVENTIONS (CONTINUED)

- Review for ROI for coordination of care with behavioral health provider (if there is established behavioral health provider)
  - If ROI is present, contact providers and inform of current treatment plan
  - If ROI is not present, request member sign and send ROI paperwork to member with provider information completed
- If member does not have current behavioral health provider, offer to assist member with locating provider and obtaining appointment. Coordinate ROI paperwork with provider and member once appointment is secured
- Refer for therapy if warranted and/or psychiatric assessment with psychiatrist and assist with appointment scheduling
- If member has current behavioral health provider (medication management and/or talk therapy):
  - Contact provider to confirm next appointment and coordinate services including transportation for appointments and medication refills (can engage Health Plan CM to assist)
  - If member has BH talk therapy provider, if there is no improvement within 4-6 weeks, discuss possible assessment for medication
    - If member has Medication therapy only provider, discuss with member augmenting through talk therapy (especially if increased psychosocial stressors are present)
    - If member has a provider but no upcoming appointments, coordinate appointment scheduling
      - If member does not have behavioral health provider: (Evaluate for next steps)
    - Is member's BH medication needs being met through PCP?
    - If so, then consider referral to psychiatric prescriber (psychiatrist or nurse practitioner).
    - If not, then does member have a preference for treatment?
    - Talk therapy – counselor/therapist
    - Medication only - psychiatrist
      - Considerations for both types of providers
    - ✓ Provider gender preference
    - ✓ Cultural preferences and language needs
    - ✓ Transportation needs (i.e. on a bus line?)
    - ✓ Specific scheduling needs - Office hour needs (days, times, evening appointments needed)

HIGH RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 20 or higher
- A member may also have identified one or more severe risk depression items on the PHQ-9 but has a score below 20
- Member has had recent hospitalization for depression (within last 1-3 months)

Interventions that can be provided at this Level:

- All interventions listed for **MODERATE RISK**
- Monitoring of post-discharge aftercare and encourage patient to be seen within the first week following discharge from inpatient psychiatric care if applicable by a behavioral health practitioner
  - Phone contact with the member to encourage them to make this scheduled aftercare appointment
  - Consider a nutritional assessment and meal plan completed by a registered dietitian
- Referral to Molina Case Management Team for additional support

- The member should receive regular re-evaluation until the member's PHQ-9 drops below 20 or the member's high-risk items have been resolved (supplemental mental health screening tools may be considered when score increases or stays constant ≥ 3 months)

- At the choice of the member, provide "coaching" in the form of phone contact to review member's tolerance of initial side eff ects of antidepressants during the 6 to 12 weeks following its prescription, given the risk this period presents to medication adherence

Screening for Clinical Depression & Follow-Up Plan for Members Enrolled in a Medicare-Medicaid Plan (MMP)

Purpose

- The *Centers for Medicare & Medicaid Services* requires all members enrolled in a Medicare-Medicaid Plan (also known as 'dual eligible') to be screened for depression on an annual basis using a standardized depression-screening tool. If positive, a follow-up plan is documented on the date of the positive screen. Depression screening and follow-up plan must be completed by a Molina Member Care Provider.
- All members age 18 and older who complete a physical or behavioral health outpatient visit must complete depression screening even in the absence of symptoms.
- This guidance is intended to ensure that Molina Member Care Providers are using a standardized screening tool, documenting a follow-up plan and correctly coding the service.

PHQ-9 (Standardized Depression Screening Tool)

- Molina endorses the use of the PHQ-9 (nine-question Patient Health Questionnaire), a standardized depression-screening tool with established clinical validity.
- The PHQ-9 screening tool, scoring instructions and description of depression risk levels (low/maintenance level; moderate; high/severe) can be found on the SAMHSA website at http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
- Also refer to Molina's *Depression Clinical Guidelines Quick Reference Guide* for recommended patient interventions based on risk-level.

Codes for Documenting Clinical Depression Screen

- The following HCPCS codes are required to document either a positive or a negative depression screen:

Code	Description
G8431	Screening for clinical depression is documented as being positive and a follow-up plan is documented.
G8510	Screening for clinical depression is documented as negative. A follow-up plan is not required as patient not eligible/appropriate for follow-up.

- To improve coding capture, save these G codes as 'favorites' in your electronic medical record (EMR).

Documenting the Follow-Up Plan

- The follow-up plan is the proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for positive depression screening must include one (1) or more of the following:
  - Additional evaluation
  - Suicide risk assessment
  - Referral to a practitioner who is qualified to diagnose and treat depression
  - Pharmacological interventions
  - Other interventions or follow-up for the diagnosis of depression
- The documented follow-up plan must be related to positive depression screening, for example: "***Patient referred for psychiatric evaluation due to positive depression screening.***"

Documenting Exclusions

- A patient is not eligible if one or more of the following conditions are *documented in the patient's medical record*:
  - Patient has an active diagnosis of Depression or Bipolar Disorder
  - Patient refuses to participate
  - Patient is in an urgent or emergent situation where time is of the essence and to delay the patient's treatment would jeopardize the patient's health status
  - Situations where the patient's functional capacity or motivation to improve may impact the accuracy of the screening tool, for example, court-appointed cases or cases of delirium

Codes for Documenting Exclusions

- The following HCPCS codes are required to document exclusions:

Code	Description
G8433	Screening for clinical depression not documented. Medical record documents that the patient is not eligible/appropriate.
G8940	Screening for clinical depression documented as positive. A follow-up plan not documented. Medical record documents that the patient is not eligible/appropriate.

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Alcohol and Other Drug Abuse & Dependence Screening

Molina Healthcare recommends the use of the ***CAGE-AID Screening Tool*** to assess alcohol and other drug abuse & dependence:

- The CAGE-AID questionnaire is used to test for alcohol and other drug abuse and dependence in adults
- The tool is not diagnostic but is indicative of the existence of an alcohol or other drug problem
- Item responses on the CAGE-AID are scored 0 or 1, with a higher score indicating alcohol or drug use problems
- *A total score of 2 or greater is considered clinically significant*, which then should lead the physician to ask more specific questions about frequency and quantity
- CAGE is derived from the four questions of the tool:
  - *Cut down*
  - *Annoyed*
  - *Guilty*
  - *Eye-opener*
- AID refers to *"Adapted to Include Drug Use"*

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.	**YES**	**NO**
1. Have you ever felt that you ought to cut down o your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you ever felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		
TOTAL 'YES' SCORE:		

SCORING	Regard one or more positive responses to the CAGE-AID as a positive screen.

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

- Brown RL, Rounds LA. *Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice*. Wis Med J. 1995; 94: 135-40.

DSM-5 Diagnostic Criteria – Diagnosing Alcohol and Other Drug Abuse & Dependence

Complete diagnostic criteria for *Substance Related and Addictive Disorders* can be found in the DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Substance Use Disorder (adapted from DSM-5)

A problematic pattern of [substance] use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. [Substance] is often taken in larger amounts or over longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control [substance] use.
3. A great deal of time is spent in activities necessary to obtain [substance], use [substance], or recover from its effects.
4. Craving, or a strong desire or urge to use [substance].
5. Recurrent [substance] use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued [substance] use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of [substance].
7. Important social, occupational, or recreational activities are given u or reduced because of [substance] use.
8. Recurrent [substance] use in situations in which it is physically hazardous.
9. [Substance] use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [substance].
10. Tolerance, as defined by either of the following:
    a. need for markedly increased amounts of [substance] to achieve intoxication or desired effect.
    b. markedly diminished effect with continued use of the same amount of [substance].
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for [substance].
    b. [Substance] (or closely related substance) is taken to avoid withdrawal symptoms.

Severity

- **Mild (Abuse)**: Presence of 2-3 symptoms
- **Moderate (Dependence)**: Presence of 4-5 symptoms
- **Severe (Dependence)**: Presence of 6 or more symptoms

Bipolar Disorder Screening

Molina Healthcare recommends the use of the ***Mood Disorder Questionnaire (MDQ)*** to assess bipolar disorder.

- The *MDQ* is a screening instrument for bipolar disorder that can easily be utilized in primary and other health care settings.
- It can correctly identify 7 of 10 patients with bipolar disorder, while 9 of 10 patients without bipolar disorder would be correctly screened out.
- If the patient screens positive on the *MDQ*, the physician should proceed with a full clinical evaluation for bipolar disorder.
- Probing based on the *MDQ* responses may be helpful in guiding questions.

1. Has there ever been period of time when you were not your usual self and …	**YES**	**NO**
. . . you felt so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
. . . you were so irritable that you shouted at people or started fights or arguments?		
. . . you felt much more self-confident than usual?		
. . . you got much less sleep than usual and found that you really didn't miss it?		
. . . you were more talkative or spoke much faster than usual?		
. . . thoughts raced through your head or you couldn't slow your mind down?		
. . . you were so easily distracted by things around you that you had trouble concentrating or staying o track?		
. . . you had more energy than usual?		
. . . you were much more active or did many more things than usual?		
. . . you were more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
. . . you were much more interested in sex than usual?		
. . . you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
. . . spending money got you or your family in trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? ☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem		

SCORING
In order to screen positive for possible bipolar disorder, all <u>three</u> parts of the following criteria must b met: • **YES** to 7 or more of the 13 items in Question 1, **AND;** • **YES** to Question 2, **AND;** • ***'Moderate Problem'*** or ***'Serious Problem'*** to Question 3

For a positive MDQ screen, further clinical assessment is needed to determine diagnosis.

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

- Hirschfeld, RMA et al., *Development and validation of a screening instrument for bipolar spectrum disorder*, American J of Psychiatry. 2000 Nov; 157(11): 1873-1875.
- Hirschfeld, RMA, *The Mood Disorder Questionnaire: A Simple, Patient-Rated Screening Instrument for Bipolar Disorder,* Prim Care Companion J Clin Psychiatry. 2002; 4(1): 9–11.

Diagnosing Bipolar Disorder

A person with bipolar disorder may have distinct manic or depressed states. A person with mixed episodes experiences both extremes simultaneously or in rapid sequence. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. Someone who is manic might believe he has special powers and may display risky behavior. Someone who is depressed might feel hopeless, helpless and be unable to perform normal tasks. People with bipolar disorder who have psychotic symptoms may be wrongly diagnosed as having schizophrenia.

Mania. To be diagnosed with bipolar disorder, a person must have experienced mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function normally in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times; others may experience them only rarely.

Bipolar I Disorder is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with Bipolar I Disorder will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with Bipolar I Disorder, a person's manic or mixed episodes must last at least seven days or be so severe that he requires hospitalization.

DSM-5 Diagnostic Criteria

Complete diagnostic criteria for *Bipolar and Related Disorders* can be found in the DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Bipolar I Disorder, Manic Episode 296.4x /F31.1x (adapted from DSM-5)

Manic Episode includes a period of at least one week during which the person is in an abnormally and persistently elevated or irritable mood. While an indiscriminately euphoric mood is the classical expectation, the person may instead be predominately irritable. He or she may also alternate back and forth between the two. This period of mania must be marked by three of the following symptoms to a significant degree. If the person is only irritable, they must experience four of the following symptoms.

1. Inflated self-esteem or grandiosity (ranges from uncritical self-confidence to delusional sense of expertise).
2. Decreased need for sleep.
3. Intensified speech (possible characteristics: loud, rapid and difficult to interrupt, a focus o sounds, theatrics and self-amusement, non-stop talking regardless of other person's participation/interest, angry tirades).
4. Rapid jumping around of ideas or feels like thoughts are racing.
5. Distractibility (attention easily pulled away by irrelevant/unimportant things).
6. Increase in goal-directed activity (i.e. excessively plans and/or pursues a goal; either social, work/school or sexual) or psychomotor agitation (such as pacing, inability to sit still, pulling o skin or clothing).
7. Excessive involvement in pleasurable activities that have a high risk consequence.

Assessment and Diagnosis of Schizophrenia

- **A clinical assessment is needed to determine a diagnosis of schizophrenia or other psychotic disorder.**

Schizophrenia is characterized by delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social or occupational dysfunction. For a diagnosis, symptoms must have been present for six months and include at least one month of active symptoms.

Psychotic disorders are characterized by dysregulation of thought processes. In particular, schizophrenia has hallmark symptoms of delusions – which are false beliefs – and hallucinations – which are hearing and/or seeing sensory information which is not actually present and is not apparent to others. Schizoaffective disorder is a disorder in which, as its name implies, individuals have features of both schizophrenia and mood disorders. Typically, psychotic disorders are treated with antipsychotic medications and some forms of psychosocial interventions.

DSM-5 Diagnostic Criteria

Complete diagnostic criteria for *Schizophrenia Spectrum and Other Psychotic Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Schizophrenia 295.90/F20.x (adapted from DSM-5)

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5), to meet the criteria for diagnosis of schizophrenia, the patient must have experienced at least 2 of the following symptoms[2] :

- Delusions*
- Hallucinations*
- Disorganized speech*
- Disorganized or catatonic behavior
- Negative symptoms *(e.g., decrease in emotional range, poverty of speech, and loss of interests and drive; the person with schizophrenia has tremendous inertia)*

*At least 1 of the above symptoms must be the presence of delusions, hallucinations, or disorganized speech.

Continuous signs of the disturbance must persist for at least 6 months, during which the patient must experience at least 1 month of active symptoms (or less if successfully treated), with social or occupational deterioration problems occurring over a significant amount of time. These problems must not be attributable to another condition.

Assessment and Diagnosis of Attention-Deficit/Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is defined by a persistent pattern of inattention (for example, difficulty keeping focus) and/or hyperactivity-impulsivity (for example, difficulty controlling behavior, excessive and inappropriate motor activity). Children with ADHD have difficulty performing well in school, interacting with other children, and following through on tasks. There are three sub-types of the disorder:

- Predominantly hyperactive/impulsive
- Predominantly inattentive
- Combined hyperactive/inattentive

The three overarching features of ADHD include inattention, hyperactivity, and impulsivity. Inattentive children may have trouble paying close attention to details, make careless mistakes in schoolwork, are easily distracted, have difficulty following through on tasks, such as homework assignments, or quickly become bored with a task. Hyperactivity may be defined by fidgeting or squirming, excessive talking, running about, or difficulty sitting still. Finally, impulsive children may be impatient, may blurt out answers to questions prematurely, have trouble waiting their turn, may frequently interrupt conversations, or intrude on others' activities.

The following clinical practice guidelines may be helpful in the assessment, diagnosis and treatment of ADHD:

- **American Academy of Pediatrics**. *Clinical Practice Guideline: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. Pediatrics 2011 Oct; 128:5 1007-1022; doi:10.1542/peds.2011-2654.
- http://pediatrics.aappublications.org/content/128/5/1007.full

- **American Academy of Child and Adolescent Psychiatry**. *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):894Y921.
- http://www.jaacap.com/article/S0890-8567(09)62182-1/pdf

American Academy of Pediatrics* & *American Academy of Child and Adolescent Psychiatry
Summary of Guidelines for ADHD: Diagnosis, Evaluation and Treatment

A. Consider Diagnosis in Patients who are:
Any child age 4-18 experiencing symptoms including the following which *substantially interfere with healthy functioning and quality of life at home and school*:

- Inattention
- Hyperactivity
- Impulsivity

B. Establishing Diagnostic Criteria:
Symptom criteria information should be obtained from parents and include information from teachers, caregivers and any school mental health clinicians, caregivers or other health providers regarding the child's behavior. Physicians should use the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to review criteria and conduct differential diagnosis. Helpful tools in pinpointing criteria are evidence-based behavior-rating scales.

Psychological and neuropsychological tests are not mandatory for the diagnosis of ADHD but should be performed if the patient's history suggests low general cognitive ability or low achievement in language or mathematics relative to the patient's intellectual ability. *(AACAP, 2007)*

Sources of Information for Diagnosis:

- Parent informant who has gathered information from teachers, school professionals, other health providers and caregivers.
- DSM-5
- Behavior-rating scales:
  - **a)** Vanderbilt Assessment Scale *(©2002 American Academy of Pediatrics* and *National Initiative for Children's Healthcare Quality*)
    - http://www.chadd.org/Understanding-ADHD/Parents-Caregivers-of-Children-with-ADHD/Evaluation-and-Treatment/Evaluation-and-Assessment-Tools.aspx
    - Samples of parent and teacher scales provided at the end of this chapter
  - **b)** Disruptive Behavior Disorder Rating Scale (RS-DBD)
    - http://ccf.buffalo.edu/pdf/DBD_rating_scale.pdf
    - Sample of rating scale provided at the end of this chapter
  - **c)** Conners 3 ADHD Index (Conners 3AI)
    - https://ecom.mhs.com/(S(hrenkp5520h10m55sddhd5zf))/product.aspx?gr=edu&prod=conners3ai&id=overview

C. Differential Diagnosis and Co-Morbid Disorders
As stated, physicians should work with a parent or guardian informant and use the DSM-5 to establish criteria and conduct differential diagnosis. Physicians must establish whether there are also criteria for co-morbid disorders. Differential diagnosis and co-morbid disorders to check for include:

- Anxiety
- Depression
- Oppositional-Defiant Disorder
- Conduct Disorder
- Learning Disorder
- Language Disorder
- Other Neurodevelopmental Disorder
- Physical disorders such as sleep apnea and tics

D. Age-Specific Treatment Summaries

1. Preschool-Age (4-5 years of age):
Evidence-based parent and/or teacher administered behavior interventions are the ***first line of treatment.*** Methylphenidate may be prescribed if these interventions are not followed by behavioral improvement or if the behavior continues to affect the child's functioning and quality of life at a moderate to severe level. If such interventions are not possible at the level of home and school, physicians contemplating prescribing medication must consider the risks of starting medication in a developing child against the risks of not treating.

2. Elementary and School-Age (6-11 years of age):
Prescribe US Food and Drug Administration-approved medication for ADHD AND/OR evidence-based interventions enacted by parents, teachers or both parents and teachers.
The ***preferred*** treatment is BOTH medication AND evidence-based interventions enacted by parents AND teachers.

AAP ADHD CPG, 2011: "The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order)." (2011)

3. For Adolescents (12-18 years of age):
Physicians should prescribe Food and Drug-approved medications for ADHD ***with the assent of the adolescent***.
Behavior therapy may be prescribed involving evidence-based treatments enacted by parents, teachers or both.
The ***preferred*** treatment is BOTH medication AND evidence-based interventions enacted by parents AND teachers.

AAP ADHD CPG, 2011: "The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects."

E. Referral to a Specialist
The AAP acknowledges that some primary care clinicians might not be confident of their ability to successfully diagnose and treat ADHD in a child because of the child's age, coexisting conditions, or other concerns. At any point at which a clinician feels that he or she is not adequately trained or is uncertain about making a diagnosis or continuing with treatment, a referral to a pediatric or mental health subspecialist should be made.

DSM-5 Diagnostic Criteria

Complete diagnostic criteria for ADHD can be found under *Neurodevelopmental Disorders* in the DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Attention-Deficit/Hyperactivity Disorder – 314.0x/F90.x (adapted from DSM-5)

Patients with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:

1. Inattention: Six or more symptoms of inattention for children u to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:
    - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
    - Often has trouble holding attention o tasks or play activities.
    - Often does not seem to listen when spoken to directly.
    - Often does not follow through o instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
    - Often has trouble organizing tasks and activities.
    - Often avoids, dislikes, or is reluctant to d tasks that require mental effort over a long period of time (such as schoolwork or homework).
    - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
    - Is often easily distracted
    - Is often forgetful in daily activities.

2. Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to ag 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least months to an extent that is disruptive and inappropriate for the person's developmental level:
    - Often fidgets with or taps hands or feet, or squirms in seat.
    - Often leaves seat in situations when remaining seated is expected.
    - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
    - Often unable to play or take part in leisure activities quietly.
    - Is often "on the go" acting as if "driven by a motor".
    - Often talks excessively.
    - Often blurts out an answer before a question has been completed.
    - Often has trouble waiting his/her turn.
    - Often interrupts or intrudes o others (e.g., butts into conversations or games)

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before ag 1 years.
- Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms d not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Educating Parents on Myths and Facts about ADHD

Knowing some of the myths parents often hear or believe can help physicians provide high-touch, quality care. Primary care providers can meet the myths with facts and provide parents the comfort and confidence of having correct information. The next section covers some of the most common myths and the facts to correct them.

ADHD is frequently discussed condition among parents, teachers and the community. The media, neighbors, friends and other outside influences can affect how parents interact with providers as they contemplate treatment about their child's behavior. This tool can help strengthen communication with parents in the exam room.

- *My child is too young to have ADHD*
  Signs and symptoms of ADHD can occur as early as the preschool years. Impulsive and active behavior can be normal characteristics in a young child, but it is important for a provider to evaluate these symptoms and ensure that they are not interfering with the child's life, development, self-esteem and general functioning.

- *ADHD isn't a real medical condition.*
  ADHD is recognized as a medical condition by the Centers for Disease Control and Prevention, American Psychiatric Associate and American Academy of Pediatrics. It is important to treat it timely because it can impact a child's everyday life.

- *All children are active and just lose focus sometimes.*
  It is normal for children to act impulsive and inattentive sometimes. However, in a child with ADHD it can be extreme and impede day-to-day activity, as well as affect a child's ability to control activity or impulses. It is important to differentiate the functional disability from normal activity.

- *All children diagnosed with ADHD are hyperactive.*
  While hyperactivity is a common sign, a child can have ADHD without being hyperactive. Types of ADHD include:
  1. Predominantly Inattentive – When he/she finds it hard to pay attention to detail or instructions. He/she easily forgets and gets distracted.
  2. Predominantly hyperactive-impulsive – When he/she fidgets a lot or can't sit still. He or she has a hard time waiting for his or her turn. It is also hard to listen to directions.
  3. Combined - When he/she has symptoms of both Inattentive and Hyperactive-Impulsive.

- *ADHD is a result of poor parenting.*
  Raising a child with ADHD can be a challenge, but parental style does not cause a child to develop ADHD. However, a stressful home environment or inconsistent parenting practices can aggravate ADHD behaviors. It is important to maintain a clear set of limits and expectations to help reduce ADHD symptoms.

- *Children with ADHD will eventually outgrow the condition.*
  ADHD is a lifelong condition and can continue even through adult years. The symptoms may change as the child grows older but, if managed correctly, he/she can continue to live happy and productive lives.

Tools for Providers to Use in Educating Parents (*American Academy of Pediatrics* and the *National Initiative on Children's Healthcare Quality*)

Knowing What to Tell the Doctor

Parents may wonder what information to give a provider in the short span of time in the exam room. The next series of tools on the following pages, *Does My Child of ADHD?* provide clear answers to parents' questions. It also explains what types of behavior to monitor and who to talk to about their child's behavior prior to a doctor's appointment.

What to Look For with Medication and Behavior after Diagnosis

Behavior monitoring and medication adherence monitoring are an essential part of treating ADHD. A child's behavior and the household schedule can affect medication adherence and treatment outcome. For this reason, it is important for providers to offer parents medication adherence tips. By talking with parents about the child's experience with the medication, adverse side effects or other adherence challenges can be properly addressed. The following tools are provided for use in ongoing monitoring.

Many parents worry about this question. The answer comes from children, families, teachers, and doctors working together as a team. Watching your child's behavior at home and in the community is very important to help answer this question. Your doctor will ask you to fill out rating scales about your child. Watching your child's behavior and talking with other adults in the child's life will be important for filling out the forms.

Here are a few tips about what you can do to help answer the question:

Watch your child closely during activities where he or she should pay attention.

- ☐ Doing homework
- ☐ Doing chores
- ☐ During storytelling or reading

Watch your child when you expect him or her to sit for a while or think before acting.

- ☐ Sitting through a family meal
- ☐ During a religious service
- ☐ Crossing the street
- ☐ Being frustrated
- ☐ With brothers or sisters
- ☐ While you are on the phone

Pay attention to how the environment affects your child's behavior. Make changes at home to improve your child's behavior.

- ☐ Ensure that your child understands what is expected. Speak slowly to your child. Have your child repeat the instructions.
- ☐ Turn off the TV or computer games during meals and homework. Also, close the curtains if it will help your child pay attention to what he or she needs to be doing.
- ☐ Provide structure to home life, such as regular mealtimes and bedtime. Write down the schedule and put it where the entire family can see it. Stick to the schedule.
- ☐ Provide your child with planned breaks during long assignments.
- ☐ Give rewards for paying attention and sitting, not just for getting things right and finishing. Some rewards might be: dessert for sitting through a meal, outdoor play for finishing homework, and praise for talking through problems.
- ☐ Try to find out what things set off problem behaviors. See if you can eliminate the triggers.

If your child spends time in 2 households, compare observations.

- ☐ Consult your child's other parent about behavior in that home. Cooperation between parents in this area really helps the child.
- ☐ If the child behaves differently, consider differences in the environment that may explain the difference in behavior. Differences are common and not a mark of good or bad parenting.

Talk to your child's teacher.

- ☐ Learn about your child's behavior at school. Talk about how your child does during academic lessons and also during play with other children.
- ☐ Compare your child's behavior in subjects he or she likes and those in which he or she has trouble with the work.
- ☐ Determine how the environment at school affects your child's behavior. When does your child perform well? What events trigger problem behaviors?
- ☐ Consider with the teacher whether your child's learning abilities should be evaluated at school. If he or she has poor grades in all subjects or in just a few subjects or requires extra time and effort to learn material, then a learning evaluation may be valuable.

Gather impressions from other adult caregivers who know your child well.

- ☐ Scout leaders or religious instructors who see your child during structured activities and during play with other children
- ☐ Relatives or neighbors who spend time with your child
- ☐ Determine how other environments affect your child's behavior. When does your child perform well? What events trigger problem behaviors?

Make an appointment to see your child's doctor.

- ☐ Let the receptionist know you are concerned that your child might have ADHD.
- ☐ If possible, arrange a visit when both parents can attend.

Adapted from materials by Heidi Feldman, MD, PhD

General Tips

1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD. Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems

It is very hard to get my child ready for school in the morning.

- Create a consistent and predictable schedule for rising and getting ready in the morning.
- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:

  Alarm goes off → Brush teeth → Wash face → Get dressed → Eat breakfast → Take medication → Get on school bus

- Reward and praise your child! This will motivate your child to succeed. Even if your child does not succeed in all parts of the "morning routine," use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to "rest" in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

My child is very irritable in the late afternoon/early evening.
(Common side effect of stimulant medications)

- The late afternoon and evening is often a very stressful time for all children in all families because parents and children have had to "hold it all together" at work and at school.
- If your child is on medication, your child may also be experiencing "rebound"—the time when your child's medication is wearing off and ADHD symptoms may reappear.
- Adjust your child's dosing schedule so that the medication is not wearing off during a time of "high demand" (for example, when homework or chores are usually being done).
- Create a period of "downtime" when your child can do calm activities like listen to music, take a bath, read, etc.
- Alternatively, let your child "blow off extra energy and tension" by doing some physical exercise.
- Talk to you child's doctor about giving your child a smaller dose of medication in the late afternoon. This is called a "stepped down" dose and helps a child transition off of medication in the evening.

My child is losing weight or not eating enough.
(Common side effects of stimulant medication use)

- Encourage breakfast with calorie-dense foods.
- Give the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious after-school and bedtime snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Get eating started with any highly preferred food before giving other foods.
- Consider shifting dinner to a time later in the evening when your child's medication has worn off. Alternatively, allow your child to "graze" in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child's height and weight with careful measurements at your child's doctor's office and talk to your child's doctor.

Homework Tips

- Establish a routine and schedule for homework (a specific time and place.) Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (reducing unnecessary noise, activity, and phone calls, and turning off the TV).
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can watch TV or play a game."
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

Discipline

- Be firm. Set rules and keep to them.
- Make sure your child understands the rules, so he or she does not feel uninformed.
- Use positive reinforcement. Praise and reward your child for good behavior.
- Change or rotate rewards frequently to maintain a high interest level.
- Punish behavior, not the child. If your child misbehaves, try alternatives like allowing natural consequences, withdrawing yourself from the conflict, or giving your child a choice.

Taking Care of Yourself

- Come to terms with your child's challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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ADHD

Behavior-Rating Scales Samples

NICHQ Vanderbilt Assessment Scale PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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11-20/rev0303

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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NICHQ

National Initiative for Children's Healthcare Quality

11-21/rev0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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Scoring Instructions for NICHQ Vanderbilt Assessment Scales

Baseline Assessment

The validation studies for the NICHQ Vanderbilt Assessment Scales were for the 6- to 12-year-old age group. However, to the extent that they collect information to establish *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria, they are applicable to other groups, particularly preschoolers, where they have identified that *DSM-5* criteria are still appropriate.

These scales should *not* be used alone to make a diagnosis of ADHD without confirming and elaborating the information with interviews with at least the primary caregivers (usually parents) and patients. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for inattentive (items 1–9) and hyperactive (items 10–18) attention-deficit/hyperactivity disorder (ADHD).

Scoring for Diagnostic Purposes

To meet *DSM-5* criteria for the diagnosis, one must have at least 6 positive responses to the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment.

The initial scales have symptom screens for 3 other comorbidities: oppositional-defiant disorder, conduct disorder, and anxiety/depression. (The initial teacher scale also screens for learning disabilities.) These are screened by the number of positive responses in each of the segments. The specific item sets and numbers of positives required for each comorbid symptom screen set are detailed below and on the next page.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least 2 items of the performance set in which the child scores a 4, or 1 item of the performance set in which the child scores a 5; ie, there must be impairment, not just symptoms, to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s).

Scoring to Monitor Symptom and Performance Improvement

For the purposes of tracking symptoms and symptom severity, calculate the mean response for each subsegment of the ADHD symptom assessment screen items (inattentive 9 and hyperactive 9). To calculate the mean responses, first total the responses (0s, 1s, 2s, and 3s) from each item within the inattentive subsegment (items 1–9) and divide by the number of items that received a response. For example, if a parent only provided responses to 7 of the first 9 items, the responses would be totaled and divided by 7. Follow the same calculation instructions for the hyperactive subsegment (items 10–18).

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Predominantly Inattentive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
Predominantly Hyperactive/Impulsive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Predominantly Hyperactive/Impulsive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
ADHD Combined Inattention/Hyperactivity ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes	**ADHD Combined Inattention/Hyperactivity** ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes
Oppositional-Defiant Disorder ● Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Oppositional-Defiant/Conduct Disorder** ● Must score a 2 or 3 on 3 out of 10 items on questions 19–28. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
Conduct Disorder ● Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	

Parent Assessment Scale	Teacher Assessment Scale
Anxiety/Depression ● Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Anxiety/Depression** ● Must score a 2 or 3 on 3 out of 7 items on questions 29–35. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
	Learning Disabilities ● Must score a 4 on both, or 5 on 1, of questions 36 and 38.

Follow-up Assessment

Scoring for Diagnostic Purposes

The parent and teacher follow-up scales have the first 18 core ADHD symptoms and the comorbid symptoms oppositional-defiant (parent) and oppositional-defiant/conduct (teacher) disorders. The Performance section has the same performance items and impairment assessment as the initial scales; it is followed by a side-effect reporting scale that can be used to assess and monitor the presence of adverse reactions to prescribed medications, if any.

Scoring the follow-up scales involves tracking inattentive (items 1–9) and hyperactive (items 10–18) ADHD, as well as the aforementioned comorbidities, as measures of improvement over time with treatment.

Scoring to Monitor Symptom and Performance Improvement

To determine the score for follow-up, calculate the mean response for each of the ADHD subsegments. Compare the mean response from the follow-up inattentive subsegment (items 1–9) to the mean response from the inattentive subsegment that was calculated at baseline assessment. Conduct the same comparison for the mean responses for the hyperactive subsegment (items 10–18) taken at follow-up and baseline.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Predominantly Inattentive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.
Predominantly Hyperactive/Impulsive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Predominantly Hyperactive/Impulsive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.
ADHD Combined Inattention/Hyperactivity ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes	**ADHD Combined Inattention/Hyperactivity** ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes
Oppositional-Defiant Disorder ● Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Oppositional-Defiant/Conduct Disorder** ● Must score a 2 or 3 on 3 out of 10 items on questions 19–28. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.

Parent I Teacher DBD Rating Scale

Child's Name: _____ Form Completed by: _____

Grade: _____ Date of Birth: _____ Sex: _____ Date Completed: _____

Check the column that best describes your/this child. **Please write DK next to any items for which you don't know the answer.**

	Not at All	Just a Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				
21. often shifts from one uncompleted activity to another				
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)				

SCORING INSTRUCTIONS FOR THE DISRUPTIVE BEHAVIOR DISORDER RATING SCALE

There are two ways to determine if a child meets the criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder. The first method involves counting symptoms for each disorder using the Disruptive Behavior Disorders (DBD) rating scale. The second method involves comparing the target child's factor scores on the DBD Rating Scale to established norms. The factor scores method is preferable for diagnosis of females (e.g., using a 2 SD cutoff), as the symptom counting method often results in underdiagnosis of female children. Please note that items 10, 14, and 21 are from DSM-III-R and are not included in the scoring for a DSM-IV diagnosis.

Method 1: Counting Symptoms

To determine if a child meets the symptom criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder as measured by the DBD Parent / Teacher Rating Scale, count the number of symptoms that are endorsed "pretty much" or "very much" by either parent or teacher in each of the following categories: Note that impairment and other criteria must be evaluated in addition to symptom counts.

Attention-Deficit/Hyperactivity Disorder

_____Attention-Deficit/Hyperactivity Disorder - Inattention Symptoms
(items 9, 18, 23, 27, 29, 34, 37, 42, 44)

6 or more items must be endorsed as "pretty much" or "very much" to meet criteria for **Attention-DeficitlHyperactivity Disorder, Predominantly Inattentive Type.** The six items may be endorsed on the teacher DBD, the parent DBD, or can be a combination of items from both rating scales (e.g., 4 symptoms endorsed on the teacher DBD and 2 separate symptoms endorsed on the parent DBD). The same symptom should **not** be counted twice if it appears on both versions (parent and teacher) of the rating scale.

_____Attention-Deficit/Hyperactivity Disorder - Hyperactivity/Impulsivity Symptoms
(items 1, 7, 12, 19, 22, 25, 30, 33, 35)

6 or more items must be endorsed as "pretty much" or "very much" on the parent and/or the teacher DBD to meet criteria for **Attention-DeficitlHyperactivity Disorder, Predominantly Hyperactive-Impulsive Type.**

If 6 or more items are endorsed for Attention-Deficit/Hyperactivity Disorder - inattention **and** 6 or more items are endorsed for Attention-Deficit/Hyperactivity Disorder - hyperactivity/impulsivity, then criteria is met for **Attention-DeficitlHyperactivity Disorder, Combined Type.**

Some impairment from the symptoms must be present in two or more settings (e.g., school, home)

Oppositional Defiant Disorder

_____Oppositional Defiant Disorder (items 3, 13, 15, 17, 24, 26, 28, 39)

A total of 4 or more items must be endorsed as "pretty much" or "very much" on either the parent or the teacher DBD to meet criteria for **Oppositional Defiant Disorder.**

Conduct Disorder

_____Conduct Disorder - aggression to people and animals (items 6, 20, 31, 32, 36, 40, 45)
_____Conduct Disorder - destruction of property (items 16, 41)
_____Conduct Disorder - deceitfulness or theft (items 4, 8, 43)
_____Conduct Disorder - serious violation of rules (items 2, 11, 38)

A total of 3 or more items in any category or any combination of categories must be endorsed as "pretty much" or "very much" on either the parent or the teacher DBD to meet criteria for **Conduct Disorder**

Method 2: Using Factor Scores

Factor scores for the two ADHD and ODD dimensions for teacher ratings on the DBD are reported in *Pelham, et al. (1992), Teacher ratings of DSM-III-R symptoms for the disruptive behavior disorders: Journal of the American Academy of Child and Adolescent Psychiatry, 31, 210-218*. The factor scores for DSM IV factors are the same as for the DSM III-R factors reported in that paper. To determine how a child's scores compare to normative data, compute the average rating for the items from each factor (listed below) using the following scoring: Not at all = 0, Just a little = 1, Pretty much = 2, Very much = 3. Then, using the information from the attached table of norms, determine where the child falls in relation to other children. A variety of cutoff scores can be used (e.g., 2 standard deviations above the mean).

Factors

Oppositional/Defiant	(items 3, 13, 15, 17, 24, 26, 28, 39)
Inattention	(items 9, 18, 23, 27, 29, 34, 37, 42, 44)
Impulsivity/Overactivity	(items 1, 7, 12, 19, 22, 25, 30, 33, 35)

HEDIS Tips

Antidepressant Medication Management

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an *acute phase,* during which remission is induced; a *continuation phase,* during which remission is preserved; and a *maintenance phase,* during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Antidepressant Medication Management* measures (AMM), which guide our efforts in measuring the quality and effectiveness of the care provided. The AMM measures specifically focus on promoting adequate and continuous medication therapy and adherence for patients diagnosed with Major Depression.

What are the HEDIS® AMM measures?

This two-part measure looks at:

- The percentage of patients 18 years of age and older with major depression who were initiated on an antidepressant drug and who received an adequate acute-phase trial of medications (three months).
- The percentage of patients with major depression who were initiated on an antidepressant drug and who completed a period of continuous medication treatment (six months).

What are the best practices regarding these HEDIS® measures?

- Regularly monitor patients to assess response to therapy as well as emergence of side effects, clinical condition and safety.
- Educate patients that it usually takes from one to six weeks to start feeling better. In many cases, sleep and appetite improve first while improvement in mood, energy, and negative thinking may take longer.
- Inform patients that once they begin to feel better it's important to stay on the medication for another six months to prevent a relapse.
- Develop a plan with the patient in the event of a crisis or thoughts of self-harm.

What is the relevance of these measures?

- Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 11th leading cause of death in the United States (U.S.) each year (National Alliance on Mental Illness [NAMI], 2013; Centers for Disease Control and Prevention [CDC], 2012). Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects (Birnbaum et al., 2010).
- In a given year, major depression affects 6.7 percent of the U.S. adult population (approximately 14.8 million American adults) (National Institute of Mental Health [NIMH], 2012).
- Severity of major depression is significantly associated with poor work performance (Birnbaum et al., 2010). Lost work productivity costs the U.S. up to $2 billion monthly (Birnbaum et al., 2010).
- Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

- Birnbaum HG, Kessler RC, Kelley D, Ben-Hamadi R, Joish VN, Greenberg PE. Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. Depress Anxiety. 2010;27(1):78-89.
- Centers for Disease Control and Prevention (CDC). Suicide facts at glance 2012. [internet]. Atlanta (GA): Centers for Disease Control and Prevention (CDC); 2012 [accessed 2014 Jun 20].
- National Alliance o Mental Illness (NAMI). Major depression fact sheet: what is major depression?. [internet]. Arlington (VA): National Alliance on Mental Illness (NAMI); 2013 [accessed 2014 Jun 20].
- National Committee for Quality Assurance (NCQA). The state of health care quality 2014. Washington (DC): National Committee for Quality Assurance (NCQA); 2014 Oct. 18 p.
- National Institute of Mental Health (NIMH). The numbers count: mental disorders in America. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2013 [accessed 2014 Jun 20].

HEDIS® TIPS:
Antidepressant Medication Management

MEASURE DESCRIPTION

The percentage of adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remain on an antidepressant medication treatment. Two rates are reported:

Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). (Continuous treatment allows gaps in treatment up to a total of 30 days during the *Acute Phase*).

Effective Continuation Phase Treatment: The percentage members who remained on an antidepressant medication for at least 180 days (6 months). (Continuous treatment allows gaps in treatment up to a total of 51 days during the *Acute and Continuation Phases* combined).

USING CORRECT BILLING CODES

Codes to Identify Major Depression

Description	ICD-9 Codes	*ICD-10 Codes
Major Depression	296.20-296.25, 296.30-296.35, 298.0, 311	F32.0-F32.4, F32.9, F33.0-F33.3. F33.41, F33.9

*ICD-10 codes to be used on or after 10/1/15

ANTIDEPRESSANT MEDICATIONS

Description	Generic Name	Brand Name
Miscellaneous antidepressants	Buproprion Vilazodone Vortioxetine	Wellbutrin®; Zyban® Viibryd® Brintellix®
Phenylpiperazine antidepressants	Nefazodone Trazodone	Serzone® Desyrel®
Psycho-therapeutic combinations	Amitriptyline-chlordiazepoxide; Amitriptyline-perphenazine; Fluoxetine-olanzapine	Limbitrol® Triavil®; Etrafon® Symbax®
SNRI antidepressants	Desvenlafaxine Levomilnacipran Duloxetine Venlafaxine	Pristiq® Cymbalta® Effexor®
SSRI antidepressants	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Sertraline	Celexa® Lexapro® Prozac® Luvox® Paxil® Zoloft®
Tetracyclic antidepressants	Maprotiline Mirtazapine	Ludiomil® Remeron®
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6mg) Imipramine Nortriptyline Protriptyline Trimipramine	Elavil® Asendin® Anafranil® Norpramin® Sinequan® Tofranil® Pamelor® Vivactil® Surmontil®
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine Selegiline Tranylcypromine	Marplan® Nardil® Anipryl®; Emsam® Parnate®

HOW TO IMPROVE HEDIS® SCORES

- ❑ Educate patients on the following:
  - ○ Depression is common and impacts 15.8 million adults in the United States.
  - ○ Most antidepressants take 1-6 weeks to work before the patient starts to feel better.
  - ○ In many cases, sleep and appetite improve first while improvement in mood, energy and negative thinking may take longer.
  - ○ The importance of staying on the antidepressant for a minimum of 6 months.
  - ○ Strategies for remembering to take the antidepressant on a daily basis.
  - ○ The connection between taking an antidepressant and signs and symptoms of improvement.
  - ○ Common side effects, how long the side effects may last and how to manage them.
  - ○ What to do if the patient has a crisis or has thoughts of self-harm.
  - ○ What to do if there are questions or concerns.
- ❑ Patients with at least six (6) chronic medications and at least three (3) qualifying diagnoses may be eligible for Medication Therapy Management (MTM) sessions. For additional information about MTM criteria and to request a referral, contact Health Care Services at your affiliated Molina Healthcare State plan.

Updated 9/9/2015

Initiation and Engagement of Alcohol and Other Drug Treatment

The *Initiation and Engagement of Alcohol and Other Drug Treatment* measure assesses the degree to which patients with a need for alcohol and other drug (AOD) dependence services are engaged in initiating and continuing treatment once the need for care has been identified. Identifying patients with alcohol and other drug dependence disorders is an important first step in the process of care but identification often does not lead to initiation of care. The patient may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services.

Treatment engagement is an intermediate step between initially accessing care (the first visit) and completing a full course of treatment. This measure is an important intermediate indicator, closely related to outcome. In fact, studies have tied frequency and intensity of engagement as important in treatment outcome and in reducing drug-related illnesses. (Batten et al., 1992; McLellan et al., 1997).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Initiation and Engagement of Alcohol and Other Drug Treatment* (IET) measures, which guide our efforts in measuring the quality and effectiveness of the care provided. The IET measures specifically focus on improving the degree to which members initiate and continue treatment.

What are the HEDIS® IET measures?

This two-part measure looks at:

- *Initiation Phase*. The percentage of adolescent and adult patients age 13 years and older with a new diagnosis of alcohol or other drug dependency who complete a first treatment visit (initiation) within 14 days of the date of the initial diagnosis.
- *Engagement Phase.* The percentage of patients who completed the first treatment visit (initiation) and who had *two or more additional visits* with an AOD diagnosis within 30 days of the first visit.
- Following the date of the initial diagnosis*, a total of at least three visits* are required over both phases of the measure.

What are the best practices regarding these HEDIS® measures?

- Annually assess each patient for alcohol and other drug use, or whenever the possibility of substance abuse having an impact on a patient's presenting issues is suspected.
- Document the diagnosis of a suspected substance abuse issue. Often, practitioners are reluctant to use a substance abuse diagnosis for fear of stigmatizing a patient who has discussed his or her struggles with substances. Lack of labeling a diagnosis, however, prevents other clinicians from working with a patient in a coordinated manner, ultimately resulting in less effective care for the patient.
- Follow up with the patient. Schedule a follow-up appointment, or schedule appointments with a qualified behavioral health clinician. Ensure that a substance abuse diagnosis is included in each follow-up visit.
- Patients may want to minimize their substance abuse, so persistence is required in raising the topic and keeping it at the forefront of a patient's treatment.

What is the relevance of these measures?

- There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. (Schneider Institute for Health Policy & Brandeis University, 2001).
- Numerous studies indicate that individuals who remain in treatment for a longer duration of time have improved outcome, but the 1990 Drug Service Research Survey suggested that many clients (52 percent) with AOD disorders leave treatment prematurely. (Institute of Medicine [IOM], 1990).
- Alcohol and other drug (AOD) dependence is common across many age groups and a cause of morbidity, mortality and decreased productivity.
- In 2012, an estimated 23.1 million Americans (8.9 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (1 percent) received treatment (National Institute on Drug Abuse [NIDA], "Nationwide," 2014).
- Abuse of alcohol and illicit drugs totals more than $700 billion annually in costs related to crime, lost work productivity and health care (NIDA, "Drugs, brain," 2014).
- Abuse of alcohol, illicit and prescription drugs contributes to the death of more than 90,000 Americans each year (NIDA, "Drugs, brain," 2014).
- There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs.

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HEDIS® TIPS:
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment

MEASURE DESCRIPTION

The percentage of adolescent and adult members 13 years of age and older with a new diagnosis of alcohol or other drug (AOD) dependence with the following:

- *Initiation of AOD Treatment.* Initiate treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.
- *Engagement of AOD Treatment.* Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

USING CORRECT BILLING CODES

Codes to Identify AOD Dependence

ICD-9-CM Diagnosis
291.0-291.5, 291.81, 291.82, 291.89, 291.9, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.30, 535.31, 571.1
ICD-10-CM Diagnosis (to be used on or after 10/1/15)
F10.10 – F10.20, F10.22 – F10.29, F11.10 – F11.20, F11.22 – F11.29, F12.10 – F12.20, F12.22 – F12.29, F13.10 – F13.20, F13.22 – F13.29, F14.10 – F14.20, F14.22 – F14.29, F15.10 – F15.20, F15.22 – F15.29, F16.10 – F16.20, F16.22 – F16.29, F18.10 – F18.20, F18.22 – F18.29, F19.10 – F19.20, F19.22 – F19.29

Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits (*use these visit codes along with the one of the diagnosis codes above to capture initiation and engagement of AOD treatment*)

CPT	HCPCS	UB Revenue
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064,S0201, S9480, S9484, S9485, T1006, T1012, T1015	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983

CPT		POS
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❒ Consider using screening tools or questions to identify substance abuse issues in patients.
- ❒ If a substance abuse issue is identified, document it in the patient chart and submit a claim with the appropriate codes, as described above.
- ❒ Using diagnosis codes that are the result of alcohol or drug dependency (ex. Cirrhosis) also qualify patients for the measures, so avoid inappropriate use of these codes.
- ❒ When giving a diagnosis of alcohol or other drug dependence, schedule a follow-up visit within 14 days and at least two additional visits within 30 days, or refer immediately to a behavioral health provider.
- ❒ Involve family members or others who the patient desires for support and invite their help in intervening with the patient diagnosed with AOD dependence.
- ❒ Provide patient educational materials and resources that include information on the treatment process and options.
- ❒ If a Molina Care Manager contacts you about a recent encounter by a patient for substance dependency, it will be important to work collaboratively with the Care Manager to motivate the patient to initiate treatment.
- ❒ The timeframe for initiating treatment is brief (14 days) but ongoing discussions with patients about treatment help increase their willingness to commit to the process.

Updated 10/20/2015

Follow-Up After Hospitalization for Mental Illness

Effective discharge planning ensures continuous and coordinated quality behavioral health care treatment for patients following discharge from acute care facilities. Timely follow-up after an inpatient psychiatric hospitalization promotes continuity of behavioral health care and supports a patient's return to baseline functioning in a less restrictive level of care. These factors are key in facilitating therapeutic gains and successful outcomes.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of National Committee for Quality Assurance (NCQA) HEDIS® *Follow-Up After Hospitalization for Mental Illness* (FUH) measures, which guide our efforts in measuring the quality and effectiveness of the care provided. The FUH measures specifically focus on follow-up care after an acute care hospitalization.

What are the HEDIS® FUH measures?
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

1. The percentage of patients who received follow-up within 30 days of discharge
2. The percentage of patients who received follow-up within 7 days of discharge

What are the best practices regarding these HEDIS® measures?
Inpatient Providers:

- Discharge planning should begin as soon as a patient is admitted and should be ongoing
- Ensure the patient's discharge paperwork is sent to his or her outpatient provider within 24 hours
- Schedule the patient's aftercare appointment prior to discharge
- Attempt to alleviate barriers to attending appointments prior to discharge

Outpatient Providers:

- Ensure flexibility when scheduling appointments for patients who are being discharged from acute care; the appointment should be scheduled within seven days of discharge.
- Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration.

What is the relevance of these measures?

- Approximately one in four adults in the United States (U.S.) suffers from mental illness in a given year and nearly half of U.S. adults will develop at least one mental illness in their lifetime (National Alliance on Mental Illness [NAMI], "Mental illness," 2011; Centers for Disease Control and Prevention [CDC], 2011).
- Mental health care costs the health care system $113 billion annually (Garfield & Kaiser Commission on Medicaid and the Uninsured, 2011). Mental health costs increase to $300 billion annually when they include health care and treatment services, lost earnings and wages and disability benefits (Reeves et al., 2011).
- About 3 percent of adults with mental illness receive treatment in inpatient settings, which constitutes the largest share of mental health spending (28 percent) (Levit et al., 2008).
- People with mental illness are at increased risk of suicide, which is the 11th leading cause of death in the U.S., accounting for 30,000 deaths each year (NAMI, "The impact," 2011).
- Mental health is the leading cause of disability in the U.S. Around 45 percent of persons with a mental health disorder suffer from two or more diagnosable disorders (National Institute of Mental Health [NIMH], 2013).
- Mental health is an important aspect of health and well-being. Proper follow-up care can improve health outcomes for adults and children.

- American Academy of Child and Adolescent Psychiatry, American Psychiatric Association. Criteria for short-term treatment of acute psychiatric illness. 1997.
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- Garfield RL, Kaiser Commission on Medicaid and the Uninsured. Mental health financing in the United States: a primer. Washington (DC): The Henry J. Kaiser Family Foundation; 2011 Apr. 46 p.
- Levit KR, Kassed CA, Coffey RM, Mark TL, McKusick DR, King E, et al. Projections of national expenditures for mental health services and substance abuse treatment, 2004-2014. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2008.
- National Alliance on Mental Illness (NAMI). Mental illness: what is mental illness: mental illness facts. [internet]. Arlington (VA): National Alliance on Mental Illness (NAMI); 2011 [accessed 2014 Jun 20].
- National Alliance on Mental Illness. The impact and cost of mental illness: the case of depression. [internet]. Arlington (VA): National Alliance on Mental Illness; 2011 [accessed 2011 Jun 10].
- National Institute of Mental Health (NIMH). The numbers count: mental disorders in America. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2013 [accessed 2014 Jun 20].
- Reeves WC, Strine TW, Pratt LA, Thompson W, Ahluwalia I, Dhingra SS, McKnight-Eily LR, Harrison L, D'Angelo DV, Williams L, Morrow B, Gould D, Safran MA, Centers for Disease Control and Prevention (CDC). Mental illness surveillance among adults in the United States. MMWR Surveill Summ. 2011 Sep 2;60 Suppl 3:1-29.

HEDIS® TIPS:
Follow-up After Hospitalization for Mental Illness

MEASURE DESCRIPTION

Patients 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7- and 30- days of discharge.

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits *(must be with mental health practitioner)*

Description	Codes
Follow-up Visits	**CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510 **Transitional Care Management Visits:** 99495 (only for 7-day indicator), 99496 (only for 30-day follow-up indicator) **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **UB Rev (visit in a behavioral health setting):** 0513, 0900-0905, 0907, 0911-0919 **UB Rev (visit in a non-behavioral health setting):** 0510, 0515-0523, 0526-0529, 0982, 0983

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876	***WITH***	**POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	**POS:** 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❑ The literature indicates that during the first 7 days post-discharge the member is at greater risk for rehospitalization and, within the first 3 weeks post-discharge the risk of self-harm is high.
- ❑ Ensure that the follow-up appointment is made before the patient leaves the hospital and is scheduled within 7 days of discharge. Same-day outpatient visits count.
- ❑ Assist the patient with navigation of barriers, such as using their transportation benefit to get to their follow-up appointment.
- ❑ Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration.
- ❑ Ensure accurate discharge dates and document not just appointments scheduled, but appointments kept. Visits must be with a *mental health practitioner.*
- ❑ Follow-up visits must be supported by a claim, encounter or note from the mental health practitioner's medical chart.
- ❑ Since the window for timely follow-up is so brief, patients discharged to lower levels of care need to be documented accurately for the measure logic to be applied properly.

HEDIS® TIPS:
Follow-up After Hospitalization for Mental Illness (Florida)

MEASURE DESCRIPTION

Patients 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7- and 30- days of discharge.

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits *(must be with mental health practitioner)*

Description	Codes
Follow-up Visits	**CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510 **Transitional Care Management Visits:** 99495 (only for 7-day indicator), 99496 (only for 30-day follow-up indicator) **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **UB Rev (visit in a behavioral health setting)**: 0513, 0900-0905, 0907, 0911-0919 **UB Rev (visit in a non-behavioral health setting)**: 0510, 0515-0523, 0526-0529, 0982, 0983 **Community Behavioral Health Codes (must use codes with 2-letter modifiers as identified below):** H2019 HR, H2019 HR GT, H2019 HQ, H2030, H2019 HO, H2019 HN, H2020 HA, H2000 HP, H2000 HP GT, H2000 HO, H2010 HO, H2010 HO GT, H0031 HO, H0031 HO GT, H0031 TS, H0031 HN, H0031 HN GT, H0032. H0032 TS, T1015 GT, H2010 HE, H2010 HE GT, H2010 HQ, T1023 HE, H0046, H0046 GT, T1015 HE, H2020 HA

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876	***WITH***	**POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	**POS:** 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❑ The literature indicates that during the first 7 days post-discharge the patient is at greater risk for rehospitalization and, within the first 3 weeks post-discharge the risk of self-harm is high.
- ❑ Ensure that the follow-up appointment is made before the patient leaves the hospital and is scheduled within 7 days of discharge. Same-day outpatient visits count.
- ❑ Assist the patient with navigation of barriers, such as using their transportation benefit to get to their follow-up appointment.
- ❑ Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration.
- ❑ Ensure accurate discharge dates and document not just appointments scheduled, but appointments kept. Visits must be with a *mental health practitioner.*
- ❑ Follow-up visits must be supported by a claim, encounter or note from the mental health practitioner's medical chart.
- ❑ Since the window for timely follow-up is so brief, patients discharged to lower levels of care need to be documented accurately for the measure logic to be applied properly.

Updated 10/22/2015

Follow-Up Care for Children Prescribed ADHD Medication

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems (American Academy of Pediatrics [AAP], 2000). Given the high prevalence of ADHD among school-aged children (4 to 12 percent), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition (AAP, 2001).

Practitioners can convey the efficacy of pharmacotherapy to their patients. AAP guidelines (2000) recommend that once a child is stable, an office visit every 3 to 6 months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication* (ADD) measures, which guide our efforts in measuring the quality and effectiveness of the care provided. The ADHD measures focus on promoting appropriate follow-up care to monitor clinical symptoms and potential adverse events for patients with ADHD.

What are the HEDIS® ADHD measures?
This two-part measure looks at:

- *Initiation Phase.* The percentage of patients 6 to 12 years of age prescribed an ADHD medication who had *one follow-up visit* with a prescribing practitioner within 30 days of the initial prescription.
- *Continuation an Maintenance Phase.* The percentage of patients who remain on ADHD medication for 6 or more months and who complete at least *two additional follow-up visits* within a 9 month period.
- *A total of at least three visits* are required over both phases of the measure.

What are the best practices regarding these HEDIS® measures?

- When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- Schedule two more visits in the 9 months after the first 30 days, to continue to monitor your patient's progress.
- Use a **phone visit** for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult.
- NEVER continue these controlled substances without at least 2 visits per year to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure they are on the correct dosage.

What is the relevance of these measures?

- Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. Ten percent of American children have been diagnosed with ADHD, whose main features are hyperactivity, impulsiveness and an inability to sustain attention or concentration (Bloom, Jones, & Freeman, 2013; American Psychiatric Association [APA], 2012).
- Children with ADHD add a high annual cost to the United States (U.S.) education system–on average, $5,000 each year for each student with ADHD (Robb et al., 2011).
- Studies suggest that there is increased risk for drug use disorders in adolescents with untreated ADHD (National Institute on Drug Abuse [NIDA], 2011).
- When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.

- American Academy of Pediatrics. Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics. 2000 May;105(5):1158-70. [60 references]
- American Academy of Pediatrics. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. Pediatrics. 2001 Oct;108(4):1033-44. PubMed
- American Psychiatric Association (APA). Children's mental health. [internet]. Arlington (VA): American Psychiatric Association (APA); 2012 [accessed 201 Jun 01].
- Bloom B, Jones LI, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2012. Vital Health Stat 10. 2013 Dec;(258):1-81. PubMed
- National Committee for Quality Assurance (NCQA). The state of health care quality 2014. Washington (DC): National Committee for Quality Assurance (NCQA); 2014 Oct. 182 p.
- National Institute on Drug Abuse (NIDA). Comorbidity: addiction and other mental illnesses. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2011 [accessed 201 Sep 06].
- Robb JA, Sibley MH, Pelham WE, Foster ME, Molina BS, Gnagy EM, Kuriyan AB. The estimated annual cost of ADHD to the US education system. School Mental Health. 2011;3:167-77.

HEDIS® TIPS:

Follow-up Care for Children Prescribed ADHD Medication

MEASURE DESCRIPTION

Patients 6-12 years old, with a new prescription for an attention-deficit/hyperactivity disorder (ADHD) medication who had:

- At least one follow-up visit with practitioner with prescribing authority during the first 30 days of when the ADHD medication was dispensed. (Initiation Phase)
- At least two follow-up visits within 270 days (9 months) after the end of the initiation phase. One of these visits may be a telephone call. (Continuation and Maintenance Phase)

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits

Description	Codes
Follow-up Visits	**CPT:** 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411, 99412, 99510 **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **UB Revenue:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
Telephone Visits	**CPT:** 98966-98968, 99441-99443 (Can use for one Continuation and Maintenance Phase visit)

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	***WITH***	**POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	**POS:** 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❑ When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- ❑ Schedule two more visits in the 9 months after the first 30 days to continue to monitor your patient's progress.
- ❑ Use a **phone visit** for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult **(codes: 98966-98968, 99441-99443).** Only one phone visit is allowed during the Continuation and Maintenance Phase. If a phone visit is done, at least one face-to-face visit should also be completed.
- ❑ NEVER continue these controlled substances without at least 2 visits per year to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure they are on the correct dosage.

Updated 7/31/2015

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

People with schizophrenia are at a greater risk of metabolic syndrome due to their serious mental illness (Cohn et al., 2004) Diabetes screening is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen people with schizophrenia for diabetes. Diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication may lead to earlier identification and treatment of diabetes.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting recommended diabetes screening for schizophrenic and bipolar patients prescribed antipsychotic medications.

What is the HEDIS® Diabetes Screening measure?

- The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- A glucose test or an HbA1c test is required by the measure.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- In 2007, diabetes was estimated to cost the U.S. economy $174 billion. Of this, $116 billion was attributed to medical care and $58 billion to disability, work loss and premature death (Roger et al., 2011).
- People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

- Cohn T, Prud'homme D, Streiner D, Kameh H, Remington G. Characterizing coronary heart disease risk in chronic schizophrenia: high prevalence of the metabolic syndrome. Can J Psychiatry. 2004 Nov;49(11):753-60.
- Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.
- Roger VL, Go AS, Lloyd-Jones DM, Adams RJ, Berry JD, Brown TM, Carnethon MR, Dai S, de Simone G, Ford ES, Fox CS, Fullerton HJ, Gillespie C, Greenlund KJ, Hailpern SM, Heit JA, Ho PM, Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Makuc DM, Marcus GM, Marelli A, Matchar DB, McDermott MM, Meigs JB, Moy CS, Mozaffarian D, Mussolino ME, Nichol G, Paynter NP, Rosamond WD, Sorlie PD, Stafford RS, Turan TN, Turner MB, Wong ND, Wylie-Rosett J. Heart disease and stroke statistics--2011 update: a report from the American Heart Association. Circulation. 2011 Feb 1;123(4):e18-209.
- Vinogradova Y, Coupland C, Hippisley-Cox J, Whyte S, Penny C. Effects of severe mental illness on survival of people with diabetes. Br J Psychiatry. 2010 Oct;197(4):272-7.

HEDIS® TIPS:

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (glucose test or HbA1c test) during the measurement year.

USE CORRECT BILLING CODES

Codes to Identify Diabetes Screening

Description	Codes
Codes to Identify Glucose Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3045F (if HbA1c 7%-9%), 3046F (if HbA1c>9%)

Antipsychotic Medications

Description	Generic Name	Brand Name
Miscellaneous antipsychotic agents	Aripiprazole, Asenapine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone	Abilify, Saphris, Clozaril, Haldol, Fanapt, Loxipac/Loxitane, Latuda, Moban, Zyprexa, Invega, Orap, Seroquel, Seroquel XR, Risperdal, Geodon
Phenothiazine antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluperazine	Thorazine, Prolixin, Trilafon, Etrafon, Compazine, Mellaril, Stelazine
Psychotherapeutic combinations	Fluoxetine-olanzapine	Symbyax
Thioxanthenes	Thiothixene	Navane
Long-acting injections	Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone	Abilify Maintena, Prolixin, Haldol Decanoate INJ, Zyprexa Relprew, Invega Sustenna, Risperdal Consta

HOW TO IMPROVE HEDIS® SCORES

- ❑ Patients with schizophrenia and bipolar disorder who are prescribed antipsychotic medication may be at a higher risk for developing diabetes than the population at large. Therefore, care coordination between the primary care physician (PCP) and behavioral health (BH) prescriber is a key component in the development of a comprehensive treatment plan.
- ❑ Whether the antipsychotic medication is prescribed by a PCP or psychiatrist, the patient will need assistance with scheduling a follow-up appointment in 1-3 months with their PCP to screen for diabetes. If the patient is not ready to schedule appointment, make note or flag chart to contact the patient with a reminder to schedule an appointment.
- ❑ Ensure patient (and/or caregiver) is aware of the risk of diabetes and have awareness of the symptoms of new onset of diabetes while taking antipsychotic medication.
- ❑ PCP's office should schedule lab screenings prior to next appointment.
- ❑ The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- ❑ Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.

Updated 9/9/2015

Diabetes Monitoring for People with Diabetes and Schizophrenia

Prevalence rates of metabolic syndrome in people with schizophrenia is 42.6 percent for males and 48.5 percent for females, compared with rates in the general population (24 percent for males, 23 percent for females) (Cohn et al., 2004).

Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent (Nasrallah et al., 2006). In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine (Nielsen, Skadhede, & Correll, 2010).

Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment (Asche, LaFleur, & Conner, 2011). People who control their diabetes also report improved quality of life and emotional well - being (Saatci et al., 2011).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting appropriate diabetes monitoring for patients diagnosed with *both* diabetes and schizophrenia.

What is the HEDIS® Diabetes Monitoring measure?

- This measure is used to assess the percentage of patients 18 to 64 years of age with schizophrenia and diabetes who had *both* an LDL-C test and an HbA1c test during the measurement year.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- In 2007, diabetes was estimated to cost the U.S. economy $174 billion. Of this, $116 billion was attributed to medical care and $58 billion to disability, work loss and premature death (Roger et al., 2011).
- People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

- Asche C, LaFleur J, Conner C. A review of diabetes treatment adherence and the association with clinical and economic outcomes. Clin Ther. 2011 Jan;33(1):74-109.
- Cohn T, Prud'homme D, Streiner D, Kameh H, Remington G. Characterizing coronary heart disease risk in chronic schizophrenia: high prevalence of the metabolic syndrome. Can J Psychiatry. 2004 Nov;49(11):753-60.
- Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.
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- Nielsen J, Skadhede S, Correll CU. Antipsychotics associated with the development of type 2 diabetes in antipsychotic-naive schizophrenia patients. Neuropsychopharmacology. 2010 Aug;35(9):1997-2004.
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- Saatci E, Tahmiscioglu G, Bozdemir N, Akpinar E, Ozcan S, Kurdak H. The well-being and treatment satisfaction of diabetic patients in primary care. Health Qual Life Outcomes. 2010;8:67.
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HEDIS® TIPS:

Diabetes Monitoring for People with Diabetes and Schizophrenia

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

USE CORRECT BILLING CODES

Description	Codes
Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3045F (if HbA1c 7%-9%, 3046F (if HbA1c>9%)
Codes to Identify LDL-C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F
Codes to Identify Schizophrenia	**ICD-9 CM:** 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295.75, 295.80-295.85, 295.90-295.95 ***ICD-10 CM:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Codes to Identify Diabetes	**ICD-9 CM:** 250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, 250.50-250.53, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04 ***ICD-10 CM:** E.10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39-E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.620-E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40-E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620-E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40-E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620-E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.68, E13.8, E13.9, O24.011-O24.013, O24.019, O24.02, O24.03, O24.111-O24.113, O24.119, O24.12, O24.13, O24.311-O24.313, O24.319, O24.32, O24.33, O24.811-O24.813, O24.819, O24.82, O24.83

**ICD-10 codes to be used on or after 10/1/2015*

HOW TO IMPROVE HEDIS® SCORES

- ❑ Review diabetes services needed at each office visit.
- ❑ Order labs prior to patient appointments.
- ❑ If point-of-care HbA1c tests are completed in-office, helpful to bill for this; also ensure HbA1c result and date are documented in the chart.
- ❑ For LDLs, if patient is not fasting, order a direct LDL to avoid a missed opportunity. Some lab order forms have conditional orders – if fasting, LDL-C; if not fasting, direct LDL.
- ❑ The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- ❑ Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes.
- ❑ If patient has a caregiver, make sure they are given instruction on the course of treatment, labs or future appointment dates.
- ❑ Regular monitoring of body mass index, plasma glucose level, lipid profiles and signs of prolactin elevation should be done at each appointment.
- ❑ Continue to educate patients about appropriate health screenings with some medication therapies.
- ❑ Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Care Coordination with the patient's behavioral health provider is a key component in the development of a comprehensive treatment plan.

Updated 9/9/2015

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Patients with schizophrenia are likely to have higher levels of blood cholesterol and are more likely to receive less treatment. Patients with schizophrenia and elevated blood cholesterol levels are prescribed statins at approximately a quarter of the rate of the general population. Furthermore, certain atypical antipsychotic drugs increase total and low-density lipoprotein (LDL) cholesterol and triglycerides, and decrease high-density lipoprotein (HDL) cholesterol, which increases the risk of coronary heart disease (Hennekens et al., 2005).

Among patients with co-occurring schizophrenia and metabolic disorders, rates of non-treatment for hyperlipidemia and hypertension were 62.4 percent for hypertension and 88.0 percent for hyperlipidemia (Nasrallah et al., 2006). Atypical antipsychotic medications elevate the risk of metabolic conditions, relative to typical antipsychotic medications (Nasrallah, 2008).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting appropriate cardiovascular monitoring for patients diagnosed with *both* cardiovascular disease and schizophrenia.

What is the HEDIS® Cardiovascular Monitoring measure?

- This measure is used to assess the percentage of patients 18 to 64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- The total cost of cardiovascular disease in 2010 was estimated to be $315.4 billion (Go et al., 2014).
- Cardiovascular disease is the greatest contributor to death in patients with schizophrenia (Capasso et al., 2008).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

- Capasso RM, Lineberry TW, Bostwick JM, Decker PA, St Sauver J. Mortality in schizophrenia and schizoaffective disorder: an Olmsted County, Minnesota cohort: 1950-2005. Schizophr Res. 2008 Jan;98(1-3):287-94.
- Go AS, Mozaffarian D, Roger VL, Benjamin EJ, Berry JD, Blaha MJ, Dai S, Ford ES, Fox CS, Franco S, Fullerton HJ, Gillespie C, Hailpern SM, Heit JA, Howard VJ, Huffman MD, Judd SE, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Mackey RH, Magid DJ, Marcus GM, Marelli A, Matchar DB, McGuire DK, Mohler ER, Moy CS, Mussolino ME, Neumar RW, Nichol G, Pandey DK, Paynter NP, Reeves MJ, Sorlie PD, Stein J, Towfighi A, Turan TN, Virani SS, Wong ND, Woo D, Turner MB, American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics--2014 update: a report from the American Heart Association. Circulation. 2014 Jan 21;129(3):e28-292.
- Hennekens CH, Hennekens AR, Hollar D, Casey DE. Schizophrenia and increased risks of cardiovascular disease. Am Heart J. 2005 Dec;150(6):1115-21. [58 references]
- Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.
- Nasrallah HA, Meyer JM, Goff DC, McEvoy JP, Davis SM, Stroup TS, Lieberman JA. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophr Res. 2006 Sep;86(1-3):15-22.
- Nasrallah HA. Atypical antipsychotic-induced metabolic side effects: insights from receptor-binding profiles. Mol Psychiatry. 2008 Jan;13(1):27-35. [94 references]

HEDIS® TIPS:

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.

Members who have cardiovascular disease are defined as having any of the following:

- Discharged from an inpatient setting with an Acute Myocardial Infarction (AMI) or any setting with a Coronary Artery Bypass Graft (CABG) during the year prior to the measurement year,
- Members who had a Percutaneous Coronary Intervention (PCI) during the year prior to the measurement year, or
- Members diagnosed with Ischemic Vascular Disease (IVD) during both the measurement year and the year prior to measurement year.

USE CORRECT BILLING CODES

Description	Codes
Codes to Identify LDL–C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F

HOW TO IMPROVE HEDIS® SCORES

- ❑ Patients with schizophrenia and cardiovascular disease require care coordination between the primary care physician (PCP) and behavioral health (BH) provider. This care coordination is a key factor in the development of a comprehensive treatment plan.
- ❑ Order labs prior to patient appointments.
- ❑ The BH provider can order lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- ❑ Review cardiovascular services needed at each office visit and ensure lipid levels, blood pressure and glucose are monitored at every appointment.
- ❑ Educate patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle. This includes nutrition, exercise and smoking cessation.
- ❑ For LDLs, if patient is not fasting, order direct LDL to avoid a missed opportunity.
- ❑ Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes.
- ❑ Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.

Updated 10/21/2015

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

For people with schizophrenia, nonadherence to treatment with antipsychotics is common, and medication nonadherence is a significant cause of relapse (Olfson, Hansell, & Boyer, 1997; Ascher-Svanum et al., 2010). Measuring antipsychotic medication adherence may lead to less relapse and fewer hospitalizations. Additionally, there is potential to lead to interventions to improve adherence and help close the gap in care between people with schizophrenia and the general population.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting medication adherence and compliance for patients diagnosed with schizophrenia.

What is the HEDIS® Adherence to Antipsychotic Medications measure?

- This measure is used to assess the percentage of patients 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

What are the best practices regarding this HEDIS® measure?

- Schedule appropriate follow-up with the patient to assess if medication is taken as prescribed.
- Continue educating patients about the importance of adhering to their medication therapy and follow-up visits with their provider(s).
- Do not rely on the patient to follow through with scheduling subsequent appointments. Routinely arrange the next appointment when the patient is in the office. If the patient misses a scheduled appointment, office staff should contact the patient to:
    - Assess why the appointment was missed
    - Reschedule the appointment and assess the possibility of a relapse
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment and incoherent speech (American Psychiatric Association [APA], n.d.). Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization (Busch et al., 2009).
- In 2002, the overall economic burden of schizophrenia was estimated to be $62.7 billion (Wu et al., 2005).
- The cost of care for people with schizophrenia and a history of prior relapse is three times higher than it is for people without a history of prior relapse (Ascher-Svanum et al., 2010).
- 1.1 percent of adults in the United States have schizophrenia (Wu et al., 2005).
- Approximately 40 percent of hospital readmissions for patients with schizophrenia are attributed to nonadherence to antipsychotic medications (Weiden & Olfson, 1995).
- Nearly half of people with schizophrenia take less than 70 percent of prescribed medication doses (Goff, Hill, & Freudenreich, 2010).
- People with schizophrenia who discontinue their medications are twice as likely to experience a relapse in symptoms than those who continue their prescribed doses (Wunderink et al., 2007).
- Schizophrenia is a life-long mental illness that can be tough to treat and manage. Continuation of medication is important to reduce the number of relapse episodes and the need for hospitalization.

- American Psychiatric Association (APA). Schizophrenia fact sheet. [internet]. Arlington (VA): American Psychiatric Association (APA); [accessed 2014 Jun 19].
- Ascher-Svanum H, Zhu B, Faries DE, Salkever D, Slade EP, Peng X, Conley RR. The cost of relapse and the predictors of relapse in the treatment of schizophrenia. BMC Psychiatry. 2010;10:2.
- Busch AB, Lehman AF, Goldman H, Frank RG. Changes over time and disparities in schizophrenia treatment quality. Med Care. 2009 Feb;47(2):199-207.
- Goff DC, Hill M, Freudenreich O. Strategies for improving treatment adherence in schizophrenia and schizoaffective disorder. J Clin Psychiatry. 2010;71 Suppl 2:20-6.
- Olfson M, Hansell S, Boyer CA. Medication noncompliance. New Dir Ment Health Serv. 1997 Spring;(73):39-49. [36 references]
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- Wu EQ, Birnbaum HG, Shi L, Ball DE, Kessler RC, Moulis M, Aggarwal J. The economic burden of schizophrenia in the United States in 2002. J Clin Psychiatry. 2005 Sep;66(9):1122-9.
- Wunderink L, Nienhuis FJ, Sytema S, Slooff CJ, Knegtering R, Wiersma D. Guided discontinuation versus maintenance treatment in remitted first-episode psychosis: relapse rates and functional outcome. J Clin Psychiatry. 2007 May;68(5):654-61.

HEDIS® TIPS:

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

MEASURE DESCRIPTION

The percentage of patients 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

USE CORRECT BILLING CODES

Codes to Identify Schizophrenia

Description	Codes
Schizophrenia	**ICD-9CM:** 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295.75, 295.80-295.85, 295.90-295.95 ***ICD-10CM:** F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

**ICD-10 codes to be used on or after 10/1/2015*

Codes to Identify Long-Acting Injections

Description	Codes
Long-Acting Injections	**HCPCS:** J2794, J0401, J1631, J2358, J2426, J2680

ANTIPSYCHOTIC MEDICATIONS

Description	Generic Name	Brand Name
Miscellaneous antipsychotic agents	Aripiprazole, Asenapine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone	Abilify, Saphris, Clozaril, Haldol, Fanapt, Loxipac/Loxitane, Latuda, Moban, Zyprexa, Invega, Orap, Seroquel, Seroquel XR, Risperdal, Geodon
Phenothiazine antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluperazine	Thorazine, Prolixin, Trilafon, Etrafon, Compazine, Mellaril, Stelazine
Psychotherapeutic combinations	Fluoxetine-olanzapine	Symbyax
Thioxanthenes	Thiothixene	Navane
Long-acting injections	***28 days supply***: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate ***14 days supply***: Risperidone	Abilify Maintena, Prolixin, Haldol Decanoate INJ, Zyprexa Relprew, Invega Sustenna, Risperdal Consta

HOW TO IMPROVE HEDIS® SCORES

- ❑ Schedule appropriate follow-up with the patients to access if medication is taken as prescribed.
- ❑ Continue educating patients about the importance of adhering to their medication therapy and follow-up visits with their provider(s).
- ❑ Patients with at least six (6) chronic medications and at least three (3) qualifying diagnoses may be eligible for Medication Therapy Management (MTM) sessions. For additional information about MTM criteria and to request a referral, contact Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Do not rely on the patient to follow through with scheduling subsequent appointments. Routinely arrange the next appointment when the patient is in the office. If the patient misses a scheduled appointment, office staff should contact the patient to:
  - Assess why the appointment was missed
  - Reschedule the appointment and assess the possibility of a relapse
- ❑ Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.

Updated 9/9/2015

Risk Adjustment

The following pages provide a one page educational tool for the mental disorders that are risk adjustable as well as the codes that can be used for each mental disorder for risk adjustment purposes. Such risk adjustment codes represent a subset of all diagnostic codes for mental disorders. For a complete list of all diagnostic codes, refer to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition). Providers should only use a risk adjustable code if it represents a condition that the Provider believes the Member has.

Risk Adjustment

- Risk Adjustment is the process by which the *Centers for Medicare and Medicaid Services* (CMS) uses health status and demographic information gathered from providers and health plans to stratify patients by risk.
- This information is used to determine Medicare Advantage Plan premiums.
- Some State Medicaid programs use risk adjustment to determine premium revenue as well.
- Accurate Risk Adjustment submissions allow a complete picture of a patient's health status with resulting benefits to CMS, State Medicaid programs, health plans, providers and the beneficiary.

Risk Adjustment Diagnostic Code Sets & Documentation

CMS requires the use of specific ***diagnostic codes*** as well as accurate ***medical record documentation*** to support the diagnostic code.

❖ Diagnostic Codes

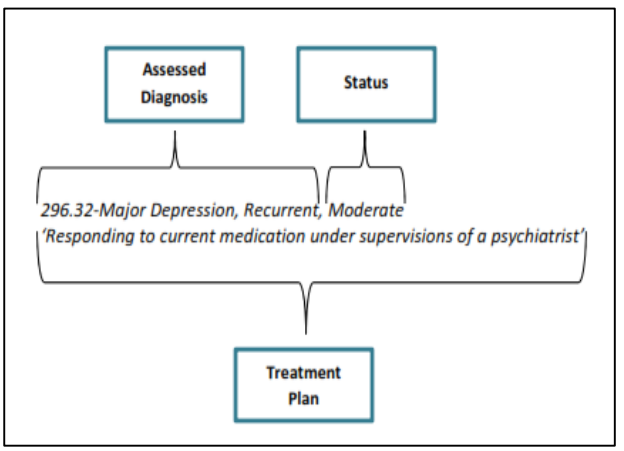
Acceptable Risk Adjustment diagnostic codes for the behavioral health conditions listed below can be found in this document:

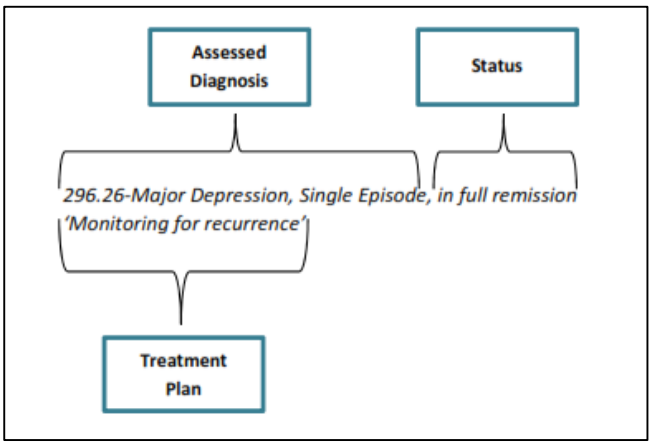
- Major Depressive Disorder
- Alcohol and Other Drug Dependencies
- Bipolar Disorder
- Schizophrenia

❖ Required Medical Record Documentation

Documentation must include:

- Assessed Diagnosis – **Evidence** in chart the condition is present
- Status – **Evaluation** of the condition in the note
- Treatment Plan - Linked **plan** of action in the note
    - A **plan** can include:
        - Description of a procedure
        - Referral to a specialist
        - Medication change
        - Lab order
        - Monitoring, planning to follow-up
- Examples of complete documentation:





Molina Healthcare Education Tool
for Major Depression

Clinicians often struggle with accurately diagnosing Major Depression. The distinction between a single episode and a recurrent episode is necessary to identify and document the manifestations of your patient's disease burden. The other key factor to remember is that the term chronic can apply to a recurrent or single episode. To further clarify, a single or first time event is coded as **296.20* (ICD-9)/F32.0-F32.5* (specifier required) (ICD-10)** and any patient who has experienced subsequent episodes should be coded as **296.30* (ICD-9)/F33.9* (ICD-10).**

ICD-9: 296.20*, Major Depressive Disorder, *single episode, unspecified*

ICD-10: F32.0-F32.5*, Major Depressive Disorder, *single episode, specifier required* *(e.g., mild, F32.0*; moderate, F32.1*; severe without psychotic symptoms, F32.2*; severe with psychotic symptoms, F32.3*; in partial remission, F32.4*; in full remission, F32.5*)*

OR

ICD-9: 296.30*, Major Depression, *recurrent, unspecified*

ICD-10: F33.9*, Major Depressive Disorder, *recurrent, unspecified*

Documentation Examples:

- 65 year old Latina presenting with new onset depressive symptoms for past 2 months including daily depressed mood, loss of energy and inability to concentrate. PHQ-9 score of 12 (moderate depression).

  Assessment: Patent is newly diagnosed with major depression, single episode, moderate; needing medical and cognitive therapy

  Plan: Start Citalopram 20 mg and refer for psychotherapy

  ICD-9: 296.22*, Major Depressive Disorder, single episode, moderate

  ICD-10: F32.1*, Major Depressive Disorder, single episode, moderate

  OR

- 73 year old female with many known episodes of Major Depression now complaining of worsening symptoms including increased loss of interest in activities, hypersomnia, increased tearfulness and sadness. Denies thoughts of self-harm.

  Assessment: Patient diagnosed with Major Depression, recurrent, unspecified; currently symptoms not controlled

  Plan: Increase SSRI dosage and close follow-up recommended.

  ICD-9: 296.30*, Major Depression, recurrent

  ICD-10: F33.9*, Major Depressive Disorder, recurrent, unspecified

**The codes used in this document are for illustrative purposes only*

The ***Patient Health Questionnaire-9 (PHQ-9)*** i a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. It's a ***diagnostic*** measure for Major Depression as well as for recognizing sub-threshold depressive disorders. It can be administered repeatedly – reflecting improvement or worsening of depression in response to treatment.

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Major Depression Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29621	Major depressive disorder, single episode-mild
29622	Major depressive disorder, single episode-moderate
29623	Major depressive disorder, single episode-severe, without mention of psychotic behavior
29624	Major depressive disorder, single episode-severe, specified as with psychotic behavior
29625	Major depressive disorder, single episode-in partial or unspecified remission
29626	Major depressive disorder, single episode-in full remission
29630	Major depressive disorder, recurrent episode-unspecified
29631	Major depressive disorder, recurrent episode-mild
29632	Major depressive disorder, recurrent episode-moderate
29633	Major depressive disorder, recurrent episode-severe, without mention of psychotic behavior
29634	Major depressive disorder, recurrent episode-severe, specified as with psychotic behavior
29635	Major depressive disorder, recurrent episode-in partial or unspecified remission
29636	Major depressive disorder, recurrent episode-in full remission

Major Depression Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F32.0	Major depressive disorder, single episode-mild
F32.1	Major depressive disorder, single episode-moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode-in partial remission
F32.5	Major depressive disorder, single episode-in full remission
F33.0	Major depressive disorder, recurrent episode-mild
F33.1	Major depressive disorder, recurrent episode-moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent episode-in partial remission
F33.42	Major depressive disorder, recurrent episode-in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

Molina Healthcare Education Tool
for Alcohol Dependency

DSM-5 diagnostic criteria for:
Alcohol dependency (moderate to severe)

A problematic pattern of alcohol use leading to clinical impairment as manifested by 4 or more of the following symptoms within a 12-month period:

1. Alcohol taken in larger amounts or over longer period than was intended.
2. Persistent desire or unsuccessful efforts to cut down or control use.
3. Large amount of time spent in activities necessary to obtain or use alcohol, or recover from effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent use resulting in failure to fulfill major role obligations at work, school or home.
6. Continued use despite knowledge of having persistent or recurrent social/interpersonal problems caused or exacerbated by effects of alcohol.
7. Important social, occupational or recreational activities given up or reduced because of use.
8. Recurrent use in situations in which it's physically hazardous.
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal symptoms of alcohol.
    b. Alcohol (or a closely related substance, e.g., a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Documentation Examples:

1. ***Assessment:*** Patient with tolerance - use has increased from 12 12-oz beers daily to 18-20 12-oz beers daily. Has tried but states he's unable to stop use despite work and marriage problems due to alcohol dependence. Missing work 3-4 days/month. Late to work several times/week. Increase in intensity of arguments with wife. Wife threatening to divorce. Patient is aware of risks of continuing use especially given A-fib and Coumadin medication therapy.

   Plan: Referred patient to AA meetings or other 12-step support program. Patient will consider.

   ICD-9 Code: 303.90*, Alcohol dependence, unspecified

   ICD-10 Code: F10.20*, Alcohol dependence, uncomplicated

2. ***Assessment:*** Patient is alcohol dependent, sober for 8 years.

   Plan: Patient encouraged to continue abstinence and continue AA attendance.

   ICD-9 Code: 303.93*, Alcohol dependence, in remission

   ICD-10 Code: F10.21*, Alcohol dependence, in remission

**The codes used in this document are for illustrative purposes only*

The ***CAGE Questionnaire*** is an effective tool in assessing alcohol abuse and dependence. The tool is not diagnostic but is indicative of the existence of an alcohol problem. A positive screen must be followed by a clinical assessment to determine diagnosis.

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
30301	Acute alcohol intoxication-continuous
30302	Acute alcohol intoxication-episodic
30303	Acute alcohol intoxication-in remission
30390	Other and unspecified alcohol dependence-unspecified
30391	Other and unspecified alcohol dependence-continuous
30392	Other and unspecified alcohol dependence-episodic
30393	Other and unspecified alcohol dependence-in remission
30400	Opioid type dependence-unspecified
30401	Opioid type dependence-continuous
30402	Opioid type dependence-episodic
30403	Opioid type dependence-in remission
30410	Sedative, hypnotic or anxiolytic dependence-unspecified
30411	Sedative, hypnotic or anxiolytic dependence-continuous
30412	Sedative, hypnotic or anxiolytic dependence-episodic
30413	Sedative, hypnotic or anxiolytic dependence-in remission
30420	Cocaine dependence-unspecified
30421	Cocaine dependence-continuous

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
30422	Cocaine dependence-episodic
30423	Cocaine dependence-in remission
30430	Cannabis dependence-unspecified
30431	Cannabis dependence-continuous
30432	Cannabis dependence-episodic
30433	Cannabis dependence-in remission
30440	Amphetamine and other psychostimulant dependence-unspecified
30441	Amphetamine and other psychostimulant dependence-continuous
30442	Amphetamine and other psychostimulant dependence-episodic
30443	Amphetamine and other psychostimulant dependence-in remission
30450	Hallucinogen dependence-unspecified
30451	Hallucinogen dependence-continuous
30452	Hallucinogen dependence-episodic
30453	Hallucinogen dependence-in remission
30460	Other specified drug dependence-unspecified
30461	Other specified drug dependence-continuous
30462	Other specified drug dependence-episodic

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
\30463	Other specified drug dependence-in remission
30470	Combinations of opioid type drug with any other drug dependence-unspecified
30471	Combinations of opioid type drug with any other drug dependence-continuous
30472	Combinations of opioid type drug with any other drug dependence-episodic
30473	Combinations of opioid type drug with any other drug dependence-in remission
30480	Combinations of drug dependence excluding opioid type drug-unspecified
30481	Combinations of drug dependence excluding opioid type drug-continuous
30482	Combinations of drug dependence excluding opioid type drug-episodic
30483	Combinations of drug dependence excluding opioid type drug-in remission
30490	Unspecified drug dependence-unspecified
30491	Unspecified drug dependence-continuous
30492	Unspecified drug dependence-episodic
30493	Unspecified drug dependence-in remission

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F11.29	Opioid dependence with unspecified opioid-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.20	Cocaine dependence, uncomplicated

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.229	Inhalant dependence with intoxication, unspecified
F18.24	Inhalant dependence with inhalant-induced moo disorder
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder

Alcohol and Other Drug Dependence Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder

Molina Healthcare Education Tool
for Bipolar Disorder

DSM-5 diagnostic criteria for:
Bipolar I disorder, manic episode

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep.
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility, as reported or observed.
   6. Increase in goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation.
   7. Excessive involvement in activities that have high potential for painful consequences.

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance or to another medical condition.

NOTE: A manic episode that emerges during antidepressant treatment but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Documentation Example:

A 29-year old married, mother of a young child age 2, presents with a history of recurrent and disabling depression and headaches. Several weeks prior to presentation, she became severely depressed and had difficulty moving, had diminished appetite, had crying spells much of the day and felt suicidal. She is on Prozac 20 mg a day, and describes herself as getting "manicky" on the Prozac. She "rushes around, laughs a lot and has more anxiety." A past trial with Wellbutrin was poorly tolerated because of sweating episodes, insomnia and agitation. Her depression is worsening despite the Prozac treatment.

She also describes a history of mood swings for many years. Family history revealed severe mood swings in both her father and paternal grandmother. Grandmother at times would take to bed for long spells, and she had been hospitalized for "unknown reasons".

Assessment: Diagnosis of major depressive disorder is suspect, given patient's poor response to both antidepressants. Prozac was discontinued because it appeared to be worsening the underlying mood swings. Diagnosis of Bipolar Disorder, single episode, manic can be made given patient's symptoms and family history.

Plan: Discontinue Prozac. Patient placed on Seroquel 100 mg at bedtime. Also referred to supportive psychotherapy.

ICD-9 Code: 296.01*, Bipolar I disorder, single manic episode, mild

ICD-10 Code: F30.11*, Bipolar disorder, manic episode without psychotic symptoms, mild

The ***Mood Disorder Questionnaire (MDQ)*** is an effective screening instrument for bipolar disorder. The tool is not diagnostic but is indicative of the existence of bipolar disorder. A positive screen must be followed by a clinical assessment to determine diagnosis.

**The codes used in this document are for illustrative purposes only*

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Bipolar Disorder Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29601	Bipolar I, disorder, single manic episode-mild
29602	Bipolar I, disorder, single manic episode-moderate
29603	Bipolar I, disorder, single manic episode-severe, without mention of psychotic behavior
29604	Bipolar I, disorder, single manic episode-severe, specified as with psychotic behavior
29605	Bipolar I, disorder, single manic episode-in partial or unspecified remission
29606	Bipolar I, disorder, single manic episode-in full remission
29610	Manic disorder, recurrent episode-unspecified
29611	Manic disorder, recurrent episode-mild
29612	Manic disorder, recurrent episode-moderate
29613	Manic disorder, recurrent episode-severe, without mention of psychotic behavior
29614	Manic disorder, recurrent episode-severe, specified as with psychotic behavior
29615	Manic disorder, recurrent episode-in partial or unspecified remission
29616	Manic disorder, recurrent episode-in full remission
29640	Bipolar I, disorder, most recent episode (or current) manic-unspecified
29641	Bipolar I, disorder, most recent episode (or current) manic-mild
29642	Bipolar I, disorder, most recent episode (or current) manic-moderate
29643	Bipolar I, disorder, most recent episode (or current) manic-severe, without mention of psychotic behavior
29644	Bipolar I, disorder, most recent episode (or current) manic-severe, specified as with psychotic behavior
29645	Bipolar I, disorder, most recent episode (or current) manic-in partial or unspecified remission
29646	Bipolar I, disorder, most recent episode (or current) manic-in full remission

Bipolar Disorder Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29650	Bipolar I, disorder, most recent episode (or current) depressed-unspecified
29651	Bipolar I, disorder, most recent episode (or current) depressed-mild
29652	Bipolar I, disorder, most recent episode (or current) depressed-moderate
29653	Bipolar I, disorder, most recent episode (or current) depressed-severe, without mention of psychotic behavior
29654	Bipolar I, disorder, most recent episode (or current) depressed-severe, specified as with psychotic behavior
29655	Bipolar I, disorder, most recent episode (or current) depressed-in partial or unspecified remission
29656	Bipolar I, disorder, most recent episode (or current) depressed-in full remission
29660	Bipolar I, disorder, most recent episode (or current) mixed-unspecified
29661	Bipolar I, disorder, most recent episode (or current) mixed-mild
29662	Bipolar I, disorder, most recent episode (or current) mixed-moderate
29663	Bipolar I, disorder, most recent episode (or current) mixed-severe, without mention of psychotic behavior
29664	Bipolar I, disorder, most recent episode (or current) mixed-severe, specified as with psychotic behavior
29665	Bipolar I, disorder, most recent episode (or current) mixed-in partial or unspecified remission
29666	Bipolar I, disorder, most recent episode (or current) mixed-in full remission
2967	Bipolar I, disorder, most recent episode (or current) unspecified
29680	Bipolar disorder-unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Bipolar disorder, not elsewhere classified
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder

Bipolar Disorder Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate

Bipolar Disorder Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder

Bipolar Disorder Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F31.9	Bipolar disorder, unspecified
F33.8	Other recurrent depressive disorders
F34.8	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder

Molina Healthcare Education Tool
for Schizophrenia

DSM-5 diagnostic criteria for:
Schizophrenia

A. Two or more of the following, each present for a significant portion of time during a 1-month period. At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech.
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms.

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset.

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet Criterion A and may include periods of prodromal or residual symptoms.

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out.

E. The disturbance is not attributable to the psychological effects of a substance or another medical condition.

Documentation Example:

Patient is a 21 year-old business major at a large university but has stopped attending classes altogether. Over the past few weeks his family and friends have noticed increasingly bizarre behaviors. On many occasions they've overheard him whispering in an agitated voice, even though there is no one nearby. Lately, he has refused to answer or make calls on his cell phone, claiming that if he does it will activate deadly chip that was implanted in his brain by evil aliens.

Patient accuses parents on several occasions of conspiring with the aliens to have him killed so they can remove his brain and put it inside one of their own. Patient drinks beer occasionally but has never been known to abuse alcohol or use drugs. Family history: Maternal aunt has been in and out of psychiatric hospitals over the years due to erratic and bizarre behavior.

Assessment: Patient experiencing first psychotic episode. Diagnosis of Schizophrenia, first episode, currently in acute episode can be made given patient's symptoms and family history.

Plan: Start patient on Zyprexa 10 mg daily. Refer for individual therapy and family therapy; consider partial hospitalization program.

ICD-9 Code: 295.90*, unspecified schizophrenia, unspecified condition

ICD-10 Code: F20.9*, Schizophrenia, unspecified

**The codes used in this document are for illustrative purposes only*

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Schizophrenia Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29501	Simple schizophrenia - subchronic condition
29502	Simple schizophrenia -chronic condition
29503	Simple schizophrenia - subchronic condition with acute exacerbation
29504	Simple schizophrenia - chronic condition with acute exacerbation
29505	Simple schizophrenia - in remission
29510	Disorganized schizophrenia-unspecified condition
29511	Disorganized schizophrenia-subchronic condition
29512	Disorganized schizophrenia-chronic condition
29513	Disorganized schizophrenia-subchronic condition with acute exacerbation
29514	Disorganized schizophrenia-chronic condition with acute exacerbation
29515	Disorganized schizophrenia-in remission
29520	Catatonic Schizophrenia- unspecified condition
29521	Catatonic Schizophrenia- subchronic condition
29522	Catatonic Schizophrenia- chronic condition
29523	Catatonic Schizophrenia- subchronic condition with acute exacerbation
29524	Catatonic Schizophrenia- chronic condition with acute exacerbation
29525	Catatonic Schizophrenia- in remission

Schizophrenia Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29530	Paranoid schizophrenia- unspecified condition
29531	Paranoid schizophrenia - subchronic condition
29532	Paranoid schizophrenia - chronic condition
29533	Paranoid schizophrenia - subchronic condition with acute exacerbation
29534	Paranoid schizophrenia - chronic condition with acute exacerbation
29535	Paranoid schizophrenia - in remission
29540	Schizophreniform disorder- unspecified condition
29541	Schizophreniform disorder - subchronic condition
29542	Schizophreniform disorder - chronic condition
29543	Schizophreniform disorder - subchronic condition with acute exacerbation
29544	Schizophreniform disorder - chronic condition with acute exacerbation
29545	Schizophreniform disorder - in remission
29550	Latent schizophrenia- unspecified condition
29551	Latent schizophrenia- subchronic condition
29552	Latent schizophrenia - chronic condition
29553	Latent schizophrenia - subchronic condition with acute exacerbation
29554	Latent schizophrenia - chronic condition with acute exacerbation

Schizophrenia Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29555	Latent schizophrenia - in remission
29560	Schizophrenic disorder residual type - unspecified condition
29561	Schizophrenic disorder residual type- subchronic condition
29562	Schizophrenic disorder residual type- chronic condition
29563	Schizophrenic disorder residual type- subchronic condition with acute exacerbation
29564	Schizophrenic disorder residual type- chronic condition with acute exacerbation
29565	Schizophrenic disorder residual type- in remission
29570	Schizoaffective disorder- unspecified condition
29571	Schizoaffective disorder - subchronic condition
29572	Schizoaffective disorder - chronic condition
29573	Schizoaffective disorder - subchronic condition with acute exacerbation
29574	Schizoaffective disorder - chronic condition with acute exacerbation
29575	Schizoaffective disorder - in remission
29580	Other specified types of schizophrenia- unspecified condition
29581	Other specified types of schizophrenia - subchronic condition
29582	Other specified types of schizophrenia - chronic condition
29583	Other specified types of schizophrenia - subchronic condition with acute exacerbation

Schizophrenia Diagnoses Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29584	Other specified types of schizophrenia - chronic condition with acute exacerbation
29585	Other specified types of schizophrenia - in remission
29590	Unspecified schizophrenia - unspecified condition
29591	Unspecified schizophrenia - subchronic condition
29592	Unspecified schizophrenia - chronic condition
29593	Unspecified schizophrenia - subchronic condition with acute exacerbation
29594	Unspecified schizophrenia - chronic condition with acute exacerbation
29595	Unspecified schizophrenia - in remission
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state

Schizophrenia Diagnoses Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F22	Delusional diosrders
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified

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