Measure Information	2026 Performance Period
Title	Follow-Up Care for Children Prescribed ADHD Medication
CMS eCQM ID	CMS136v15
CBE ID*	Not Applicable
MIPS Quality ID	366
Measure Steward	National Committee for Quality Assurance
Description	Percentage of children 6-12 years of age and newly prescribed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 treatment days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rationale	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 (AAP, 2019). Given the high prevalence of ADHD among U.S. children (8.7%, or 5.3 million individuals), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition (AAP, 2019; Bozinovic et al. 2021). Medication may be recommended for ADHD treatment. American Academy of Pediatrics (AAP) guidelines recommend that the prescribing clinician should titrate ADHD medication to achieve maximum benefit with tolerable side effects, and once symptom improvement is achieved, provide chronic care management with at least two visits annually (AAP, 2019).

	Providers have an opportunity to track medication use in patients and provide the appropriate f ollow-up care to monitor clinical symptoms and potential adverse events.
Clinical Recommendation Statement	American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation and T reatment of ADHD in Children and Adolescents (2019) - Key Action Statement (KAS) 1: The pediatrician or other primary care clinicians (PCC) should initiate an evaluation for ADHD for any child or adolescent age 4 years to the 18th birthday who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or i mpulsivity. Grade B: Strong Recommendation - KAS 4: ADHD is a chronic condition; therefore, the PCC should manage children and adolesc ents with ADHD in the same manner that they would children and youth with special health car e needs, following the principles of the chronic care model and the medical home. Grade B: Str ong Recommendation - KAS 5b: For elementary and middle school-aged children (age 6 years to the 12th birthday) w ith ADHD, the PCC should prescribe FDA-approved medications for ADHD, along with parent tr aining in behavior management (PTBM) and/or behavioral classroom intervention (preferably b oth PTBM and behavioral classroom interventions). Educational interventions and individualize d instructional supports, including school environment, class placement, instructional placemen t, and behavioral supports, are a necessary part of any treatment plan and often include an Ind ividualized Education Program (IEP) or a rehabilitation plan (504 plan). Grade A: Strong Recom mendation - KAS 6. “The PCC should titrate doses of medication for ADHD to achieve maximum benefit wi th tolerable side effects”. Grade B, strong recommendation American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the A ssessment and Treatment of Children and Adolescents with ADHD (2007) - Overall Guideline: The key to effective long-term management of the patient with ADHD is co ntinuity of care with a clinician experienced in the treatment of ADHD. The frequency and durati on of follow-up sessions should be individualized for each family and patient, depending on the severity of ADHD symptoms; the degree of comorbidity of other psychiatric illness; the respons e to treatment; and the degree of impairment in home, school, work, or peer-related activities. T he clinician should establish an effective mechanism for receiving feedback from the family and other important informants in the patient's environment to be sure symptoms are well controlle

	d and side effects are minimal. Although this parameter does not seek to set a formula for the method of follow-up, significant contact with the clinician should typically occur two to four time s per year in cases of uncomplicated ADHD and up to weekly sessions at times of severe dysf unction or complications of treatment. - Recommendation 6: A Well-Thought-Out and Comprehensive Treatment Plan Should Be Dev eloped for the Patient With ADHD. The treatment plan should be reviewed regularly and modifie d if the patient's symptoms do not respond. Minimal Standard [MS] - Recommendation 9. During a Psychopharmacological Intervention for ADHD, the Patient Sho uld Be Monitored for Treatment-Emergent Side Effects. Minimal Standard [MS] - Recommendation 12. Patients Should Be Assessed Periodically to Determine Whether There Is Continued Need for Treatment or If Symptoms Have Remitted. Treatment of ADHD Should C ontinue as Long as Symptoms Remain Present and Cause Impairment. Minimal Standard [MS]
Improvement Notation	Higher score indicates better quality
Definition	Intake Period: The twelve-month period starting March 1 of the year prior to the measurement period and ending the last calendar day of February of the measurement period. Index Prescription Start Date (IPSD): The earliest prescription date for an ADHD medication w here the date is in the Intake Period and the patient is not actively on ADHD medication during the 120 days prior. Initiation Phase: The 30 days following the IPSD. Continuation and Maintenance Phase: The 300 days following the IPSD. Treatment days (covered days): The actual number of calendar days covered with prescriptions during the 301-day period. Use the following steps to identify and calculate covered days. Step 1: For same medications that are prescribed on the same day or on different days with ov erlapping days supply, the days supply is summed. The start and end dates are then identified. The start date is the date of service of the earliest prescription event and the first covered day.

	The end date is the calendar day when the days supply runs out. The start date through the end date are considered covered days. This rule assumes that the patient will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription). For example: - If there are three 7-days supply prescription events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21. - If there are two 7-days supply prescription events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14. - If there are three 7-days supply prescription events for the same medication on January 1, a 7-days supply prescription event on January 20 and a 7-days supply prescription event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4. Step 2: For all other events (multiple prescriptions for the same medication on different days without overlap, multiple prescriptions for different medications on the same or different days, with or without overlap), the covered days are identified by the start and end dates for each prescription event individually. The start date through the end date are considered covered days. This rule assumes the member will take the different medications concurrently. Step 3: Each calendar day covered by one or more medications is considered one covered day.
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to theQDM pagefor more information on the QDM.
Initial Population	Initial Population 1: Children 6-12 years of age as of the Intake Period who had an IPSD and who had a visit within 6 months prior to the IPSD including the IPSD. Children are removed if they had an acute inpatient stay with a principal diagnosis of mental, behavioral or neurodevelopmental disorder during the Initiation Phase. Initial Population 2: Children 6-12 years of age as of the Intake Period who had an IPSD and remained on the medication for at least 210 treatment days during the 301-day period, beginning on the IPSD through 300 days after the IPSD, and who had a visit within 6 months prior to the I

	PSD including the IPSD. Children are removed if they had an acute inpatient stay with a principal diagnosis of mental, behavioral or neurodevelopmental disorder during the Continuation and Maintenance Phase.
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients diagnosed with narcolepsy at any point in their history or during the measurement period.
Numerator	Numerator 1: Patients who had at least one visit with a practitioner with prescribing authority during the Initiation Phase. Numerator 2: Patients who had at least one visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits on different dates of service during th
Numerator Exclusions	None
Denominator Exceptions	None
Telehealth Eligible	Yes