Clinical Policy: Attention Deficit Hyperactivity Disorder Assessment and Treatment

Reference Number: CP.MP.124 [Coding Implications](#Coding_Implications)

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[Revision Log](#Revision_Log)

**See** [Important Reminder](#Important_Reminder) **at the end of this policy for important regulatory and legal information.**

## Description

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders in children and also occurs with an increasing prevalence of diagnosis in adults. ADHD affects the cognitive, academic, emotional, and social well-being of individuals and can persist throughout life. While there is no single test to diagnose ADHD, a clinical assessment based on defined clinical parameters establishes criteria for diagnosis in children and adults.

## Policy/Criteria

1. It is the policy of health plans affiliated with Centene Corporation® that the following services for the assessment and treatment of ADHD are **medically necessary**:
   1. Assessment
   2. Complete medical evaluation with history and physical examination;
   3. Parent/child interview or patient interview, if adult, to obtain information listed in Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5);
   4. Complete psychiatric evaluation or other services provided by a psychiatrist, psychologist, or other behavioral health professional;
   5. Laboratory evaluation prior to stimulant medication therapy, including any of the following:
      1. Complete blood count;
      2. Liver function tests;
      3. Cardiac evaluation and screening incorporating an electrocardiogram (ECG);
   6. Measurement of thyroid hormone levels if patient exhibits clinical manifestations of hyperthyroidism;
   7. Assessment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
   8. When not otherwise excluded, other services for the assessment of ADHD to meet the DSM-5 criteria.
   9. Treatment:
      1. Pharmacotherapy;
      2. Behavioral modification;
      3. Treatment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
      4. When not otherwise excluded, other services for the treatment of ADHD.
2. It is the policy of health plans affiliated with Centene Corporation that the following services for the assessment and treatment of ADHD are **investigational or unproven** (may not be all-inclusive):
3. Assessment:
   1. Actimeter
   2. AFF2 gene testing
   3. Computerized electroencephalogram (EEG)
   4. Computerized Tests of Attention and Vigilance
   5. Education and achievement testing
   6. Electronystagmography in the absence of symptoms of vertigo or balance dysfunction
   7. Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)
   8. Event-related potentials
   9. Functional near-infrared spectroscopy
   10. Hair analysis
   11. IgG blood tests
   12. Measurement of peripheral brain-derived neurotrophic factor
   13. Measurement of zinc
   14. Neuroimaging (e.g., CT [computed tomography], CAT [computerized axial tomography], MRI [magnetic resonance imaging], including diffusion tensor imaging), MRS (magnetic resonance spectroscopy), PET (positron emission tomography), and SPECT (single-photon emission computerized tomography)
   15. Neuropsychiatric EEG-based assessment aid system
   16. Neuropsychologic testing for suspected uncomplicated cases of ADHD (without history of head trauma, seizures)
   17. Otoacoustic emissions in the absence of signs of hearing loss
   18. Quotient ADHD system / test
   19. Synaptosomal-associated protein (SNAP) 25 gene polymorphisms testing
   20. Transcranial magnetic stimulation – evoked measures (e.g., short-interval cortical inhibition in motor cortex) as a marker of ADHD symptoms
   21. Tympanometry in the absence of hearing loss
4. Treatment:
   1. Acupuncture/acupressure
   2. Anti-*candida albicans* medication
   3. Anti-fungal medication
   4. Anti-motion sickness medication
   5. Auditory Integration Therapy
   6. Applied kinesiology
   7. Brain integration
   8. Chelation
   9. Chiropractic manipulation
   10. Cognitive behavior modification
   11. Cognitive rehabilitation
   12. Computerized training on working memory
   13. Deep pressure sensory vest
   14. Dietary counseling and treatments, i.e., Feingold diet
   15. Dore program / dyslexia – dyspraxia attention treatment (DDAT)
   16. Educational intervention (e.g., classroom environmental manipulation, academic skills training, and parental training)
   17. EEG biofeedback
   18. Herbal remedies
   19. Homeopathy
   20. Intensive behavioral intervention programs
   21. Megavitamin therapy
   22. Metronome training
   23. Mineral supplementation
   24. Music therapy
   25. Optometric vision training
   26. Psychopharmaceuticals (lithium, benzodiazepines, and selective serotonin reuptake inhibitors, unless the patient also exhibits anxiety and depression)
   27. Reboxetine
   28. Sensory integration therapy
   29. The Good Vibrations Device
   30. The Neuro Emotional Technique
   31. Therapeutic eurythmy (movement therapy)
   32. Transcranial magnetic stimulation / cranial electric stimulation
   33. Yayarin
   34. Vision therapy
   35. Yoga

## Background

ADHD is among the most commonly diagnosed neurodevelopmental disorders in children and adolescents and is increasingly being diagnosed in adults. The main characteristics of ADHD are symptoms of inattention, hyperactivity, and impulsivity that have continued for at least six months and are maladaptive and inconsistent with development level.1 There is no single genetic or behavioral test to diagnose ADHD. Instead a clinical diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders*-*5* (DSM-5) criteria is applicable for both children and adults.2 The prevalence of adult ADHD has been estimated to be around 4.4% in the United States and 3.4% internationally, whereas the prevalence in children and adolescents ranges from 2 –18%.2,3

In 2011, the American Academy of Pediatrics (AAP) published a clinical practice guideline to clarify the diagnosis, evaluation, and treatment parameters of ADHD.4 This guideline expanded the age range of children to include preschool aged children and adolescents and suggests an expanded scope for behavioral interventions.4 The evaluation of comorbid conditions that might coexist with ADHD must also be considered.4 Similar clinical recommendations have been made by various organizations for adults, including the Canadian ADHD Resource Alliance, the American Academy of the Child and Adolescent Psychiatry, the National Institutes of Health, and the British Association for Psyschopharmacology.5 Pharmacotherapy can provide a way to manage ADHD symptoms and improve quality of life.

Stimulants and non-stimulants are common examples of medications prescribed to treat ADHD. Chan, *et al,* performed a systemic review of sixteen randomized clinical trials and one meta-analysis that involved 2668 participants and evaluated pharmacological and psychosocial treatments of ADHD in adolescents aged 12 years to 18 years. They found that extended-release methylphenidate and amphetamine formulations, atomoxetine, and extended-release guanfacine led to clinically significant symptom reduction.6

While the pathogenesis of ADHD is unknown, the clinical impairments in neurobehavioral and neurodevelopmental functioning pathways elicit deficiencies in vigilance, perceptual-motor speed, working memory, verbal learning, and response inhibition.2 Consequently ADHD affects the cognitive, academic, emotional, and social wellbeing of individuals and can persist throughout life.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

**CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD**

| **CPT® Codes** | **Description** |
| --- | --- |
| 70450 | Computed tomography, head or brain; without contrast material |
| 70460 | Computed tomography, head or brain; with contrast material(s) |
| 70470 | Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections |
| 70551 | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material |
| 70552 | Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s) |
| 70553 | Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences |
| 76390 | Magnetic resonance spectroscopy |
| 78600 | Brain imaging, less than 4 static views; |
| 78601 | Brain imaging, less than 4 static views; with vascular flow |
| 78605 | Brain imaging, minimum 4 static views; |
| 78606 | Brain imaging, minimum 4 static views; with vascular flow |
| 78607 | Brain imaging tomographic (SPECT) |
| 78608 | Brain imaging, positron emission tomography (PET); metabolic evaluation. |
| 78609 | Brain imaging, positron emission tomography (PET); perfusion evaluation |
| 81229 | Cytogenetic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities |
| 82365 | Calculus; Infrared spectroscopy |
| 82728 | Ferritin |
| 82784 | Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each |
| 82787 | Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each |
| 83540 | Iron |
| 83550 | Iron binding capacity |
| 84630 | Zinc |
| 86001 | Allergen specific IgG quantitative or semiquantitative, each allergen |
| 92065 | Orthoptic and/or pleoptic training, with continuing medical direction and evaluation |
| 90867 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management |
| 90868 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session |
| 90869 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management |
| 90901 | Biofeedback training by any modality |
| 92540 | Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording |
| 92541 | Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording |
| 92542 | Positional nystagmus test, minimum of 4 positions, with recording |
| 92544 | Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recordings |
| 92550 | Tympanometry and reflex threshold measurements |
| 92558 | Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis |
| 92567 | Tympanometry (impedance testing) |
| 92585 | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive |
| 92586 | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited |
| 92587 | Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report |
| 92588 | Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report |
| 95803 | Actigraphy testing recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) |
| 95812 | Electroencephalogram (EEG) extended monitoring; 41-60 minutes |
| 95813 | Electroencephalogram (EEG) extended monitoring; greater than 1 hour |
| 95816 | Electroencephalogram (EEG); including recording awake and drowsy |
| 95819 | Electroencephalogram (EEG); including recording awake and asleep |
| 95827 | Electroencephalogram (EEG); all night recording |
| 95925 | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs |
| 95926 | Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs |
| 95927 | Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head |
| 95928 | Central motor evoked potential study (transcranial motor stimulation); upper limbs |
| 95929 | Central motor evoked potential study (transcranial motor stimulation); lower limbs |
| 95930 | Visual evoked potential (VEP) testing central nervous system, checkerboard or flash |
| 95933 | Orbicularis oculi (blink) reflex, by electrodiagnostic testing |
| 95937 | Neuromuscular junction testing (repetitive stimulation paired stimuli), each nerve, any 1 method |
| 95938 | Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs |
| 95939 | Central motor evoked potential study (transcranial motor stimulation);in upper and lower limbs |
| 96116 | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour |
| 96130 | Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |
| 96131 | Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure) |
| 96132 | Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |
| 96133 | Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure) |
| 96136 | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes |
| 96137 | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure) |
| 96138 | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes |
| 96139 | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure) |
| 96146 | Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only |
| 96365 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour |
| 96366 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour |
| 96367 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour |
| 97127 | Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact |
| 97530 | Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes |
| 97810 | Acupuncture, one or more needles, w/o electric stimulation; initial  15 minutes of personal one-one contact with the patient. |
| 97811 | Acupuncture, one or more needles, w/o electric stimulation; each additional 15 minutes of personal one-one contact with the patient with re-insertion of needles. |
| 97813 | Acupuncture, one or more needles, with electric stimulation; initial  15 minutes of personal one-one contact with the patient. |
| 97814 | Acupuncture, one or more needles, with electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of the needle(s). |
| 98940 | Chiropractic manipulative treatment (CMT); spinal, 1-2 regions |
| 98941 | Chiropractic manipulative treatment (CMT); spinal, 3-4 regions |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, 5 regions |
| 98943 | Chiropractic manipulative treatment (CMT); extraspinal, 1 or more  Regions |

**HCPCS codes considered not medically necessary when billed with a sole diagnosis of ADHD**

| **HCPCS Codes** | **Description** |
| --- | --- |
| P2031 | Hair analysis (excluding arsenic) |
| S8040 | Topographic brain mapping |

**ICD-10-CM Diagnosis Codes that Support Medical Necessity**

| **ICD-10-CM Code** | **Description** |
| --- | --- |
| F90.0 – F90.9 | Attention-deficit hyperactivity disorders |

| Reviews, Revisions, and Approvals | Date | Approval Date |
| --- | --- | --- |
| Policy developed | 08/16 | 08/16 |
| References reviewed and updated | 07/17 | 08/17 |
| Assessment: Added “Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)” as not medically necessary. References and Codes reviewed and updated. | 05/18 | 05/18 |
| Added AFF2 gene testing and measurement of peripheral brain-derived neurotrophic factor as investigational to II.A. Code updates-deleted CPT 96101, 96102, 96103, 96118, 96119, 96120, and 97532. Added CPT-96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, and 97127. References reviewed and updated. Specialist reviewed. | 04/19 | 05/19 |
| Revised description for CPT-96116 | 05/19 |  |

### References

1. Post, Robert E., and Stuart L. Kurlansik. "Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder in Adults." *American family physician* 85.9 (2012).
2. Bukstein O. “Attention deficit hyperactivity disorder in Adults: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis. In: UpToDate, Brent D, Hermann R. (Eds), UpToDate, Waltham, MA. Accessed on April 29, 2019.
3. Krull KR. “Attention deficit hyperactivity disorder in children and adolescents: Epidemiology and pathogenesis.” In: UpToDate. Torchia MM (Ed), UpToDate, Waltham, MA. Accessed on April 29, 2019.
4. Krull KR. “Attention deficit hyperactivity disorder in children and adolescents: Overview of treatment and prognosis.” In: UpToDate. Agustyn M, Torchia MM (Eds), UpToDate, Waltham MA. Accessed on April 29, 2019.
5. ATTENTION-DEFICIT, SUBCOMMITTEE ON. "ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents." *Pediatrics* (2011): peds-2011.
6. Gibbins, Christopher, and Margaret Weiss. "Clinical recommendations in current practice guidelines for diagnosis and treatment of ADHD in adults." *Current psychiatry reports* 9.5 (2007): 420-426.
7. Chan, Eugenia, Jason M. Fogler, and Paul G. Hammerness. "Treatment of Attention-Deficit/Hyperactivity Disorder in Adolescents: A Systematic Review." *JAMA* 315.18 (2016): 1997-2008.
8. American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 46:7, 894-921, 2007
9. Gloss D, Varma JK, Pringsheim T, Nuwer MR. Practice advisory: The utility of EEG theta/beta power ratio in ADHD diagnosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2016;87(22):2375-2379.
10. Tseng PT, Cheng YS, Yen CF, et al. Peripheral iron levels in children with attention-deficit hyperactivity disorder: a systematic review and meta-analysis. Sci Rep. 2018 Jan 15;8(1):788. doi: 10.1038/s41598-017-19096-x.
11. Wang Y, Huang L, Zhang L, et al. Iron Status in Attention-Deficit/Hyperactivity Disorder: A Systematic Review and Meta-Analysis. PLoS One. 2017 Jan 3;12(1):e0169145. doi: 10.1371/journal.pone.0169145. eCollection 2017.
12. Krull KR. Attention deficit hyperactivity disorder in children and adolescents: Clinical features and diagnosis. In:UpToDate, Augustyn M, Torchia MM (Eds). UpToDate, Waltham MA. Accessed April 29, 2019
13. National Institute of Clinical Excellence. Attention deficit hyperactivity disorder: diagnosis and management. NICE guideline [NG87] Published date: March 2018

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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

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

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