



Developmental Screening/Testing

Coding Fact Sheet for Primary Care Pediatricians

I. CODING

Developmental screening, surveillance, and assessment are often complemented by the use of special tests, which vary in length. This Coding Fact Sheet provides guidance on how pediatricians can appropriately report limited and extended developmental screening and testing services.

A. How To Report Developmental Testing

96110 Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

The use of developmental screening instruments of a limited nature (eg, Developmental Screening Test II, Early Language Milestone Screen, PEDS, Ages and Stages, and Vanderbilt ADHD rating scales) is reported using CPT code 96110 (*developmental testing; limited*). Code 96110 is often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits. On the 2005 Medicare Fee Schedule (Resource-Based Relative Value Scale or RBRVS), the Centers for Medicare and Medicaid Services (CMS) published a total relative value unit (RVU) of 0.36 for 96110, which amounts to a Medicare payment of \$13.64 ($0.36 \times \37.8975 {Medicare 2005 conversion factor} = \$13.64). Because an office nurse or other trained non-physician personnel typically performs the service, this relative value reflects only the practice expense of the office staff and nurses, the cost of the materials, and professional liability -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code 96110 but the time and effort to perform the testing itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a limited screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both services should be reported and modifier -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other*

service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

96111 *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report*

Extended developmental testing using standardized instruments (eg, Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition)) are reported using CPT code 96111. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (eg, an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code. In 2005, code 96111 has 3.83 total RVUs, which calculates to a Medicare payment of \$145.15 ($3.83 \times \37.8975 {Medicare 2005 conversion factor} = \$145.15).

When 96111 is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for 96110, if the E/M code is reported with 96111, modifier -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) should be appended to the E/M code or modifier -59 (*distinct procedural service*) should be appended to the developmental testing code, showing that the services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of 96111 was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, starting January 1, 2005, physicians will report the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

B. When To Report Developmental Testing

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The frequency of reporting 96110 is dependent on the clinical situation. The AAP "Recommendations for Preventive Pediatric Health Care" schedule recommends developmental/behavioral assessment at each preventive medicine visit, and the AAP

"Developmental Surveillance and Screening of Infants and Young Children" policy statement recommends that physicians use validated developmental screening tools to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening tests of a limited nature seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider's judgement as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history, this is not a "test" as such, **and is not separately reportable**. Examples of validated limited screening tests along with clinical vignettes are provided below.

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Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code 96111 (*developmental testing; extended*). These tests are typically performed by physicians or psychologists and require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code 96110, the frequency of reporting code 96111 is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code 96111 is reported only once the testing and its accompanying report are completed.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been "significantly low," but who was clearly at risk for maintaining appropriate acquisition of new skills.

II. CLINICAL VIGNETTES

96110 Vignette #1

At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question "Do you have concerns about your child's language skills?" The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her

observations of the child's language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

<u>CPT</u>		<u>ICD-9-CM</u>
99392-25	Preventive medicine service; established patient, age 1-4 (appended with modifier -25)	V20.2 Routine infant or child health check
96110	Developmental testing; limited	V20.2 Routine infant or child health check 315.31 Expressive language disorder

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the 99201-99215 series may be reported using a modifier -25, linked to the appropriate ICD-9-CM code(s) as appropriate (eg, 315.31, *Expressive language disorder*; 315.32, *Mixed receptive-expressive language disorder*; 315.39, *Other developmental speech or language disorder*).

96110 Vignette #2

At a five-year health maintenance visit, a father discusses his daughter's difficulty "getting along with other little girls." "Doctor, she wants friends, but she doesn't know how to make — much less keep — a friend." Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child's physical exam consistently fell in the range of 'normal for age' in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger's Syndrome and the father's responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

<u>CPT</u>		<u>ICD-9-CM</u>
99393-25	Preventive medicine service; established patient, age 5-11 (appended with modifier -25)	V20.2 Routine infant or child health check
96110	Developmental testing; limited	V20.2 Routine infant or child health check 315.4 Developmental coordination disorder 313.9 Unspecified emotional disturbance of childhood

96111 Vignette #1

An eight-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

CPT

96111 Developmental testing; extended

ICD-9-CM

314.0x Attention deficit disorder

x = 0 for no hyperactivity

x = 1 for hyperactivity

96111 Vignette #2

A 5 4/12 year old boy just beginning kindergarten whose mother's responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays was seen for developmental testing. After greeting the parent and child and explaining to the child that he and the doctor would do some 'non-school' activities to see how he 'used words to tell others about (his) good ideas', the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Third Edition, and the Clinical Evaluation of Language Fundamentals-Fourth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive Composite on the CELF-4. Both test scores were abnormal, indicating a mixed receptive-expressive disorder.

CPT

96111 Developmental testing; extended

ICD-9-CM

315.32 Mixed receptive expressive language disorder

III. DOCUMENTATION GUIDELINES

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (eg, a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress report of the visit itself. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

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PEDS (Parents' Evaluation of Developmental Status)

This questionnaire is designed to identify any parent/primary caretaker's concerns about a birth through eight-year child's developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, "please list any concerns about your child's learning, development and behavior" and a final "please list any other concerns." The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the test.

ASQ (AGES AND STAGES Questionnaire)

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The ASQ also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any "Yes" responses should also be referred.

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In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child's level of cooperation and observations of child's behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child's particular developmental or physical needs should be described, and specific notations should be made if any items

offered resulted in a change in the child's level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records). A brief interpretation should be recorded and notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear.

IV. SAMPLE TESTING TOOLS

96110

Ages and Stages Questionnaire-Second Edition (ASQ) and Ages and States Questionnaire: Social-Emotional (ASQ:SE) (Brookes Publishing: Jane Squires, PhD and Diane Bricker, PhD, et. al)

Australian Scale for Asperger's Syndrome (ASAS) (Michelle Garnett, Master's Clinical Psychology and Anthony Attwood, PhD)

Behavior Assessment Scale for Children-Second Edition (BASC-II) (American Guidance Service: Cecil Reynolds and Randy Kanphaus)

Behavioral Rating Inventory of Executive Functioning (BRIEF) (Psychological Assessment Resources, Inc.: Gerald Gioia, PhD, Kimberly Espy, PhD, and Peter Isquith, PhD)

Child Development Review (Behavior Science Systems, Inc.: Harold Ireton, PhD, et. al.)

Communication and Symbolic Scales Developmental Profile (CSBS DP) (Brookes Publishing: Amy Wetherby, PhD, CCC-SLP, Barry M. Prizant, PhD, CCC-SLP)

Kaufman Brief Intelligence Test (American Guidance Service: Alan Kaufman and Nadeen Kaufman)

Parents' Evaluation of Developmental Status (PEDS) (Ellsworth and Vandermeer Press, LLC: Frances Page Glascoe, PhD)

Pediatric Symptom Checklist: A Primary Care Screening Tool to Identify Psychosocial Problems (PSC) (<http://psc.partners.org>: Michael Jellinek, MD, and J. Michael Murphy, PhD)

Vanderbilt Rating Scales (Mark L. Wolraich, MD)

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Beery-Buktenica Developmental Test of Visual-Motor Integration-Fourth Edition, Revised (VMI) (Modern Curriculum Press: Keith E. Beery, PhD)

Clinical Evaluation of Language Fundamentals-Fourth Edition (The Psychological Corporation: Eleanor Semel, PhD, CCC-SLP, Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP)

Clinical Evaluation of Language Fundamentals-Preschool Version-Second Edition (Psychological Corporation: Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP, and Eleanor Semel, PhD, CCC-SLP)

Comprehensive Test of Nonverbal Intelligence (Pro-Ed: Donald Hammill, Nils Pearson, and J. Lee Wiederholt.)

Developmental Test of Visual Perception-Second Edition (Pro-Ed: Donald Hammill, Nils Pearson, Judith Voress)

Peabody Picture Vocabulary Test-Third Edition (American Guidance Service: Lloyd M. Dunn and Leola M. Dunn)

Test of Auditory-Perceptual Skills-Revised (Psychological and Educational Publications: Morrison Gardner)

Test of Language Competence-Expanded Edition (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Test of Nonverbal Intelligence-Third Edition (Pro-Ed Publishing: Linda Brown, Rita Sherbenou, Susan Johmsen)

Test of Problem Solving-Revised (LinguiSystems, Inc: Linda Zachman, Rosemary Huisingh, Mark Barrett, Jane Orman, Carolyn LoGiudice)

Test of Word Knowledge (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Woodcock-Johnson Test of Cognitive Abilities-Third Edition (Riverside Publishing: Richard W. Woodcock, PhD, Kevin S. McGrew, PhD, and Nancy Mather, PhD)