

### 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.

#### 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, Parents' Evaluation of Developmental Status [PEDS], Ages & Stages Questionnaire [ASQ], Vanderbilt attention-deficit/hyperactivity disorder [ADHD] rating scales, Pediatric Symptom Checklist [PSC]) is reported using *Current Procedural Terminology (CPT®)* code **96110** (developmental testing; limited). Code **96110** is often reported when performed in the context of preventive medicine services. This code also may 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 2010 Medicare physician fee schedule (Resource-Based Relative Value Scale [RBRVS]), the Centers for Medicare & Medicaid Services (CMS) published a total relative value unit (RVU) of 0.20 for **96110**, which amounts to a Medicare payment of \$7.21 (0.20 x \$36.0666 [Medicare 2010 conversion factor; *note*: President Obama has signed the Department of Defense Appropriations Act, 2010, which provides for a zero-percent (0%) update to the 2010 Medicare physician fee schedule for a 2-month period, January 1, 2010, through February 28, 2010. This has been extended through March 31, 2010]). Because office nurses or other trained nonphysician personnel typically perform 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 when 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 examination, 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, office outpatient), **96110** and the E/M service should be reported and either modifier **25** (significant, separately identifiable E/M 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, *or* modifier **59** (distinct procedural service) should be appended to the limited developmental testing code, showing that limited developmental testing services were separate 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 [3rd Edition], Clinical Evaluation of Language Fundamentals [4th 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 E/M 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 (RBRVS) for this code. In 2010 code **96111** has 3.61 total RVUs, which calculates to a Medicare payment of \$130.20 (3.61 x \$36.0666 [Medicare 2010 conversion factor; *note*: President Obama has signed the Department of Defense Appropriations Act, 2010, which provides for a zero-percent (0%) update to the 2010 Medicare physician fee schedule for a 2-month period, January 1, 2010, through February 28, 2010. This has been extended through March 31, 2010]).

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 examination, 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**, either

modifier **25** (significant, separately identifiable E/M 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 extended developmental testing code, showing that the extended developmental testing services were separate and necessary at the same visit.

In 2005, the *CPT* code descriptor for **96111** was revised to reflect the deletion of the test examples as well as the *per-hour* designation. Thus, effective January 1, 2005, physicians 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 more than an hour.

### When to Report Developmental Testing **96110**

The frequency of reporting **96110** is dependent on the clinical situation. The AAP “Recommendations for Preventive Pediatric Health Care” schedule recommends developmental and behavioral assessment at each preventive medicine visit, and the AAP “Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening” 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 depends on the clinical setting and the provider’s judgment 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 follow.

### **96111**

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 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 with 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 per date of service. There must be an accompanying report describing and interpreting all testing.

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.

## Clinical Vignettes

### **96110 Vignette I**

At a follow-up visit for bilateral otitis media, the pediatrician notes the patient missed her 12-month well-child visit. He requests the child’s father complete the ASQ. The father endorses no concerns in any developmental domain. The pediatrician reviews the father’s completed ASQ and asks him if his daughter is using single words to convey her wants and using words to label common objects. The father assures him that she is doing this, and in fact, other nonfamily adults have commented on her clear articulation. No concerns at all are reported and this is consistent with what the pediatrician has observed in office visits. He tells the father they will continue to monitor for any evidence the child is not acquiring skills at an expected rate. All of this is noted in a few sentences in the chart note.

<i>CPT</i>		<i>International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)</i>
<b>99392-25*</b>	<b>Preventive medicine service; established patient, age 1-4 (appended with modifier 25)</b>	<b>V20.2 Routine infant or child health check</b>
<b>96110</b>	<b>Developmental testing; limited</b>	<b>V20.2 Routine infant or child health check</b>

\*Note: Some payers may require alternate reporting wherein modifier **59** is appended to the limited developmental testing code.

## 96110 Vignette 2

At a 24-month well-child check, the mother describes her toddler as “wild,” completes the PEDS, 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.

CPT	ICD-9-CM
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

\*Note: Some payers may require alternate reporting wherein modifier 59 is appended to the limited developmental testing code.

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

## 96110 Vignette 3

At a 5-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 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 examination 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 of 24 items with an abnormal score being more than 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.

CPT	ICD-9-CM
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

\*Note: Some payers may require alternate reporting wherein modifier 59 is appended to the limited developmental testing code.

## 96110 Vignette 4

A 7-year-old boy with previously diagnosed ADHD is being seen for a health maintenance visit. At the end of the visit his mother asks if she can discuss her son’s medication. She hands you a Vanderbilt ADHD rating scale completed 2 weeks ago by his classroom teacher. “Bobby’s teacher says she keeps a stack of blank forms so she can give her students’ doctors her impressions. She downloaded it off the Internet.” You give this to your medical assistant to score while you obtain more interim history from Bobby’s mother. After reviewing the scored teacher Vanderbilt form and discussing the results with Bobby’s mother, you both decide to increase his stimulant medication. A follow-up appointment is scheduled in 4 weeks.

CPT	ICD-9-CM
99393-25* Preventive medicine service; established patient, age 5-11 (appended with modifier 25)	V20.2 Routine infant or child health check
99213 Office or other outpatient service, established patient, 15 minutes “typical time”	314.01 Attention-deficit/hyperactivity disorder, combined type
96110 Developmental testing; limited	V20.2 Routine infant or child health check 314.01 Attention-deficit/hyperactivity disorder, combined type

\*Note: Some payers may require alternate reporting wherein modifier 59 is appended to the limited developmental testing code.

### 96111 Vignette 1

An 8-year-old boy with impulsive, overly active behavior and previously assessed average intelligence is referred for evaluation of ADHD. 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 4 years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier E/M service appointment. History and physical and neurologic examinations 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 the patient’s education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow-up visit to discuss the report and the final diagnosis and treatment plan with the physician.

CPT		ICD-9-CM
96111	Developmental testing; extended	314.0x Attention-deficit disorder x = 0 for no hyperactivity x = 1 for hyperactivity

### 96111 Vignette 2

A 5½-year-old boy just beginning kindergarten was seen for developmental testing. At a previous visit, his mother’s responses on the PEDS suggested expressive language delays. After greeting the parent and child and explaining to the child that he and the doctor would do some “nonschool” activities to see how he “used words to tell others about [his] good ideas,” the child and examiner spent 50 minutes together completing the tasks on the Peabody Picture Vocabulary Test, 4th Edition, and the Clinical Evaluation of Language Fundamentals, 4th Edition (CELF-4). The examiner scored the 2 tests in 5 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, however, indicating a mixed receptive–expressive language disorder.

CPT		ICD-9-CM
96111	Developmental testing; extended	315.32 Mixed receptive–expressive language disorder

### 96111 Vignette 3

A 9-year-old girl being treated for ADHD and receiving language therapy to improve her weak receptive and expressive language skills comes in for a medication visit. Her mother and teacher feel the current dosage of her stimulant medication is effective and neither perceives a need for any changes. Your services meet the limited level of complexity for the visit. However, while asking about her school performance, the child’s mother volunteers, “I know she has been seeing the speech pathologist once a week for 7 months now, but I can’t see any signs her vocabulary is increasing.” You administer and score the Peabody Picture Vocabulary Test, 4th Edition. The performance standard score increased by one standard deviation from her initial performance 8 months ago. You show her mother the improvement and document the test administration, results, and interpretation in the medical record.

CPT		ICD-9-CM	
99213-25*	Office or other outpatient service, established patient, 15 minutes “typical time” (appended with modifier 25)	314.01 Attention-deficit disorder, with hyperactivity	315.32 Mixed receptive–expressive language disorder
96111	Developmental testing; extended	314.01 Attention-deficit disorder, with hyperactivity	315.32 Mixed receptive–expressive language disorder

\*Note: Some payers may require alternate reporting wherein modifier 59 is appended to the extended developmental testing code.

## Documentation Guidelines

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (ie, 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. 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:

### 96110

#### Parents’ Evaluation of Developmental Status (PEDS)

This questionnaire is designed to identify any parent or primary caregiver’s concerns about a birth through 8-year-old child’s developmental attainment and behavioral or

mental health concerns. There are 8 specific domain queries, one requesting, “Please list any concerns about your child’s learning, development, and behavior,” and a final request, “Please list any other concerns.” The parent answers are scored into the risk categories of high, moderate, and low. The report form is included with the questionnaire.

### **Ages & Stages Questionnaire (ASQ)**

This parent report instrument, covering ages 1 through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are 6 questions in each of 5 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 nonspecific comprehensive section in which general concerns are addressed. No score is provided for these answers, but the instrument developers note any “Yes” responses should prompt a referral.

### **96111**

In general, the documentation of developmental testing includes scoring, interpretation, and report development. 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 or 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, or apparent ease of task accomplishment. The item results should be scored and the test protocol and any and 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.

## **Sample Assessment and Testing Tools**

(*Note:* These are provided as examples only; the AAP implies no endorsement or restriction of code use to these instruments.)

### **96110**

*Ages and Stages Questionnaire-Second Edition (ASQ)* and *Ages and Stages 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)

*Modified Checklist for Autism in Toddlers (M-CHAT)* (Robins, Fein, and Barton, 1999)

*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://www2.massgeneral.org/allpsych/psc/psc\\_home.htm](http://www2.massgeneral.org/allpsych/psc/psc_home.htm): Michael Jellinek, MD, and J. Michael Murphy, PhD) *Vanderbilt Rating Scales* (Mark L. Wolraich, MD)

### **96111**

*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)

*Kaufman Brief Intelligence Test-Second Edition* (American  
Guidance Service: Alan Kaufman and Nadeen Kaufman)

*Peabody Picture Vocabulary Test-Fourth 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 Johnsen)

*Test of Problem Solving 3: Elementary Version*  
(LinguSystems, Inc: Linda Zachman, Rosemary Huisingsh,  
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)

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