American Academy of Pediatrics
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Standardized Screening/Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Behavioral/Emotional

I. CODING

Developmental screening and assessment are often complemented by the use of standardized instruments, which vary in length. This coding fact sheet provides guidance on how pediatricians can appropriately report standardized developmental screening and testing services.

A. How To Report Developmental Screening/Testing

96110 *Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

The use of standardized developmental screening instruments (eg, PEDS, Ages and Stages, M-CHAT) is reported using Current Procedural Terminology(CPT®) code **96110** (*Developmental screening*). Code **96110** is 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.

In 2012, the **96110** code descriptor was revised to differentiate it from the "testing" that is referenced under code **96111**. *Screening* asks a child's observer to provide his/her observations of the child's skills, which are then recorded on a standardized and validated screening instrument. Screening is subjective and only reports the assessment of the patient's skills through observation by the informal observer. On the other hand, testing measures what the patient is actually able to do on a standardized psychometric instrument at that time. Screening does not imply a diagnosis; only the means by which information is collected on the patient.

Because clinical staff typically performs the **96110** service, the Medicare Resource-Based Relative Value Scale (RBRVS) relative values reflect only the practice expense (clinical staff time, medical supplies, medical equipment) and professional liability insurance -- 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 screening 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 screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96110** and the and E/M service 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 **or** modifier **59** *(distinct procedural service*) should be appended to the developmental

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screening code, showing the developmental screening services were separate and necessary at the same visit.

Additionally in 2012, code **96110** was revised to clarify that the instrument used must be standardized and that the code may be reported more than once on a single date of service. The code descriptor states "per standardized instrument." Therefore, if you are performing multiple standardized screens on a patient (eg, an M-CHAT and ASQ), you will report **96110** with 2 units (or on separate line items). Modifier **59** may be required to indicate that the services are distinct.

In 2015, the descriptor for code **96110** was revised to remove reference to "with interpretation and report" and replace it with "scoring and documentation" since this more accurately reflects the work performed. A notation was also added which refers the physician to code **96127** for emotional/behavioral assessment. This code will be discussed below.

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

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 distinct 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.

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 developmental testing 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, effective January 1, 2005, physicians reported 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 Screening/Testing

96110

The frequency of reporting **96110 (***Developmental screening***)** depends on the clinical situation. The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule recommends

developmental/behavioral surveillance at each preventive medicine visit, and the AAP "Developmental Surveillance and Screening of Infants and Young Children" policy statement recommends that physicians use validated/standardized developmental screening instruments 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 instruments 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 judgment as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history (eg, surveillance) or complete checklists, this is not formal "screening" as such, **and is not separately reportable**. Examples of validated/standardized screening instruments along with clinical vignettes are provided below.

96111

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code **96111** (*Developmental testing*). These tests are typically performed by physicians, psychologists or other trained professionals 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 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.

II. CLINICAL VIGNETTES

96110 Vignette # 1

At a follow-up visit for bilateral otitis media, the pediatrician notes the patient missed her 12 month well-child visit. He requests and the child's father completes the Ages and Stages Questionnaire (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 is using words to label common objects. The father assures him that she is doing this and, in fact, other non-family adults have commented on her clear articulation. No concerns at all are reported and this is consistent with what the pediatrician has observed in the 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 this is noted in a few sentences in the chart note.

CPT	ICD-10-CM
99392-25* Preventive medicine service established patient, age 1-4	**Z00.129** Encounter for routine child health examination w/o abnormal findings
96110 Developmental screening	**Z00.129**

*NOTE: Some payers may require alternate reporting wherein the modifier **59** is appended to the developmental screening code, however according to *CPT* guidelines, that is not appropriate and actually no modifier is required.

96110 Vignette #2

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.

CPT	ICD-10-CM
99392-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination w/ abnormal findings
96110 Developmental screening	**Z00.121** **F80.1** Expressive language disorder

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental screening code, however according to CPT guidelines, that is not appropriate and actually no modifier is required.

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-10-CM code(s) as appropriate (eg, **F80.1**, *Expressive language disorder*; **F80.2**, *Mixed receptive-expressive language disorder*; **F80.89**, *Other developmental disorders of speech or language*).

96110 Vignette #3

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.

Note: Health Risk Assessments are not coded here and have their own fact sheet

CPT	ICD-10-CM
99393-25* Preventive medicine service established patient, age 5-11	**Z00.121** Encounter for routine child health examination w/ abnormal findings
96110 Developmental screening	**Z00.121** **F82** Specific developmental disorder of motor function **F98.9** Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental screening code, however according to CPT guidelines, that is not appropriate and actually no modifier is required.

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	ICD-10-CM
96111 Developmental testing	**F90.-** Attention deficit disorder 4th digit **0** = inattentive type **1** = hyperactive type

96111 Vignette #2

A 5 4/12 year old boy just beginning kindergarten was seen for developmental testing. At a previous visit, his mother's responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays. 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-Fourth Edition, and the Clinical Evaluation of Language Fundamentals-Fifth 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- 5. Both test scores were abnormal, however, indicating a mixed receptive–expressive language disorder.

CPT	ICD-10-CM
96111 Developmental testing	**F80.2** Mixed receptive-language disorder 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 both 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 [Fourth Edition]. The performance standard score had increased by one standard deviation from her initial performance eight months ago. You show her mother the improvement and document the test administration, results and interpretation in the medical record.

CPT	ICD-10-CM
99213-25* Office service, established patient, 15 minutes "typical time"	**F90.1** Attention-deficit hyperactivity disorder **F80.2** Mixed receptive-expressive language disorder
96111 Developmental testing	**F90.1** **F80.2**

III. DOCUMENTATION GUIDELINES

Each administered developmental screening instrument is accompanied by scoring and documentation (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. 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

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 questionnaire.

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 prompt a referral.

96111

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.

How to Report Emotional/Behavioral Assessment

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

This code (**96127**) was introduced in 2015 to allow for the appropriate reporting of standardized emotional and/or behavioral assessments.

Because clinical staff typically performs the **96110** service, the Medicare Resource-Based Relative Value Scale (RBRVS) relative values reflect only the practice expense (clinical staff time, medical supplies, medical equipment) and professional liability insurance -- 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 **96127** but the time and effort to perform the screening 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 an assessment is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96127** and the and E/M service 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

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same visit or modifier **59** (distinct procedural service) should be appended to the developmental screening code, showing that developmental screening services were separate and necessary at the same visit.

When to Report Emotional/Behavioral Assessment

The frequency of reporting **96127** (emotional/behavioral assessment) is dependent on the clinical situation. The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule recommends developmental/behavioral surveillance at each preventive medicine visit, and a formal assessment (eg, PHQ-2) for depression is recommended at every annual visit beginning at age 11 with a validated/standardized assessment instrument to improve detection of depression at the earliest possible age to allow for appropriate intervention services.

Thus, the use of assessment instruments as a screening mechanism seems to enhance the task of identifying those who may be suffering from an emotional or behavioral disorder. The exact frequency of testing therefore depends on the clinical setting and the provider's judgment as to when it is medically necessary. When physicians ask questions about a patients emotional or behavioral health as part of the general informal history (eg, surveillance), this is not a formal "screen" as such, and is not separately reportable. Examples of validated/standardized screening instruments along with clinical vignettes are provided below.

Developmental Screening Vs Behavioral Emotional Assessment

At first glance, it may be difficult to discern if a standardized instrument falls under a developmental screen (**96110**) or an emotional/behavioral assessment (**96127**). Developmental screening really takes a look at a patient's overall development and will include questions on motor skills, language skills, cognitive function, as well as may include questions on social, emotional and behavioral issues. However, the emotional and behavioral questions are being asked as part of an overall developmental inventory. An emotional or behavioral assessment instrument will look specifically at behavior and emotional health related to key symptoms of those conditions classified as behavioral or emotional conditions, such as ADHD, depression or anxiety.

96127 Vignette # 1

A 12 year old girl presents with her dad for her annual preventive medicine service. Patient's history and interview do not show any concerns of depression, however following Bright Futures guidelines, the patient is given a PHQ-2. The patient answers the questions and the screen is normal.

CPT	ICD-10-CM
99394-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination
96127 Behavioral/Emotional Assessment	

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96127 Vignette #2

A seven 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 2 Vanderbilt ADHD rating scales completed two weeks ago by his classroom teacher and tutor. You give these 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 for four weeks.

CPT	**ICD-10-CM**
99392-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination w/ abnormal findings
99213-25 Office service, established patient, 15 minutes "typical time"	**F90.2** Attention-deficit hyperactivity disorder, combined type
96127 Behavioral/Emotional Assessment **96127-59**	

*NOTE: Some payers may require alternate reporting wherein the modifier **59** is appended to the developmental screening code. Some payers may also require the **96127** to be reported in 2 units on one line item.

The Affordable Care Act and Standardized Screening

There is much confusion as to whether codes **96110** and **96127** fall under the no cost-sharing provision in the Affordable Care Act (ACA). The answer is - it depends. Only those services performed as part of routine screening services as either recommended under the United States Preventive Medicine Services Task Force (Recommendation A or B) or under the AAP's Periodicity Schedule are covered as part of the ACA no cost sharing. However, when **96110** or **96127** is performed and reported as part of a diagnostic service (ie, a problem is suspected) or when the screen is done outside of the routine recommendations (ie, more than the recommendations stipulate), the codes may fall under a cost sharing arrangement. Of course any plan that is not required to follow ACA provisions will have their own rules on this. One way to ensure that the developmental or behavioral/emotional screen service is covered under ACA provisions (as appropriate) is to link the service to either the "well baby/child" ICD code or the "screening for" code. Note that in order to report the "screening for" ICD code the patient has to be asymptomatic.

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IV. SAMPLE ASSESSMENT/TESTING TOOLS

[NOTE: These are provided as examples only; the AAP implies no endorsement or restriction of code use to these instruments. If you choose to use an instrument not listed below, be sure they are validated/standardized.]

Instrument	Abbreviation	CPT Code
Ages and Stages Questionnaire-Third Edition	ASQ	**96110**
Ages and States Questionnaire: Social-Emotional	ASQ:SE	**96127**
Australian Scale for Asperger's Syndrome	ASAS	**96127**
Battelle Developmental Inventory Screening Tool	BDI-ST	**96110**
Bayley Infant Neuro-developmental Screen	BINS	**96110**
Beck Youth Inventories - Second Edition	BYI-II	**96127**
Beck Anxiety Inventory	BAI	**96127**
Beck Depression Inventory	BDI	**96127**
Beery-Buktenica Developmental Test of Visual-Motor Integration-6th Ed	BEERY-VMI	**96111**
Behavior Assessment Scale for Children-Second Edition	BASC-2	**96127**
Behavioral Rating Inventory of Executive Function	BRIEF	**96127**
Brigance Screens-II		**96110**
Child Behavior Checklist	CBCL	**96127**
Children's Depression Inventory	CDI	**96127**
Child Development Inventory (CDI)	CDI	**96110**
Clinical Evaluation of Language Fundamentals-Fifth Edition	CELF-5	**96111**
Clinical Evaluation of Language Fundamentals-Preschool Version-2		**96111**
Columbia DISC Depression Scale		**96127**
Comprehensive Test of Nonverbal Intelligence Second Edition	CTONI-2	**96111**
Connor's Rating Scale		**96127**
Developmental Test of Visual Perception-Third Edition	DTVP-3	**96111**
Hamilton Anxiety Scale		**96127**
Hamilton Rating Scale for Depression	HRSD	**96127**
Infant Development Inventory		**96110**
Kaufman Brief Intelligence Test-Second Edition	KBIT-2	**96111**
Modified Checklist for Autism in Toddlers	M-CHAT	**96110**
Multidimensional Anxiety Scale for Children	MASC	**96127**
Patient Health Questionnaire	PHQ-2 or PHQ-9	**96127**
Parents' Evaluation of Developmental Status (Developmental Milestones)	PEDS / PEDS-DM	**96110**
Peabody Picture Vocabulary Test-Fourth Edition	PPVT™-4	**96111**
Pediatric Symptom Checklist	PSC / PSC-Y	**96127**
Screen for Child Anxiety Related Disorders	SCARED	**96127**
Test of Auditory-Perceptual Skills-Third Edition	TAPS-3	**96111**
Test of Language Competence-Expanded Edition		**96111**
Test of Nonverbal Intelligence-Fourth Edition		**96111**
Test of Problem Solving 3: Elementary Version	TOPS 3: Elementary	**96111**
Test of Word Knowledge		**96111**
Vanderbilt Rating Scales		**96127**
Woodcock-Johnson® Test of Cognitive Abilities-Third Edition		**96111**
Kaufman Brief Intelligence Test-Second Edition	KBIT-2	**96111**

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