American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Coding for Standardized Assessment, Screening and Testing

Developmental

I. CODING

Developmental screening is conducted using age-appropriate instruments, which vary in length. This coding fact sheet provides guidance on how pediatricians can appropriately report those instruments which are considered to be *standardized** developmental screening and testing services. Surveillance and non-standardized instruments are not separately reported from the evaluation and management service (eg, preventive medicine service).

***Standardized Instruments*:** Used in the performance of these services. Standardized instruments are validated tests that are administered and scored in a consistent or "standard" manner consistent with their validation.

For further guidance on the performance of developmental screening and surveillance, please reference the AAP clinical report titled "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders through Developmental Surveillance and Screening" and the Screening Technical Assistance & Resource (STAR) Center.

A. How To Report Developmental Screening/Testing

Screening

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 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. If multiple standardized* screens are performed on a patient, report 96110 with 2 units (or on separate line items). Modifier 59 may be required to indicate that the services are distinct.

The **96110** code descriptor includes the word screening which differentiates it from the word testing that is included in the descriptor under codes **96112-96113**. *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.

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Because clinical staff typically performs the **96110** services, 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 only the ordering would count under the data point for MDM. Do not include the time spent administering the test in the time for the E/M service. When an assessment is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96110** and the 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.

Testing

96112 *Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour*

+**96113** *each additional 30 minutes* (Add-on code, list separately in addition to code **96112)**

Developmental testing using standardized* instruments are reported using CPT codes **96112-96113**. 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 RBRVS for this code. Please note that you may not report code 96112 for 30 minutes of time or less. This includes testing time and interpretation and report; however, you may only count the reporting provider's (eg, physician or psychologist) time.

When **96112/96113** is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the time for selecting the accompanying E/M code.

Just as discussed for 96110, if the E/M code is reported with 96112, 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.

Time Spent and Reporting

Time Spent	**Code(s) Reports**
30 minutes or less	Use E/M service
31-75 minutes	96112
76-121 minutes	96112 and 96113
122-167 minutes	96112 and 96113 and 96113

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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 "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders through Developmental Surveillance and Screening" clinical report 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.

The use of validated/standardized* developmental screening instruments enhances the task of developmental assessment typically done in the preventive medicine setting. Screening using a validated/standardized* developmental screening instrument should be routinely conducted at the 9-, 18-, and 30-month visits and screening for autism spectrum disorder should be conducted at the 18 and 24month visits. However, a standardized* screening instrument can be administered at any encounter when the physician determines that the patient requires one. This may be due to the fact that a patient may not have had one at a previous visit, or a concern is raised. There is no limitation on when to perform if a concern is raised or a problem is suspected. 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**. Vignettes are provided below.

96112-96113

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code 96112/96113 (Developmental testing). These tests are typically performed by physicians, psychologists or other trained professionals and require a minimum of 31 minutes of time spent and documented. They also are accompanied by an interpretation and formal
report, which may be completed at a time other than when the patient is present but is included under the initial 96112-96113 reporting.

Like code 96110, the frequency of reporting code 96112/96113 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 evaluate the problem properly. Code 96112 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 a validated/standardized* developmental screening instrument. The father endorses no concerns in any developmental domain. The pediatrician reviews the father's completed instrument and asks him if his daughter is using single words to convey her

wants and uses 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 that 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	**Z13.42** Encounter for screening for global developmental delays

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental screening code.

96110 Vignette #2

At a 24-month well child check, the mother describes her toddler as "wild," completes a validated/standardized* developmental screening instrument, and responds positively to a question about concerns with language skills. The nurse scores the instrument 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.

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the 99202-99215 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)

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	**Z13.42** Encounter for screening for global developmental delays **F80.1** Expressive language disorder

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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 previous health maintenance visits. The pediatrician asks her nurse to administer a screening tool for autism spectrum disorder and the father's responses yield an abnormal score. 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 disorder.

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** Encounter for routine child health examination w/ abnormal findings **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.

96112/96113 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. Prior history reading and written expression skills at first-grade level and received speech and language therapy during his attendance at Head Start at 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 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 his education and treatment plan. Testing and the report took 85 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
96112 Developmental testing, first hour **96113** Additional 30 minutes	**F90.-** Attention-deficit hyperactivity disorders 4th digit **0** = predominantly inattentive type **1** = predominantly hyperactive type

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	2 = combined type **8** = other type **9** = unspecified type

96112 Vignette #2

A 5 ½- year-old patient just beginning kindergarten was seen for developmental testing. At a previous visit, the caregiver's responses on a validated/standardized* developmental screening tool suggested expressive language delays. After greeting the parent and child and explaining to the child that, along with the doctor, they would do some 'non-school' activities to see how the patient 'used words to tell others about good ideas,' the patient and the examiner spent fifty minutes together completing the tasks for developmental testing. The examiner scored the two tests in five minutes, and there was a significant discrepancy detected. Both test scores were abnormal, however, indicating a mixed receptive–expressive language disorder.

CPT	ICD-10-CM
96112 Developmental testing	**F80.2** Mixed receptive-expressive language disorder

96112 Vignette #3

A 9-year-old established patient, being treated for ADHD and receiving language therapy to improve weak receptive and expressive language skills, comes in for a medication visit. Both the mother and teacher feel the current dosage of her stimulant medication is effective and neither perceives a need for any changes. The pediatrician's services meet the "limited" level of complexity for the visit. However, while asking about school performance, the child's mother volunteers, that the patient has been seeing the speech pathologist once a week for 7 months now but can't see any signs that her vocabulary is increasing.

The pediatrician administers and scores a standardized* developmental test. The performance standard score had increased by one standard deviation from the initial performance eight months ago. The pediatrician shows the child's mother the improvement and documents the test administration, results, and interpretation in the medical record. The total time spent on both testing and interpretation with the report was documented at 65 minutes, not including the E/M service, which was documented as 20 minutes.

CPT	ICD-10-CM
99213-25* Office service, established patient, 20- 29 mins	**F90.1** Attention-deficit hyperactivity disorder **F80.2** Mixed receptive-expressive language disorder
96112 Developmental testing, first hour	**F90.1** Attention-deficit hyperactivity disorder, predominantly hyperactive type **F80.2** Mixed receptive-expressive language disorder

III. DOCUMENTATION GUIDELINES

96110

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. Since 96110 does not have any physician work, this can all be done by clinical staff. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

96112-96113

In general, the documentation of developmental testing includes the scoring, interpretation, and 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, and 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). An interpretation should be recorded, and a notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear. The *total time* spent on these services for the patient is required. If time is not documented, the code(s) may not be reported.

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Emotional/Behavioral Assessment

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

Because clinical staff typically performs the **96127** service, the Medicare 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 only the ordering would count under the data point for MDM. Do not include the time spent administering the test in the time for the E/M service. When an assessment is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96127** and the 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.

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 health supervision visit, and a formal assessment for depression is recommended at every annual visit beginning at age 12 with a validated/standardized* assessment instrument to improve detection of depression at the earliest possible age to allow for appropriate intervention services. The AAP clinical report "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" provides additional guidance for emotional/behavioral screening.

Thus, the use of assessment instruments as a screening mechanism enhances 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 patient's emotional or behavioral health as part of the general informal history (eg, surveillance), this is not a formal "screen" and, therefore, not separately reportable.

Developmental Screening versus Emotional/Behavioral 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, and cognitive function, as well as may include questions on social, emotional, and behavioral issues.

On the other hand, 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. The patient's history and interview do not show any concerns of depression; however, following Bright Futures guidelines, the patient is given a screening instrument. 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 Emotional/Behavioral Assessment	**Z13.31** Encounter for screening for depression

96127 Vignette #2
A seven-year-old boy with previously diagnosed ADHD is being seen for a preventive medicine visit. At the end of the visit, the father asks if he can discuss the patient's ADHD medication. The father handed over 2 ADHD assessments completed two weeks ago by his classroom teacher and tutor. The pediatrician gives these to the medical assistant to score while you obtain more interim history. After reviewing the scored form and discussing the results, it is decided to increase his stimulant medication. A follow-up appointment is scheduled for four weeks. Medical decision-making (MDM) is of moderate complexity.

CPT	ICD-10-CM
99393-25* Preventive medicine service established patient, age5-11 years	**Z00.121** Encounter for routine child health examination w/abnormal findings
99213-25 Moderate MDM	**F90.2** Attention-deficit hyperactivity disorder, combined type
96127 (2 units) Emotional/Behavioral Assessment	

*NOTE: 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 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 Periodicity Schedule are covered as part of the ACA no cost sharing.

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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 its own rules. One way to ensure that the developmental or emotional/behavioral screen service is covered under ACA provisions (as appropriate) is to link the service to either the "well baby/child" ICD-10-CM code or the "screening for" code. Note that in order to report the "screening for" ICD-10-CM code, the patient has to be asymptomatic.

Health Risk Assessment

★ **96160** *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument*
★ **96161** *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*

Because clinical staff typically performs the **96160/96161** service, the Medicare 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 these codes.

A less common occasion where a physician performs this service it may still be reported with code **96160/96161,** but only the ordering would count under the data point for MDM. Do not include the time spent administering the test in the time for the E/M service. When an assessment is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96160/96161** and the 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.

When to Report Emotional/Behavioral Assessment
The frequency of reporting **96160/96161** (health risk assessment) is dependent on the clinical situation. The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule recommends formal health risk assessments throughout a patient's life. For example, maternal depression screening (**96161**) is recommended at 1 - 6 months visits with a validated/standardized* instrument. In addition, standardized* risk assessments for alcohol or tobacco use (**96160**) may also be separately reported.

Social determinants of health risk assessments would also fall under these codes. Whether to choose **96160** versus **96161** depends entirely on what is being assessed. For food insecurity, the code would be **96160**. For environmental assessments, including risk factors associated with living situations, again choose **96160**.
Unless the assessment focuses solely on the caregiver (as in maternal depression screening billed under the baby), the code is **96160**.

96161 Vignette
A 3-week-old established patient presents with her mom for a preventive medicine service. The mother is asked to complete a maternal depression screen, which is negative.

CPT	ICD-10-CM
99391-25* Preventive medicine service established patient, age 1-4	**Z00.111** Health examination for newborn 8 to 28 days old
96161 Caregiver risk assessment	

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96160 Vignette

A 2-year-old patient presents for their preventive medicine visit. During the encounter, the caregiver is asked to complete a standardized* food insecurity inventory. It is positive. The caregiver is given some community resources and the chart is flagged for follow-up with the caregiver.

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
96160 Patient risk assessment	**Z59.41** Food insecurity

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