Supplemental Information

Supplemental Table 1 Developmental Screening Tests

	Description	Age Range	No. Items	Administration Time	Forms Available EHR Compatible	Psychometric Properties[a]	Utility as Autism Screener	Scoring Method	Cultural Considerations	Purchase and Obtainment Information	Key References
General Developmental Screening Tests											
Ages and Stages Questionnaires – 3	Parent-completed questionnaire. Series of 21 questions screening communication, gross motor, fine motor, problem-solving, and personal adaptive skills. Results in pass, monitor, or fail score for domains	2–60 mo	30	10–15 min	Electronic format that can be adapted for an EH	Standardized on 2008 children from diverse ethnic and socioeconomic backgrounds, including Spanish-speaking Sensitivity: 0.70–0.90 (moderate to high) Specificity: 0.76–0.91 (moderate to high) Across ages: Sensitivity: 86% Specificity: 85% By domain: Sensitivity: 83% Specificity: 91%	General screen: Sensitivity: 0.86 Specificity: 0.85 Using the monitor cutoff in communication domain: identified 95% of children positive on ASD-specific screen	Risk categorization. Provides a cutoff score in 5 domains of development that indicates possible need for further evaluation and a monitoring zone that identifies children who should be monitored and rescreened	Available in multiple languages; see test information for details	Paul H. Brookes Publishing Co, Inc: 800-638-3775 or www.brookespublishing.com	Squires J, Potter L, Bricker D. *The ASQ User's Guide: Third Edition*. Baltimore, MD: Paul H. Brookes Publishing Co; 2009
PEDS	Parent interview form. Designed to screen for developmental and behavioral problems needing further evaluation. Single response form used for all ages. May be useful as a surveillance tool	0–8 y	10	2–5 min	Electronic format that can be adapted for an EHR	2013 restandardization (n = 47 531 families from diverse ethnic and socioeconomic backgrounds) Sensitivity: 96% Specificity: 83%	At 12 mo, PEDS is 83% sensitive to an ASD diagnosis at 36 mo but 60% specific. Utility as a component of ongoing surveillance	Risk categorization. Provides algorithm to guide need for referral, additional screening, or continued surveillance	Available in multiple languages; see test information for details.	Ellsworth and Vandermeer Press, LLC: 888-729-1697 or www.pedstest.com	Glascoe FP. *Collaborating with Parents: Using Parents' Evaluation of Developmental Status (PEDS) to Detect and Address Developmental and Behavioral Problems*. Second ed. Nolansville, TN: PEDSTest.com, LLC; 2013
PEDS: Developmental Milestones Screening Version	Parent interview form. Designed to screen for developmental and social-emotional problems	0–8 y	6–8 items at each age level	4–6 min	Electronic format that can be adapted for an EHR	Standardized with 1600 children from diverse ethnic and socioeconomic backgrounds. Sensitivity: 0.70–0.94 Specificity: 0.77–0.93 across ages	—	Risk categorization. Tied to performance above and below the 16th percentile for each item and domain. Provides algorithm to guide need for referral, additional screening, or continued surveillance	Available in multiple languages; see test information for details	Ellsworth and Vandermeer Press, LLC: 888-729-1697 or www.pedstest.com	Brothers KB, Glascoe FP, Robertshaw NS. PEDS: developmental milestones–an accurate brief tool for surveillance and screening. *Clin Pediatr (Phila)*. 2008;47(3):271-279
SWYC: milestones	12 age-specific forms, keyed to pediatric periodicity schedule. Includes cognitive, language, and motor skills	1–65 mo	10	~5 min	Available through Patient Tools, Epic, and CHADIS Available for free download as PDFs from www.theswyc.org	Sensitivity: Average across ages: 75.8% Specificity: Average across ages: 78.3%	Not evaluated; see SWYC: POSI	Risk categorization. Provides a cutoff score that varies by age that indicates possible need for further evaluation	Available in multiple languages; see test information for details	Available for free download from www.theswyc.org	Sheldrick RC, Perrin EC. Evidence-based milestones for surveillance of cognitive, language, and motor development. *Acad Pediatr*. 2013;13(6):577–586 Publications and User's Manual available at www.theswyc.org
Behavioral Screening Tests											
Ages and Stages Questionnaire: Social-Emotional–2 (2015)	Screening and surveillance of milestones in social-emotional and mental health. Items focus on self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people	1–72 mo	9 age-specific forms (each 4–6 pages long) with 19–33 items	10–15 min	Electronic format that can be adapted for an EHR	By age and disability (ie, social-emotional problems) Sensitivity: 78% Specificity: 95%	Need Ages and Stages Questionnaire: Social-Emotional studies in ASD	Cutoff score indicating when further evaluation is needed; monitoring zone that identifies children who should be monitored and rescreened	Available in multiple languages; see test information for details	Paul H. Brookes Publishing Co, Inc: 800-638-3775 or www.agesandstages.com	Squires J, Bricker DD, Twombly E. *Ages & Stages Questionnaires: Social-Emotional -2(ASQ:SE-2). A Parent- Completed, Child-Monitoring System for Social-Emotional Behaviors*. Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2016 Briggs RD, Stettler EM, Johnson Silver, E, Schrag RDA, Nayak M, Chinitz S, Racine AD. Social-emotional screening for infants and toddlers in primary care. *Pediatrics*. 2012;129(2):1–8
PSC											
PSC-17b (17 items)	General psychosocial screening and functional assessment in the domains of attention, externalizing, and internalizing symptoms	4–16 y	17 items	<5 min	Yes	Subscales have obtained reasonable agreement with validated and accepted parent-report instruments. Cronbach α was high for each subscale	Not examined	Cut points for overall screen and subscales	Available in multiple languages; see test information for details.	http://www.massgeneral.org/psychiatry/services/psc_about.aspx	Gardner W, Lucas A, Kolko DJ, Campo JV. Comparison of the PSC-17 and alternative mental health screens in an at-risk primary care sample. *J Am Acad Child Adolesc Psychiatry*. 2007;46:611–618
PSC-35b (35 items)	Pictorial version available with English, Spanish, Filipino subtitles	Youth self-report: ≥11 y	35 items	<5 min	Yes Online form available	General psychosocial screen: Sensitivity: 80%–95% Specificity: 68%–100%	Not examined	Cut points for overall screen and subscales	Available in multiple languages; see test information for details.	http://www.massgeneral.org/psychiatry/services/psc_about.aspx	Jellinek MS, Bishop SJ, Murphy JM, Biederman J, Rosenbaum JF. Screening for dysfunction in the children of outpatients at a psychopharmacology clinic. *Am J Psychiatry*. 1991;148:1031–1036 Jellinek MS, Murphy JM, Little M, Pagano ME, Comer DM, Kelleher

Supplemental Table 1 Continued

	Description	Age Range	No. Items	Administration Time	Forms Available EHR Compatible	Psychometric Properties[a]	Utility as Autism Screener	Scoring Method	Cultural Considerations	Purchase and Obtainment Information	Key References
											KJ. Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. *Arch Pediatr Adolesc Med.* 1999;153: 254–260
SDQ	Resilience and psychosocial risk for mental health and social-emotional, behavioral skills. Generates indicators for conduct problems, hyperactivity, emotional symptoms, peer problems, and prosocial behavior. Youth self-report and parent and teacher report	4–17; 3- to 4-y-old version available. Youth self-report: 11–16 y	25; 22 items for 3- to 4-y-olds	5–10 min	Yes, but must first contact youthinmind@gmail.com	Reliable and valid in various populations and for a No. general mental health conditions Sensitivity: 63–94% Specificity: 88%–98% Cross-cultural research and translations	Not examined	Produces a total strengths versus total difficulties score	Available in multiple languages; see test information for details	Not in the public domain. Downloadable in multiple languages. For permission to use the SDQ, contact Robert Goodman at www.sdqinfo.org	Stone LL, Otten R, Engels RC, Vermulst AA, Janssens JM. Psychometric properties of the parent and teacher versions of the strengths and difficulties questionnaire for 4- to 12-y-olds: a review. *Clin Child Fam Psychol Rev.* 2010;13(3): 254–274
SWYC: Baby PSC	Screening of social-emotional health and behavior	1–18 mo	12	∼5 min	Available through Patient Tools, Epic, and CHADIS. Available for free download as PDFs from www.theswyc.org	Correlation 0.61–0.70 with ASQ-SE	Not evaluated, see SWYC: POSI	Cutoff score of 3 for each of 3 subscales	Available in multiple languages; see test information for details	Available for free download from www.theswyc.org	Publications and User's Manual available at www.theswyc.org Sheldrick RC, Henson BS, Neger EN, Merchant S, Murphy JM, Perrin EC. The Baby Pediatric Symptom Checklist: development and initial validation of a new social/emotional screening instrument for very young children. *Acad Pediatr.* 2013;13(1):72–80
SWYC: Preschool PSC	Screening of social-emotional health and behavior	18–65 mo	18	∼5 min	Available through Patient Tools, Epic, and CHADIS. Available for free download as PDFs from www.theswyc.org	Correlation 0.88–0.89 with ASQ-SE	Not evaluated, see SWYC: POSI	Single cutoff score of 9	Available in multiple languages; see test information for details	Available for free download from www.theswyc.org	Publications and User's Manual available at www.theswyc.org Sheldrick RC, Henson BS, Merchant S, Neger EN, Murphy JM, Perrin EC. The Preschool Pediatric Symptom Checklist (PPSC): development and initial validation of a new social/emotional screening instrument. *Acad Pediatr.* 2012; 12(5):456–467
					Promising Tests: Behavioral Screening						
Brief Early Childhood Screening Assessment	Screening tool developed to facilitate primary care pediatrician's identification of young children who need further assessment of their emotional and social development	1.5–5 y	22 items. 4 items on maternal distress	5 min	No	Fifth grade reading level. Normative studies conducted in New Orleans, Louisiana; Providence, Rhode Island; and Florida. Sensitivity: 89% Specificity: 85%	No	Single cutoff score of 9	English	https://medicine.tulane.edu/centers-institutes/tecc/provider-resources/general-screens	Fallucco EM, Wysocki T, James L, Kozikowski C, Williams A, Gleason MM. Brief Early Childhood Screening Assessment: preliminary validity in pediatric primary care. *J Dev Behav Pediatr.* 2017;38(2):89–98
					Language Screening Test						
Communication and Symbolic Behavior Scales Developmental Profile: Infant Toddler Checklist	Standardized tool for screening of communication and symbolic abilities up to the 24-mo level. The Infant Toddler Checklist is a 1-page parent-completed screening tool	6–24 mo	24	5–10 min	No	Standardized on 2188 North American children 6–24 mo of age. Correlations 0.59–0.75 with Mullen Scales at 2 y of age. Sensitivity: 0.76–0.88 in low- and at-risk children at 2 y of age (moderate). Specificity: 0.82–0.87 in low- and at-risk children at 2 y of age (moderate)	Identifies language delays, discriminates language delay alone from ASD risk for ASD by 12 mo. Risk status for social, speech, symbolic composites and total score	Risk categorization (concern or no concern) in 3 categories (social, speech, and symbolic) and overall total score	Available in multiple languages; see test information for details	Paul H. Brookes Publishing Co, Inc: 800-638-3775 or www.brookespublishing.com	Wetherby AM, Prizant BM. *Communication and Symbolic Behavior Scales: Developmental Profile.* Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
					Autism Screening Tests						
Modified Checklist for Autism in Toddlers, Revised with Follow-up	Parent-completed questionnaire designed to identify children at risk for autism from the general population. Follow-up clinician administered questions and repeat questionnaire	16–30 mo	20 (averaged)	5–10 min	Yes	Standardization sample included 16 071 children screened, 115 had a positive result, 348 needed evaluation, 221 evaluated, and 105 diagnosed with ASD. Validated using ADI-R, ADOS-G, CARS, DSM-IV-TR. Sensitivity: 0.91 Specificity: 0.95 for low-risk 18- and 24-mo-olds with follow-up questionnaire and interview.	Yes	Risk categorization for questionnaire (pass, need interview, fail). After interview (pass, fail)	Available in multiple languages; see test information for details	http://mchatscreen.com/	Robins DL, Casagrande K, Barton M, Chen CM, Dumont-Mathieu T, Fein D. Validation of the modified checklist for autism in toddlers, revised with follow-up (M-CHAT-R/F). *Pediatrics.* 2014;133(1):37–45

Supplemental Table 1 Continued

	Description	Age Range	No. Items	Administration Time	Forms Available EHR Compatible	Psychometric Properties[a]	Utility as Autism Screener	Scoring Method	Cultural Considerations	Purchase and Obtainment Information	Key References
	required for specificity					45% of children with score ≥3 on initial screen and ≥2 on follow-up have ASD; 95% have clinically significant developmental delay					
Social Communication Questionnaire	Parent-completed questionnaire. Designed to identify children at risk for ASD from the general population. Based on items in the ADI-R.	4+ y	40 (averaged)	5–10 min	No	Validated using the ADI-R and DSM-IV on 200 subjects (160 with pervasive developmental disorder, 40 without pervasive developmental disorder). For use in children with mental age of at least 2 y and chronologic age 4+ y. Available in 2 forms: lifetime and current. Overall test sensitivity: 0.85 (moderate). Specificity: 0.75 (moderate). Varies by age. Sensitivity can be improved with lowering cutoff for children <5 y and 5–7 y, specificity poor for younger children	Yes	Risk categorization (pass, fail).	Available in multiple languages; see test information for details	Western Psychological Corporation: www.wpspublish.com	Rutter M, Bailey A, Lord C. *The Social Communication Questionnaire (SCQ) Manual*. Los Angeles, CA: Western Psychological Services; 2003. Corsello C, Hus V, Pickles A, Risi S, Cook EH Jr, Leventhal BL, Lord C. Between a ROC and a hard place: decision making and making decisions about using the SCQ. *J Child Psychol Psychiatry*. 2007; 48(9):932–940
Screening Tool for Autism in Toddlers and Young Children, 24–35 mo	Clinician-directed, interactive and observation measure. Requires training of clinician for standardized administration. Not for population screening	24–35 mo, <24 mo (exploratory)	12 (averaged)	20–30 min	No	Validated by comparison with ADOS-G results in 52 children 24–35 mo (26 autism, 26 developmental delay). Sensitivity: 0.83 Specificity: 0.86 PPV: 0.77 NPV: 0.90. For <24 mo: Sensitivity: 0.95 Specificity: 0.73 PPV: 0.56 NPV: 0.97. Screening properties improved for >14-mo-old	Yes	12 activities to observe early social-communicative behavior; risk categorization (high risk, low risk)	English	http://stat.vueinnovations.com	Stone WL, Coonrod EE, Ousley O. Brief report: screening tool for autism in 2-year-olds (STAT): development and preliminary data. *J Autism Dev Disord*. 2000; 30:607–612. Stone WL, Coonrod EE, Turner LM, Pozdol SL. Psychometric properties of the STAT for early autism screening. *J Autism Dev Disord* 2004;34:691–701
						Autism Screening: Promising Tests					
The Infant and Toddler Checklist (Communication and Symbolic Behavior Scales Developmental Profile) usefulness for autism screening	Parent questionnaire: screens for language delay	6–24 mo	24 (averaged)	15 min	Yes	PPV DD: 0.43 (6–8 mo) PPV DD: 0.79 (21–24 mo)	Yes	Identifies language delays (alone, with ASD), risk for ASD; risk status for social, speech, symbolic composites and total score	Available in multiple languages; see test information for details	Paul H. Brookes Publishing Co, Inc: 800-638-3775 or www.brookespublishing.com	Wetherby AM, Brosnan-Maddox S, Peace V, Newton L. Validation of the Infant-Toddler Checklist as a broadband screener for autism spectrum disorders from 9–24 mo of age. *Autism*. 2008 Sep; 12(5):487-511
Early Screening for Autism and Communication Disorders	Parent questionnaire: research edition, 47 items	12–36 mo	47 (averaged)	10–15 min	No	Sensitivity: 0.85–0.91 Specificity: 0.82–0.84 PPV: 0.55–0.81 NPV: 0.88–0.98	Yes	Investigation ongoing of subset (24 items)	English	https://firstwordsproject.com/screen-my-child/	Not in peer-reviewed literature; presented at IMFAR 2009, 2015. First Words Project (http://med.fsu.edu/index.cfm?page=autismInstitute.firstwords)
First Year Inventory	Parent questionnaire: population screening tool to identify 12-mo-old infants	12 mo	63 (averaged)	10 min	No	Sensitivity, specificity, PPV not reported	Yes	Scores at risk. Promising in high-risk (infant sibling) cohort (Rowberry et al).	English	https://www.med.unc.edu/ahs/pearls/research/first-year-inventory-fyi-development/	Rowberry JJ. Screening for autism spectrum disorders in 12-mo-old high-risk siblings by parental report. *J Autism Dev Disord*. 2015;45:221-229
SWYC: POSI	7 questions; assesses autism risk	16–35 mo	7 (averaged)	~5 min	Available through Patient Tools, Epic, and CHADIS. Available for free download as PDFs from www.theswyc.org.	Sensitivity: 83%–93% (average: 88.5%) Specificity: 42%–75% (average: 56.9%)	Included on 18-, 24-, and 30-mo SWYC forms	3 of 7 symptoms in at-risk range	Available in multiple languages; see test information for details	Available for free download from www.theswyc.org	Publications and User's Manual available at www.theswyc.org. Smith N, Sheldrick R, Perrin E. An Abbreviated Screening Instrument for Autism Spectrum Disorders. *Infant Mental Health J*. 2013;34(2):149–155. Salisbury LA, Nyce JD, Hannum CD, Sheldrick RC, Perrin EC. Sensitivity and specificity of 2 autism screeners among referred children between 16 and 48 mo of age. *J Dev Behav Pediatr*. 2018;39(3):254–258

Supplemental Table 1 Continued

	Description	Age Range	No. Items	Administration Time	Forms Available EHR Compatible	Psychometric Properties[a]	Utility as Autism Screener	Scoring Method	Cultural Considerations	Purchase and Obtainment Information	Key References
Rapid Interactive Screening Test for Autism in Toddlers 13	Clinician observation: administered by trained examiner	12–36 mo	9 interactive items (averaged)	20–30 min	No	Cutoff >15 Sensitivity: 1 Specificity: 0.84 PPV: 0.88 NPV: 0.94. Needs further study in larger samples	Yes	9 interactive activities. Total score summed, cutoff score of 15 (for that sample)	English	https://umassmed.edu/AutismRITA1/about-the-test/	Chouinri R, Wagner S. A new interactive screening test for autism spectrum disorders in toddlers. *J Pediatr* 2015;167:460–466

The AAP does not approve or endorse any specific tool for screening purposes. This table is not exhaustive, and other tests may be available. ADI-R, Autism Diagnostic Interview, Revised; ADOS-G, Autism Diagnostic Observation Schedule, Generic; CARS, Childhood Autism Rating Scale; DD, developmental disorder; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; DSM-IV-TR, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*; EHR, electronic health record; IMFAR, International Meeting for Autism Research (now International Society for Autism Research [INSAR]); PEDS, Parents' Evaluation of Developmental Status; POSI, Parent's Observations of Social Interactions; PSC, Pediatric Symptom Checklist; SDQ, Strengths and Difficulties Questionnaire; SWYC, The Survey of Wellbeing of Young Children; —, not evaluated.

[a] Sensitivity and specificity were categorized as follows: low, ≤69; moderate, 70–89; high, ≥90.

CODING AND PAYMENT

Separate *Current Procedural Terminology* (CPT)[101] codes exist for developmental screening (96110: developmental screening) and testing (96112–96113: developmental testing). Please note that 96111 has been deleted for CPT 2019. The new developmental testing codes are 96112 and 96113. A CPT code for brief behavioral assessment, 96127, also is available to allow the separate reporting of this service if completed in conjunction with developmental screening. Psychosocial risk screening, as recommended by the AAP, is now represented under "Health Risk Assessment screening" with 2 CPT codes: 96160 (patient focused) and 96161 (caregiver focused).[24]

The relative values for these codes are published in the Medicare Resource-Based Relative Value Scale and reflect physician work, practice expenses, and professional liability expenses (although 96110, 96127, 96160, and 96161 do not incorporate physician work relative value units). A table outlining the appropriate codes to use when billing for the processes described in this statement's algorithm is included in this document (Supplemental Table 2). Health plans should adhere to CPT guidelines and provide coverage and payment for developmental screening and testing.

Billing processes related to developmental screening and surveillance should be carefully reviewed to ensure appropriate CPT codes are used to document screening procedures and to ensure proper payment. CPT code 96110 for developmental screening does not incorporate physician work relative value units. The expectation is that a nonphysician will administer the screening test to the parent and then score the responses. If the developmental screen was completed outside of the office setting (eg, in the child care setting), this will increase the complexity of the visit. The physician reviews and interprets the screening results; the physician's work is included in the evaluation and management code used for the child's visit. Medicaid may not pay separately for developmental screening when provided as part of early and periodic screening, diagnostic, and treatment services. The preventive care code is used with the modifier 25 appended and 96110 listed for each developmental screening test administered. Billing practices should include time-based billing if extended time is spent on care coordination or counseling. The CPT code 96111 has been deleted for the 2019 CPT. To report developmental testing (based on time), 2 codes have been developed (96112 and 96113), which includes medical provider work and allows for reporting on the basis of the first hour and each additional 30 minutes of test administration with interpretation and report. This code would more appropriately be used when the medical provider performs longer, more-comprehensive developmental assessments using standardized instruments, which include assessment of motor, language, social, adaptive, and/or cognitive functioning and which include physician work as part of the service.[102]

The codes in Supplemental Table 2 may be applicable to the phases of developmental surveillance, screening, and evaluation described in the proposed algorithm (Fig 1). Supplemental Table 3 contains tips for coding when multiple screens are administered.

SUPPLEMENTAL TABLE 2 CPT Codes Relevant to Pediatric Developmental Care

Services or Step in Algorithm	Notes	CPT Code	Comments
(1) Pediatric preventive care visit	All preventive care visits should include developmental surveillance; screening is performed as needed or at periodic intervals	99381–99394 (EPSDT[a])	—
(3a–d) Developmental screening (also used for autism screening)	The expectation is that the screening tool will be completed by a parent or nonphysician staff member and reviewed by the pediatric care provider	96110	Developmental screening with scoring and documentation, per standardized instrument
(3a–d) Behavioral screening	The expectation is that the screening tool will be completed by a parent or nonphysician staff member and reviewed by the pediatric care provider	96127	Brief emotional and behavioral assessment with scoring and documentation, per standardized instrument
(4) Health risk assessment	The code can be used for a screening tool to update family's psychosocial history (including poverty), assess for toxic stress exposure, etc. The expectation is that the screening will be reviewed by the pediatric care provider	96160 (patient focused); 96161 (caregiver focused)	Administration of health risk assessment instrument (eg, health hazard appraisal)
(7, 8, 9) Developmental or medical evaluation	If performed by the physician as an outpatient return office visit	99212–99215[b]	Established office and office consultation codes are selected based on threshold levels of either key components (history, examination, decision-making) or face-to-face time (when counseling and/or coordination of care dominates the visit)
	If a developmental problem is identified during a preventive care visit, the additional work of addressing this problem should be reported with an office code and 25 modifier	96112–96113	96112 is for 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 is for each additional 30 min
	Outpatient consultation. For rendering opinions and addressing questions, not assuming care	99241–99245	99244 is used for "moderate activities" of up to 60 min; 99245 is used for "high" activity of up to 80 min
(14) Developmental disorder identified	For follow-up visits with the patient and parents to complete the consultation or to discuss the results of the initial consultation. Once care is assumed, established office visit coding is used	99212–99215	—
(15) Identify as a child with special health care needs, initiate chronic condition management	Children with special health care needs are likely to require expanded time and a higher level of medical decision-making found in these "higher-level" outpatient codes. These codes are appropriate for services in the office and for outpatient facility services for established patients. These codes may be reported using time alone as the factor if more than half of the reported time is spent in counseling	99212–99215	See steps 7–9
Prolonged services	At any point during the algorithm when outpatient office or consultation codes are used, prolonged physician service codes may be reported in addition	99354 99355 99358 99359	99354 for first 30–74 min of outpatient face-to-face prolonged services. 99355 for each additional 30 min. 99358 for first 30–74 min of

SUPPLEMENTAL TABLE 2 Continued

Services or Step in Algorithm	Notes	CPT Code	Comments
	when visits require considerably more time than typical for the base code alone. Both face-to-face and non–face-to-face codes are available in CPT		non–face-to-face prolonged services. 99359 for each additional 30 min
(9) Developmental testing or evaluation	Used for developmental testing typically provided by physician or other qualified health care provider, including the evaluation interpretation and report	96112–96113	Reported in addition to E/M services provided on the same date (see steps 7–9)
(15) Care plan oversight	Recurrent physician supervision of a complex patient or patient who requires multidisciplinary care and ongoing physician involvement; reflects complexity and time required to supervise care	99339: 15–29 min 99340: >30 min/mo	Reported separately from E/M services; reported on the basis of amount of physician or qualified health care professional time spent in a calendar month
(15) Management services codes	These codes accommodate clinical staff time expended over 1 mo managing patients who have chronic care management conditions and complex chronic care management conditions[c]	99490: chronic care management 99487 and 99489: complex chronic care management	Reported separately from E/M services; reported on the basis of amount of clinical or office staff time spent in a calendar month but would not also report these services in the same month that one is reporting care plan oversight

E/M, evaluation and management. —, not applicable.

[a] Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is the federal Medicaid program for preventive services. States may require physicians to use different codes to report these services. In general, for non-Medicaid commercial insurers, the E/M *Current Procedural Terminology* (CPT) codes for preventive medicine services (99381–99394) are used for the basic service (history, physical examination, and counseling and anticipatory guidance), with separate CPT codes reported additionally for the additional screening of hearing, vision, development, laboratory services, and immunization administration.

[b] CPT E/M code levels are selected on the basis of the amount of physician work (history, physical examination, and medical decision-making) and/or time used in the encounter.

[c] These codes require a minimum threshold of chronic condition severity: 2 or more chronic continuous or episodic health conditions that are expected to last at least 12 mo, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. Not all, but some, children with developmental disorders will meet this threshold.

SUPPLEMENTAL TABLE 3 Coding Tips for Multiple Screens

When standardized developmental screening, autism screening, behavioral and emotional rating, and health risk assessment instruments are administered, scored, and interpreted as part of an E/M service, each instrument form is individually coded. For example, if an established 18-mo-old patient receives 1 autism screen and 1 developmental screen, 2 units of 96110 would then be coded. It may be necessary to append modifier 25 (separate and identifiable service) to the preventive service code to alert the payer that the preventive service was a separate and identifiable service from the procedure (96110) also coded for at that visit. For an 18-mo-old infant receiving 1 autism screen and 1 developmental screen, all services at that visit would thus be coded as E/M code No.-25, (2) 96110
If a health risk assessment of the primary caregiver (eg, parent) on behalf of the patient is also completed using a standardized scale that is completed, scored, interpreted, and discussed with the parent and documented in the child's medical record, then CPT96161, "Administration of a standardized health risk assessment to a caregiver for the benefit of the patient," would be coded on a line separate from the 96110 codes: E/M code No.-25, (2) 96110, (1) 96161. Although this is the correct coding, payers may have their own policies about which procedures they will pay for and how many per encounter.
If the payer does not accept the 25 modifier, it may be necessary to use the 59 modifier "distinct procedural service," used to report procedures distinct from other non E/M services on the same day. In the example above, append 59 to all subsequent rating scales after the initial 96110, as follows: 96110, (1) 96110-59, (1) 96161-59.

E/M, evaluation and management.

SUPPLEMENTAL REFERENCES

101. American Medical Association. *Current Procedural Terminology (CPT) 2019 Professional Edition*. Chicago, IL: American Medical Association; 2018

102. American Academy of Pediatrics. Standardized screening/testing coding fact sheet for primary care pediatricians: developmental/behavioral/emotional. 2017. Available at: https://www.aap.org/en-us/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf. Accessed July 2, 2018