1. What Is the Primary Purpose of Developmental Screening in Your Setting or Practice?

Before selecting a screening instrument, it is necessary to consider the primary purpose of developmental screening in your setting or practice. For example, do you wish to enhance developmental surveillance, detect general developmental problems, or identify specific developmental problems or disorders? Use the table below to begin to explore your options.

Purpose	Screening Implications
Is your practice interested in a comprehensive approach? Can your practice implement more than one screening procedure?	Consider a "parental concern"–based instrument for developmental surveillance at well-child visits and the administration of a more comprehensive screening measure at intervals recommended by the AAP.
Do you wish to focus efforts on eliciting parental concerns?	Consider an instrument that elicits parental concerns about their children's development such as the Parents' Evaluation of Developmental Status (PEDS).
Do you wish to obtain parents' views on developmental skills in specific developmental domains (e.g., language) for the purpose of referral or treatment planning?	Consider an instrument that measures a range of different developmental skills such as the Ages and Stages Questionnaire (ASQ).
Do you wish to screen for specific developmental disorders such as language delay or autism?	Consider an instrument that is designed for the assessment of specific disorders.

2a. What Are the Characteristics of Patients in Your Practice?

The characteristics of patients who are seen in your practice will influence both the screening instrument that you select and the best way to use it in your practice. Consider the following questions and implications.

Characteristics of Patients and Families	Screening Implications
Do you have patients and families with risk factors for delay in your practice?	Consider a screening instrument that documents specific skills rather than concerns alone.
Do you have parents with limited reading skills?	Consider offering the option of completing forms with assistance from staff.
Do you have parents with limited English proficiency?	Consider instruments that have foreign language translations available (e.g., in Spanish) and relevant norms.
Do you have a practice with high base rates of developmental problems and/or risk factors (e.g., histories of very low birth weight) for developmental problems?	Consider instruments that have demonstrated sensitivity, specificity, and predictive value for high-risk populations.

2b) What Are the Base Rates of Developmental Problems in Your Practice?

The base rates or prevalence of target developmental problems (e.g., developmental delay, autism, language disorders) in your practice are critical in determining the accuracy or predictive values of developmental screening instruments in your setting. In general, the lower the prevalence of delay in a practice, the more accurate (e.g., higher sensitivity and specificity) a screening method needs to be in order to limit the number of false-positive and false-negative results.

How can you identify the base rates of target developmental problems in your practice setting? Clinic records of rates of diagnoses of developmental problems in your practice are one way to identify base rates. However, unless you are routinely screening every child, this may underestimate the true prevalence of developmental problems in your practice. Another way is to estimate the level of biologic/environmental risk for developmental problems experienced by children seen in your practice. The following table can help you determine the level of risk for the prevalence of developmental problems in your practice.

Biologic and Environmental Risk		
Lower risk	**Intermediate Risk**	**Higher risk**
• Regular well-child care • Full-term birth • Maternal prenatal care • Normal birthweight • Normal growth • Adequate financial resources • Healthy parent • Two-parent family • Family history of developmental problems	• Intermittent well-child care • Intermittent maternal prenatal care • Prenatal tobacco exposure • Feeding/growth problem • Multiple caregivers • Stressed parent • Single-parent family	• Infrequent well-child care. No maternal, paternal care • Premature birth • Prenatal exposure to drugs/alcohol • Low birthweight • Genetic disorder • Chronic illness • Feeding/growth disorder • Poverty • Foster care • International adoption • Parental depression, mental illness, or substance abuse • Exposure to lead, toxins • Teen parent • Family history of developmental problems

3. What Resources for Implementing Developmental Screening Are Available in Your Practice?

The resources your practice has will play a role in your developmental screening instrument selection and its application. Consider the following implications.

Practice Resources	Screening Implications
Do you have professional staff that can assist families with screening procedures during visits?	• Consider training staff to administer, score, and possibly interpret results for families.
Are you in a group practice or do you have a group affiliation?	• Consider pooling resources to bring in a developmental specialist to administer screening instruments and provide other developmental services.
How is developmental screening reimbursed in your practice?	• Consider methods that are more likely to lead to reimbursement. For example, if a standardized instrument is used and results are recorded, then CPT codes (96110) for screening can be used in many practices. • Consider consulting with other practices that have used developmental screening instruments about their billing experiences. (See #4 Technical Assistance).
Who in your office can be in charge of implementation and maintenance of screening procedures?	• Consider delegating the major responsibilities for developmental screening to someone in your practice. • Consider obtaining technical assistance for training and supervision.
What if you can expect no more than minimal clerical assistance from your office staff?	• Consider mailing screening forms and instructions to homes before pediatric visits. • Focus staff training on scoring and record keeping.

4. What Technical Assistance and Experience Are Available to You to Help Implement a Developmental Screening Program in Your Practice?

Practices can benefit from technical assistance when developing and effectively implementing a developmental screening program. You might wish to consider the following sources of technical assistance when implementing a screening program in your practice.

Technical Assistance	Screening Implications
Do you have access to a pediatric psychologist or developmental behavioral pediatrician in your community?	Consider obtaining consultation to help select instruments to train your staff and implement the screening program.
Do you know of pediatric practices or pediatric residency programs in your community that are conducting developmental screening using a specific instrument?	Consider contacting these practices or residency programs about their experiences and recommendations.
Does your state's early and periodic screening, diagnosis and treatment (EPSDT) program use a developmental screening instrument?	Consider contacting relevant state-level professionals about their experiences and recommendations in developmental screening.
Does your state's AAP chapter offer technical assistance for developmental screening?	Consider obtaining technical assistance from your state's AAP chapter.
Have you chosen a specific developmental screening instrument?	Consider obtaining training and technical assistance from the test developer.

5. What Resources for Assessment and Intervention for Developmental Problems are Available in Your Community?

According to the AAP, developmental screening does not result in a specific diagnosis or treatment plan but identifies areas in which a child's development differs from age-related norms. Nevertheless, developmental screening should be followed by a positive clinical action that has the potential to enhance the child's development.

If the child's developmental status is found to be within normal limits, relevant clinical actions include the reassurance of parents and anticipatory guidance addressing the parents' concerns and/or relevant developmental issues for the child. If the screening test is positive, the family should be referred for evaluation and treatment planning, such as to a psychologist or a speech, language, or occupational therapist, and early intervention.

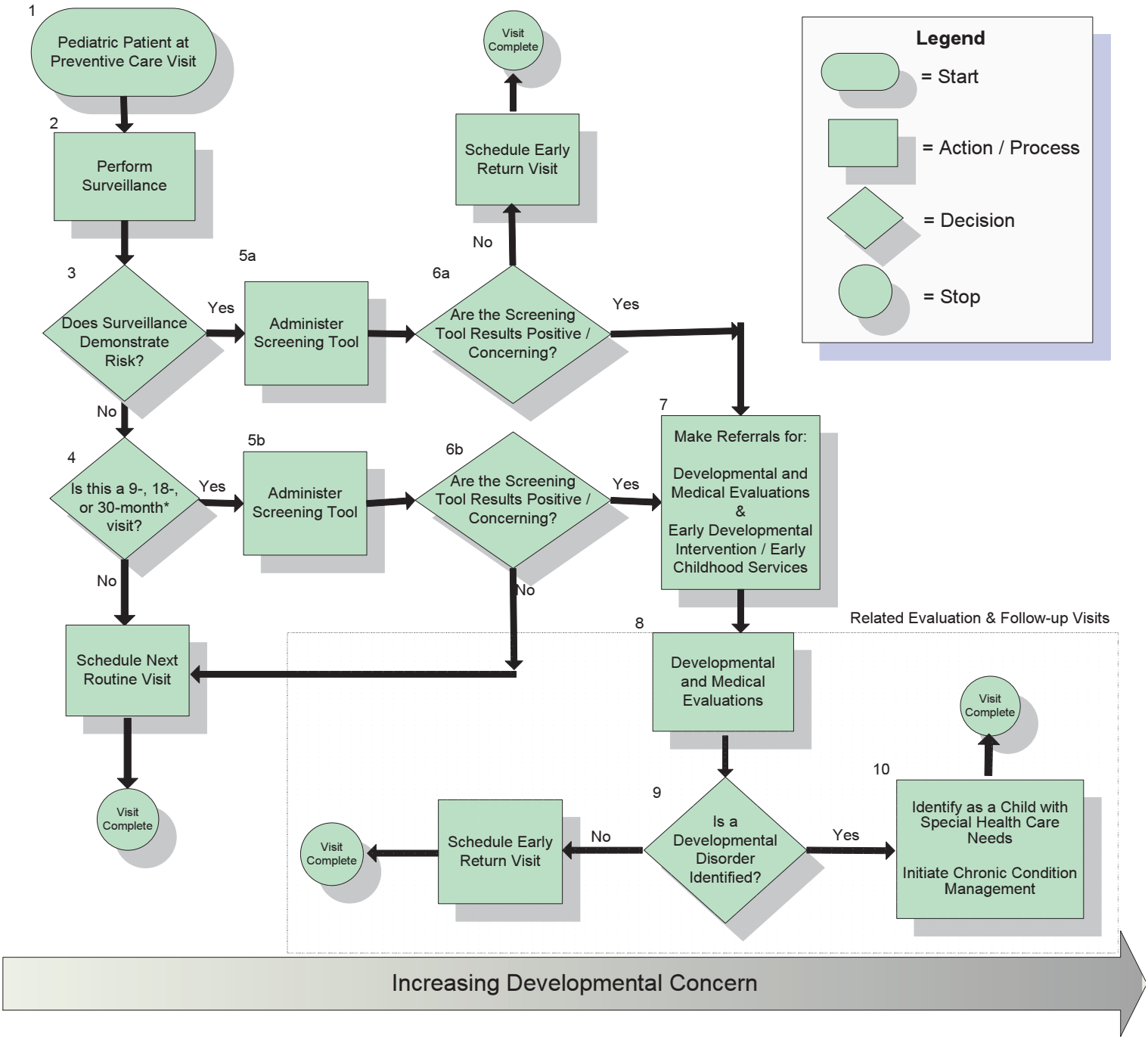
Knowledge of available community resources will improve effective follow-up. Consider the following when researching your options.

Available Community Resources	Implications
What community resources are available to assess the developmental problems that are identified by screening and plan for treatment?	Consider developing a referral network of psychologists, speech/language therapists to provide occupational and physical therapy to your patients and their families.
Does your community's Early Intervention System recommend a specific instrument or method for documenting need for services?	Consider use of the recommended procedures to facilitate and streamline referrals into the early intervention system.
What community resources are available for early intervention for developmental problems?	Find out about available community resources for early intervention. Consider developing a close collaboration with early intervention programs in your community.

Handout 7

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

Developmental Surveillance and Screening Algorithm Within a Pediatric Preventive Care Visit



*Because the 30-month visit is not yet a part of the preventive care system and is often not reimbursable by third-party payers at this time, developmental screening can be performed at 24 months of age.

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PEDIATRICS (ISSN 0031 4005).

Developmental and Screening Algorithm Within a Pediatric Preventive Care Visit

Pediatric Patient at Preventive Care Visit

1. Developmental concerns should be included as one of several health topics addressed at each pediatric preventive care visit throughout the first 5 years of life.[5]

Perform Surveillance

2. ***Developmental Surveillance*** is a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. There are 5 components of development surveillance: eliciting and attending to the parents' concerns about their child's development, documenting and maintaining a developmental history, making accurate observations of the child, identifying the risk and protective factors, and maintaining an accurate record and documenting the process and findings.

Does Surveillance Demonstrate Risk?

3. The concerns of both parents and child health professionals should be included in determining whether surveillance suggests the child may be at risk of developmental delay. If either parents or the child health professional express concern about the child's development, a developmental screening to address the concern specifically should be conducted.

Is this a 9-, 18-, or 30-month* visit?

4. All children should receive developmental screening using a standardized test. In the absence of established risk factors or parental or provider concerns, a general developmental screen is recommended at the 9-, 18-, and 30-month* visits. Additionally, autism-specific screening is recommended for all children at the 18-month visit.
**Because the 30-month visit is not yet a part of the preventive care system and is often not reimbursable by third-party payers at this time, developmental screening can be performed at 24 months of age.*

Administer Screening Tool

5a & 5b. ***Developmental screening*** is the administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder. Developmental screening that targets the area of concern is indicated whenever a problem is identified during developmental surveillance.

Are the Screening Tool Results Positive / Concerning?

6a & 6b. When the results of the periodic screening tool are normal, the child health professional can inform the parents and continue with other aspects of the preventive visit. When a screening tool is administered as a result of concerns about development, an early return visit to provide additional developmental surveillance should be scheduled, even if the screening tool results do not indicate a risk of delay.

Make Referrals for:

Developmental and Medical Evaluations
&
Early Developmental Intervention / Early Childhood Services

Developmental and Medical Evaluations

7-8. If screening results are concerning, the child should be scheduled for developmental and medical evaluations. ***Developmental evaluation*** is aimed at identifying the specific developmental disorder or disorders affecting the child. In addition to the developmental evaluation, a ***medical diagnostic evaluation*** to identify an underlying etiology should be undertaken. ***Early Developmental Intervention/Early Childhood Services*** can be particularly valuable when a child is first identified to be at high risk of delayed development, because these programs often provide evaluation services and can offer other services to the child and family even before an evaluation is complete.[24] Establishing an effective and efficient partnership with early childhood professionals is an important component of successful care coordination for children.[39]

Is a Developmental Disorder Identified?

9. If a developmental disorder is identified, the child should be identified as a child with special health care needs and chronic condition management should be initiated (see No. 10 below). If a developmental disorder is not identified through medical and developmental evaluation, the child should be scheduled for an early return visit for further surveillance. More frequent visits, with particular attention paid to areas of concern, will allow the child to be promptly referred for further evaluation if any further evidence of delayed development or a specific disorder emerges.

Identify as a Child with Special Health Care Needs

Initiate Chronic Condition Management

10. When a child is discovered to have a significant developmental disorder, that child becomes a child with special health care needs, even if that child does not have a specific disease etiology identified. Such a child should be identified by the medical home for appropriate chronic condition management and regular monitoring and entered into the practice's children and youth with special health care needs registry.[40]

Handout 8

Your Baby at 9 Months

Child's Name | **Child's Age** | **Today's Date**

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 9 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most babies do at this age:

Social/Emotional

- ❑ May be afraid of strangers
- ❑ May be clingy with familiar adults
- ❑ Has favorite toys

Language/Communication

- ❑ Understands "no"
- ❑ Makes a lot of different sounds like "mamamama" and "bababababa"
- ❑ Copies sounds and gestures of others
- ❑ Uses fingers to point at things

Cognitive (learning, thinking, problem-solving)

- ❑ Watches the path of something as it falls
- ❑ Looks for things he sees you hide
- ❑ Plays peek-a-boo
- ❑ Puts things in her mouth
- ❑ Moves things smoothly from one hand to the other
- ❑ Picks up things like cereal o's between thumb and index finger

Movement/Physical Development

- ❑ Stands, holding on
- ❑ Can get into sitting position
- ❑ Sits without support
- ❑ Pulls to stand
- ❑ Crawls

Act early by talking to your child's doctor if your child:

- ❑ Doesn't bear weight on legs with support
- ❑ Doesn't sit with help
- ❑ Doesn't babble ("mama", "baba", "dada")
- ❑ Doesn't play any games involving back-and-forth play
- ❑ Doesn't respond to own name
- ❑ Doesn't seem to recognize familiar people
- ❑ Doesn't look where you point
- ❑ Doesn't transfer toys from one hand to the other

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

The American Academy of Pediatrics recommends that children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

Su bebé a los 9 meses

Nombre del niño | **Edad del niño** | **Fecha de hoy**

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 10 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

En las áreas social y emocional

- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Puede ser que se aferre a los adultos conocidos todo el tiempo
- ❑ Tiene juguetes preferidos

En las áreas del habla y la comunicación

- ❑ Entiende cuando se le dice “no”
- ❑ Hace muchos sonidos diferentes como “mamamama” y “dadadadada”
- ❑ Copia los sonidos que hacen otras personas
- ❑ Señala objetos con los dedos

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Observa el recorrido de las cosas al caer
- ❑ Va en busca de las cosas que usted esconde
- ❑ Juega a esconder su carita detrás de las manos
- ❑ Se pone las cosas en la boca
- ❑ Pasa objetos de una mano a la otra con facilidad
- ❑ Levanta cosas como cereales en forma de “o” entre el dedo índice y el pulgar

En las áreas motora y de desarrollo físico

- ❑ Puede sentarse solo
- ❑ Se sienta sin apoyo
- ❑ Se parar sosteniéndose de algo
- ❑ Gatea

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No se apoya en las piernas con ayuda
- ❑ No se sostiene en las piernas con apoyo
- ❑ No balbucea (“mama”, “baba”, “papa”)
- ❑ No juega a nada que sea por turnos como “me toca a mí, te toca a ti”
- ❑ No responde cuando le llaman por su nombre
- ❑ No parece reconocer a las personas conocidas
- ❑ No mira hacia donde usted señala
- ❑ No pasa juguetes de una mano a la otra

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños a los 9 meses. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

Your Child at 18 Months (1½ Years)

Child's Name | **Child's Age** | **Today's Date**

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 18 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Likes to hand things to others as play
- ❑ May have temper tantrums
- ❑ May be afraid of strangers
- ❑ Shows affection to familiar people
- ❑ Plays simple pretend, such as feeding a doll
- ❑ May cling to caregivers in new situations
- ❑ Points to show others something interesting
- ❑ Explores alone but with parent close by

Language/Communication

- ❑ Says several single words
- ❑ Says and shakes head "no"
- ❑ Points to show someone what he wants

Cognitive (learning, thinking, problem-solving)

- ❑ Knows what ordinary things are for; for example, telephone, brush, spoon
- ❑ Points to get the attention of others
- ❑ Shows interest in a doll or stuffed animal by pretending to feed
- ❑ Points to one body part
- ❑ Scribbles on his own
- ❑ Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- ❑ Walks alone
- ❑ May walk up steps and run
- ❑ Pulls toys while walking
- ❑ Can help undress herself
- ❑ Drinks from a cup
- ❑ Eats with a spoon

Act early by talking to your child's doctor if your child:

- ❑ Doesn't point to show things to others
- ❑ Can't walk
- ❑ Doesn't know what familiar things are for
- ❑ Doesn't copy others
- ❑ Doesn't gain new words
- ❑ Doesn't have at least 6 words
- ❑ Doesn't notice or mind when a caregiver leaves or returns
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

Su bebé a los 18 meses (1½ años)

Nombre del niño | **Edad del niño** | **Fecha de hoy**

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 19 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Le gusta alcanzarle cosas a los demás como un juego
- ❑ Puede tener rabietas
- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Le demuestra afecto a las personas conocidas
- ❑ Juega a imitar cosas sencillas, como alimentar a una muñeca
- ❑ Se aferra a la persona que le cuida en situaciones nuevas
- ❑ Señala para mostrarle a otras personas algo interesante
- ❑ Explora solo, pero con la presencia cercana de los padres

En las áreas del habla y la comunicación

- ❑ Puede decir varias palabras
- ❑ Dice “no” y sacude la cabeza como negación
- ❑ Señala para mostrarle a otra persona lo que quiere

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Sabe para qué sirven las cosas comunes; por ejemplo, teléfono, cepillo, cuchara
- ❑ Señala una parte del cuerpo
- ❑ Señala para llamar la atención de otras personas
- ❑ Demuestra interés en una muñeca o animal de peluche y hace de cuenta que le da de comer
- ❑ Hace garabatos sin ayuda
- ❑ Puede seguir instrucciones verbales de un solo paso que no se acompañan de gestos; por ejemplo, se sienta cuando se le dice “siéntate”

En las áreas motora y de desarrollo físico

- ❑ Camina solo
- ❑ Jala juguetes detrás de él mientras camina
- ❑ Puede subir las escaleras y correr
- ❑ Puede ayudar a desvestirse
- ❑ Bebe de una taza
- ❑ Come con cuchara

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No señala cosas para mostrárselas a otras personas
- ❑ No puede caminar
- ❑ No sabe para qué sirven las cosas familiares
- ❑ No copia lo que hacen las demás personas
- ❑ No aprende nuevas palabras
- ❑ No sabe por lo menos 6 palabras
- ❑ No se da cuenta ni parece importarle si la persona que le cuida se va a o regresa
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que, a los 18 meses de edad, se evalúe el desarrollo general de los niños y se realicen pruebas de detección del autismo. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

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Your Child at 2 Years

Child's Name | **Child's Age** | **Today's Date**

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 2nd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Copies others, especially adults and older children
- ❑ Gets excited when with other children
- ❑ Shows more and more independence
- ❑ Shows defiant behavior (doing what he has been told not to)
- ❑ Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication

- ❑ Points to things or pictures when they are named
- ❑ Knows names of familiar people and body parts
- ❑ Says sentences with 2 to 4 words
- ❑ Follows simple instructions
- ❑ Repeats words overheard in conversation
- ❑ Points to things in a book

Cognitive (learning, thinking, problem-solving)

- ❑ Finds things even when hidden under two or three covers
- ❑ Begins to sort shapes and colors
- ❑ Completes sentences and rhymes in familiar books
- ❑ Plays simple make-believe games
- ❑ Builds towers of 4 or more blocks
- ❑ Might use one hand more than the other
- ❑ Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- ❑ Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development

- ❑ Stands on tiptoe
- ❑ Kicks a ball
- ❑ Begins to run
- ❑ Climbs onto and down from furniture without help
- ❑ Walks up and down stairs holding on
- ❑ Throws ball overhand
- ❑ Makes or copies straight lines and circles

Act early by talking to your child's doctor if your child:

- ❑ Doesn't use 2-word phrases (for example, "drink milk")
- ❑ Doesn't know what to do with common things, like a brush, phone, fork, spoon
- ❑ Doesn't copy actions and words
- ❑ Doesn't follow simple instructions
- ❑ Doesn't walk steadily
- ❑ Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

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Su hijo de 2 años

Nombre del niño | **Edad del niño** | **Fecha de hoy**

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 2 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Copia a otras personas, especialmente a adultos y niños mayores
- ❑ Se entusiasma cuando está con otros niños
- ❑ Demuestra ser cada vez más independiente
- ❑ Demuestra un comportamiento desafiante (hace lo que se le ha dicho que no haga)
- ❑ Comienza a incluir otros niños en sus juegos, como jugar a sentarse a comer con las muñecas o a correr y perseguirse

En las áreas del habla y la comunicación

- ❑ Señala a objetos o ilustraciones cuando se los nombra
- ❑ Sabe los nombres de personas conocidas y partes del cuerpo
- ❑ Dice frases de 2 a 4 palabras
- ❑ Sigue instrucciones sencillas
- ❑ Repite palabras que escuchó en alguna conversación
- ❑ Señala las cosas que aparecen en un libro

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Encuentra cosas aun cuando están escondidas debajo de dos o tres sábanas
- ❑ Empieza a clasificar por formas y colores
- ❑ Completa las frases y las rimas de los cuentos que conoce
- ❑ Juega con su imaginación de manera sencilla
- ❑ Construye torres de 4 bloques o más
- ❑ Puede que use una mano más que la otra
- ❑ Sigue instrucciones para hacer dos cosas como por ejemplo, “levanta tus zapatos y ponlos en su lugar”
- ❑ Nombra las ilustraciones de los libros como un gato, pájaro o perro

En las áreas motora y de desarrollo físico

- ❑ Se para en las puntas de los dedos
- ❑ Patea una pelota
- ❑ Empieza a correr
- ❑ Se trepa y baja de muebles sin ayuda
- ❑ Sube y baja las escaleras agarrándose
- ❑ Tira la pelota por encima de la cabeza
- ❑ Dibuja o copia líneas rectas y círculos

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No usa frases de 2 palabras (por ejemplo, “toma leche”)
- ❑ No sabe cómo utilizar objetos de uso común, como un cepillo, teléfono, tenedor o cuchara
- ❑ No copia acciones ni palabras
- ❑ No puede seguir instrucciones sencillas
- ❑ No camina con estabilidad
- ❑ Pierde habilidades que había logrado

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que, a los 24 meses de edad, se evalúe el desarrollo general de los niños y se realicen pruebas de detección del autismo. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

Developmental Screening/Testing
Coding Fact Sheet for Primary Care Pediatricians

I. CODING

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

A. How To Report Developmental Testing

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

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

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

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

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

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

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

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

B. When To Report Developmental Testing

96110

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

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

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

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

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

II. CLINICAL VIGNETTES

96110 Vignette #1

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

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

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**

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

96110 Vignette #2

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

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**

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

96111 Vignette #2

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

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

III. DOCUMENTATION GUIDELINES

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

Following are examples of appropriate documentation for some testing tools:

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 test.

ASQ (AGES AND STAGES Questionnaire)

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

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

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

IV. SAMPLE TESTING TOOLS

96110

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

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

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

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

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

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

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

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

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

Vanderbilt Rating Scales (Mark L. Wolraich, MD)

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

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

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

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

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

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

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

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

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

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

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

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