Screening and Testing for Autism: Coding Fact Sheet for Primary Care Pediatricians

Screening for Autism by the Use of Specific Tests

96110 *Developmental testing; limited with interpretation and report*

This code is used when a developmental screening instrument of a limited nature, such as Modified Checklist for Autism in Toddlers or Pervasive Developmental Disorders Screening Test-II, is performed. *Current Procedural Terminology (CPT®)* code **96110** can be reported when this service is performed in the context of preventive medicine services or with other evaluation and management (E/M) services such as acute illness or follow-up office visits. In the 2007 Medicare physician fee schedule (Resource-Based Relative Value Scale), the Centers for Medicare & Medicaid Services (CMS) published total relative value units (RVUs) of 0.36 for **96110** based on practice expense (ie, clinical staff time, medical supplies) and professional liability insurance expense for this service. Therefore, it can be reported when performed by the clinical staff. There is no physician work value published for this code.

When to Report 96110

The frequency of reporting **96110** is dependent on the clinical situation. The American Academy of Pediatrics Autism Expert Panel recommends screening for autism using validated instruments at 18 and 24 months for all children and at all other times that concerns arise as a result of developmental surveillance, to improve detection of problems at the earliest possible age to allow further assessment and appropriate early intervention services. When physicians ask questions about development as part of the general informal developmental surveillance or history, this is not considered standardized screening and is not separately reportable. Each screen administered is reported separately.

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

Extended objective developmental testing for autism using standardized instruments (eg, Autism Diagnostic Observation Scale-R) can be reported using code **96111**. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (eg, an E/M code for outpatient consultation). Only a physician or other trained professional can perform this testing service because there are physician work RVUs (2.60) published on the 2007 CMS Medicare physician fee schedule for this code.

When to Report 96111

Longer, more comprehensive, objective autism assessments are typically reported using *CPT* code **96111** (developmental testing; extended). These tests are typically performed by physicians or psychologists and are variable in length. While this testing may require more than 60 minutes to complete, **96111** may only be reported once each day of face-to-face patient contact. If the patient is seen more than once and testing is done on more than 1 day, **96111** may be reported for each day that testing was done. The testing must be accompanied by an interpretation and formal report. This report, however, may be included as part of a larger comprehensive report. The interpretation and report may be completed at a time other than when the patient is present.

96116 *Neurobehavioral status examination (clinical assessment of thinking, reasoning, and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report*

This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the neurobehavioral assessment (eg, an E/M code for outpatient consultation and/or **96111** for direct testing completed on the patient). Only a physician or other trained professional can perform this testing service because there are physician work RVUs (1.86) published on the 2007 CMS Medicare physician fee schedule for this code.

When to Report 96116

Code **96116** can be used for autism assessment tools such as the Autism Diagnostic Interview-Revised or Childhood Autism Rating Scale that are not directly administered to the child. Although the work RVUs are lower than for **96111, 96116** can be reported in multiple units for the same-day service.

Documentation Guidelines

Each administered 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.

Evaluation and Management Codes

A pediatrician can perform the assessment on a new patient using the consultation codes **(99241–99245)** provided the following conditions are met: (A) a written or verbal request for consultation was made by a physician (can be another colleague in the same office) or other appropriate source (eg, schools, psychologists, courts, nurse practitioners); (B) the consultant must provide an opinion or services; and (C) the consultant's opinion or services must be communicated back to the requesting physician or other appropriate source via *written* report. All 3 elements must be documented in the patient's medical record.

If the autism evaluation is completed on a new or established patient and no consultation has been requested, the appropriate E/M codes to report are **99201–99205** (new patient visit) or **99211–99215** (established patient visit).

Billing for Counseling and Coordination of Care

If greater than 50% of the total face-to-face consultation or new or established patient visit time is spent in counseling or coordinating care, the practitioner can select a level of service using time as the key factor. *CPT* has assigned each code in the family a typical time (eg, the typical time for **99244** is 60 minutes). Usually, the level of a consultation is determined by the key components of E/M (ie, history, physical examination, and medical decision-making), with time only a contributory factor. However, if a physician performs an E/M visit at the **99243** level (typical time 40 minutes), but a total of 64 face-to-face minutes are spent because the patient or parent had questions about the diagnosis, etiology, and management of autism, you can bill it at the **99244** level (typical time 60 minutes) if you spent more than 32 minutes of the total time in face-to-face counseling. Be sure to document the time in, time out, issues discussed, and individuals present.

When **96110, 96111,** or **96116** are reported with an E/M service, the time and effort to perform the testing itself should not count toward the key components or time for selecting the accompanying E/M code. If the E/M code is reported with **96110, 96111,** or **96116,** modifier **25** *(significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service)* should be appended to the E/M code or modifier **59** *(distinct procedural service)* should be appended to the testing code, showing that the services were separate and necessary at the same visit.

Reporting Prolonged Physician Service Codes With Evaluation and Management Codes

CPT codes **99354–99355** are reported *in addition* to any level office or other outpatient consultation code, when a physician provides services in the office setting involving direct face-to-face patient care for 30 minutes or more beyond the typical time listed in the code's *CPT* descriptor. The prolonged physician service codes are time-based and reported for the total duration of face-to-face time spent by a consultant on a given date, even if the time is not spent continuously. Code **99354** is used to report the first hour of prolonged service of 30 to 74 minutes beyond the typical time. Code **99355** is used to report each additional 30 minutes beyond the first hour of prolonged services and the final 15 to 30 minutes of prolonged service on a given date. Fewer than 15 minutes beyond the first hour and fewer than 15 minutes beyond the final 30 minutes cannot be reported.

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