EPSDT Developmental Screening Policy – Alaska

Alaska's Medicaid program has adopted the American Academy of Pediatrics (AAP) Bright Futures Recommendations for Preventive Pediatric Health Care which includes a recommendation for developmental screening in infancy and early childhood. To be covered by Alaska Medicaid a comprehensive medical exam must meet theses minimum recommendations. AAP and Bright futures recommends a standardized developmental screening to be administered at the 9, 18, and 30 month visit. Standardized developmental screening is a way to identify areas in which a child's development differs from same-age norms so health care professionals can determine if further evaluation is needed. Early identification of developmental disorders is critical to the well-being and improved outcomes of children and their families. This policy is intended to give guidance and support to providers regarding these newly adopted standards for regularly and routinely addressing developmental concerns in children.

Minimum recommendations for developmental screening and surveillance:

(1) Standardized developmental screenings should be administered routinely at the 9-month, 18-month, and 30-month visits; additionally, standardized developmental screening should be completed when surveillance demonstrates risk or when any concerns arise during surveillance.

(2) Developmental surveillance is a cumulative and continuous process that should be performed at every preventive visit throughout childhood and adolescence in order to ensure optimal health outcomes. The components of developmental surveillance include: eliciting and attending to parents' concerns regarding the child's development, documenting and maintaining a developmental and health history, making behavioral observations of the child, identifying risks and protective factors; and accurate documentation of the findings.

Rationale for standardized developmental screening tools:

Many developmental delays and social-emotional issues of young children are not identified accurately without the help of standardized screening tools.[1] Many physicians report that they monitor children's development by relying on their knowledge of child development and clinical judgment. The percentage of pediatricians who reported using one or more formal screening tools more than doubled between 2002 and 2009. Despite greater attention to consistent use of appropriate tools, the percentage remains less than half of respondents providing care to patients younger than 36 months.

With growing evidence of the benefit of early and intensive intervention for infants as well as toddlers and older children with autism and/or other developmental disorders, early identification

[1] In the study, "**Trends in the Use of Standardized Tools for Developmental Screening in Early Childhood: 2002-2009**," in the July 2011 issue of *Pediatrics* (published online June 27), an AAP Periodic Survey of Fellows found the percentage of pediatricians using one or more screening tools more than doubled between 2002 and 2009 (from 23 percent to 47.7 percent). Despite this increase, approximately half of the pediatricians reported that they do not routinely use the recommended screening tools for patients younger than 36 months.

is seen as critical to initiate work interventions with the children and their families at the earliest opportunity.

The recommendation supports global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays. Surveillance and screening activities should include consideration of family conditions, such as parental depression or alcohol or substance abuse, that impact the child's development and security.

Screening is especially important as a way to facilitate early identification and referral for infants and children who need early intervention services. Delayed or disordered development may be a sign of specific medical conditions that indicate a risk of behavior disorders and other medical complications. In a recent study, one in four low-income pre-school aged children screened positive for social-emotional problems in a study done on 254, 3 and 4 year-old children at two urban primary clinics, and it found that most of the parents were amenable to referrals to preschool or early intervention programs.[2] However, as evidenced by the finding that only 30% of children needing services are identified by school age, primary care physicians and other caregivers do not yet identify the majority of needs. This underscores the potential improvements if practices adopt and use formal, validated screening tools. [3]

Given the critical importance of developmental screening in early identification, evaluation, and intervention, The Department of Health and Social Services has adopted this policy and recommends use of valid, development, global, standardized screening tools listed below for all children at the specified ages.

Recommended developmental screening tools

The Department of Health and Social Services has committed to reporting to the Centers for Medicare and Medicaid Services (CMS) on the Children's Health Insurance Program Reauthorization Act (CHIPRA) children's core quality measures (CQMs). The developmental screening metric measure steward is the Oregon Health Science University (OHSU). In order to capture from Medicaid administrative claims data information needed to meet the measure specifications, the tools listed below meet the following important criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant

[2] (Brown, C.M., Copeland, K.A., Sucharew, H., Kahn, R.S. *Pediatric & Adolescent Medicine*, October, 2012, Vol 166, No. 10).

[3] (*Earls M.F., Hays S. Pediatric Digest. 2006; 118: e183-e188*)).

number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Current recommended standardized global developmental screening tools:

1. Ages and Stages Questionnaire– 3rd edition (ASQ – 3) standardized for children 2 months to 5 years.
2. Ages and Stages Questionnaire – 2nd edition (ASQ-2) standardized for children 4 to 60 months.
3. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months.
4. Bayley Neuro-developmental Screen (BINS) - 3 months-2 years.
5. Brigance Screens-II- Birth to 90 months.
6. Child Development Inventory (CDI) - 18 months- 6 years.
7. Infant Development Inventory- Birth-18 months.
8. Parents' Evaluation of Developmental Status (PEDS) – standardized for children birth to 8 years.
9. Parent's Evaluation of Developmental Status – Developmental Milestones (PED-DM) – standardized for children birth to 8 years.

The nine standardized developmental screening tools listed above are anchored to recommendations related to ***global developmental screening*** using tools that identify risk for developmental, behavioral and social delays and the use of these standardized tools will assist the Medicaid Agency in gathering data when one of these tools is used to support quality improvement through use of the core CQMs.

Domain-specific screening instruments below, not included in the global list above may continue to be used for domain specific screening:

1. Ages and Stage Questionnaire - Social-Emotional (ASQ –SE) – validate for children 6 to 60 months.
2. The Modified Checklist for Autism in Toddlers (M-CHAT) free online version available. For use in children from 16 to 30 months.

Medicaid reimbursement for developmental screening services:

Enrolled Medicaid providers may be reimbursed when a developmental screening is performed on an eligible Medicaid beneficiary. The screening tool may be completed by the parent/guardian or other healthcare staff but must be reviewed by a physician, physician's assistant, advanced nurse practitioner, physical therapist, occupational therapist, speech language

pathologist, audiologist, psychologist or psychological associate, community health aids (Level III or Level IV), EPSDT screener, or public health nurse.

CPT code 96110 is used to bill for a developmental screening, with interpretation and report per standardized instrument form.

Modifier 33 is used to identify **one of the recommended nine standardized global developmental screening instruments listed above are used**. This **modifier should not be used for the domain specific screening instruments.**

The following limitations apply to code 96110:

- A maximum of 2 screenings may be performed per visit.
- Modifier 33 is not used when billing for domain or disorder specific screening tools such as the M-CHAT. CPT code 96110 can be used without a modifier in this circumstance.
- Code will deny if billed on same date of service as code 96111(Developmental Testing)

Recommendations for Provider Records:

The healthcare provider shall maintain all records in accordance to 7 AAC 105.230 and will have the following screening information recorded in the record:

1. A note indicating the date on which (a) the screening tool was administered.
2. Name of the standardized tool or test used (also use the modifier 33 if an approved standardized, global, developmental screening tool was used), and
3. Evidence that the tool was completed and scored.

Recommended Practices:

To be covered by Alaska Medicaid an EPSDT visit must include a comprehensive medical screening(s) that meets the minimum recommendations of the *Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Care*, with additional screening performed as medically necessary. Bright Futures/American Academy of Pediatrics recommends all pediatric health care professionals implement developmental surveillance and screening in their offices.[4]

Suggestions for successful practice implementation are to:

- Identify and implement a valid, standardized, developmental tool for screening in your practice.
- Implement developmental surveillance and screening practice policies and procedures.
- Communicate with office staff and colleagues about the importance of implementing developmental surveillance and screening.
- Perform developmental surveillance at every preventive visit.
- Use the standardized developmental screening tool at the 9, 18, and 30 month well-child visits, and whenever a concern or risk is identified.

- Communicate with parents about the importance of developmental surveillance and screening.
- Communicate the desire to learn about and discuss parental concerns regarding their child's development
- Bill appropriately for developmental screening services (see table above).
- Refer children with developmental delays or social emotional concerns to appropriate resources.

References and Resources:

1. http://brightfutures.aap.org/pdfs/Guidelines_PDF/20-Appendices_PeriodicitySchedule.pdf
2. http://dhss.alaska.gov/ocs/Pages/infantlearning/default.aspx
3. http://brightfutures.aap.org/materials.html
4. https://www.m-chat.org/
5. http://www.pedstest.com/AboutOurTools/LearnAboutPEDS/IntroductiontoPEDS.aspx
6. http://www.brightfutures.org/georgetown.html
7. http://www.mdaap.org/BI-PED.html
8. http://www.mchlibrary.info/
9. http://dhss.alaska.gov/dph/Chronic/Pages/InjuryPrevention/akfvpp/clearinghouse.aspx#amazingbrain
10. http://gpo.gov/fdsys/pkg/FR-2010-07-19/pdf/2010-17242.pdf.
11. http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.
12. https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Pages/Division-of-State-Government-Affair.aspx

[4] Alaska Admin Code - EPSDT