

Developmental-behavioral Pediatrics – What and Why

What is a Developmental-behavioral Pediatrician?

Psychiatrists diagnose and manage major mental illnesses.

Developmental-behavioral Pediatricians are not psychiatrists but many of the children they treat have psychiatric disorders. Developmental-Behavioral Pediatricians are trained to manage many of these conditions, using a wide range of medication and therapeutic modalities. They understand the importance of recognizing and referring seriously ill children to psychiatrists and of participating in multi-disciplinary care teams when appropriate.

Psychologists assess and assist children to explore how they think and feel.

Developmental-behavioral Pediatricians are not psychologists but some of the children they treat may have psychological problems - usually as referrals from psychologists or schools - and they are experts in interpreting and integrating the results of psychological testing as part of the overall diagnostic process.

General pediatricians help families understand normal development and behavior.

Developmental-behavioral Pediatricians are board-certified general pediatricians first; they pursue specialized training beyond their pediatric residency and must pass a national certification examination. Developmental-Behavioral Pediatricians understand considerably more about normal development and behavior than do general pediatricians - and are experts in diagnosing and treating abnormal development and behavior.

Counselors, psychologists, mental health workers help children solve their problems.

Developmental-behavioral Pediatricians are not primarily counselors or psychologists or mental health workers but they do plenty of counseling - especially for distraught parents about how to care for their child. Many Developmental-Behavioral Pediatricians do have training and experience in various areas of psychology as part of their background, such as my Ph.D. in Educational Psychology (the science of how children learn.)

Mental health is an area of debate between many insurance companies and neuroscientists because many "mental health" and "behavioral" designations were labeled based on symptoms - before modern science discovered the biological basis for those conditions. Now we know that these disorders have physical (CT/MRI) and biochemical markers and measurable group differences which reveal them to be medical (neurological) disorders with manifestations which include mental and/or emotional signs and symptoms. Developmental-behavioral Pediatricians are particularly well qualified to treat these complex conditions because of their medical expertise combined with their command of inter-related disciplines, such as psychology and education.

**Developmental-behavioral Pediatricians
specialize in the whole child
promoting balance and harmony – physical, mental, emotional**

**Developmental-behavioral Pediatricians evaluate
the whole child
using**

what they discover	from the child
background information	from everyone
testing and reports	from the school
observations and insights	from the family
records and recommendations	from the general pediatrician
evaluation and treatment results	from psychologists and other professionals

Developmental-Behavioral Pediatricians

help the family develop a plan to meet their goals for their child
help the general pediatrician manage areas of the child's care
help the school understand how to meet the child's needs
help psychologists and counselors coordinate treatments
help arrange other treatments as part of a comprehensive program
refer to psychiatrists children with serious mental illness –
or uncertain diagnosis

Our model of service is to evaluate a child
offer recommendations to the family
help mobilize resources
get treatments going
remain available for future follow-up consultation
return the child's care to the pediatrician
for continued management

Our preference is to see children
as young as possible (newborn to six weeks ideally)
as soon as someone worries about the child's progress or problems
to **prevent** delays or problems related to any abnormal conditions –
to take positive action **before** the child fails to meet milestones

Physician services available for infants, children and teens:

Comprehensive Developmental Evaluation
including treatment plan
Diagnostic and Therapeutic Behavioral Assessment
with follow-up as indicated
Initial adjustment of psychotropic medications
with optional continued management of complicated regimens
“Second opinion” examinations regarding diagnosis, management, prognosis

Services provided at initial developmental-behavioral evaluation

96150 *Health and Behavior Assessment*

This assessment is separate from the history of present illness and past medical history; it is distinct from the health risk assessment and the neurobehavioral status exam. This assessment is an extensive inquiry into details of general health and behavior areas *not* identified as problematic and not included in the HPI or PMH - such as extended details of current and past dietary history, sleep routine and history, toileting habits and history, strategies of behavior management used at school and at home (where this is *not* part of the HPI, etc.)

99420 *Health Risk Assessment*

Appropriate overall health-lifestyle management and anticipatory guidance are extremely important for any patient. The child with developmental-behavioral problems is subject to more serious and a wider range of consequences than typically developing peers. An informed individualized analysis of health risks is essential - and beyond the scope of most general pediatricians to perform because of the complex interactions of various manifestations of the child's underlying conditions with differing configurations of risk factors, such as undiagnosed parental depression, history of child abuse against parents as children, substance abuse in the family and neighborhood, cholesterol levels in grandparents, educational levels and employment history of bio-parents and adoptive or step-parents, etc.

Because these developmental-behavioral conditions manifest differently as children mature and tend to impair function of these children well into adulthood, primary prevention assumes an urgency that matches its importance - and must be incorporated into the child's overall treatment program as early and as comprehensively as possible.

Results of the health risk assessment (and recommendations) are provided for caretakers and care providers as part of the comprehensive report covering all areas of the evaluation.

99173 *Screening for Visual Acuity (V70.0)*

Quantitative, bilateral, near-point and distance; necessary to ensure validity of D-B evaluation

92551 *Audiologic Screening (V70.0)*

Pure tone, air only; necessary to ensure validity of D-B evaluation

99245 *Office-based Consult*

This comprehensive consultation visit is conducted and recorded in the usual fashion: presenting complaint and comprehensive history of present illness; comprehensive past medical history, including family and social history; extensive review of all systems; comprehensive physical exam - bulleted (and additional) elements of *all* organ systems; complex medical decision-making regarding (usually five or more) significant diagnoses with high potential for morbidity and/or mortality. This is in addition to all other aspects of evaluation and management previously enumerated. No specific components of any different E&M codes are repeated or overlapping. Each element is separate and distinguishable from elements comprising required documentation for all other distinct E&M codes.

96116 *Neurobehavioral Status Exam*

This expanded exam is performed separately from and in addition to the standard neurological exam that is part of the "all-system" comprehensive physical. The comprehensive physical looks for abnormalities in every organ system; the neurobehavioral status exam is an in-depth investigation of the child's overall neurobehavioral functioning and of specific neurological, developmental and behavioral signs and symptoms. These exams are distinct from one another and each is needed because these children usually have subtle genetic conditions or undiagnosed medical conditions underlying or influencing their neurological, developmental and behavioral symptoms - findings that may be revealed only by a thorough assessment of each organ system.

The specific neurobehavioral status exam is required because (unlike the standard neurological section of the comprehensive exam) it includes analyzing multiple parent and teacher behavioral scales and questionnaires (such as the Connors or Vanderbilt profiles) and other extensive instruments (such as the ANSER system or Vineland Adaptive Scales); it includes rating each element comprising the child's temperamental profile (using the Chess and Thomas model); it involves expanded neurological and mental status exams (including informal clinical testing of these domains: language, cognition, motor, social, emotional and adaptive.) Results are outlined in their respective sections of the comprehensive report.

96111 *Standardized Developmental Testing (extended with interpretation and report)*

There is no substitute for this type of testing because it was developed to achieve a particular goal which no other process addresses - to assess a child's skills objectively and compare them with those of typically developing youngsters. The advantage of standardized developmental testing over informal measures or clinical estimates is that standardized instruments have been normed against a national group of the child's peers and yield comparison scores of specific skills.

Standardized testing is expensive and time-consuming. In the developmental-behavioral pediatric setting it is done one-on-one by a trained expert in administration of specific test batteries - which have been hand-picked to elucidate areas of interest in a particular patient. Properly done, standardized testing yields precise estimates of a child's performance in defined skills.

96110 *Developmental testing, limited*

This is analysis of diagnostic questionnaires such as parent and teacher behavioral scales and questionnaires (such as the Connors or Vanderbilt profiles) and other extensive instruments (such as the ANSER system or Vineland Adaptive Scales) or self-reports of emotional symptoms (such as Spence Anxiety or Hamilton Depression Scales.)

96118 *Neuropsychological testing battery, including interpretation and report*

This is testing of specific neuropsychological functions, such as visuo-motor processing, which may hinder academic progress for reasons unrelated to intelligence, achievement levels or socio-emotional status. This intensive testing is performed only if it appears there are specific neuropsychological factors interfering with a student's performance - factors which must be identified and addressed as part of the patient's evaluation and treatment.

Classically, 908xx codes are considered "psychiatric"; however the following procedures form an integral part of the comprehensive Developmental-Behavioral Pediatric evaluation.

90802 *Interactive Diagnostic Interview*

This is a child-oriented comprehensive targeted examination performed by a board-certified specialist in Developmental-Behavioral Pediatrics. This specialized examination is necessitated by the inability of children to participate in standard verbally mediated diagnostic interviews. This exam requires the use of a specially designed area with developmentally appropriate toys and evaluation materials; it takes approximately 60-90 minutes to conduct. This evaluation yields a report highlighting developmental strengths and weaknesses; characteristics and stages of observed play; behavioral symptoms; signs of psychiatric (or psychological) disorders; assessment of mental status and general functioning.

The diagnostic playroom contains objects inviting sensorimotor, construction and symbolic play.

Sensorimotor toys include baby toys to grasp, mouth, transfer, pat and shake; cause and effect toys that spin, pop up, play music or display lights; motion toys to pull, push or chase; and toys to "fiddle with" such as wire and bead toys, toys that twist, toys to place into and out of receptacles.

Construction toys include blocks of various sizes, shapes, colors, densities and composition; Duplos and Legos; plasticene clay, Play-doh, glitter dough and Wiki-Stix; different types of scissors, glue, tape, stapler, assorted paper supplies including origami paper; parquetry and other pattern sets. Symbolic toys and dramatic props include a child-sized wooden kitchen with plastic tableware, utensils, cooking equipment and pretend food; a furnished wooden dollhouse and two families including grandparents; a baby doll set-up with stroller, crib, toys, feeding and diapering supplies; cars and train sets; people and animal figures for the train sets and building toys. "School supplies" to span the continuum from whole-fisted crayon marks to sophisticated drawings with accompanying stories include slate and chalk, white board and markers, crayons from extra jumbo to standard size, colored pencils and watercolor pencils, number cubes and games, board books, nature magazines and classic children's books.

Playroom protocol is for the child to explore and play at will (with only one prohibition - no deliberate hurting of people or objects.) One or two parents or support persons may be present at the child's option; parents are invited to participate with their child's play and exploration as they normally would - to initiate, support or engage in their own pursuits while remaining available or to instruct or correct their child in the same way they would do at their own home. Examiners (representing one or more disciplines) evaluate the child's use of large and small muscles, hand-eye coordination, language and problem-solving, social interaction and emotional expression, psychological functioning and mental status. This play-based assessment is the cornerstone of the diagnostic process. Historical data, formal testing results, special studies (if indicated) and functional physical findings combine with the Interactive Diagnostic Interview to form a recognizable pattern and yield the named (DSM-IV) developmental-behavioral diagnoses.

90885 *Comprehensive review of records:*

- ★ medical records from primary care provider(s), hospital(s) of birth and any
- ★ subsequent admission(s), reports from specialists and consultants;
- ★ educational records from school and daycare (if available) including progress reports, previous teachers' anecdotal notes, standardized achievement testing, diagnostic academic testing, IEP records and recommendations, guidance counselor and/or school social worker reports;
- ★ psychiatric and psychological reports and records including standardized measures of cognitive and executive functioning, analyses of relative strengths and weaknesses in the various

modalities, emotional functioning, personality characteristics, psychiatric evaluations, diagnoses, treatments and results

For the purpose of:

- understanding the child's whole life story from a variety of perspectives,
- identifying contributory factors to current developmental and behavioral problems,
- initiating the diagnostic process through integration of all available information -
 - as a guide to further investigation and
 - as a backdrop against which to compare the present state

This process typically takes 60+ minutes and findings form a specific section of the comprehensive report (generated to summarize the entire evaluation, discuss diagnoses and present treatment recommendations.)

99361 *Team Meeting*

This multidisciplinary team meeting - led by the developmental-behavioral pediatrician - brings together the best analytical and creative talents of multiple contributors to the child's treatment plan. These meetings typically take 30-60 minutes (plus transportation to school, home, hospital, etc. if needed to involve additional participants.)

The evaluation of a child with developmental-behavioral problems involves several disciplines and professionals. The team meeting is the forum for integrating all the findings of these disparate elements with the impressions from the physician (incorporating physical exam, neurobehavioral status exam, interactive interview, any standardized or other testing, review of all records and reports - current and previous - including questionnaires and other instruments used in the health and behavior and health risk assessments) to formulate a multimodal treatment and lifestyle management program.

90887 *Family Consultation to Discuss Diagnoses and Adopt a Targeted Treatment Plan*

Parents bring their children to a specialist because all their efforts and their primary pediatrician's efforts haven't resolved the difficulty. Because children referred to a specialist have failed other options, there is no easy cure or simple answer. These children usually have at least five significant diagnoses destroying their health and ruining their lives. Each condition or disease is complicated and difficult to understand - and harder still to treat. The interactions of multiple diagnoses and their implications for treatment - what helps one disease often worsens two others - are mind-boggling to families. Each condition or disease has connotations to the family and the family may have strong beliefs about that condition or what constitutes acceptable treatment.

Because the identified patient is a child, the true "patient" is the family - whether the child's pathology is the result of inappropriate caretaking - meaning the child will never improve until the family system changes - or whether an accident of fate was the first domino to fall - and all the rest came later in response. Regardless of causality - multifactorial at the least - families have made their own sense of their situation; they have formed hypotheses about diagnoses and treatment options; they have assigned blame and assumed guilt; they have heard or seen on the internet too many conflicting opinions to fathom; these families range from discouraged and afraid to suspicious and scared to resistant and frightened.

The family consultation is a separate meeting between the developmental-behavioral pediatrician and the main caretakers scheduled a week or so after the completion of the comprehensive evaluation. Because the issues are so complex and emotionally challenging, this is a separate visit from the lengthy

and exhausting examination sequence. The caretakers return after the "dust has settled" from the "big bang." At this meeting, the physician discusses the diagnoses in layman's terms, explains current understanding of etiologies, describes various treatments and outcomes (benefits and risks), presents a menu of available choices for this patient, recommends (with rationale) those options most likely to be beneficial for this particular child, reassures parents of their capacity to help their child - with added support - in spite of previous bad experiences, helps the family adopt an initial treatment program using those interventions with which they are comfortable, addresses the issues of blame, shame and guilt, outlines the child's and family's strengths as reasons for realistic hope, answers questions about all of the above.

This visit typically lasts an hour or more; many families need a second consultation in another week or so because of the volume of material to absorb and consider.

99080 *Special Report (more than standard reporting form); Report for Other Physician or Agency*

The most time-consuming* aspect of the comprehensive developmental-behavioral evaluation is preparation of the 25-50 page report (as opposed to the 2-3 page letter outlining major findings and specifically responding to the referral source.) This extensive report is used by the school system in the IEP or other educational process, by the court or department of family and children services in placement and other decision-making, by the primary care provider and any specialists to provide continuity of care, by Social Security and other agencies in determining eligibility for certain types of assistance or special programs.

* (average = 5 hours)

98960 *Parent and Patient Education*

Because of the complexity of these diagnoses and their interactions, most parents require extended and repeated explanations - with the chance to ask and ask and ask about all the things that don't make sense or the things they think they understand but need to hear one more time just to be sure. This process is different from sharing results of the child's evaluation and making his treatment plan (90887); this is detailed information about specific individual diagnoses - how the diagnosis is made, usual historical course, varying opinions about treatment options with details of how and why, prognostic indicators, resources for further research, techniques for applying this new information to this particular child.

99071 *Educational Supplies*

Besides face-to-face educational visits, many parents benefit from resources such as books or CD's about one or more of the child's special needs or diagnosed conditions, e.g. *ADHD* by the American Academy of Pediatrics, *The Bipolar Child* by Drs. Papolous, *SOS! Help for Parents* by Lynn Clark. Because these items cost an average of \$25, plus shipping and handling, we usually charge for them (although we give them away when the situation warrants it.)

99371 *Phone Calls*

During the initial stabilization process, parents must keep in close touch as medications are titrated and other treatments initiated and fine-tuned. Frequent phone calls can reduce the frequency of visits during those first few weeks when the child's status is fluctuating hour by hour and day by day. Once the child is doing well, most updates can take place by phone, eliminating the need for most office visits during the consolidation phase.

Phone management during stabilization is a time-consuming process because the calls are fairly involved - reviewing the child's baseline condition (typically five or more significant diagnoses) and recent changes in each cluster of symptoms, assessing which aspects of the treatment regimen are responsible

for the positive and negative changes (or non-response), recommending modifications and further monitoring as indicated, reiterating instructions and precautions, reassuring the parent about the benefits, risks, alternatives and indications of the child's new and continuing treatment modalities.

90882 *Environmental Management and Intervention*

Because developmental-behavioral patients are children, their treatment consists of interventions performed by their caretakers in numerous settings - parents, teachers and relatives; by agency officials or representatives such as social workers and case managers; by organizations such as hospice or Head Start; by other medical professionals such as the primary pediatrician and other specialists or therapists; by community volunteers such as sports coaches, religious mentors and scout leaders.

This service consists of determining optimal (or at least acceptable) ways to create a therapeutic milieu for the child and to integrate treatment recommendations into the child's daily routine; discussing, negotiating, debating with all of the above managers of the child's environment; educating each of them regarding benefits, risks, alternatives and indications for the proposed intervention - and teaching, coaching, urging, cajoling, cheerleading them in performing the intervention; providing appropriate evaluation of the on-going treatment with feedback to family and to those providing the intervention.

The time required varies from minutes to hours - per day or per week or per month - depending on the complexity of the child's situation (foster care, new school, debilitating disease, parental pathology) and the degree of cooperation present in each of the potential adult "helpers."

99354, 99355 *Prolonged Services (direct patient contact)*

99358, 99359 *Prolonged Services (patient not present)*

These are codes for those occasions when a particular procedure or service requires significantly more time than usual but another CPT code is not more accurate in describing what was done during the additional time spent.