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

THE Prevention & INTERVENTION NEWS

SPRING/SUMMER 2009

A Publication of the Tennessee Chapter of the American Academy of Pediatrics

TennCare and EPSDT Related Activities in Early 2009

At the January TNAAP board meeting, Dr. Wendy Long, Chief Medical Officer for TennCare, presented proposed budget cuts for TennCare. One of the worrisome eliminations included cutting off grants to Regional Perinatal Centers across the state.

With wide support from the membership, TNAAP forwarded a letter to TennCare (along with various supporting documentation) stressing the success and importance of our Centers and requesting that these cuts be reconsidered.

TNAAP "kicked off" 2009 with lots of activity and multiple projects supporting our members and children in Tennessee. In a series of meetings with TennCare regarding retroactive eligibility claim recoupments, it became clear that at least one MCO had not been processing recoupments correctly. Rather, they had been going back to the provider to recover these funds instead of approaching the MCO to which the patient was retroactively reassigned. These discussions spurred an avenue for practices to regain these funds and for TennCare to address appropriate handling of these transactions with the MCOs.

Dr. Wendy Long (in red) addresses the TNAAP Board of Directors.

The Chapter's EPSDT staff has been busy conducting regional and office-based trainings and exhibiting at professional conferences. Follow-up surveys of those who attended Screening Tools and Referral Training (START) sessions during the previous fiscal year showed that those who are participating are implementing use of

Continued on page 6

In This Issue . . .

TNAAP Staff

Catherine M. Fenner
Executive Director
Phone: 615-383-6004
Fax: 615-383-7170
Email: tnaap@aol.com

Ruth E. Allen
TNAAP EPSDT Director
Phone: 865-927-3030
Fax: 865-927-8039
Email: rutheallen@yahoo.com

Knox C. Brewer
Program Director
Phone: 615-730-6568
Fax: 615-730-6581
Email: knox.tnaap@gmail.com

Deborah O. Usry, M.Ed.,
Developmental Services Coordinator
Phone: 615-376-4829
Fax: 615-371-1702
Email: dusrytnaap@comcast.net

Janet Smith, CPC, RHIT
Coding Educator
Phone: 615-672-1355
Fax: 615-672-1356
Email: janettnaap@comcast.net

Cathy Jolley
Financial Manager
Phone: 615-383-6004
Fax: 615-383-7170
Email: cathyjolley@bellsouth.net

Hib Vaccine Shortage Update

By Kelly L. Moore, MD, MPH

Medical Director of the Tennessee Immunization Program

Dr. Moore is a graduate of the Vanderbilt School of Medicine and the Harvard School of Public Health, and is board certified in preventive medicine and public health. After completing her pediatric internship at the Johns Hopkins Hospital, she joined the Epidemic Intelligence Service and completed her preventive medicine residency at the Centers for Disease Control and Prevention (CDC). In 2004, she became the first Medical Director of the Tennessee Immunization Program (TIP).

In December 2007, Merck voluntarily recalled certain lots of its Haemophilus influenzae, type B (Hib) vaccines and suspended production after detecting the potential for bacterial contamination during the manufacturing process. Contamination was not detected in the vaccine and no infections were linked to the recalled lots. Merck's Hib products require a 2-dose primary series at 2 and 4 months, followed by a booster dose after the first birthday.

Since the shortage began, Sanofi Pasteur has been the sole source of Hib-containing vaccines in the U.S. market, with ActHIB® (monovalent Hib) and Pentacel® (DTaP/IPV-Hib). Sanofi Hib products require a 3-dose primary series at 2, 4 and 6 months, followed by a booster dose after the first birthday. In order to stretch the existing supply, the Advisory Committee on Immunization Practices (ACIP) recommended deferral of Hib booster doses for healthy children until the end of the shortage[1]. The Tennessee Department of Health initiated the temporary suspension of the requirement for Hib vaccine as a condition of daycare attendance. These recommendations remain in effect.

In January 2009, one year after the shortage began, the Centers for Disease Control and Prevention (CDC) published a report of 5 cases of invasive Hib disease among children under age 5 years in Minnesota: 4 were not immunized or were incompletely immunized and one had an underlying immunodeficiency[2]. A 7 month old whose parents had refused immunization died of Hib meningitis. An examination of the Minnesota immunization registry revealed that fewer than half (46.5%) of 7 month old children had received the complete 3-dose primary series, lower than the corresponding 3-dose coverage levels for DTaP and pneumococcal conjugate vaccine for children the same age. With the deferral of booster doses among toddlers, it is hypothesized that Hib carriage rates may have increased, leading to increased risk that infants will be exposed to Hib and develop invasive disease.

Surveillance has been stepped up to detect Hib disease. Tennessee already requires the reporting of all cases of invasive Haemophilus influenzae by laboratories and clinicians, as well as the submission of clinical isolates to the state public health laboratory for serotyping. Since the shortage began, one case of invasive Hib disease (epiglottitis) was confirmed in October 2008 in an underimmunized 4 year old who survived the illness.

To minimize the risk of Hib disease, preparation is necessary to assure that full immunization is completed in a timely manner for all children. All practices should use an ongoing recall system to track and catch up all infants who miss any one of the three primary series (2, 4, 6 month) doses as

soon as possible during the shortage. Continue to complete the primary series for older children when needed for catch-up. Children at high risk for Hib disease should still receive a full series, including the booster dose. Because supplies of monovalent Hib (ActHIB®) have been insufficient to meet these critical objectives, Tennessee health departments are primarily using the combination DTaP/IPV-Hib (Pentacel®) for Hib immunization.

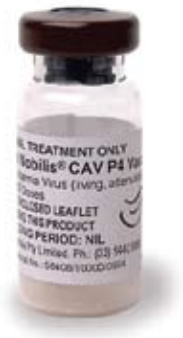
There are indications that the shortage will subside sometime mid-2009 as Sanofi Pasteur increases production of its Hib-containing vaccines and Merck prepares to return to the market. All children whose booster doses have been deferred should be recalled once the ACIP recommends the resumption of the full schedule. In addition, notices will be posted on the Department of Health Immunization Program website (http://health.state.tn.us/CEDS/immunization.htm) and communicated to the public once the Hib vaccine requirement for enrollment in a child care facility resumes. Please contact the Tennessee Immunization Program at 615-741-7247 with questions about Hib disease or vaccine. For the latest updates on all vaccine supply issues, visit the CDC website: http://www.cdc.gov/vaccines/vac-gen/shortages/default.htm.

References:

1. CDC. Interim recommendations for the use of Haemophilus influenzae type b (Hib) conjugate vaccines related to the recall of certain lots of Hib-containing vaccines (PedvaxHIB® and Comvax®). MMWR 2007;56:1318--20.
2. CDC. Invasive Haemophilus influenzae Type B Disease in Five Young Children — Minnesota, 2008. MMWR 2009;58(03);58-60.

Vaccine Costs on the Rise… Getting Your Fair Share

Glaxo SmithKline, Merck and Sanofi Pasteur all increased their prices on the cost of vaccines at the beginning of this year. However, while these increases were reported to the MCOs a number of weeks before the price increases took effect, most MCOs only review price changes on a quarterly basis. It is imperative that each practice do their due diligence and contact their MCOs to make sure that the reimbursement they receive for the cost of vaccines reflects the increased cost. In addition, each clinic should check their contract language to make sure the MCOs review and adjust their fee schedule on a quarterly basis.



TNAAP Board of Directors

The printing of these articles does not necessarily imply that TNAAP endorses the thoughts and comments expressed therein.

TNAAP Provides Free Pediatric Coding and EPSDT Trainings and Resources

Ask Janet
at www.tnaap.org

TNAAP conducts free EPSDT and coding trainings, offered both regionally and at individual practices. Training topics may be selected from specific modules (such as an overview of annual coding changes, evaluation and management components and required documentation, "EPSDT 101," and changes to the periodicity schedule), or we can provide you with customized topic-specific sessions based on your individual needs. Office-based training may be conducted formally or informally (such as a "lunch and learn" format).

TNAAP EPSDT and Coding Training Modules

Module 1 -1 Hour	Module 3 - 2 Hour
EPSDT Overview EPSDT Components EPSDT Required Documentation EPSDT Reimbursement Key EPSDT Codes Developmental/Behavioral Screening	Principles of Documentation Benefits of Thorough Documentation E/M Components E/M Required Documentation Time-based Coding Preventive Medicine/EPSDT CPT Modifiers Getting to Level 99214/99215
Module 2 - 1.5 Hour	**Module 4 - 2 Hour**
EPSDT Overview EPSDT Components EPSDT Required Documentation EPSDT Reimbursement Key EPSDT Codes Developmental/Behavioral Screening Current CPT Coding Updates Current ICD-9 Coding Updates CPT Modifiers	EPSDT Overview and Components EPSDT Required Documentation EPSDT Reimbursement Key EPSDT Codes New vs. Established Patient Developmental/Behavioral Screening Immunizations/Vaccines Getting to Level 99214/99215 Current CPT Coding Updates Current ICD-9 Coding Updates CPT Modifiers

Customized Modules

Practices may customize their own list of topics (mix topics offered in the other modules) or choose from the topics listed below:

Topics:

- Office Procedures for EPSDT screens
- OIG Risk Areas
- NCQA Guidelines
- National Correct Coding Initiative (NCCI)
- Coding for:
  - Obesity
  - Fractures
  - Foreign Body Removal
  - Determining Level of Service
  - Sports Physicals
  - Vaccines/Immunizations
- Psych/Behavioral Disorders
- Critical Care
- Hydration
- Hospital and Observation Coding
- Asthma
- Strapping/Splinting
- Sutures
- ADD/ADHD
- Prolonged Service, Holiday/Weekend Hours
- Consultations

Chart Review - EPSDT

TNAAP staff provides complimentary chart reviews of EPSDT visits to ensure medical record documentation meets the audit criteria for the seven EPSDT Components and documentation requirements. Includes an exit conference with physicians to discuss findings and recommendations. Free follow-up training is offered if needed.

Chart Review - Pediatric Coding

TNAAP staff provides complimentary chart reviews of Evaluation and Management services and procedures to ensure medical record documentation meets the criteria for Documentation Guidelines for Evaluation and Management services and CPT guidelines for procedural coding. This includes an exit conference with physicians to discuss findings and recommendations. Free follow-up training is offered if needed.

2009 EPSDT and Pediatric Coding Update Workshop

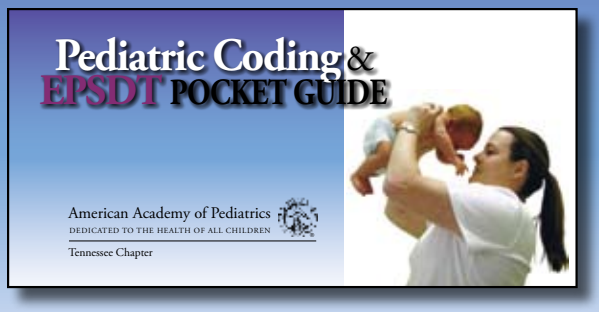
T.C. Thompson Children's Hospital
910 Blackford Street
Massoud Building, Room 140
Chattanooga, TN 37403

April 14th, 6-7:30 pm

Topics covered will include:

- 2009 ICD-9 and CPT coding updates
- Changes to the AAP periodicity schedule
- Coding for EPSDT and related services
- Coding for Developmental and Behavioral Screening
- Information about the START (Screening Tools and Referral Training) program

RSVP to Janet Smith at janettnaap@comcast.net or 615-672-1355.



TNAAP also offers complimentary chart reviews to ensure proper documentation and coding for EPSDT, evaluation and management and other services with free follow-up training.

Participation in our trainings and/or chart reviews can help your practice:

- Improve the quality of preventive health screens you perform
- Detect developmental and behavioral problems earlier
- Maximize reimbursement for preventive health services
- Improve audit outcomes

We also offer numerous resources that are available in hard copy or can be downloaded from our website, such as:

- Comprehensive EPDST manual outlining the required components and documentation requirements for EPSDT exams
- Pediatric Coding Manual
- Age-specific chart documentation forms
- Other sample forms such as lead, TB and cholesterol risk assessment

TNAAP has recently produced a Pediatric Coding and EPSDT Pocket Guide (shown above). This "pocket-sized" quick reference guide includes the most frequently used codes for EPSDT, office visits, and newborn care with instructions and requirements for evaluation and management services. We hope you will find this tool helpful and easy to use in your practice.

To schedule a training, get more information or request your copy of the Pediatric Coding and EPSDT Pocket Guide, contact Janet Smith at 615-672-1355 or janettnaap@comcast.net. For answers to your coding, EPSDT and/or billing questions, you can access the "Ask Janet" link on our website at www.tnaap.org.

TNAAP EPSDT staff while exhibiting at the Mid South Seminar on the Care of the Complex Newborn held in Memphis, TN, during January of 2009, with Ramasubbareddy Dhanireddy, M.D., Chief of the Division of Neonatology at UT and Le Bonheur.

Attendees at the TNAAP's EPSDT and Coding training in Memphis (February 2009)

TNAAP Staff Janet Smith and Deborah Usry talk with participants at the Tennessee Academy of Physician Assistant's 2009 Continuing Medical Education Conferences in Murfressboro, TN.

EPSDT/TennCare Report

Continued from page 1

screening tools in their practices and getting paid for it. (See pages 6 and 7 for more on survey results). The START program continues to get interest from states across the nation. Most recently, in February, representatives of Children's Mercy Hospital and Clinics of Overland Park, Kansas attended a START program in Jackson, Tennessee with hopes of duplicating a similar program in Kansas.

Multiple TNAAP representatives participated in a 2-day workshop with key policy-makers and stakeholders focused on increased access for preventive services for children on TennCare with a special focus on adolescents. TNAAP received major "kudos" from the out of state consultant (who has conducted similar workshops in 14 other states) for the quality and comprehensiveness of TNAAP's EPSDT and developmental and behavioral training programs and resources provided to our members.

In this third edition of our TPIN, you'll find useful information about upcoming events such as the 2009 Practice Manager's Network Meeting scheduled for June 26, 2009, information about how to access free trainings and/or "lunch and learns" for practices, updates about 2009 coding changes, information about referral resources and other items of note for your practice.

Dr. Quentin Humberd delivers a START training presentation at the Jackson Madison County General Hospital in Jackson, TN.

START Follow-Up Evaluation Summary, FY 2007-2008

One of TNAAP's quality improvement initiatives includes conducting follow-up surveys of those who participate in our Screening Tools And Referral Training (START) trainings (TNAAP's 3 hour CME program which teaches participants about developmental and behavioral screening). A 12-question follow-up evaluation was sent to all doctors who participated in the START program during FY 2007-2008.

Survey Findings

All but one of the respondents indicated that they are currently using standardized screening tools to screen for developmental or behavioral delays.

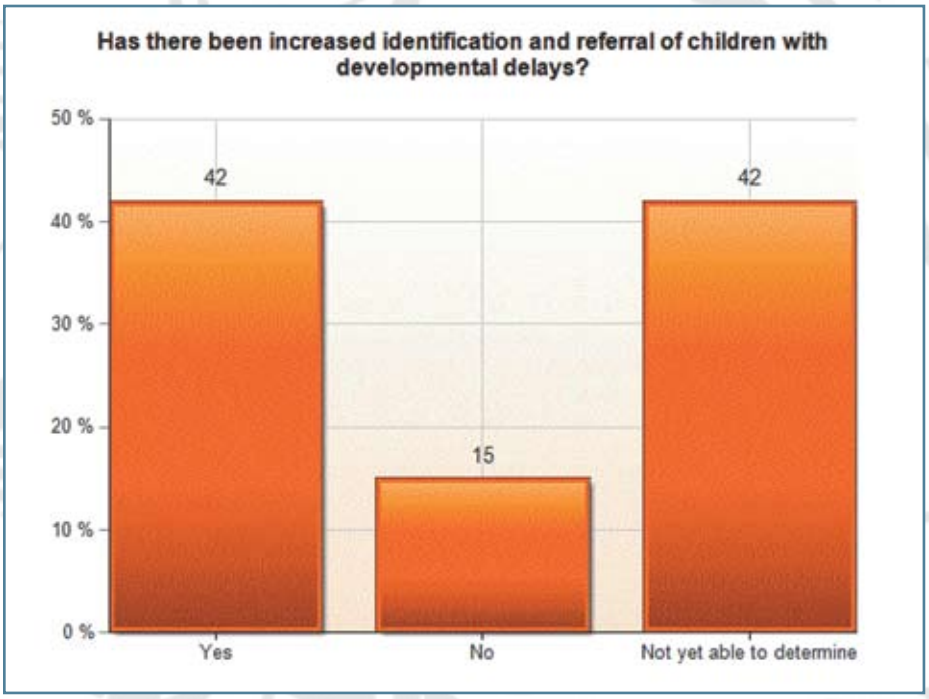
When asked about which screening tools the used, we learned the following:

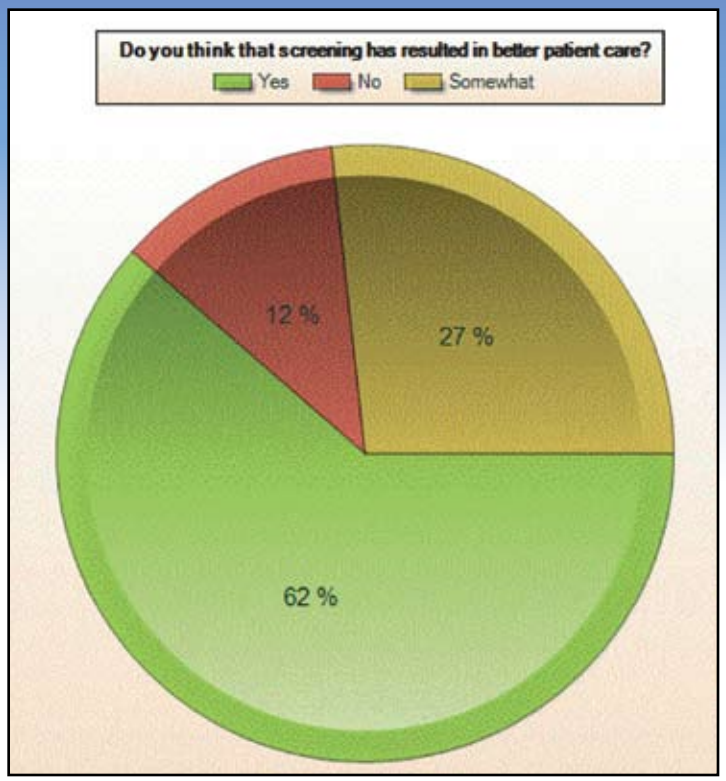
- 96% are using validated parent questionnaires.
- 60% are using the Parents' Evaluation of Developmental Status (PEDS);
- 20% are using the Ages & Stages Questionnaire (ASQ);
- 68% are using the Pediatric Symptom Checklist (PSQ);
- 84% are using the Modified Checklist for Autism in Toddlers (M-CHAT);

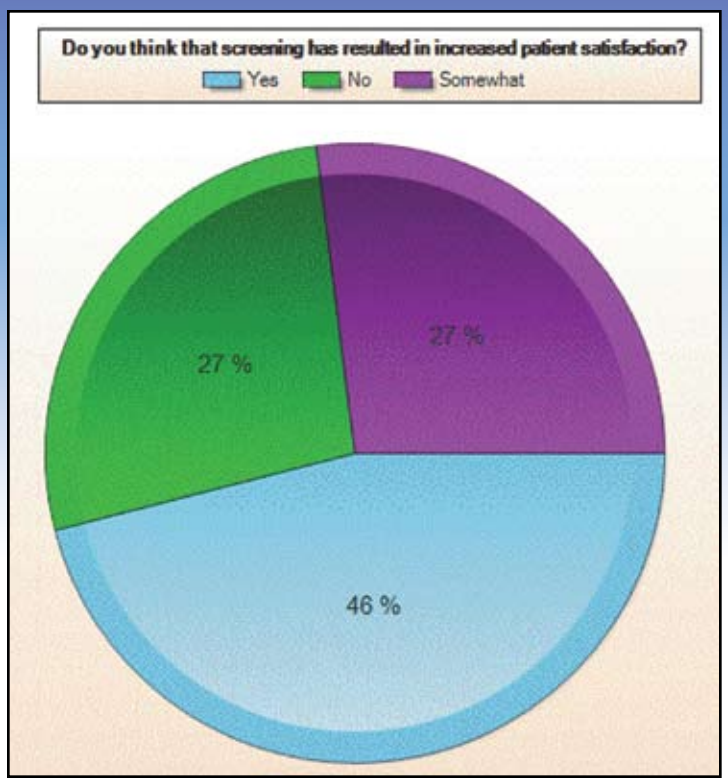
Other validated tools being used by those surveyed include the Edinburgh Post-Natal Depression Scale and the Vanderbilt ADHD Scales.

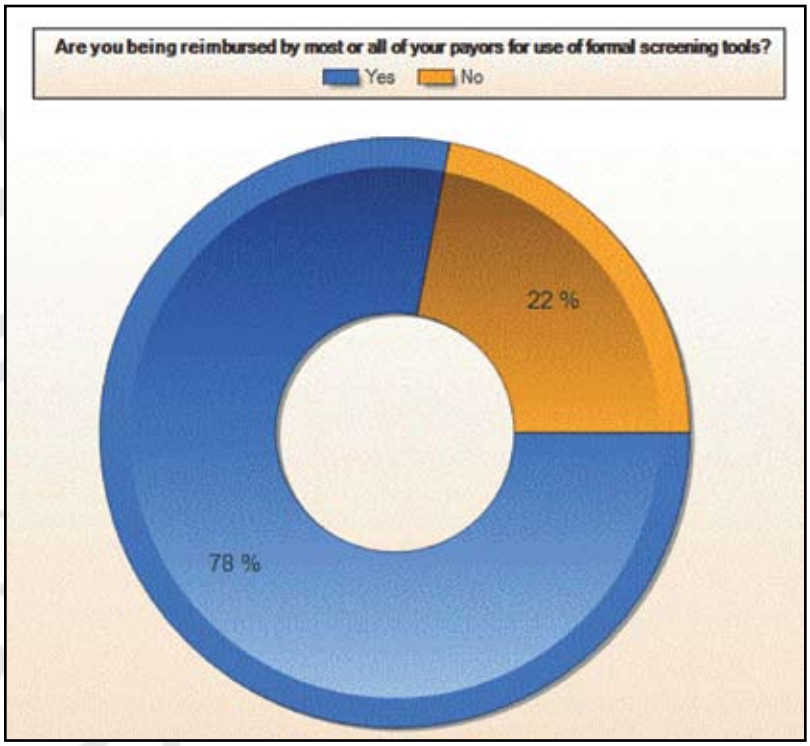
100% indicated that they are using these tools routinely.

The majority of the respondents indicated they believe that use of these screening tools has resulted in better patient care and that they are being reimbursed (by most or all payers) for administering these screens.







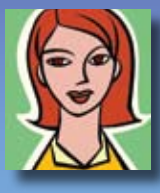


If you are interested in learning more about TNAAP's START program or to schedule a free training, please contact Deborah Usry, TNAAP Developmental Services Coordinator at 615-376-4829 or dusrytnaap@comcast.net.

To find out more about START training, you can also visit our web site at www.tnaap.org.

If you are a pediatrician interested in delivering the START program to other practices, please email Dr. Quentin Humberd at quentin.humberd@amedd.army.mil.

2009 Pediatric Coding Update



It is time to update your software and superbills with the new and revised CPT and ICD-9 codes for 2009. There were several code changes specific to pediatrics this year. Some of the new codes include Normal Newborn Care, Pediatric Critical Care Patient Transport, Inpatient Neonatal and Pediatric Critical Care, and Initial and Continuing Intensive Care Services. Revisions have been made to the Preventive Medicine Services language and Prolonged Service codes.

The list below includes the most significant changes in CPT for pediatrics. Please visit our website **(www.tnaap.org)** for additional CPT pediatric changes and a complete list of ICD-9 pediatric coding changes or refer to your 2009 CPT and ICD-9 coding manuals.

New Codes

Normal Newborn Care
Codes **99431-99440** have been renumbered. The following new codes **99460-99465** will be used to report normal newborn care services beginning January 1, 2009.

99460 Initial hospital or birthing center care, per day, for the evaluation and management of the normal newborn infant

99461 Initial care, per day, for the evaluation and management of the normal newborn infant seen in other than hospital or birthing center

99462 Subsequent hospital care, per day, for the evaluation and management of a normal newborn

99463 Initial hospital or birthing center care, per day, for the evaluation and management of the normal newborn infant admitted and discharged on the same date

99464 Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn

99465 Delivery/birthing room resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Revised Codes

Preventive Medicine Services
New language has been added to the instructions in the Preventive Medicine section **(99391-99397)** to clarify services that are separately reported in conjunction with preventive evaluation and management services. The instructions further clarify that vaccine counseling is not included in the preventive medicine service codes.

> *"Vaccine/toxoid products, immunization administrations, ancillary studies including laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90465-90474. For vaccine/toxoid products, see 90476-90749."*

The code descriptions for preventive medicine services **(99381-99397)** have been revised deleting the language "ordering of immunizations."

For answers to your pediatric coding questions, please contact Janet Smith at janettnaap@comcast.net or 615-672-1355, or visit our "Ask Janet" link on our website at www.tnaap.org.

TNAAP Coding Educator, Janet Smith, discusses coding issues with Dr. Joan White, Rivergate Pediatrics, Goodlettsville.

Knoxville Speech and Hearing Center Saved from Closing

The University of Tennessee Speech and Hearing Center in Knoxville narrowly escaped being discontinued during the fall of 2008. As part of President (of UT) Peterson's original budget cutting plan, the Speech and Hearing department in the College of Arts and Sciences was to be discontinued.

Loss of the program would have left TennCare and uninsured children in the Knoxville area with no available speech and hearing services. Larry Silverstien, a local attorney (whose father actually helped found the Center) worked tirelessly with several local pediatricians, including Dr. Mark Gaylord and Dr. Greg Blackmon, who helped to publicize the issue and wrote letters to the university's Board of Trustees and President Peterson.

A solution was reached to move the school out of the College of Arts and Sciences in Knoxville and into the School of Allied Health Sciences which is centered on the Memphis Campus. Dr. Hershel (Pat) Wall, Chancellor of the Memphis campus and also a pediatrician and TNAAP member, helped to engineer the switch. A firm business plan was developed to allow the change, without further increasing the Medical campus's own financial difficulties. The center in Knoxville thus remains open but is now administered out of Memphis.

Advocacy by Knoxville pediatricians and work by TNAAP members on both sides of the state contributed to saving a necessary resource for East Tennessee children.

Frequently Asked Questions About the American Recovery and Reinvestment Act of 2009

Developed by the AAP Departments of Practice and Federal Affairs

Pediatricians have many questions about the impact of the incentives available through the American Recovery and Reinvestment Act of 2009 (ARRA) to support the adoption of health information technology. While many of the details will need to be determined through the regulatory process, AAP staff has developed the following FAQs to provide answers to some of the most common questions.

1. Q: Is it true that the economic stimulus package includes financial incentives for both Medicare and Medicaid providers?
A: Yes, the economic stimulus package does contain financial incentives through both Medicare and Medicaid.

2. Q: Who will qualify for Medicaid incentives for health information technology adoption?
A: Pediatricians will need to have at least a 20% Medicaid patient population in order to qualify for incentives through this program. The legislation does not indicate how this percentage is to be calculated: per physician, per practice, or by some other means. These details will likely be addressed as part of the regulatory process in the coming months.

Please note that the AAP also advocates for financial incentives through private payers, but that was not addressed in this particular legislation. The AAP will continue to advocate for financial support to help pediatricians move toward health information technology adoption.

3. Q: How soon can I receive my share of the Medicaid incentives?
A: Incentives will not begin until 2011, and will likely provide reimbursement for some of the practice's cost post-implementation. So you'll need to adopt an electronic health record (EHR) first in order to qualify for the incentives.
The AAP has several resources available to help its members select and implement an EHR. Please see below for more information.

4. Q: Are there any restrictions on which EHRs will qualify for incentives?
A: It is likely that physicians will need to demonstrate that they have implemented a "certified" EHR in order to qualify for the incentives. The exact definition of "certified" will have to be determined through the regulatory process, but this may refer to EHRs that have been certified through the Certification Commission on Health Information Technology. You can find out more information at www.cchit.org. The AAP also encourages its members to look for vendors that have the CCHIT's Child Health add-on certification.

In addition, healthcare providers will need to implement "meaningfully useful" health information technology, and the EHR must permit some form of health information exchange. Once again, the exact requirements will need to be determined via the regulatory process. The AAP will closely monitor ongoing developments and provide feedback to the US Department of Health and Human Services and the Centers for Medicare and Medicaid Services when feasible.

Each year at the National Conference & Exhibition (NCE), the AAP Council on Clinical Information Technology sponsors a Pediatric Documentation Challenge. This event provides pediatricians with the opportunity to see several EHRs in action. If you are planning to attend this year's NCE in Washington, DC, please plan to attend the Pediatric Documentation Challenge to see how available EHRs handle a typical pediatric office visit.

For more information and continuing updates regarding ARRA and available resources for selecting and implementing an EHR, please contact Beki Marshall at 800/433-9016, ext 4089, or see the TNAAP web site at www.tnaap.org.

Centers for Disease Control (CDC) Act Early Summit Held in Nashville

By Quentin Humberd, MD, FAAP,
TNAAP Developmental/Behavioral Screening Medical Director
and immediate past president

A look at statewide approaches to enhance screening, identification, service provisions and coordination for families and children with autism spectrum disorders (ASDs) and related disabilities, the CDC Act Early Summit was held in January 8-9, 2009 in Nashville. The Summit included Tennessee, North Carolina, South Carolina, and Kentucky.

Quentin Humberd, MD, FAAP

TNAAP was invited to participate as part of the Tennessee state team, and collaborated with similar teams from the other states to review current policies and explore opportunities for collaboration and learn from each other as we began to lay the groundwork for more effective statewide intervention early intervention and early childhood services for children with ASDs and related disabilities. The conference was hosted by the Vanderbilt Kennedy Center for Excellence in Developmental Disabilities, one of the participating institutions in the network of University Centers for Excellence in Developmental Disabilities.

The Tennessee team was led by TNAAP member Dr. Fred Palmer from Memphis, a developmental pediatrician and director of the UT Boling Center for Developmental Disabilities. He was joined by a diverse team of like-minded constituents from state agencies, academic programs, legislative representatives, and parent advocates. The team had previously developed an overview of autism services in Tennessee and reviewed needs as well as promising practices and resources. Each state reviewed their summary plans on Day 1, and, following presentations on the national priorities for CDC and the Maternal Child Health Bureau (MCHB), our team began to work on a logic model to help our team develop a plan to address needs statewide. Our goal is for Tennessee to derive maximum benefit from the national priorities to address autism and related disabilities as part of the "Combating Autism Research, Training, and Demonstration Initiative".

Tennessee's current state system includes early identification and screening provided by Tennessee's Early Intervention System (TEIS), as well as Health Department Clinics and child care agencies, but there are many gaps. Likewise, assessment and diagnosis are provided by academic centers around the state and a handful of providers, but the time to diagnosis is hampered by extended waiting lists. Tennessee has a committed statewide parent to parent support system sponsored by Family Voices, and active Autism Society chapters in each Grand Division of the state, and the need continues to increase, as 25% of calls received by parent advocacy agencies are ASD related.

On Day 2 our team continued to discuss and work on a state plan to deal with the identified problems in identification, diagnosis and provision of services. TNAAP was identified as an important partner via the Screening Tools and Referral Program (START) program, which continues to train practices in techniques to improve early detection and referral of children and families with a wide variety of developmental, behavioral and emotional concerns. In addition, a recent expansion of START to include evaluation and diagnosis of children with suspected autism (START ED) was identified as a promising practice by the team. Work will continue with a presentation at the Governor's Office of Children's Care Coordination meeting, and a follow-up meeting will occur as well. Both TEIS and the Boling Center will have representatives apply for technical assistance from the National Professional Development Center on ASD. This will provide the state with aid in developing evidence-based practices via grant proposals that are to be submitted in June 2009.

Interested members can find out more on the development of Tennessee's plan and can contribute by contacting Dr. Fred Palmer, Tennessee's team leader for the Summit, at 901-448-6512 or fpalmer@utmem.edu, or Dr. Quentin Humberd, TNAAP's liason, (and TNAAP's START Medical Director) at 270-798-8955 or qhumberd@bellsouth.net.

Additional Resources for Obtaining a Consultation and Assessment for a Child with a Suspected Autism Spectrum Disorder (ASD)

By Quentin Humberd, MD, FAAP

Early identification of children with suspected autism spectrum disorder (ASD) is needed and leads to earlier treatment and improved outcomes. A model of training community pediatricians in ASD diagnosis could potentially help correctly identify a substantial number of children and reduce the delay in receiving a diagnostic assessment at existing referral centers. TNAAP, in collaboration with Vanderbilt University's Treatment and Research Institute for Autism Spectrum Disorders (TRIAD), and funded by a grant from the Bureau of TennCare, developed a pilot training initiative in 2007 for a group of pediatricians in Middle Tennessee to perform 1 hour extended developmental assessments of children ages 24 to 36 months who had been previously screened as having a possible ASD. The goal of the training was to help clinicians place assessed children into three categories: ASD present, ASD not present, or diagnosis of ASD deferred and needs more detailed evaluation. The pilot was completed in 2008 and the original group of pediatricians have continued to incorporate the tools and training in their offices to provide extended assessments for children referred in their communities. Plans for 2009 include continuing and expanding the training in order to develop a community of practice model for each region in the state. The first training is planned for March and will be supported through The Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental Disabilities (MIND) Training Program, funded by part of a larger Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant.

Each of the pediatricians that participated in the pilot program has agreed to act as a resource in their practice regions to help in the further screening and assessment of these children, and their contact information is listed below. Please contact their offices for further information or questions about obtaining a consultation and assessment for a child with a suspected autism spectrum disorder.

Larry Faust, MD
Pediatric Specialists of Nashville
310 25th Avenue North, Suite 204, Nashville, TN 37203
Phone: 615-620-5151, Fax: 615-620-5155
E-mail: lfaust@centpeds.com

Michelle Fiscus, MD
Cool Springs Pediatrics, PLLC
508 Autumn Springs Ct, Suite 2B, Franklin, TN 37067
Phone: 615-261-5437
Web site: www.coolspringspediatrics.com

Cliff Seyler, MD
Tullahoma Pediatrics
1330 Cedar Lane, Bldg. B., Ste. 900, Tullahoma, TN 37388
Phone: 931-455-2674
E-mail: cseyler@tullahomapeds.com

Vanderbilt Resources Available

In addition to partnering with TNAAP to provide this training, Vanderbilt University has established the Vanderbilt Autism Clinic (877-ASD-VUMC (273-8862); autismclinic@vanderbilt.edu; a single helpline staffed by an autism expert who can make referrals for what is needed at Vanderbilt's affiliated clinics and beyond.

The Vanderbilt Kennedy Center (VKC) Treatment and Research Institute for Autism Spectrum Disorders (TRIAD) also offers a screening program for parents of infants and toddlers who have concerns about autism.

VANDERBILT KENNEDY CENTER
TREATMENT & RESEARCH INSTITUTE FOR AUTISM SPECTRUM DISORDERS

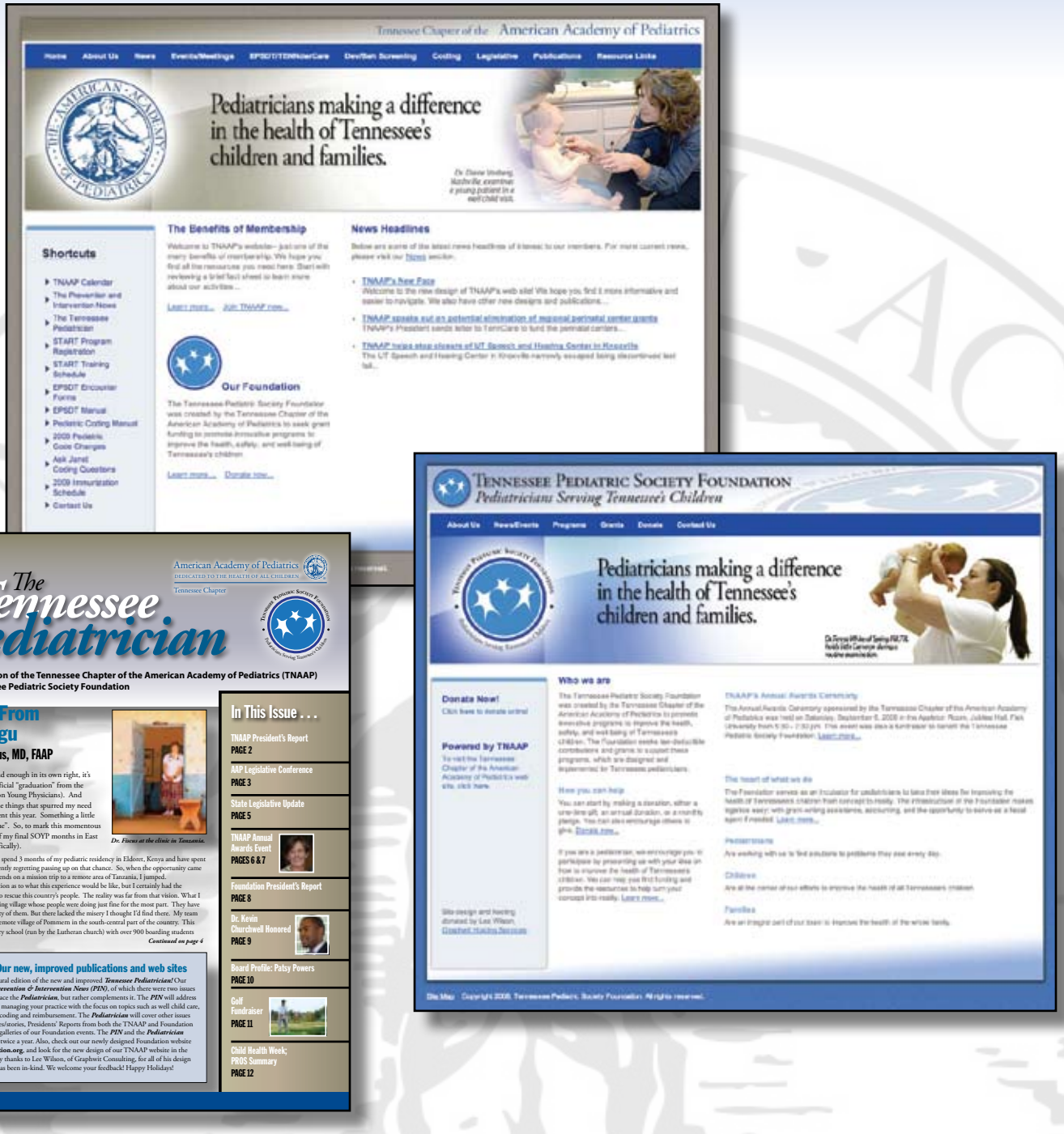
VKC / TRIAD Infant and Toddler Screening Clinic
Zachary Warren, Ph.D.,
Director, Assistant Professor of Pediatrics
615-322-7565

For further questions about the ongoing training initiative for pediatricians, contact Ruth Allen, TNAAP EPSDT Director at 865-927-3030.

New TNAAP Web Sites and Publications

Please see the new design of TNAAP's web site (**www.tnaap.org**)! We hope you find it more informative and easier to navigate than ever before. We also have other new designs and publications.

Our newest publication, The Prevention & Intervention News (PIN), of which there were two issues this year prior to this one, does not replace The Tennessee Pediatrician, but rather complements it. The PIN will address tools and resources for managing your practice with the focus on topics such as well child care, referral resources, and coding and reimbursement. The TN Pediatrician will cover other issues such as member profiles/stories, Presidents' Reports from both the TNAAP and Foundation Presidents, and photo galleries of our Foundation events. The PIN and the TN Pediatrician will each be published twice a year. Also, check out our newly designed Foundation website at **www.tnpedfoundation.org**. We welcome your feedback on both websites and both publications!



Sports Clearance Offers Opportunity to Provide Health Maintenance for Teens

By Michael Warren, MD, FAAP

Medical Director of the Governor's Office of Children's Care Coordination

As spring and summer approach, many practices are gearing up for the onslaught of pre-participation physical examinations (PPEs). For many children, especially adolescents, this may be their only encounter with a health provider throughout the entire year. For providers, this is not just a time to fill out required forms, but also a great opportunity to reconnect with this group of patients and offer recommended health maintenance.

Reports in the literature show that adolescent athletes often substitute the PPE for their annual exam. While the PPE is appropriate for clearing a child for sports participation, it is not a substitute for a complete checkup. Parents may not understand that when a provider performs a PPE, they are not performing all the other components of the annual checkup.

The American Academy of Pediatrics recommends annual health maintenance exams for children ages 5-21. The number of children who actually receive annual exams drops rapidly once children reach school age and continues to fall as children move into adolescence. According to 2007 CMS data, only 54% of Tennessee's Medicaid-eligible children ages 10-14 received an annual EPSDT. This is not unique to Tennessee. Nationally, older children and adolescents are much less likely to get an annual checkup as compared to their younger counterparts. This is true regardless of insurance status.

Regularly scheduled well-child checkups within the medical home promote healthy development and enable early identification and treatment of diseases, often before they become chronic or debilitating. With obesity rates skyrocketing in Tennessee (one-third of high-school students in Tennessee are overweight or obese), the annual checkup is an important time to review the importance of healthy food choices and daily physical activity, and to screen for early signs of chronic disease related to obesity.

A complete health maintenance exam includes a comprehensive health and developmental history, comprehensive physical exam, appropriate immunizations, laboratory tests, hearing and vision screening, and health education. The anticipatory guidance provided during annual checkups has been shown to be effective in changing a number of health-related behaviors of patients and their parents. This is especially important for adolescents, who may engage in numerous risk-taking behaviors that threaten their health and well-being. Research indicates that many adolescents want information on topics such as exercise, stress, depression, sexually transmitted infections, and weight control. Additional studies also show that while adolescents are receptive to being asked sensitive health-related questions (sexual health, eating disorders, alcohol/nicotine use, etc), they do not believe that the PPE is the appropriate setting for these questions. The private setting of the annual checkup affords providers the opportunity to address these vital issues with adolescents, in the context of a complete health maintenance exam.

TNAAP recently revised the templates for 11-14 year-old and 15-20 year-old visits to include physical exam components appropriate for PPEs. TNAAP also has a one-page questionnaire to help providers identify potential red flags prior to clearance for sports participation. All these documents are available for download free of charge at www.tnaap.org.

Over the next few months, think about the best ways that your practice can reach older children and adolescents. When students or parents call for a sports physical, take the opportunity to schedule a complete checkup instead. Or, for those checkups scheduled in the late spring, ask if the child is going to participate in sports next year—this is a great way to encourage physical activity, and be proactive about getting clearance forms filled out before the late summer rush. Some electronic medical record systems will actually allow you to search for patients who are delinquent on annual checkups, or search for patients of a particular age. This can allow you to provide targeted outreach (postcards, phone calls, etc) to a specific patient population.

Newborn Hearing:
Pediatricians Are a Vital Part of 1-3-6

By Julie Beeler, MA, CCC-A/SLP, Newborn Hearing Audiology Consultant and Jacque Cundall, RN, BSN, Newborn Hearing Screening Coordinator

In 2008, Tennessee joined the ranks of other states across the country and passed a legislative mandate, known as Claire's Law, that all newborns receive a hearing screen prior to discharge from the hospital.

Dr. Julia Thompson explains to mom what to do for her child.

Prior to the passing of Claire's Law, Tennessee was already doing a very good job of screening newborns for hearing loss. The Early Hearing Detection and Intervention (EHDI) Program in Tennessee is called Newborn Hearing Screening (NHS). Tennessee's NHS statistics indicate that, as of September 2008, 78 birthing hospitals and centers (100%) were conducting newborn hearing screening. The number of hospitals screening greater than 95% of their infants increased from 47% in 2007 to 59% (46 hospitals) in 2008, with an additional 18% screening between 90 – 94% of infants. In 2007, the total percentage of infants reported to have a hearing screening was 93.1%; preliminary data for January – November 2008 is 93.7%. The number of infants that did not pass the screening and required follow-up in 2007 was 3,706 (3.6%). Follow-up was completed on 68% of these infants, therefore 32% were lost to follow-up in 2007. Seventy infants were reported with permanent, fluctuating, or late onset hearing loss in 2007.

Medical providers play a significant role in the series of events that must occur to assure families receive timely service to increase the benefits of early identification.

For this reason, the Newborn Hearing Screening (NHS) Program continues to encourage pediatricians in Tennessee to take an active role in assuring each newborn referred to your practice meets the 1-3-6 rule. The 2007 Position Statement from the Joint Committee on Infant Hearing (JCIH) and the American Academy of Pediatrics (AAP) has set forth the following recommendations:

By 1 month of age
Every newborn should receive a hearing screen

By 3 months of age
Every infant that does not pass the hearing screen should have a comprehensive audiologic evaluation

By 6 months of age
Every baby with a confirmed hearing loss should receive intervention from healthcare and educational professionals with expertise in hearing loss and deafness with children

1-3-6 Breakdown

By One Month…

A small number of babies do not, for various reasons, receive their first hearing screen prior to discharge. How Can You Help? At the first well-baby visit, pediatricians should verify the results of the each newborn's hearing screen. If you have not received the results or parents are uncertain if their baby had a hearing screen, you can call the Tennessee Voice Response System (VRS) at 1-866-355-6132 or local to Nashville 262-3041 to learn of hearing screening outcomes. You can also call the NHS Program at 615-262-6160. Some families may refuse the screen while in the hospital. Determining the reason for refusal is sometimes difficult, but oftentimes the procedures involved in the screening process were unclear to the family due to language barriers or other uncertainties. The physician (a source of trust for the family) can often convince parents to have their baby screened by simply clarifying information about the hearing screen. Some pediatricians' offices utilize a hand-held otoacoustic emissions (OAE) screener. These offices are able to screen newborns that missed the initial hospital screen or conduct re-screens on babies who referred on their first newborn screen.

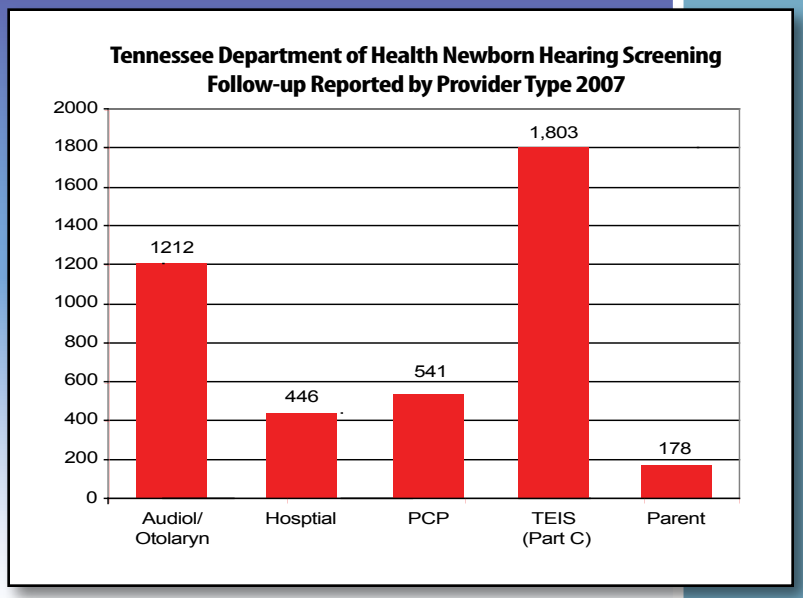
By Three Months…

In the JCIH position statement, the "3" goal emphasizes that babies who refer on the initial hearing screen receive a comprehensive audiologic evaluation no later than three months of age. As mentioned earlier, approximately 32% of the newborns in Tennessee who referred on their initial hearing screen in 2007 did not return for the follow-up screen. In addition, of the seventy babies that were identified with hearing loss in 2007, 47% were identified by 3 months of age. The NHS Program would like to improve the timeliness of appropriate follow-up. The role of the pediatrician in achieving this goal cannot be understated. How Can You Help? The medical provider can assist families to obtain follow-up on their baby's abnormal hearing screen. Parents may not understand the hospital's instructions for follow-up due to a language barrier or may not know where to take their baby for the audiologic evaluation. A working group with the National Institute of Deafness and Other Communication Disorders (NIDCD) has recommended three primary ways to increase parental follow-up:

- Parents must fully understand their child's screening results;
- Parents must fully understand the importance of the diagnostic evaluation; and
- Parents must be provided with necessary contact and resource information.

Follow-up procedures are in place through the NHS Program, but efforts to contact parents are sometimes slowed by changes of names, addresses, and phone numbers. The medical home provider plays an important role in scheduling appointments with audiologists who specialize in pediatric services. You can obtain a copy of Tennessee's Pediatric Audiology Directory by calling 615-262-6160, or at http://health.state.tn.us/NBS/hearing.htm.

Pediatricians are encouraged to fax all hearing follow-up to the NHS program at 615-262-6159. As reported to the NHS program in 2007, 269 follow-up hearing screenings were conducted by the primary care provider and 541 follow-ups were reported by the primary care provider. In 2007, the number of follow-ups submitted by medical home providers increased from 385 in 2006 to 541 - almost meeting the NHS goal of 600. (See table at right).



By six months…

According to the JCIH position statement, "all infants with confirmed permanent hearing loss should receive intervention services before 6 months of age." Early intervention includes a combination of:

- Appropriate amplification within one month of diagnosis (elective based on parents desire);
- Family education and support; and
- The development of communication, utilizing an option chosen by the family.

The JCIH statement also emphasizes that, "a simplified, single point of entry into an intervention system appropriate to children with hearing loss is optimal". Tennessee Early Intervention System (TEIS) is our state's voluntary (Part C) educational program for families with children under the age of three with disabilities or developmental delays. Fortunately, any child who is diagnosed with hearing loss (mild to profound, unilateral or bilateral) will automatically become eligible for services offered through TEIS, once a referral is made. Unfortunately, parents may not be aware of these services. Research has clearly indicated how the lack of early intervention services can negatively impact a child's speech and language development, academic achievement, and social-emotional development. How Can You Help? Parents and medical providers should be aware that amplification and other services can start as early as one month. More than any other healthcare provider, the physician can influence parents to pursue needed services. At every well-baby visit, physicians should confirm the family's participation in early intervention services. Ask families if they know about TEIS and if they are enrolled.

Babies who present with a mild or unilateral hearing loss can also benefit from early intervention services, but parents may not often recognize this. Pediatricians are encouraged to immediately refer every baby with any degree of suspected or confirmed hearing loss to TEIS.

Identifying and Tracking High-Risk Babies...

Babies who present with one or more risk factors for progressive or late onset hearing loss at birth do not always evidence the hearing loss immediately. Risk indicators that are associated with hearing loss have been clearly defined within the JCIH '07 Position Statement. The Tennessee Pediatric Audiology Assessment and Amplification Guidelines (last updated in '05) recommend that infants and young children who prove to be at-risk for the development of late-onset hearing loss "receive audiologic monitoring every 6 months until age 3 years." How can you help? In Tennessee, parents of newborns that exhibit risk factors but pass the initial hearing screen receive a letter from the NHS Program's office. This letter reminds parents of the need to have their at-risk infant tested for hearing loss at least every six months. The baby's medical home physician also receives a similar letter. Pediatricians can assist families to obtain routine follow-up with an audiologist by using the Pediatric Audiology Directory mentioned earlier.

Newborns who graduate from the Neonatal Intensive Care Unit (NICU) are 10 to 20 times more likely to evidence permanent hearing loss than babies born in the well baby nursery. However, this population may not refer on the initial auditory brainstem response (ABR) screening performed prior to the baby's discharge. For this reason, pediatricians should pay particular attention to the NICU graduate with expectations of a possible delayed-onset hearing loss.

The NHS Program appreciates the assistance of Tennessee's pediatricians in meeting the 1-3-6 challenge.

For information on follow-up and reporting, contact Jacque Cundall, NHS Coordinator, at 615-262-6160. For information on audiology services, contact Julie Beeler, NHS Audiology Consultant, at 865-765-3586. For information on early intervention services, contact Susie McCamy, Deaf Education Consultant, at 865-974-4137.

TNAAP Calendar of Events

April 14 – 2009 EPSDT and Coding Workshop – (Chattanooga)

April 25 – TNAAP Board Meeting (Nashville)

May 15 – Deadline for submission of articles for *The Tennessee Pediatrician*

June 19 – TNAAP Practice Manager Network Conference (Radisson Hotel Nashville Airport)

August 11 - TNAAP/TennCare Quarterly Meeting (Nashville)*

September 10 - 13- AAP District IV Meeting*

September 26 – TNAAP Annual Awards Event and Board Meeting (Nashville)

October 7 – Centennial Pediatrics/Tennessee Pediatric Society Foundation Second Annual "Drive for the Green" Golf Tournament

October 17 - 20 - AAP National Conference and Exhibition (Washington, DC)

October 23 - 24 - Pediatric Emergency Medicine Conference (Chattanooga)

October 27 - 30 - TNAAP exhibits at TN Academy of Family Physicians Annual Scientific Assembly (Gatlinburg)

November 1 – Deadline for submission of articles for *The Tennessee Pediatrician*

November 18 - 20 – TNAAP exhibits at the Rural Health Association Annual Meeting (Pigeon Forge)

December 8 - TNAAP/TennCare Quarterly Meeting (Nashville)*

(Invitation only)*

Save the Date!

TNAAP 2009 Pediatric Practice Manager Conference

Friday, June 19, 2009
Radisson Hotel Nashville Airport
http://www.radisson.com/nashvilletn_airport

More program details to come soon! If you have questions or need additional information, contact Knox Brewer, Program Director, at 615-730-6568 or knox.tnaap@gmail.com

Get the latest news...

- **Vaccines – Do you know if your payers are updating price changes promptly?** **(See page 3)**
- **Get the highlights on 2009 pediatric coding changes.** **(See page 8)**
- **Knoxville Speech and Hearing Center narrowly escapes closing.** **(See page 9)**
- **Pediatricians in middle Tennessee, trained in extended developmental assessments, open to consultations and/or referrals for assessments for patients with suspected ASD. Program to be expanded to other parts of the state.** **(See page 11)**

THE Prevention & INTERVENTION NEWS

Newsletter Staff

Editor: Ruth E. Allen, TNAAP EPSDT Director

Co-Editor: Eddie D. Hamilton, M.D., TNAAP EPSDT Medical Director

Co-Editor: Catherine M. Fenner, TNAAP Executive Director

Graphic Designer, Photographer: Lee Wilson, Graphwit Consulting

Web site: www.tnaap.org

This project was funded under an agreement with the State of Tennessee.

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

Tennessee Chapter

P.O. Box 159201, Nashville, TN 37215-9201

PRSRT STD
U.S. POSTAGE
PAID
KNOXVILLE, TN
PERMIT NO. 309