

the **Tennessee Pediatrician**

THE OFFICIAL PUBLICATION OF THE TENNESSEE
CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY

SPRING/SUMMER 2004



MEET OUR NEW MEMBERSHIP CHAIR (if you haven't already)



TNAAP's new Membership Chair is Dr. Hershel P. "Pat" Wall, Professor of Pediatrics and Associate Dean for Admissions and Student Affairs at the College of Medicine at UT, Memphis. Dr. Wall is a native of

Murfreesboro, graduated from UT College of Medicine, carried out an internship at the UT Research Center and Hospital in Knoxville, completed pediatric residency and served as Chief Resident at John Gaston Hospital and UT in Memphis.

During his residency, Dr. Wall began a 35-year military career, retiring in 1995 as a Colonel after active duty in Desert Storm.

Dr. Wall has been on the faculty of UT College of Medicine since 1965 and has received numerous awards for his teaching. Dr. Wall has been active at regional and national levels of the Association of American Medical Colleges.

In 1998, Dr. Wall assumed the responsibilities of Director of the College of Medicine's Underserved Areas Program. He was appointed to Governor Sundquist's Commission on the Future of TennCare in 2000, where he represented pediatric interests well.

Dr. Wall received the TNAAP's Pediatrician of the Year Award in 2000. Dr. Wall is well-known and highly-regarded in medical academia and among his pediatrician colleagues statewide. We appreciate his service to the Chapter as TNAAP's Membership Chair!

SAVE THE DATE!

**TNAAP's Annual CME Conference and Awards Presentation
Saturday, November 13, 2004 in Nashville**

Improving Pediatric Developmental & Behavioral Health: Practical Solutions

This conference will provide practical solutions for pediatric developmental and behavioral problems. The objectives of the conference are to provide information concerning pediatric developmental and behavioral health, including:

- ✓ the scope and demographics of pediatric developmental and behavioral problems,
- ✓ the importance of early screening,
- ✓ effective screening tools,
- ✓ treatment options and resources, and
- ✓ coding and reimbursement issues.

This continuing medical education activity has been designated for a maximum of 4.7 Category 1 credits toward the AMA Physician's Recognition Award. The event will be held in conjunction with the TNAAP Annual Awards Luncheon.

Look for the conference brochure and registration in the mail in August!

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**Tennessee Chapter,
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Tennessee Pediatric Society**

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NEWSLETTER EDITORS

Catherine M. Fenner

Joseph F. Lentz, M.D.

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

the tennessee pediatrician

President's Report

David K. Kalwinsky, MD, FAAP

**ETSU Dept. of Pediatrics, Box 70578,
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kalwinsk@mail.etsu.edu

The work force in pediatrics has expanded considerably in the past decade with the median age for generalist pediatricians now in their early forties. The pendulum from primary care to specialty pediatrics is correcting a bit, and it looks like the nation's supply of pediatric endocrinologists, gastroenterologists and nephrologists will be more in line with demand. With the concept of a medical home, demands for integration of services and with more children who are identified with medical/developmental problems; the role for the primary care pediatrician as a gatekeeper for a youngster's care looks bright.

Our state legislators plan to tackle TennCare reform this April, and the East Tennessee legislative delegation looks supportive of Governor Bredesen's TennCare reform proposals. I cannot speak for TNAAP Board, but to me personally, pediatrics has fared very well with Bredesen's recommendations (i.e., no limits on scope of services but with modified pharmacy). While there are no limits on number of prescriptions for children, there will be a restrictive formulary. As long as there is a safety-net mechanism for youngsters who need special pharmaceuticals, children should do well with these reforms. On principle, I avoid prescribing medications once an over-the-counter alternative is available, since I think we all need to play some role in containing health care costs.

Your TNAAP Chapter continues to actively work with the Director of the Bureau of TennCare with monthly meetings on expanding EPSDT screening. In addition, Drs. Quentin Humberd and Pat Davis have been quite involved, along with TNAAP staff, in proposing new developmental guidelines for EPSDT. If you have not availed yourself of the expertise of our chapter staff for education on EPSDT screening or office coding, please contact Ruth Allen (EPSDT, 865-927-3030) or Jacque Clouse (Coding, 865-670-8891), and they can arrange an in-service for your office.

Dr. Bob Lembersky from Knoxville has re-energized our Program Committee with two CME programs planned for this fall. In collaboration with the Children's Emergency Care Alliance (CECA), your Chapter will co-host "Advancing the Frontiers in Pediatric Emergency Care in Tennessee" hosted by Vanderbilt Children's Hospital on September 17-18, 2004 in Nashville. Later in the fall, on November 13, 2004, TNAAP will have a Saturday program at the Nashville Marriott on behavioral pediatrics followed by our annual awards banquet with lunch and speaker. Try to join us for one or both of these educational events. If you have specific ideas for types of programs that would best serve your practice needs for 2005, please contact Bob Lembersky at rmembersky@pol.net.

Please let me or your fellow officers know how the TN Chapter can continue to serve you educationally, improve your practice management, and represent your needs and those of Tennessee's children in the legislative arena. We need as many of you participating in the lives of the children in your community as possible and becoming more involved with this chapter. Please feel free to contact me at kalwinsk@mail.etsu.edu. I am honored to be able to represent you, the pediatricians of Tennessee, as your AAP state chapter president for the next two years.



spring/summer 2004

Reflecting on Ten Years of Growth

Executive Director's Report

Catherine M. Fenner

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A little more than a decade ago, Dr. Harold Vann had a vision for this well-respected professional organization which he chaired: to move from simply serving as a networking and educational venue for pediatricians to becoming advocates for a children in a more comprehensive, organized manner through lobbying efforts and more program work. This meant moving from an administrative outsourcing relationship with the Tennessee Medical Association to hiring a full-time dedicated staffperson with an association management and legislative advocacy background. I was blessed to be in the right place at the right time.

With exceptional volunteer leadership, TNAAP has grown into an association both staff and members can and should be very proud of. Ten years ago, we had an annual operating budget of \$70,000 and 1 staffmember; our next fiscal year's forecast (which begins 7/1/04) is over \$600,000 and will include 5-1/2 staff, plus another \$20,000-\$50,000 for our newest entity, the Tennessee Pediatric Society Foundation.

Over these years, the Chapter has launched several educational campaigns and passed numerous pieces of legislation that have prevented injuries and saved the lives of children. We have brought tools, education, and even the ears of Board and staff leaders into your offices via programs such as the Outreach Lunch Program, EPSDT guidance, and coding education. The needs of children and the pediatricians that serve them have been represented on countless coalitions, work groups, and legislative committees. Some of our programs have even been models for other AAP Chapters across the country, such as our Pediatric Residents Legislative Internship Program



TNAAP staff (l-r): Coding Educator Jacque Clouse; EPSDT Director Ruth Allen; Executive Director Cathy Fenner; Financial Manager Cathy Jolley; Program Director Patrice Mayo-Ligon.

and regular attendance at continuing education conferences aimed at strengthening the partnership between the chief elected officer and the chief executive officer. We have even returned to the "CME business," after leaving it for 10 years in order to focus staff time on legislative initiatives and the building of a solid infrastructure for the Chapter.

None of this could have happened without vision--a decade ago, and again in 2001 when we jumped in with both feet and hired a second staffperson (our Program Director), and when the TennCare Committee and other leaders submitted an EPSDT grant proposal to the Bureau of TennCare. And look at us now!

As I write this, we are preparing for our annual Board Planning Retreat. I can't help but feel a flurry of excitement when I wonder what visions will be unleashed for the next year and beyond...

It continues to be a pleasure to work for and on behalf of you for the children of this state.

Cathy

Welcome New Members

Sari Acra, MD	Nashville
S. Todd Callahan, MD	Brentwood
Keven O. Cutler, MD	Memphis
Elia C. Dimitri, MD	Wichita Falls, TX
Jeffrey M. Donohoe, MD	Nashville
Natasha B. Halasa, MD	Nashville
Hiroto Inaba, MD	Memphis
Felicia Cleora Knowles, MD	Memphis
Ameeta Lall, MD	Knoxville
Steven James Leung, MD	Lawrenceburg
Sheila Patricia McMorrow, MD	Nashville
Joseph Jacob Nania, MD	Nashville
Mitch Pullias, MD	Lascassas
Victoria Rea Rundus, MD	Hendersonville
Alan Lee Mannheimer, MD	Brentwood
Karen A. Schetzina, MD	Johnson City
Maureen Vaughan, MD	Memphis

WELCOME!

Our Month in the World of Politics

by Ty Berutti, MD, Anjie McVie, MD, and Tanya Kowalczyk, MD

The three of us had a great opportunity this spring to learn about the state legislative process. This was made possible through an Advocacy elective which is available as part of our residency at Vanderbilt and has become a favorite among the residents. It gives us a chance to get out of the hospital and experience a different and, as we would quickly realize, very important aspect of medicine. This is made possible by Cathy Fenner, Executive Director and lobbyist for the TNAAP.

We began the month becoming familiar with the legislative process: how the Senate and House are arranged, where they meet, when they meet, how bills are introduced, when they are heard, and so on. While confusing at first, the process became clear after a couple days. Next we researched the many bills (1500+) introduced and highlighted those which may be relevant to pediatricians for Cathy to review more closely. Included were bills about alarms in day care vans, intermediate drivers license restrictions, use of asthma medications at school, local regulation of tobacco use, giving psychologists the ability to prescribe medication, and our big issue of this session, eliminating non-nutritious snacks from schools.

The school nutrition bill specifies nutritious snack items that can be sold in K-8 schools. Dr. Kris Rehm came with us and testified about the increasing incidence of obesity in children, the mortalities related to obesity, and the adverse effects of soda consumption. The reactions of the various committee members were interesting: some wanted to focus on increasing school

physical education and excluding the nutrition aspect, some thought children should be able to make their own choices of snacks and drinks, and one opined that soft drinks do not contribute to obesity. There was also discussion about the potential economic impact on school systems. A particular eye-opening experience occurred when the lobbyist for the bottling companies testified before the committee. It became very clear that what is best and what is right depends on which side of the issue one stands. The bottling companies were determined to protect themselves economically and publicly, even at the cost of the health of children.

“Who better to explain the medical issues that arise in legislation than a physician?”

Private visits were also made to a number of other legislators to answer their questions about the bill. A brief explanation of how obesity and type II diabetes are linked, and that this does occur in the pediatric population, seemed to make a difference in the attitudes of some of the senators and representatives. They seemed for the most part interested in what we had to say, and many of them asked insightful questions regarding the issue of childhood obesity. Who better to explain the medical issues that arise in legislation than a physician?

In addition to advocating for children, TNAAP is also involved in issues relating to medical practitioners, such as prescribing by psychologists, DNR orders, and whether students at Tennessee state medical schools should be required to remain in practice in Tennessee as reimbursement to the state for their medical education. The prescribing by psychologists bill has also recently become a hot topic in the legislature. The bill would allow psychologists to prescribe medications after completing 300 hours of coursework and a limited period of collaborative supervision with a physician. We spent several days meeting with various legislators regarding this bill, explaining the differences in training received by physicians and psychologists.

Throughout our time with TNAAP, we learned that legislators value input from their constituents and from those of us who provide care to children. We learned there are two sides to every issue, and each side makes their wishes known, making it especially important for people who have an interest in protecting children to be vocal as well.

We would like to thank Cathy tremendously for showing us this experience. She has been working at the legislature for a long time, and that is important in

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Representative Joe Fowlkes with TNAAP legislative interns Drs. Anjie McVie and Ty Berutti.

TennCare Report

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In February, Governor Bredesen announced his plan to make TennCare workable. What he put forth will not create as many changes for our patients who are part of the core "Medicaid population" as it does for those adults who are not. A closer look at what was proposed and discussions with the governor and his staff make it clear that provider assistance will be needed to paint the details of what he has outlined. The bill that was sent to the legislature recently gave some of these details but had wording that could function as a "blank check" for the TennCare Bureau to make changes that could be harmful to our patients.

Fortunately, the Chapter has several things in place to allow us significant input into proposed changes. The first of these is through our grant from the state to help satisfy the settlement of the John B. Consent Decree, which is based on the EPSDT provisions of Medicaid Law. Since it began three years ago, the grant's scope has been enlarged once, and now there are plans to expand our services to include educational programs on developmental and behavioral health screening. Along with input through the grant, we

have Chapter members actively involved with the Governor's reforms. Dr. Bill Terrell serves as our representative on the Preferred Drug List committee, Dr. Eddie Hamilton is on the Children's Cabinet, and I sit on the TennCare Director's Advisory Board. Dr. Pat Davis is Medical Director of our EPSDT grant, and Dr. Quentin Humberd will serve as Medical Director of the new developmental/behavioral expansion of the grant. Drs. Joe Lentz, Joel Bradley, John Ring, and David Kalwinsky are also involved with the grant. Dr. Conrad Shackelford is the Assistant Medical Director of TennCare, and Dr. David Hollis, Chief Medical Officer of TennCare, is an internist who thinks like a pediatrician. Both of them have been invaluable in allowing us input into the system. Finally, due to a proposal we made to the children's hospitals over a year ago, a new advocacy partner has been organized called the Children's Hospital Alliance of Tennessee (CHAT) which will increase lobbying presence on the Hill for children's issues.

In short, the reforms presented by Governor Bredesen contain little obviously detrimental to our patients, but the devil is always in the details. Fortunately, for the first time since TennCare began, our Chapter is in an excellent position to influence changes that improve care for our patients rather than obstruct it. As always with TennCare, the coming weeks and months will be interesting.



...Politics, continued from page 4

allowing her to anticipate reactions, problems, allies, and foes – to know what angle to put on issues depending on the audience.

So, if anyone wonders, does the TNAAP do anything? The answer is YES. We encourage all of you to write to or call your representatives if you have interest in a particular issue (after checking with Cathy to see if TNAAP has an established position on that issue), and to volunteer to testify in your area of expertise. A small amount of time can make a tremendous difference.

[Postscript: At the time of this publication, the psychologists' bill and the bill that mandated practicing in Tennessee had both failed for the year. The nutrition bill passed in an amended form that mandates the Board of Education to promulgate rules regarding nutrition levels in schools by the 2005-06 school year.]

Governor Bredesen Meets with Children Advocates

Governor Phil Bredesen met with various children advocates at the Le Bonheur Children's Medical Center to head a discussion on the new TennCare strategy and reconstruction plan with regard to the changes for children and children's hospitals.

Pictured (l-r): Russ Chesney, M.D., Professor and Chair Dept. of Pediatrics and Sr Vice President, Le Bonheur; Gov. Bredesen; Peggy Troy, R.N., President, Le Bonheur; Andy Spooner, M.D., Buckman Associate Professor of Pediatrics, Univ. of TN Health Science Center.



UT Memphis Embraces Cultural Competency for Faculty, Students and Residents: Exchange Program in Guadalajara

Robert V. Walling, MD
rwalling@utmem.edu

The ever-growing number of immigrant Mexican workers, many of whom have been in the country long enough to begin families, has placed an increasing need of new skills for many pediatricians in Tennessee and other southern states. As many practitioners know, many of these families, in addition to being illegal for immigration purposes, cannot speak English. Most are from small Mexican towns in the northern section of that country, and they bring with them many cultural beliefs and customs regarding health issues that impact their access to medical care in this country.

There is an ongoing need for preventive health care measures such as immunizations and nutritional information. The majority of the young mothers breastfeed their infants, but many are not familiar with general staples used in this country for infant semi-solid and solid feeding. Older children who often live in high-crime areas of inner cities are not allowed outdoors by their parents and are thus subject to the increasing risk of obesity among all children in this country who have little outdoor physical activity. These first-generation children are also at greater risk for obesity and diabetes as some recent studies have shown. The incidence of social isolation combined with economic stress may increase the risk of child abuse, neglect and domestic violence.

Fortunately, these families quickly find medical homes through social agencies and pediatricians who have Spanish language skills and receive frequent referrals; new families are directed to such physicians by seasoned families. Language skills are just one component of being culturally competent for these families and pediatricians will increasingly find they will need better understanding of many of these issues unique to this newly largest minority in the country.

Alicia McClary, Ed.D, Professor of Preventive Medicine, and consultant to the Center on Health Disparities, and Robert Van Walling, MD, Assistant Professor of Pediatrics at UT Memphis, have developed an exchange program with the University of Guadalajara School of Medicine to provide a month-long rotation for medical students and residents at the teaching hospital there, in order to better increase their awareness of some of the issues that are unique to the immigrant population. The program also provides for some training in the Spanish language as well.

The program began three years ago, and interest in the program is growing among students and residents,



especially among the pediatric and medicine-pediatric residents. Several students and residents from Guadalajara have spent a month or more in subspecialty areas in the Department of Pediatrics. This spring, the program will also be available to faculty who have joint research interests such as obesity in children, which is becoming a major health problem in Mexico as well.

Inquiries about the program should be directed to Dr. Robert V. Walling at rwalling@utmem.edu.

Preventing Prematurity: What Can a Pediatrician Do?

Patricia C. Temple, MD, MPH
Professor of Pediatrics
Vanderbilt University School of Medicine
pat.temple@vanderbilt.edu

How can a pediatrician help decrease prematurity when the best scientists in the world still search for the causes and have only recently found one effective intervention?

When the March of Dimes asked for a pediatrician to help with their Prematurity Prevention Campaign, I volunteered. Pediatricians can make a difference. Here are five ways pediatricians can contribute.

First, let's help prevent teenage pregnancies. Fifteen percent of teenage pregnancies result in low birth weight or premature infants. Teenagers are our patients. We can help prevent pregnancies. We can be more vigilant with our teaching. We can help our parents teach their children about responsible sexual behavior; we can help our teenage boys and girls learn how important it is to say "no to intercourse." We can warn "pregnancy can happen with the first intercourse." We can prescribe emergency contraception kits, and we can give out condoms.

Second, how often do we remind our new mothers "remember to delay your next pregnancy until you are ready for a healthy term baby." Early repeat pregnancies, within 3 months for Caucasians and 9 months for African Americans increase prematurity rates by 50%. When we make newborn rounds, when

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we see our new babies to start well-baby care, we can take this opportunity to educate our new mothers and fathers about the risks of early second pregnancies. Parents of pre-term infants are at especially high risk for a repeat premature infant.

Third, let's remind mothers of preterm infants to ask their obstetricians about the new progesterone treatment for prevention of preterm infants the next time they are pregnant.

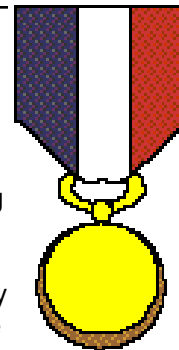
Fourth, couples using assisted reproductive technology should be reminded of the risks of multiple gestations. Implanting only a few embryos should be recommended.

Fifth, discourage smoking. Cigarette smoking contributes to prematurity and low birthweight infants.

Together, we can make a difference.

Award Nominations Being Accepted Now

Nominations are now being accepted for the following awards, which will be presented at our Awards Presentation in Nashville on November 13th. Please send your nominations in writing to the Chapter office by September 15, 2004. Include reasons why you think the candidate would be a good recipient for the award. There should be at least three (3) letters of support for any given award nominee.



The Pediatrician of the Year Award goes to a member of the Chapter who in the past year has made extraordinary and unique contributions on behalf of Tennessee's children, to his or her community, or to the Chapter.

The Senior Pediatrician of the Year Awards are given to those who have practiced pediatrics for at least 35 years, whether retired or still practicing, and have made a significant impact over time to the welfare of children in his or her community.

Distinguished Service Awards and **Friend of Children Awards** are typically given to non-pediatricians from the field of government, public health, media, advocacy, etc, who have made outstanding contributions to the health and safety of children over the past year.

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Coding Clues

WHICH WAY

??????

THIS WAY

CHOICES

Jacqueline F. Clouse
RHIT, CCP, TNAAP Coding Educator
work: 865-670-8891
fax: 865-670-8936
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Website Resources for EPSDT and Pediatric Coding

NCCI edits are available at:
<http://www.cms.gov/physicians/cciedits/>

NCCI updates/changes are available at:
<http://www.ingenixonline.com/content/pn/>

HCPCS changes effective April 1, 2004 are available at:
<http://www.ingenixonline.com/content/pn/>

CPT updates/errata/changes are available at:
<http://www.ama-assn.org>

Modifier -25 Coding Suggestions

Append modifier -25 only to Evaluation and Management (E/M) service CPT codes. Do not append the modifier to a procedure CPT code.

Append modifier -25 to the E/M code for surgical service CPT codes. Some payers restrict the use of modifier -25, for example with ancillary services like x-ray and laboratory codes. Check with your local carrier for its specific policy.

Document separately for the E/M service and procedure codes. Medical necessity must be shown to justify reporting both the E/M code and the procedure code.

Be cautious of writing the procedure note in the exam component of the E/M documentation. All elements of the exam should be documented, and the diagnosis for the E/M service code must reflect medical necessity. E/M and procedure documentation should reflect the "separate and identifiable" criteria of CPT.

If an examination is performed prior to a scheduled minor procedure for the purpose of administering conscious sedation only, this exam is a component of the minor procedure and is not separately billable, even with a modifier -25, because it does not meet the "significant, separately identifiable E/M service criteria."

If you are not receiving reimbursement for claims with modifier -25, contact your payer representative. Ask for an explanation for refusal of payment; have your information ready for an appeal, and often they can reverse modifier -25 denials.

Release of New Reason Codes for Denials by Insurers Reason Code 157:

Payment denied/reduced because service/procedure was provided as a result of an act of war.

Reason Code 159:

Payment denied/reduced because service/procedure was provided as a result of terrorism.

Reason Code 160:

Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.

For a full copy of the modified reason and remark codes, including the most recent changes, visit:
<http://www.wpc-edi.com/codes/Codes.asp>

2004 Additions, Revisions, Deletions in ICD-9-CM and CPT for Pediatrics

Visit the TNAAP website at www.tnaap.org to view the listing of 2004 code additions, revisions, and deletions, specific to Pediatrics.

Well Child (EPSDT) Screens

As summertime nears, be sure to remind parents to schedule well child visits and EPSDT screens. It might be helpful to put reminders on billings, on bulletin boards, or at check-in / check-out windows. Stay busy through the summer months while proving quality care for your patients by increasing well child visits.

EPSDT Items Most Often Missed

Remember, the two items most often missing in documentation of EPSDT exams are history and unclothed physical. Be sure to note these services in patient charts. (Note: It is acceptable to document unclothed as "unclothed but appropriately draped".)

Call for Nominations of Chapter Officers

The Nominating Committee is beginning its search for candidates to fill the following positions whose terms will begin on January 1, 2005:

- 1 Fellow At-Large, East TN (3-year term)
- 1 Fellow At-Large, Middle TN (3-year term)

If interested in running, or for more information, please contact the Chapter office at 615-383-6004. The elections will be held this Fall; nominations must be submitted by September 15, 2004.

Our "Tennessee Pediatric Society Foundation" Campaign Update



Motivated by our members to be more involved in programs to promote the health and safety of Tennessee's children, TNAAP established the Tennessee Pediatric Society Foundation as 2003 came to a close. The exciting creation of the Foundation, a 501(c)(3) tax-deductible non-profit entity, makes our Chapter newly eligible for grant and funding opportunities to carry out significant projects to benefit Tennessee's children.

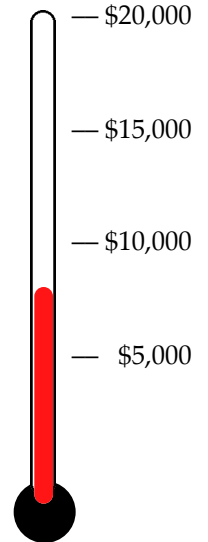
The success of the Foundation is dependent on seed-money donations from our members which support the initial work of identifying projects and procuring grants that match member interests specific to the needs of children and our mission. Contributions to the Foundation are tax-deductible and may be made at anytime. Please join the list of financial supporters!

We are more than a third of our way to our 1st year operating budget goal!

Thank you to the following donors of the Tennessee Pediatric Society Foundation:

Ruth E. Allen
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 Ellen Andrews, MD
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What Pediatricians can do to Reverse the Pandemic of Childhood Obesity and its Associated Diseases

George A. Burghen, MD
Professor of Pediatrics
Chief, Division of Endocrinology & Metabolism
UTHSC, Memphis, TN
901-572-3292

In Memphis, like many communities across the state, the pediatrician is facing a growing health problem—overweight and obese children and adolescents. This is not just a Tennessee problem but a pandemic affecting adults and children in many countries. Children referred to our pediatric center with apparent simple obesity have been found to have many risk factors for cardiovascular disease, diabetes and associated conditions (see table). Of 50 obese children studied utilizing a research protocol, none had normal cardiovascular fitness and 50%-60% had cardiovascular risk factors including hypertension and dyslipidemia. The impact of these findings has enormous implications in terms of human suffering and financial drain on our healthcare system.

The following are suggestions to help prevent and treat obesity in the family, school and community.

- 1) Determine height and weight in all children and calculate Body Mass Index (BMI). If the child has a BMI > 85th percentile he/she is overweight, and an intervention is indicated. If a tendency to be overweight is detected early in childhood, simply reducing the use of sugary beverages and “junk food” is all that may be needed to prevent a life-long problem. Family history of obesity and associated diseases is helpful in identifying children at risk.
- 2) The whole family should be encouraged to adopt a healthy lifestyle including good nutrition and

regular exercise. To this aim, television, video games, telephone and computer use should be limited to less than two hours per day.

The pediatrician is in a unique position to affect change in the school to provide an environment which will promote a healthy lifestyle in its students. To start, identify a responsible person in each school to coordinate a program of health education, physical activity, and healthy food choices. Involve parents and the family in the change.

Pediatricians can impact the community by working with influential people such as clergy, business executives and politicians to provide:

- (1) centers for the promotion of healthy lifestyles,
- (2) a safe environment for neighborhood exercise,
- (3) health programs in the workplace, and
- (4) health fairs to increase awareness and education.

They can encourage places of worship to be open in the evenings for physical as well as spiritual activities, and schools to be centers for physical activity during the school day and after school.

The Department of Pediatrics (General Pediatrics and Endocrinology Divisions at the University of Tennessee Health Science Center) has developed a resource book containing materials which physicians will be able to access in the near future through the University of Tennessee website. One can obtain some of these resource materials including suggestions for evaluation and treatment of obesity by contacting Valerie Jameson, MD or me by email at vjameson@utmem.edu or gburghen@utmem.edu.

Complicating Conditions of Obesity in Children and Adolescents

Type 2 Diabetes	Accelerated Bone Age
Acanthosis Nigricans	Steatohepatitis
Hypertension	Polycystic Ovarian Disease
Learning Disabilities	Depression
Obstructive Sleep Apnea	Pseudo-tumor Cerebri
Hypoventilation Syndrome	Slipped Capital Femoral Epiphysis
Asthma	Blount's Disease
Dyslipidemia	Pes Planus
Venous Thrombosis	Osteoarthritis
Candida Infections	Elevated Fibrinogen & CRP
Lymphadenitis	Poor Cardiovascular Fitness
Hypertropic	Stroke/Heart Failure
Cardiomyopathy	

Visit our
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Enhancing the Value of Pediatricians

Dave Tayloe, Jr., MD, FAAP, AAP District IV Chair
dtayloe@aap.org

The AAP is asking government officials, health insurers, and tax payers to invest more dollars in health and human services for children. Pediatricians have created medical homes that provide comprehensive health services for children. Pediatricians are saving society significant amounts of money through efficient medical home systems that reduce hospitalization, hospital emergency department use, and the prescribing of expensive drugs. At this time, however, pediatricians are failing to convince funding entities to invest adequate dollars in pediatricians and child health. The strongest evidence for this is the inadequate reimbursement that most pediatricians receive for providing health services for children eligible for Medicaid and SCHIP. Federal and state government officials just do not appreciate the value of our services. How can we improve this situation?

Pediatricians are respected sources of information on child health and have access to the majority of families in our communities. Public and private funders of health and human services need allies in our communities who are committed to reducing major cost centers for them. These cost centers include:

1. unplanned pregnancies;
2. mental health disorders of children;
3. child abuse/neglect that often leads to school failure, juvenile delinquency, and prison terms;
4. school drop-outs;
5. obesity/overweight leading to type II diabetes; and,
6. substance abuse including drugs, tobacco, and alcohol.



(l-r) Drs. Tim Gillespie, Quentin Humberd, Suzanne Berman, Melinda Lucas, Dave Kalwinsky, and Iris Snider unwind following February's Board meeting.



For pediatricians to address these problems, we must create community-wide networks that involve the multitude of agencies that work with children and families. These problems cannot be solved if pediatricians do not expand the traditional medical practice into a community-wide integrated medical home.

Is it time for the AAP to re-evaluate its approach to child health in an effort to enhance the value and marketability of the pediatrician, and to address some of the major psychosocial problems of our culture? I believe government leaders are more likely to listen to our plea for adequate reimbursement if we are conscientiously addressing some of the really expensive problems that government encounters. We are certainly in leadership positions in our communities such that we can be catalysts for initiatives that address these tough causes of childhood morbidity and mortality. I welcome your thoughts on the future of pediatrics and pediatricians. The Academy has just begun a project called Peds 21 that is designed to evaluate the current status of pediatrics and to suggest ways to assure a better future for pediatrics and the children and families we serve. I promise to forward your thoughts about our profession to the leaders of the Peds 21 project.

TNAAP 2004 Calendar

Jun 10

Advancing Children's Health with New Research and Medicines
Vanderbilt, 615/248-8202

Sep 17-18

Ped. Emergency Medicine CME
Nashville

Oct 9-13

AAP Annual Convention (NCE)
San Francisco

Nov 13

Behavioral Health CME/
Awards Lunch/ Board Meeting
Nashville

Car Seats: Helping Parents Understand the New Law

Gatherine M. Fenner, Executive Director

On July 1, 2004, a new law will go into effect in Tennessee that will prevent a significant number of injuries and deaths to children in vehicles...but only if parents are made aware of the new law and its requirements.

You may recall when TNAAP worked endlessly with the CRPCs, several state departments and other groups last year to pass this legislation, touted as the most significant change to the car seat law in 20 years (since our own Dr. Bob Sanders, a.k.a. Dr. Seatbelt, passed the nation's first child safety seat bill in 1977). Dr. Mick Connors' testimony before the Senate Transportation Committee really opened the eyes of the legislators to the dangers currently facing our children when they are too small to be protected by a seat belt alone. Never before had they heard of "seat belt syndrome", just as many parents today have not.

Basically, Tennessee law will now require booster seats through age 8, and it closes the loophole which previously allowed parents to take their children out of car seats to nurse, comfort, etc, while the vehicle is in motion.

More specifically, here is how this new law will change the current law:

Ages 0-1 (plus any child <20lbs)

Current law: states only that they must be in child passenger safety seat

New law: adds that they must be in rear-facing position and in the rear seat (if available)

Ages 1-3

Current law: states only that they must be in child passenger safety seat

New law: adds that they must be in forward-facing position and in the rear seat (if available)

Ages 4-8

Current law: booster seat required only if <40lbs

New law: booster seat in rear seat (if available) unless over 5'

Ages 9-12

Current law: requires seat belt

New law: requires seat belt and recommends that they be in the rear seat

Ages 13-15

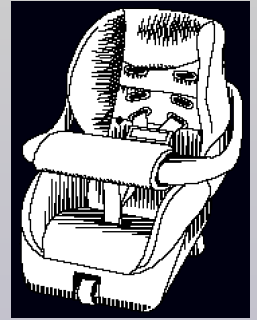
Current law: requires seat belt

New law: no change

Data from the National Highway Traffic Safety Administration (NHTSA) shows that booster seats can result in a 60% decrease in injuries and deaths. Thank you for doing what you can to help parents understand this and the importance of the new law.

[Note: We are currently producing an educational brochure regarding the new law and will let you know when it is

TNAAP legislative interns Maureen Vaughan, MD and Tanya Kowalczyk, MD at Legislative Plaza.



American Academy of Pediatrics



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