



## RSV PROPHYLAXIS- ADMINISTRATIVE ROADBLOCKS TO TREATMENT

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Lower respiratory tract infection with respiratory syncytial virus causes significant morbidity and mortality amongst the children of Tennessee. Monoclonal antibody prophylaxis with palivizumab (Synagis) has been shown to improve clinically meaningful outcomes for children who are at risk. Both the 1998 American Academy of Pediatrics Policy Statement and the 2000 Redbook recommend that infants born between 32-5 weeks gestation be considered for palivizumab prophylaxis if they have other risk factors; unfortunately, while the Policy specifically identifies those risk factors, e.g. day care attendance, crowded living conditions, and passive smoke exposure, the Red Book merely

references them in general, stating that, "given the large number of patients born between 32 and 35 weeks gestation and the cost of the drug, the use of palivizumab...should be reserved for infants with additional risk factors". New data expands the "at risk" population to include children with congenital heart disease and argues that the yearly period of prophylaxis be flexible, determined by local epidemiologic data.

Payers in Tennessee have had a variable response to claims made for prophylaxis with this drug. One appears to have made it a policy to deny claims for palivizumab if the child was born after 32 weeks gestation, regardless of

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## Recertification: What is Really Happening?

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Beginning January 1, 2003, pediatricians wishing to recertify with the American Board of Pediatrics (ABP) will follow a new protocol, which the ABP has named the Program for Maintenance of Certification in Pediatrics (PMCP). The PMCP is a four-part format that will be completely phased in by 2010. The four parts require physicians to provide evidence of:

1. Professional Standing (state licensure);
2. Lifelong Learning and Self-assessment;
3. Cognitive Expertise (closed-book secure examination); and
4. Satisfactory Performance in Practice.

By 2010, the four-part recertification process will be the norm for all pediatricians. Parts 1 and 3 will be required of pediatricians needing to recertify in 2003. Those pediatricians will be sent notices and details of the PMCP in September 2002. Parts 2 and 4 will be developed and phased in over time. The American Academy of Pediatrics (AAP) sponsors educational activities through Pedialink, PREP the Continuum (Pediatric Review and Education Program), and eQIPP (Education in Quality Improvement for Pediatric Practice) Programs that will help pediatricians prepare for Part 3, and fulfill the requirements for Parts 2 and 4.

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NEWSLETTER EDITORS

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## President s Report

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To paraphrase the Chinese, we are truly "blessed" by the "interesting times" in which we Tennesseans find ourselves living today! The AAP Annual Chapter Forum in September brought the leadership of our organization together once again to discuss the future direction of the Academy. While it would be an overstatement to say that consensus was reached on every issue, I was proud to be a member of a group that consistently, candidly, articulately, and collegially advocated what s best for children and their providers. The AAP National Conference and Exposition in October provided superb CME focused towards practicing pediatricians and gave members ample access to Academy policymakers regarding both patient care and non-patient care issues alike.

Closer to home, your Chapter partnered with the Children s Emergency Care Alliance (CECA) in presenting a very successful CME meeting in Knoxville, "Advancing the Frontiers of Pediatric Emergency Care". Our EPSDT Contract with the TennCare Bureau has benefited both members and the State through the development of documentation templates that facilitate care, confirm compliance with external regulation, and, hopefully, will improve provider reimbursement. Our Pediatric Practice Managers Network continues to grow, providing expert education and support to these key ancillary personnel. The Chapter supported the submission of several CATCH grants this cycle; the wealth of ideas presented in these submissions was matched only by the dire needs they addressed. The recent state and federal elections also present us with important challenges and opportunities.

Our Governor-Elect, his administrative appointees, and the members of the General Assembly also live in "interesting times". We need to make certain that they understand there is no policy issue of greater importance today than improving the health of the children of Tennessee. As a leading voice for children and their physician-providers in this state, the Tennessee Chapter of the American Academy of Pediatrics / Tennessee Pediatric Society recognizes that a point of crisis has been reached. In a letter to Mr. Bredesen, we emphasized the following concerns:

1. Every child deserves health care sufficient to maximize their potential for growth and development. The American Academy of Pediatrics has defined the standard of care that children should receive in order to achieve that goal. It is illogical, short-sighted in the extreme, and perhaps immoral to offer any less. As citizens, physicians, and, in many instances, parents, we can identify no valid rationale to exclude any child from such coverage.
2. Rates of compensation for children s health care remain unrealistically low. In many instances, pediatricians lose money providing necessary services to children. Adequate coverage cannot continue to be an underfunded mandate in any part of the richest country in the world.
3. Multiple obstacles exist to participation in TennCare, for both our patients and their providers. These obstacles have lead, inevitably, to the development of primary and subspecialty care networks that are woefully inadequate to treat the children for whom they are responsible. These obstacles now threaten to disenfranchise our patients regardless of their

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## *RSV...continued from page 1*

risk factors; even documentation that the infant has chronic lung disease has not always lead to approval. Other insurers have often approved payment for the drug, especially if the individual case is made to the payer's representative by the prescribing physician. Variable responses exist even within the programs administered by a single payer. A sound scientific rationale for denials is often not forthcoming.

The Tennessee Chapter of the American Academy of Pediatrics/Tennessee Pediatric Society is committed to providing children with all of the health care services that they require. We also want to provide these services in a cost-effective manner and we integrate that consideration into every management decision that we make; that is especially true in Tennessee where resources for health care remain limited. As busy practitioners, we rely heavily upon technical recommendations from the AAP, which we regard as the single best source for health care information about children. Thus, we are concerned that some payers are compromising the care which our patients deserve, placing us in the untenable position of having to deny palivizumab prophylaxis or accept the financial burden ourselves for its provision when the family cannot pay. It is possible that we will begin to encounter similar difficulties with influenza vaccination.

We need help from our members, as follows:

1. Share your experiences with us in detail, especially those instances in which you feel claims were wrongfully denied.
2. Write to the Medical Directors of your major payers, encouraging them to follow AAP Guidelines (and thanking them if they are already doing so).
3. Encourage the AAP Committee on Infectious Diseases to keep its membership aware of changing recommendations in a timely fashion, especially as they pertain to cost-efficacy data. Make them aware, too, of how apparent inconsistencies between recommendations in the Policy and the Red Book complicate reimbursement for palivizumab prophylaxis for children born between 32-5 weeks gestation.

If you are interested in helping with palivizumab advocacy or if you are having problems with particular insurers, please feel free to contact me.

## **AAP HIPAA Privacy Manual and Other HIPAA Resources**

The AAP HIPAA Privacy Manual has been updated to incorporate the most recent changes in the Privacy Rule (published on August 14, 2002). Don't miss this tremendous resource! The manual provides step-by-step instructions for evaluating your practice and implementing necessary requirements associated with privacy. The manual includes sample checklists, forms, vendor contract templates and more.

To download the HIPAA Privacy Manual go to [www.aap.org/moc](http://www.aap.org/moc) and log-in using your AAP Member ID # and password (typically your last name up to 12 characters). Click on HIPAA (left side of screen) and select Updated HIPAA Privacy Manual.

The Office of Civil Rights (OCR) released "Guidance Explaining Specific Aspects of the Privacy Rule" on December 4, 2002. OCR is the government agency charged with enforcing the privacy regulation and this document provides background information and further clarification regarding their expectations. You can review this document at: [www.hhs.gov/ocr/hipaa/privacy.html](http://www.hhs.gov/ocr/hipaa/privacy.html).

Also, check out the TNAAP website ([www.tnaap.org](http://www.tnaap.org)) for links to other useful websites for HIPAA information. Remember that you must be in compliance with the privacy requirements by April 14, 2003.

### **HIPAA Updates**

Have you been receiving our HIPAA updates via e-mail? During the last few months, you should have received email communications regarding:

- Filing an extension for "Transactions and Code Sets" (the deadline was October 15, 2002)
- Information about the revised final "Privacy Rule", and
- Notices about HIPAA round table conference calls with the Center for Medicare and Medicaid Services (CMS)

If you did not receive these communications, chances are we do not have your email. Please forward your e-mail address to the Chapter office at [tnaap@aol.com](mailto:tnaap@aol.com).

Getting a new computer this holiday season?

We would like your old one! If your "old" computer is less than 4 years old, and you want to help our new Foundation (more on that in the winter newsletter) while getting a tax deduction in 2003, please contact our Program Director, Patrice, at 615-599-6359 or [patricetnaap@comcast.net](mailto:patricetnaap@comcast.net).



## EPSDT Forms Endorsed by TNAAP

TNAAP and Blue Cross Blue Shield of Tennessee have partnered to develop Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documentation forms. These forms were created with input from TennCare managed care organizations, the Tennessee Department of Health and the TennCare Quality Oversight Division.

Use of these forms should prompt the appropriate components of the screen for each age group and, if each section is complete, will appropriately document the chart from a state audit perspective. In addition, improved documentation of EPSDT screens should increase reimbursement to providers and improve Tennessee's EPSDT compliance rates.

The most recent forms more accurately reflect the specific requirements within each age group and more closely follows the "work flow" of the physical. Many offices have found using different colors of paper for each age group to be very helpful.

Electronic copies of these forms can be found on our web site at [www.tnaap.org](http://www.tnaap.org). We hope you will find these useful. We will continually be striving to improve the forms so if you have suggested changes, additions or questions, please contact our EPSDT Director, Ruth Allen at [rutheallen@yahoo.com](mailto:rutheallen@yahoo.com) or at 865-927-3030.

Visit our web site  
[www.tnaap.org](http://www.tnaap.org)



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Stuart J. Kaplan, MD	Memphis	Clifton W. Woolley, MD	Memphis
John Austin Kirby, MD	Jefferson City	Thomas Zerfoss, MD	Nashville

## ***Recertification...continued from page 1***

If you are a pediatrician needing to recertify in 2003, you may access the ABP website at [www.abp.org](http://www.abp.org), or contact the ABP at [pmcp@abpeds.org](mailto:pmcp@abpeds.org). You will need to successfully complete parts 1 and 3 during calendar year 2003, to avoid a lapse in certification. The ABP has posted its Knowledge Self-assessment on its website to help pediatricians prepare for the types of questions and computer testing format that will be used for the closed-book proctored exam. You can register for the PMCP through the ABP website starting in January 2003. The registration process will consist of documenting that your state licensure is current and paying, via credit card, the \$1120 recertification fee. You will also be able to schedule your examination place, date and time using a toll-free telephone number, or you may use the Prometric web site ([www.prometric.com](http://www.prometric.com)) to reserve a place, date, and time much as you would when purchasing an airplane ticket on the Internet.

The examination will be given in Prometric Testing Centers (formerly Sylvan Learning Centers) and Prometric will take responsibility for making sure the examination is "secure." There are over 400 such centers in the US and Canada. The generalist's exam will be offered nine months out of the year (April through December). The closed-book secure examination will consist of approximately 200 multiple choice questions and applicants will have 4.5 hours to complete the test (including a tutorial). If an individual fails the exam, he/she will be able to retake the examination for \$195.00. There is no limit to the number of times an individual may take the examination.

Subspecialists who also wish to maintain certification in general pediatrics will need to take the generalist's examination. If subspecialists choose to remain certified only in their subspecialty, they will only be required to take the examination for their subspecialty. Those holding more than one ABP certificate, who wish to take more than one recertifying examination, may pay for an additional recertification examination at two-thirds the relevant fee. Many of the Parts 2 and 4 activities will overlap for specialists wishing to maintain generalist certification, thus reducing the burden of maintaining multiple certificates.

Most pediatricians admit the new format is more comprehensive and more likely to engender the trust of the public; however, they feel uneasy about the closed-book secure examination format for Part 3. Pediatricians complain that the closed-book situation does not measure the busy pediatrician's ability to answer questions by contacting colleagues, accessing reference publications, or going on-line. The AAP has expressed its concerns about Part 3 to the ABP. The ABP, however,

feels strongly that it maintain this format for a number of reasons: it has evidence that other medical specialties are developing this type of recertifying examination; the American Board of Medical Specialties, which is the umbrella organization for 24 national medical specialty boards, is considering a resolution that all recertification examinations must be administered in a secure format; and, some state licensing agencies are likely to require a secure examination as part of a maintenance of state licensure if recertification is used to fulfill a requirement of license renewal. Prometric Testing Centers do not permit an open-book format for the examination because they administer multiple different examinations on the same day and no other organizations (eg, National Board of Medical Examiners) allow the open-book format.

The AAP, while not responsible for certifying or recertifying pediatricians, does have a strong commitment to meeting the educational needs of the practitioner (including education for preparation for renewal of certification). Therefore, the AAP will continue to work closely with the ABP to ensure AAP professional education activities assist pediatricians in meeting all of the maintenance of certification requirements. The AAP has never excluded a Fellow from the organization because the Fellow failed to recertify. Please feel free to communicate your concerns about recertification to me as I represent you on the Board of Directors of the AAP.

I wish to thank Hazen Ham, Ph.D., Director of Recertification Programs for the American Board of Pediatrics, and Errol Alden, M.D., F.A.A.P., Deputy Executive Director of the American Academy of Pediatrics, for helping me write this commentary.

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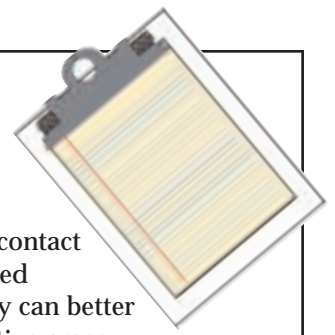
## ***President's Message...continued from page 1***

eligibility. Children with special needs are particularly vulnerable. Children's healthcare coverage cannot become a cynical, empty promise to our posterity.

We recognize that the challenges faced by State government are formidable and that time, energy, and resources are finite. We appreciate the attention that was given by all of the candidates to our issues this year; however, the election is now over and the line of responsibility is clear. We will bring to the effort not only a compelling definition of the problems, but concrete, workable solutions, based on the experience and convictions of our group. Working together, as people of good will, vision, and energy, we can reach our common goal: quality healthcare for the children of Tennessee regardless of means.



# Children in State Custody



The Tennessee Department of Children's Services (DCS) has requested assistance from TNAAP regarding issues related to EPSDT services for children in state custody. DCS acknowledges the difficulty that physicians have in obtaining historical information on children in state custody and the problems performing an EPSDT screen without this information. They are trying to improve their processes and want specific

feedback about physician issues. They are asking pediatricians to contact the DCS Health Unit Nurses (listed below) as difficulties arise so they can better address problems in their respective areas. They also request that, in those cases where little or no information can be obtained, we go ahead and see the child and complete as much of the screen as is feasible.

## Dept. of Children's Services HEALTH CARE ADVOCACY STAFF LIST (as of October 3, 2002)

REGION	NURSE	PHONE
Davidson	Patricia Slade, RN, MSN, MBA	615-253-5127
East Tennessee	Scott Melton, BS, RN, CCM	865-425-4527
Hamilton	Chip Dantzler, RN	423-634-3493
Knox	Katressa Tipton, MSN, RN, CPNP	865-594-7101 - Ext. 18
Mid-Cumberland	Patsy Sanford, RN	615-333-5425
Northeast	Rebecca Reed, RN, BSN, ANP,CS	423-727-1052
Northwest	Phyllis Parker, RN	731-884-2633
Shelby	Gerald Brown, RN	901-578-4078
South Central	Lynn Pollard, MSN, RN, CPNP	931-375-2000
Southeast	Cheryl Brazelton, RN, BSN	423-493-5960
Southwest	Sara Webb, RN	731-426-0782
Upper Cumberland	Tanna Short, MSN, RN-C, FNP	931-646-3027
Central Office	David DeGrella Program Coordinator 615-532-2267 Fax -615-741-7322 Primary Areas: MCO, TennCare Eligibility, and data quality	Diana Yelton Program Coordinator 615-253-4703 Fax -615-741-7322 Primary Areas: BHO, DCS appeals, and custody prevention for noncustody children.



*Fenner, Lentz, and Ring receive the AAP Outstanding Large Chapter Award, presented by Wyeth-Lederle reps Susan Lincoln and Mike Dugan, on either side of Lentz. The beautiful plaque was accompanied by a \$2000 check also from Wyeth.*

## 2003 Calendar

- Jan 18, 2003      TNAAP Board Meeting\*  
Nashville
- Apr 11, 2003      TNAAP Board Meeting\*  
Montg. Bell State Park
- Apr 12-13, 2003    TNAAP Planning Retreat  
Montg. Bell State Park

*\* All Chapter members are invited to attend the Board meetings, but please let the Chapter office know at least 2 weeks in advance.*



# 2002 National Early Hearing Detection and Intervention Meeting

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I was honored to represent the Tennessee AAP Chapter at the Early Hearing Detection and Intervention (EHDI) Meeting in Washington D.C. earlier this year. This valuable meeting was co-sponsored by the CDC, HRSA, All Kids Count, National Center for Hearing Assessment and Management, National Institute on Deafness and Other Communication Disorders, Department of Education, and the AAP. The purpose of the meeting was to continue the goal of providing universal hearing screening to all infants. The AAP has become a major partner in this endeavor and sponsored a contact person from each state to attend. I will continue to serve as the Chapter's EHDI representative.

Congenital hearing loss affects 2-3/1000 infants in Tennessee and the United States. Hearing loss occurs more frequently than other screened newborn conditions (0.1/1000 births have PKU; 0.25/1000 births have hypothyroidism, 0.20/1000 births have sickle cell, 2.3/1000 have hearing loss). Infants with undetected or untreated hearing loss will not develop language and communication skills at age appropriate levels. The average age of identification of a deaf child is 14-22 months. Since any degree of hearing loss can affect language and school performance and birth to age 3 years is the most critical learning age for language development, it is not unexpected that one third of children with hearing loss in just one ear had to repeat a grade in school, and the average twelfth grade deaf child reads at a third to fourth grade level.

Technology is now available to reliably screen infants at birth (otoacoustic evoked emissions automated auditory brainstem responses). There is no "best" protocol, but several have been proven to work. Each screening center chooses the one that fits their situation best. Since 1994, there has been a large increase in infants screened (2001 > 2000 hospitals) with 67% of infants screened nationwide. Referral rates nationally are 2.2% (CDC data). We now screen about 75% statewide in Tennessee with reported referral rate of 0.9 to 2%. With these large numbers of infants screened, it truly has become "standard of care". The average cost for hospital-based screening is \$26/infant; however, the cost of educating a hearing impaired child is \$9,689 in regular classes to \$35,780 in residential programs.

Studies have now shown that infants in treatment will develop near normal. Therefore, the goals of EDHI programs are to screen infants by 1 month, have a complete diagnosis by 3 months and intervention by 6 months. It is the AAP's desire that this process be integrated and linked with the pediatric medical home.

With grants from HRSA and CDC and the incorporation of newborn hearing screening in the 2003 EPDST Tennessee regulations, Tennessee hopes to exceed 90% screened. Plans are also in progress to link the reporting of referred newborn screens with the state metabolic screen form. The

Department of Education, IDEA Part C Programs that include the Tennessee Early Intervention System (TEIS) and Tennessee Infant Parent Services (TIPS), will help with coordination of services for the referred infants. TEIS service coordinators work in each county in the state. The program has over 13 years of experience in working with children birth to 3 years old that may have hearing loss or developmental disabilities. TIPS school parent advisors also work in each county of the state. This program has over 35 years experience working with families who have young children with hearing loss. These groups can assist with referrals to appropriate pediatric audiologists for definitive diagnosis and amplification and referral to early intervention specialists for other treatment, if necessary.

A large amount of research and work has occurred in the past 5 years for the diagnosis of congenital hearing loss. Outcome data now supports that early diagnosis and treatment can help avoid long-term social behavioral and educational developmental delays. In a short 7 years, the U.S. has gone from 19% of infants screened to 67%. We also have made great progress in Tennessee, but we still have at least 25% of children not being screened. The AAP is asking all pediatricians to "champion" the goal of screening all children by one month of age and include diagnosed children in their medical home. We truly have a lot of work left to do.

Please help us screen all children in your community. Also feel free to contact me about this important issue.

References: 1) American Academy of Pediatrics Task Force on Newborn and Infant Hearing, Newborn and Infant Hearing Loss: Detection and Intervention. *Pediatrics*. 1999b; 103:577-530. 2) American Academy of Pediatrics, Ad Hoc task Force on Definition of the Medical Home. *The Medical Home*. *Pediatrics*. 1998; 90:774. 3) Joint Committee on Infant Hearing Position Statement: Principles and guidelines for early hearing detection and intervention programs. *Pediatrics*. 2000; 106:798-817. 4) Moeller MP. Early intervention and language development in children who are deaf and hard of hearing. *Pediatrics*. 2000; 106:e43. 5) Yoshinago-Itano C., Sedey A.C., Coulter RA, Mehl AL. Languages of early and later-identified children with hearing loss. *Pediatrics*. 1990; 102:1168-1171. 6) Yoshinago-Itano C. Universal newborn hearing screening assessment and intervention systems. *Hearing Journal*. 1999; 5216: 10,12,14,16,19, 20-21.

## Great Web Sites

1. [www.babyhearing.org](http://www.babyhearing.org)  
Boys Town National Research Hospital
2. [www.infanthearing.org](http://www.infanthearing.org)  
National Center for Hearing Assessment

## Tennessee Resources

1. Jacque Cundall, Tennessee Department of Health  
615-741-310 [jcundall@mail.state.tn.us](mailto:jcundall@mail.state.tn.us)
2. TEIS 1-800-852-7157

# TennCare Benefits

AMN = As medically necessary

<b>Benefit</b>	<b>TennCare Coverage through 12/31/02</b>	<b>TennCare Medicaid Coverage 1/1/03</b>	<b>TennCare Standard Coverage 1/1/03</b>
Inpatient hospital services	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN for children through EPSDT; AMN for adults, with rehabilitation hospital services covered only as a cost-effective alternative	AMN, with rehabilitation hospital services covered only as a cost-effective alternative
Outpatient hospital services	AMN	AMN	AMN
Physician inpatient services	AMN	AMN	AMN
Physician out-patient services	AMN	AMN	AMN
Physical exams and check-ups	Covered	Covered for children through EPSDT; covered for adults according to TennCare schedule	Covered according to TennCare schedule (AAP guidelines for children)
Lab/X-ray services	AMN	AMN	AMN
Hospice care	AMN	AMN	AMN
Dental services	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Preventive, diagnostic and treatment services for enrollees under 21. Services for enrollees age 21 and older limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth	Limited to accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth and their replacement, and removal of impacted wisdom teeth [Additional dental package of services for children will be available for family purchase]
Vision services	Preventive, diagnostic and treatment services for enrollees under age 21; first pair of cataract glasses or contact lens/lenses following cataract surgery for adults	Preventive, diagnostic and treatment services for enrollees under age 21; routine eye care not covered for adults	Annual eye exam covered for enrollees under age 21; other routine eye care not covered for children or adults
Home health services	AMN	AMN, with a limit of 125 visits per enrollee per year for enrollees age 21 and older	AMN, with a limit of 125 visits per enrollee per year
Pharmacy	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)	AMN, but certain drugs excluded (DESI, LTE, IRS)
Durable medical equipment	AMN	AMN	AMN
Medical supplies	AMN	AMN	AMN
Emergency ambulance transportation	AMN	AMN	AMN
Non-emergency transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation
Renal dialysis services	AMN	AMN	AMN

## TennCare Benefits...continued

AMN = As medically necessary

Benefit	TennCare Coverage through 12/31/02	TennCare Medicaid Coverage 1/1/03	TennCare Standard Coverage 1/1/03
EPSDT services	Screening, diagnostic and follow-up treatment services AMN	Screening, diagnostic and follow-up treatment services AMN	Not covered
Chiropractic services	AMN for children through EPSDT; covered for adults as a cost-effective alternative	AMN for children through EPSDT; covered for adults as a cost-effective alternative	Not covered
Private duty nursing	AMN	AMN for children through EPSDT; not covered for adults	Not covered
Speech therapy	AMN for children through EPSDT; covered AMN for adults when provided by a licensed speech therapist to restore speech after a loss or impairment	AMN for children through EPSDT; for adults, limited to 60 days period from the date therapy begins for any one condition	Covered as short-term benefit per condition; limited to 60 days from original treatment
Occupational therapy		AMN for children through EPSDT; for adults, limited to 60 days period from the date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Physical therapy		AMN for children through EPSDT; for adults, limited to 60 days period from date therapy begins for any one condition	Limited to 60 days period from the date therapy begins for any one condition
Organ transplant and donor organ procurement	AMN; for adults, transplant must be non-experimental	AMN for children through EPSDT; for adults, limited to coverage of transplants also covered by Medicare	Limited to coverage of transplants also covered by Medicare for beneficiaries who have been enrolled in TennCare for a period of 6 months
Sitter services	AMN	Not covered	Not covered
Convalescent care	AMN	Not covered	Not covered
Reconstructive breast surgery	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	AMN for children through EPSDT; for adults, covered in accordance with Tennessee Public Chapter 452	Covered in accordance with Tennessee Public Chapter 452
Psychiatric inpatient facility services	AMN	AMN	AMN
Physician psychiatric inpatient services	AMN	AMN	AMN
Outpatient mental health services	AMN	AMN	AMN
Inpatient and outpatient substance abuse treatment services	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and \$30,000 in lifetime benefits	AMN for children through EPSDT; for adults, AMN limited to 10 days detox and \$30,000 in lifetime benefits	AMN limited to 10 days detox and \$30,000 in lifetime benefits
Mental health case management		AMN	AMN
24-hour residential treatment	AMN	AMN	AMN
Mental health crisis services	AMN	AMN	AMN

## Cola Wars

Tennessee Society of Pediatric Dentistry  
(Compiled by Ed Perdue, DDS, Hendersonville  
615-824-1700)

Americans consume soft drinks at an alarming rate. During the time period from 1978 to 1994, soft drink consumption by U.S. teens tripled. By 1998, Americans were consuming 15 billion gallons of soft drinks, equivalent to 558 12oz cans per person per year. The National Soft Drink Association reports that one out of every four beverages consumed in America is a soft drink. This averages to 56 gallons per year for every person in the United States. Consumption among males 12-19 years of age can be as high as 81 gallons per year.

The consumption of highly sugared, acidic, caffeinated, carbonated beverages contributes to the rapid onset and progression of dental caries in children and adolescents. The habit forming potential of the caffeine in these beverages only increases the concerns about dental disease and the overall health of children and adolescents.

According to the Center for Sciences in the Public Interest, twenty percent of one and two year old U.S. children drink soft drinks, with an average consumption of seven ounces per day, containing over 50mg of caffeine. There is concern that the pattern for caffeine ingestion begins at a very early age, as its use in medications, soft drinks, and other foods for children is common and accepted. Regular caffeine ingestion may lead to habitual usage.

The increase in cola consumption combined with an apparent decrease in the consumption of milk not only increases the risk of dental caries in children and teens, but may contribute to a wide range of other health problems, including a decrease in bone density and a subsequent increase in fractures.

National marketing and advertising campaigns for many products, especially colas, have aggressively targeted the child and teen markets. The American Dental Association has expressed concern about "pouring rights contracts" which give soft drink companies exclusive rights to place vending machines in schools in exchange for large monetary contributions.

Caffeinated carbonated beverage consumption poses significant risk to the overall health to children in America. Education is the key to helping families make informed choices about the products they purchase and consume.

## Annual Board Planning Retreat May 2002 Fall Creek Falls State Park



*Above: Immediate Past President Joe Lentz, MD, with wife Betty.*



*AAP President Steve Edwards, MD, enjoys the beauty of Tennessee.*

*Below: (r-l) Mick Connors, MD, Bob Lembersky, MD, Ovidio Bermudez, MD, and Pat Strauss with members of the Lembersky family.*



*Volunteer leaders work to set the course of TNAAP's future.*

## Local Pediatric Society Updates

### Davidson County Pediatric Association (DCPA)

Beverly Frank, MD, President  
bevfrank@comcast.net  
615-851-7865

**D**CPA had two meetings earlier this year. In late March, we met with Dr. Pedro Garcia, Nashville Metro's school superintendent. He presented his plans for increasing reading and math scores in the school system as well as his philosophy of educating children. He encouraged us to emphasize to all our parents how important it is to read with their children on a daily basis. This could be done at every physical exam, starting with infants. He also feels that this practice should continue through middle school, always reading to your children at a level higher than theirs so they are pushed to learn new vocabulary and discuss ideas with you. In May, DCPA and Vanderbilt co-hosted the annual dinner that is in memory of Dr. Overall. The speaker this year, Dr. George Lister from Yale University, discussed what he has learned over the years from his mistakes.



*Davidson County's  
Overall Dinner*

### Hamilton County Pediatric Society

Tomasz Voychehovski, MD, President  
423-855-0841  
tomekvoy@cs.com

**T**he Hamilton County Pediatric Society (which includes Chattanooga and the surrounding area of southeast Tennessee) had its first Pediatric Picnic (tagged by some as the "Picozium") at the scenic Harrison Bay State Park in April. The Society was generously supported by the companies of Daiichi, McNeil, Lederle, Ross, and Sepracor. With the fantastic spring weather, pediatricians and their families enjoyed camaraderie, food, tennis, hiking, and stories by actress/story-teller Colleen Laliberte. The Society committed its new projects to the following:



*Hamilton County's  
"Picozium"*

- (1) promoting breastfeeding and prenatal visits in alliance with ob-gyn and family practice doctors, and
- (2) the cooperation between librarians and pediatricians to promote reading.

American Academy of Pediatrics

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