



CMS, VACCINES and the PEDIATRICIAN

Joel F. Bradley, MD, FAAP,
CPT Coding Advisor
(w) 615-936-6053

Immunizations are part of what we do, and changes in the Medicare fee schedule for 2002 threaten to change our ability to keep our kids protected against disease. Developing a strategy to deal with this in your practice requires the information summarized below.

The problem- As you may recall about three years ago, billing for vaccines changed at the request of the CDC to create separate CPT codes for vaccine products and their administration. New codes for vaccine administration were developed, and in their present form allow one to bill for the first vaccine administered (90471) and subsequent vaccines (90472 for each). For a typical two month old, if one gives 4 vaccines, we submit a CPT code for each vaccine product, 90471 (once) and 90472 (three times). With over

twenty vaccines given during childhood and more to come, a little change in the reimbursement fee can produce a great change in the practice's bottom line at year's end.

CMS (formerly HCFA, now the Centers for Medicare and Medicaid Services) has published for the first time this year the relative values for 90471-2- but **without** the physician work value that was well demonstrated by our AAP surveys and recommended by the AMA RUC (relative value update committee) to CMS. As you can see from the table below, this omission lowered the total relative value by about 60%, and considering the CMS-imposed 5% decrease in the 2002 conversion factor, the reimbursement totaled \$3.98. CMS equates the code to the antibiotic administration code 99078.

continued on page 4...

District IV Chair Commentary:

Coparent or Second-Parent Adoption by Same-Sex Parents

Dave Tayloe, Jr, MD, FAAP
(w) 919-580-7209; (fax) 919-580-1017
dtayloe@aap.org

Board members of the AAP have been besieged by angry AAP Fellows and lay citizens since the publication of the Policy Statement and Technical Report on the topic of Coparent or Second-Parent Adoption by Same-Sex Parents in the February issue of Pediatrics. The Committee on Psychosocial Aspects of Child and Family Health (COPACFH) wrote these documents, multiple groups within the AAP reviewed them, and all ten members of the Board of Directors approved them. The process of developing the Intent for Statement/Technical Report and

completing the work leading to publication in Pediatrics took about three years.

I came on the Board in late October of 2001, and these documents were approved before my official duties on the Board began. When I learned of the documents after the first critical media blast, I read and studied both documents and became involved in Board-level discussions, as well as discussions with AAP Fellows and lay citizens. I believe the Committee attempted to carve out a very unusual situation and address the needs of the at-risk child who finds himself/herself

continued on page 5...



INSIDE

Page 2
New President's
Report

Page 3
Legislative Report

Page 4
New Members /
New Board
Members

Page 6
EPSDT Contract

Page 8
EPSDT Coding

Page 9
EPSDT Screens in
Health Depts

Page 10
EPSDT Audit Results
TennCare Update

Page 11
Vaccine Shortage

Back Cover
Newborn Coding



**Tennessee Chapter,
American Academy of Pediatrics/
Tennessee Pediatric Society**

BOARD OF DIRECTORS

PRESIDENT

John C. Ring, M.D.

VICE-PRESIDENT

David K. Kalwinsky, M.D.

SECRETARY-TREASURER

J. Michael Connors, M.D.

FELLOWS AT-LARGE

Martin I. Herman, M.D., West TN

Patricia C. Davis, M.D., Middle TN

Charles L. Campbell, M.D., East TN

PROGRAM CHAIR

Robert B. Lembersky, M.D.

MEMBERSHIP CHAIR

Mary E. Keown, M.D.

NOMINATING CHAIR

Elizabeth M. Andrew, M.D.

COUNCIL OF PAST PRESIDENT S CHAIR

Joseph F. Lentz, M.D.

LOCAL PEDIATRIC SOCIETY

REPRESENTATIVES

Beverly A. Frank, M.D., Nashville

Mark S. Gaylord, M.D., Knoxville

Thomas E. Mitoraj, M.D., Northeast TN

Patrice Reed, M.D., Memphis

Tomaz H. Voychehovski, M.D., Chattanooga

EX-OFFICIO MEMBERS

PEDIATRIC DEPARTMENT CHAIRS

Billy S. Arant, M.D., UT Chattanooga

Russell W. Chesney, M.D., UT Memphis

David K. Kalwinsky, M.D., ETSU

Arnold W. Strauss, M.D., Vanderbilt

Susanne Tropez-Sims, M.D., Meharry

PAST PRESIDENTS

Joseph F. Lentz, M.D. (2000-01)

Iris G. Snider, M.D. (1998-99)

Russell W. Chesney, M.D. (1995-97)

Harold F. Vann, M.D. (1992-94)

Hays Mitchell, M.D. (1989-91)

Bobby C. Higgs, M.D. (1986-88)

Luthur A. Beazley M.D. (1983-85)

George A. Zirkle, Jr., M.D. (1980-82)

Walton W. Harrison, M.D. (1977-79)

Felix G. Line, M.D. (1974-76)

George S. Lovejoy, M.D. (1968-73)

The Tennessee Pediatrician, P.O. Box 159201,
Nashville, Tennessee 37215-9201
Phone (615) 383-6004/ Fax (615) 383-7170
tnaap@aol.com www.tnaap.org

Next Issue: Summer 2002

Deadline for entries: May 10, 2002

NEWSLETTER EDITORS

Catherine M. Fenner

Joseph F. Lentz, M.D.

President s Report

John C. Ring, MD

50 N Dunlap, Memphis 38103

(w) 901-572-3292; jring@utm.edu

I am back at my childhood home, and it is real winter here. My wife Adriana and I are driving up the North Shore of Lake Superior to Bearskin Lodge, an old bass fishing camp in the Arrowhead Country of Northeastern Minnesota, where the wilderness blurs off into Canada. The rental car is warm, and I've managed to retain some skills for driving on ice and snow. Public radio's pledge week programming is dominated by the fight that state legislators are making to return their income tax rebates to Governor Ventura and apply them, instead, to support of the public schools. Amazed, we turn the radio off and listen to zydeco music on the disc player. For the fifteenth year in a row, we are joining the same group of friends for a long weekend of cross-country skiing, fellowship, and good food. Bearskin is beautiful, pristine and remote; contact with the world is limited to French-language hockey games on the radio and to a single, communal telephone. It is a place that lends itself to reflection, as does this time of life for me.

Curiously, my thoughts turn to the Chapter and not just because this report is due upon my return. Direct patient care remains a rewarding, sometimes still an exhilarating, experience for me, but I increasingly feel the need to reach beyond these very personal encounters in hope of impacting children's lives more broadly. Unabashedly, I have come to recognize that what is good for pediatricians is good for children, too. The Chapter provides the ideal venue for this type of action, one in which we can work together to improve children's healthcare at both the State and the National level. The Tennessee Chapter has an important perspective to share with the National organization. Consider our practical experience with universal health insurance coverage for children; as pediatricians, we share a common goal with our colleagues in other parts of the country but, as we have learned to our dismay, "the devil is in the details". Similarly, we recognize the importance of clearly identifying and thoroughly discussing our social agenda as we make policy. Closer to home, it is my hope and intention that new Chapter initiatives, e.g. the EPSDT contract already in place and the developing task forces on HIPAA regulations and Synergis reimbursement, will provide real value to our members. Your Chapter leadership is working to re-invigorate our committee system, modifying its structure to more completely engage the talents of our members and bring them to bear efficiently on issues of substance.

Nothing will come to us for free. Our busy professional and personal lives necessitate that we apply a healthy skepticism to any demands made upon our time and energy. It will require the courage of our convictions to advocate for tax reform, recognizing that, regardless of the cost, we must take control of the process in support of education and healthcare. I am confident that we will make the effort and that our effort will be successful. I am truly grateful for the opportunity to work with you over the next two years. It is good to be at home in Tennessee.



Legislative Advocacy



*Catherine M. Fenner,
Executive Director*

Executive Director's Report Catherine M. Fenner

Just prior to the reconvening of the 102nd Tennessee General Assembly, Vanderbilt's pediatric residency program held an Advocacy Week in January. Organized by Chief Resident Dr. Jason Kastner (some of you may remember Jason as one of my legislative interns last year), we spent three

lunch hours during the course of a week discussing various types of advocacy. The first day I presented the basics of legislative advocacy. The second day, our Chair of the Committee on Children with Special Needs, Dr. Quentin Humberd from Clarksville, spoke about community advocacy and specifically the Medical Home project he has been working on with Family Voices. Our Program Director, Patrice Mayo-Ligon, also used our recent bicycle helmet campaign as an example of a Chapter member (Dr. Mick Connors) making his interest in injury prevention and a bright idea come to fruition. We wrapped up the week with a concrete example of legislative advocacy by having Representative Gene Caldwell, Representative Kim McMillan, and Dr. Ellen Wright Clayton discuss last year's passage of the bill that granted absolute immunity to pediatricians when reporting suspected child abuse. Dr. Clayton was instrumental in the passage of that bill by spending countless hours on the Hill explaining to the legislators the real-life situation faced by pediatricians. Rep. McMillan, who sponsored the bill in the House, received the 2001 Legislator of the Year Award for her efforts.

During the first active month of session (February), I was blessed again to have two wonderful third-year pediatric residents commit their month of advocacy to learning the ropes on the Hill; this brings the number of



Rep. Kim McMillan (center), along with Dr. Ellen Clayton and Rep. Gene Caldwell, explain the importance of legislative advocacy during Vanderbilt's Advocacy Week in January.

residents trained through this arrangement with Vanderbilt to eight. Dr. Alison Asaro and Dr. Buddy Creech were constantly researching and reading bills, identifying bills of interest and sitting through hours of committee discussions. As often happens, their medical expertise was particularly helpful when we were approached by many sides regarding a bill to allow glucagon administration in schools and another mandating schools to report the number of children taking medications in schools for ADHD. (See article on back page.)

Meanwhile, we have quietly held at bay the annual bill to grant prescribing authority of psychotropic drugs to psychologists, the other annual nightmare to lift the ban of firearms on playgrounds and school property, and a bill which would require all



Dr. Quentin Humberd discusses community advocacy and his Medical Home project with Vanderbilt pediatric residents during January's Advocacy Week.

children entering any pre-K or Head Start program to have a vision screening performed exclusively by an optometrist or ophthalmologist. As the Committees are working to close down so they can turn their attention to the budget crisis, these bills should be gone-- for this year, anyway. We continue to forge new alliances with other lobbying groups on the Hill, which has been extremely helpful in defeating these bills.

In addition to the optometrists' and psychologists' bills mentioned above, scope of practice bills are abundant this year. The Tennessee Medical Association (TMA) continues to address legislation that expands the scope of practices of "advanced practice nurses", chiropractors, orthopaedic PAs, and podiatrists.

Of course, the budget remains an enigma for most legislators, and they do not seem to understand that already the needs of children in this state are not being met, and to make more cuts will only do more harm. I encourage each of you to voice your personal opinions on tax reform to your own state senator and state representative. And please, get involved in an election this year, whether it be the gubernatorial race, the U.S. Senate race, the 4th, 5th, or 7th Congressional races, or your state senator or state rep race. Your time, as well as your dollars, do not go unnoticed and can make a lasting impression.

...CMS, Vaccines, continued from page 1

Code	Proposed work rvu run by AAP-AMA	Total published work rvu - CMS	Total reimbursement AAP-AMA	Total reimbursement CMS 2002
90471	0.17	0	\$10.14	\$3.98
90472	0.15	0	\$9.41	\$3.98

CMS maintains that physicians do not spend time counseling patients about the vaccines (informed consent). While this may be true to some extent for the adult influenza and pneumonia vaccine (often given outside the practice setting such as a drugstore), it is not reflective of our practice as pediatricians. In fact, the work is increasing as many well-publicized (Rotavirus vaccine, intestinal obstruction) and unsubstantiated adverse affects (MMR-autism) appear. To make matters worse, CMS did not consider the well-demonstrated additional nurse time in giving vaccines versus another type of injection (documentation) and cost of materials like the Vaccine Information Sheets (VIS) we must furnish to each patient in an appropriate language.

Practice Impact- Since the values were never published until this year, all insurance companies and state Medicaid programs had to arrive at a reimbursement value without using the fee schedule. Surveys show values ranging from three to eighteen dollars, with an average of about \$10 nationwide. If a pediatrician has 100 newborns a year, then on average the loss would be about \$12,000 per year if those payers adopted the Medicare numbers (about two thirds of private payers or state Medicaid plans use the RBRVS).

The Solution- At the practice level, make sure you do not contract for the 2002 RBRVS fee schedule! Why not? First, it contains the low relative values for vaccine

administration, and secondly the lower conversion factor for 2002 drops the payment for all codes by over 5%. Stay with the 2001 schedule and the 2001 conversion factor. Next, start checking your remittances from payers and see where they are headed. A call to the plan's medical director may help educate them and create a quality concern for the plan. The changes to the fee schedule codes and the conversion factor may apply to the state of affairs in the Medicare world, but neither change should apply to service to children or any non-Medicare patient and service.

At the state level, report to TNAAP any payers who are using the new values so the Chapter can both monitor the size of the problem and lobby on your behalf to repeal the changes. State Medicaid officials have been apprised of the potential impact this would have on both immunization rates as well as EPSDT screening rates if physicians were unable to afford giving vaccines in the office.

On a national level, write or call your U.S. Senators and Representatives-- there is even a form letter preprinted on the AAP website that can be modified for your practice and your concerns. Meanwhile, the AAP continues to work with CMS for a remedy.

(For another discussion of the subject, see February AAP NEWS, Washington Report. If you need a basic refresher on the Medicare Fee Schedule, look for the new 2002 RBRVS brochure on the AAP website.)

Welcome New Members

Paul G. Barongan, MD	Oak Ridge
E. Heather Fairbank, MD	Nashville
Jodi Burton Gage, MD	Johnson City
Robert Higginbotham, MD	Memphis
Wendy L. Hitch, MD	Hermitage
Kasey A. Huff, MD	Collierville
Carle Crane Kalsi, MD	Memphis
Rebecca Ruby Powers, MD	Johnson City
John Proctor, MD	Nashville
George William Robertson, MD	Lebanon
Katherine Tun, MD	Chattanooga

Please Welcome Your New and Newly Elected Board Members

John C. Ring, MD, President (Memphis)
 David K. Kalwinsky, MD, Vice-President (Johnson City)
 J. Michael Connors, MD, Secretary-Treasurer (Knoxville)
 Martin I Herman, MD, Fellow At-Large, West TN (Memphis)
 Patricia C. Davis, MD, Fellow At-Large, Middle TN (Columbia)
 Charles L. Campbell, MD, Fellow At-Large, East TN (Oak Ridge)
 Robert B. Lembersky, MD, Program Chair (Knoxville)
 Mary E. Keown, MD, Membership Chair (Nashville)
 Elizabeth M. Andrew, MD, Nominating Chair (Memphis)
 Tomasz H. Voychekovski, MD, Pres., Hamilton County Pediatric Society (Chattanooga)
 Patrice Reed, MD, Pres., Memphis Pediatric Society (Memphis)

Membership

Dues

Invoices for your FY03 dues will be sent to you in May from the AAP, which we contract with as our dues billing service. Those dues will cover the period of July 1, 2002 through June 30, 2003. Please note that while both national and state chapter dues are on the same invoice, you are not obligated to be a member of both. However, we sincerely hope that the significant growth and accomplishments of your TN Chapter over the past year will warrant your renewal to your state Chapter in addition to your national membership.

Thank you!

UPCOMING WORKSHOPS

"Assessment of the Pediatric Patient"
"The Acutely Ill Pediatric Patient with a Focused Review of the Top 10 Reasons for Hospital Admissions"

Presented by:
Norman Spencer, MD, FAAP

May 13-14, 2002
Nashville, TN ¥ \$100/day

Contact:
Critical Care Program
Phone: 615-321-2271
Fax: 615-321-2195

Email: vice@criticalcareprogram.com
www.criticalcareprogram.com

District IV Chair Commentary

...continued from page 1

in the predicament of being the biological child of a gay/lesbian custodial parent. These children do not have access to a traditional family unit, and we pediatricians must help them make the best of a difficult situation. The AAP cannot, as a public policy organization, say that a given adult is unfit to be a parent simply based on the sexual orientation of that adult. We all have learned that all children need as many responsible adults in their lives as possible. Most adoption procedures require the adopting adult to prove that he/she is really worthy of being made a legal parent/guardian of the child. The AAP was simply trying to say that gay/lesbian partners of gay/lesbian biological parents should have the right to adopt the children of those biological parents. If I had been asked to approve the documents in question, I would have approved them. However, I think the AAP Fellows who have complained to me about the documents have made one point absolutely clear: that the AAP has spent an enormous amount of time and energy on a "fringe issue" as it relates to the American family. The AAP has failed to do anything substantial to publicly promote the value of the traditional family unit for the average child. It will be my task, as your representative on the Board of Directors of the AAP, to focus the Board on addressing the fact that the American family is in crisis and that pediatricians are in positions to improve the health of children by increasing the number of children who grow up in traditional family units.

When I became Vice President of the NC Chapter of the AAP in 1990, and attended my first Annual Chapter Forum (annual meeting of the AAP leadership), I recall a resolution that asked the AAP to study the growing numbers of single-parent families in America, and further asked the AAP to promote the value of the traditional family unit to the average child. The

AAP leadership, which included all the chapter vice presidents and presidents, could not pass this resolution because it appeared to say that single parents were bad parents. District IV continued to rewrite this resolution until it finally passed, several years later, and was referred to the AAP leadership for further action. When Joe Zanga, then of District IV, became President of the AAP, Joe appointed a Task Force on the Family to study family issues and develop a report for the Board of Directors. Joe appointed the original author of the single parent resolution to the Task Force.

The Report of the Task Force, in draft form, arrived on my desk during the furor that erupted after publication of the Coparent Adoption documents. This report is loaded with data to support the value of the traditional family unit to the average American child. This report is on the agenda of the Board of Directors for the upcoming May meeting. It is my hope that the AAP leadership can utilize this report to tell the public and the membership what we already sense is happening to families in America, and the devastating effects these changes are having on our children. I firmly believe that children deserve to be born into a loving family that consists of two legally married heterosexual adults who are committed to stay together "for better or worse" so that their children will have the best chance to grow up to be responsible, productive adult citizens. I fully understand that there are aberrations galore of the traditional family unit and that we all must scramble every day to help those at-risk children do the best they can in these difficult family situations, such as the gay/lesbian dilemma that started this discussion. However, the AAP must help us and the public focus on what is really best for children in these very difficult times, and I sense that our membership feels a bit betrayed by the AAP when it comes to family issues. I think we can all do better. I welcome your advice on this and any other child health issues.

EPSDT Contract with TennCare Continues



Ruth E. Allen,
EPSDT Coordinator

Ruth E. Allen, EPSDT Program Director
(o) 865-927-3030; (fax) 865-927-8039
rutheallen@yahoo.com

We were successful in renewing our Early Periodic Screening, Diagnosis and Treatment (EPSDT) contract with TennCare through June 30, 2002 and hope to obtain a 12-month contract for the fiscal year beginning July 1, 2002.

We are continuing to meet with state officials to share pediatricians' concerns about TennCare and to improve access to care for children in Tennessee. As we work with the state to improve EPSDT screening rates, one of the key focuses of our activities during the first quarter of 2002 is to obtain data from the state. We are working with the state to obtain information such as:

- ✓ network deficiencies by specialty type and geographic location;
- ✓ average TennCare reimbursement by CPT code, (we hope to obtain in order to compare to the AAP's South Central Average as published in the Medicaid Reimbursement Survey, 2001);
- ✓ results from the state's audits of primary care physician offices on the completeness of documentation regarding the seven components of EPSDT screens (see article on page 10); and
- ✓ the percentage of children who are receiving screens by age group and by geographical location.

Other key activities this quarter have included:

- ✓ We have established an EPSDT forms committee (chaired by Iris Snider, MD) to maintain the age-specific EPSDT documentation forms to be used in pediatric offices (these forms have been well-received by the majority of our members).
- ✓ I had the opportunity to visit my Medicaid counterpart at the Georgia AAP Chapter to observe and share successes and challenges.
- ✓ I have continued to represent TNAAP in various state meetings including the EPSDT work group (with MCO representation), meetings with the Children's Health Initiative, providing input regarding the EPSDT public awareness campaign, etc.
- ✓ We have established a contact person to address issues as they arise with local health departments providing EPSDT services. (See article on page 9.)
- ✓ I am working with various agencies to obtain information

on best practices across the country for outreach to parents to get their children in to their doctor's office to obtain preventive health screenings.

- ✓ I have participated in various HIPAA trainings, and we have begun compiling resources to aid members in becoming HIPAA compliant.
- ✓ We continue to stress the importance of eliminating "hassle factors" in TennCare (for example, we are still working on the issue of a common referral form). We are also helping the state understand barriers to making behavioral health referrals.

How can I help you? Do you have issues in your office that relate to EPSDT? Do you or your staff need additional training about the EPSDT services or documentation requirements? Are you having billing problems with certain MCOs for EPSDT services? Please contact me if I may be of assistance.

EPSDT Public Awareness Campaign

As part of the state's initiative to increase EPSDT screens, they have launched a public awareness campaign called "Tennessee Caring for Kids". You should have received a letter from TNAAP in February notifying you about this campaign and providing you with copies of the informational poster and brochures. If you did not receive this information or if you need additional copies of the materials, please contact Lola Potter at TennCare at 615-532-7542 or lola.potter@state.tn.us.



NEW! Enfamil LIPIL™ with Iron

*an infant formula
in a class by itself*



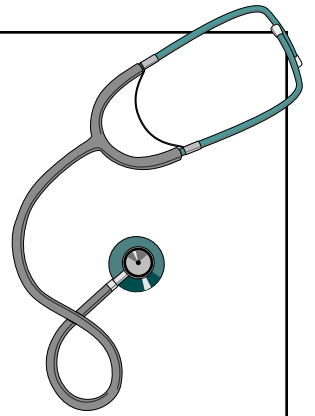
Enfamil® LIPIL contains a unique blend of DHA and ARA, important building blocks for a baby's brain and eyes.^{1,2}

For more information, ask your Mead Johnson sales representative or call 1-800-BABY123.



References: 1. Birch EE, Hoffman DR, Uauy R, et al. Visual acuity and the essentiality of docosahexaenoic acid and arachidonic acid in the diet of term infants. *Pediatr Res.* 1998;44:201-209. 2. Birch EE, Garfield S, Hoffman DR, et al. A randomized controlled trial of early dietary supply of long-chain polyunsaturated fatty acids and mental development in term infants. *Dev Med Child Neurol.* 2000;42:174-181.

Coding For Preventive Medicine and EPSDT Visits



Joel F. Bradley, MD, FAAP, CPT Coding Advisor
(w) 615-936-6053

As you know, the Chapter is working with the state to improve the EPSDT program, both at the practice level with the visit itself, and at the MCO level looking at reimbursements. One should learn the following information about coding to bill and contract for the service provided in the office.

Most EPSDT visits are performed as preventive medicine visits (CPT codes 99381-99395), although the state for counting purposes uses newborn visits in the hospital as well as obstetric visits. There are three basic points to learn, two of which affect the way you bill. MCO variation is common, and we are working with the state and MCOs to help reduce these payment policy discrepancies.

1) SCREENING SERVICES- According to CPT rules, when one does a well visit and provides screening or procedural services in addition to the well visit, they are separately billable if they have their own CPT code (this is explicitly stated in the CPT book). Such services would include formal vision screening (99173), hearing screening using an audiometer (92551), and developmental behavioral screening when a formal exam is used (96110). In addition, the vaccine administration codes and the vaccine codes, plus any labs are also billed separately. The table below lists the codes available to completely bill for the service.

Following the EPSDT guidelines (which parallel those of the AAP), these codes are used when formal objective tests are used, not simply when one takes the history of the child's ability to hear or see (as is done in the infant before office testing is usually possible). For hearing screens, most offices use an audiometer and can bill the code in addition to the well visit, and it is usually paid. The vision code, 99173, is a relatively new code, is published in the RBRVS without values, and is often not reimbursed. However, those who screen three and four year olds (we all should, according to the guidelines), understand the substantial effort and time required and subsequently the need for additional reimbursement. Similarly, a relatively new code exists

for limited developmental tests- examples given in CPT for this code include the DDST2 and the ELMS (Early Language Milestone Screen). Most of the tests recommended in the EPSDT guidelines fit this description.

The Problem: Many payers have considered some of the payment for screens to be bundled into their payment for the well visit – especially vision and hearing. The AAP surveys members each year to collect payment data; more and more payers are covering these codes each year. In Tennessee, some of the MCOs correctly allow billing/payment for all these codes, some pay only for one or two of the screening tests (usually hearing), and some do not pay separately for any.

The Solution: At the practice level, providers should survey their payers, especially the TennCare MCOs, and if these are not covered, make the case for payment when they file claims, work denials, and contract with services. At the state level, the Chapter is working as above to help decrease variation, and we will keep you posted of progress.

2) MODIFIER 25- Correctly coded, one can bill both a well visit and a separate illness/problem dealt with at the same visit by attaching the modifier 25 to an office visit code that fits the additional work done. Example: 6 year old with EPSDT which is completed, with 15 minutes additional time and additional history and medical decision-making done for asthma care. Here, one would correctly bill the well visit, 99393 linked to diagnosis code V20.2, and also bill a 99213-25 linked to the diagnosis code for asthma 493.00.

The Problem: Not all payers pay for both codes, and the ones that do not usually pick the cheaper one to pay. The good news is that most of the TennCare MCOs do pay for both, and the numbers of major carriers in the private sector who do are increasing each year since CMS recognized the code (AMA payer survey data).

The Solution: Check payer data or query your provider representative. Too many kids are sick or have a medical problem at the same time they come for a

continued on page 9...

Service	CPT Code
Well visit	99381-99385-new patient, by age 99391-99395- established, by age
Vision screen	99173
Hearing screen – screening audiogram	92551
Developmental screen	96110
Vaccine administration	90471 (first), 90472 (each subsequent)

...Coding
continued from
page 8

well visit to let this go unreimbursed if the majority of payers cover it. If yours does not, put this in the contract. Of course, if a separate problem takes little time or work (some diaper rashes, thrush), do not bill separately.

3) COMPREHENSIVE EXAM-

Comprehensive exam as described in CPT does not equal the Comprehensive exam one must do to bill for the highest level 99215 in the office. CPT states that the exam can be tailored by the provider to what is appropriate for the patient's age and sex. With input from several practices, the Chapter has developed well visit encounter forms which provide the age appropriate documentation in a checklist format, and if completed, will pass audit with both private and TennCare carriers. As you know, if the services we perform are not documented, they were not done as far as payers and malpractice attorneys are concerned.



Local Health Departments Now Providing EPSDT Screens

Annette Goodrum, RNCS, MCH Consultant,
Tennessee Department of Health
615-741-0393

[Note: This article provides an overview of the history of why this development has occurred and how the process is expected to work. TNAAP has expressed concern about the potential negative impact this could have on the medical home concept. The health department has assured us that their intent is to enhance the medical home concept, to encourage parents to be in dialogue with the PCP and to help children with out a medical home get referred to a physician who can provide one. While there is controversy about how well this will work, TNAAP wants to encourage partnering with public health to increase screening and immunization rates in Tennessee. Our EPSDT Director, Ruth Allen, has a contact person with the department of health for any issues that arise. We expect this process to have different impacts across the state. If you have a lack of communication or other issues with your local health department as they begin providing EPSDT screens, please contact Ruth Allen, our EPSDT Director, at 865-927-3030.]

In 1998 the State of Tennessee entered into a Consent Decree in Federal Court in which the state agreed to make dramatic improvement in the EPSDT (well child) screening rates. In 2001, the state was back in court facing contempt charges, because the EPSDT screening rates had not improved as promised in the decree. Under the decree, screening rates are calculated by multiplying the number of screens reported to the state by the MCOs (through claims data) times the percentage completeness of screens based on TennCare audits (see separate article on audit results). For the federal fiscal year 2001, the Tennessee screening rate is: .45 (percentage of children receiving screens based on claims data) X .70 (the completeness rate) for a screening rate of .315 or 31.5%. The decree requires that the screening rate, by federal fiscal year 2002, be 80%

In an effort to reach the 80% target and avoid serious repercussions related to failure to comply with the Consent

Decree, the state has undertaken a number of steps to improve the EPSDT screening rate. One of these steps involves requiring every MCO to contract with local health departments for EPSDT screening services. The Tennessee Department of Health has entered into an interdepartmental agreement with the Bureau of TennCare to provide outreach and screening services. As a result, local health departments are under a mandate from the Department of Health to do everything possible to encourage parents to get their children screened and to offer screening services to families with children enrolled in the TennCare program.

One way the local health departments are complying with this mandate is to offer EPSDT screening services to families whenever a child is in the health department for any kind of service (WIC, immunizations, etc.). If the parent expresses a desire to have their child screened but prefers to receive the service from their designated primary care provider (PCP), health department staff will offer to assist the family in making that appointment.

Whenever a parent does choose to have the health department provide an EPSDT screen, a form is then sent to the child's PCP to let him/her know that the screen was done and to notify him/her of any identified problem. If the child has a problem in need of immediate follow-up, health department staff will assist the family in making an appointment with the PCP or other provider recommended by the PCP.

EPSDT screens in health departments may be performed by physicians or nurse practitioners, however, the majority of screens will be performed by public health nurses. Prior to the initiation of TennCare, public health nurses were actively involved in the delivery of EPSDT services. As the local health departments across the state have prepared to become re-involved in the delivery of these services, local public health physicians and nurse practitioners statewide gave physical assessment updates to nurses previously trained in physical assessment. For nurses not previously involved in the delivery of EPSDT services, more extensive training has been provided.

TennCare Update

Iris G. Snider, MD, Chair, Committee on Child Health Finance
 111 Epperson Ave, Athens TN 37303
 423-745-5955; irisgs@aol.com

As I have talked with pediatricians across the state in the past few days, I have been impressed by the huge disparity in satisfaction with the TennCare program at this point in time. Those of us in east Tennessee had no new MCOs in our region during the changeover last fall and had only a small penetration of Access MedPlus enrollees in most practices. We have concerns about poor subspecialty and mental health coverage, but few other complaints that encompass all providers. Alas, for pediatricians in middle and west Tennessee, things have not gone so smoothly during the past 6 months. Having BlueCare, and later, Access MedPlus patients reassigned while dealing with a new MCO in each region has created many problems. For pediatricians in middle and west Tennessee, their experiences are reminiscent of the early years of TennCare. As one pediatrician told me, "only an understanding banker is keeping us from bankruptcy". This was a common concern during the first year or so of TennCare but had receded until this year. The patients who were transferred from Access MedPlus to TennCare Select are expected to be transferred to existing MCOs as soon as the MCOs have capacity. None of these patients have been moved yet, and there is some question about the actual time frame for this due to lack of space in the other MCOs.

On a more positive note, the Chapter's contract to help with EPSDT issues and the recruiting of more pediatricians into TennCare was renewed for another 6 months. Pat Davis from Columbia continues as Medical Director with Ruth Allen as our EPSDT Director.

Finally, Mark Reynolds decided to reactivate the Medical Care Advisory Committee for TennCare. This committee was authorized for Medicaid by an administrative rule in 1981 but to my knowledge, has not been in place at anytime during TennCare. I was appointed to it as the representative of our Chapter and the first meeting was February 15th. This is a committee of 15 people with representatives from provider and advocacy groups. Our mission is to bring forward the problems we are seeing with TennCare and to try to find workable solutions. This is not the "Board of Directors" for TennCare that was proposed by the Commission on the Future of TennCare (which will be announced in June rather than in January as originally stated).

I need help from all of you to be effective on this committee. I think that a review of all the agendas that we have taken to our meetings with the various heads of TennCare will show the continuing problems that need to be addressed. However, just as I was relatively unaware of the problems in middle and west TN with all the changes in MCOs, there are definite blind spots in my

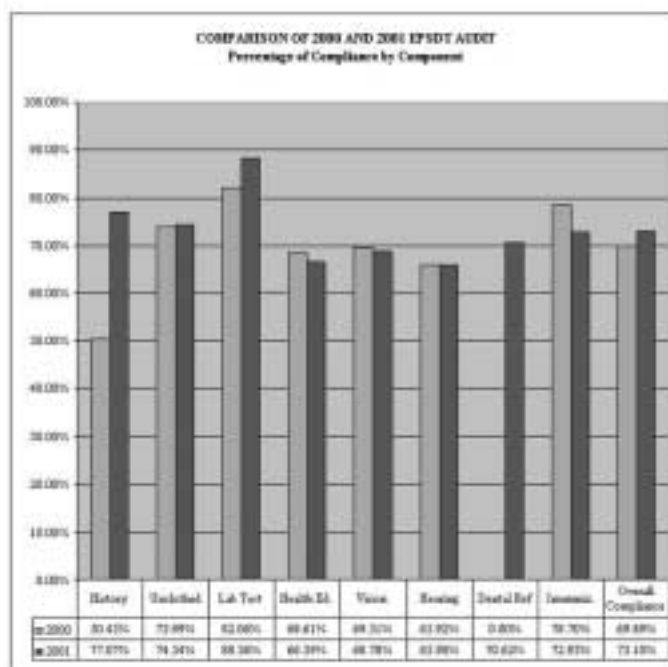
knowledge of what is happening to other pediatricians. SO, PLEASE KEEP ME INFORMED OF THE PROBLEMS YOU ARE SEEING AND THE SOLUTIONS YOU THINK WILL WORK. I have used the analogy of the blind men describing the elephant ever since I began to deal with TennCare, and that analogy holds more true than ever with the state now divided into regional MCOs. There is no reason to have a representative on this committee (or for me to spend my time as this representative), unless we can solve some of these problems by being on it. As always, I appreciate your help with this; please keep me informed of your problems with TennCare. I am hopeful we can use this committee for input about and solutions to the chronic problems of the past 8 years.



TennCare EPSDT Audit Results

TennCare conducted physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per physician site were audited (compared to 8 charts per physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).

TennCare conducted Physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per Physician site were audited (compared to 8 charts per Physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).



Vaccine Shortage

Jerry Narramore,
Immunization Program Director, TN Dept of Health
615-532-8517

The national shortage of many of the routine childhood vaccines is expected to continue into at least the summer of 2002, with some vaccines being in short supply until the fall. The shortages, brought on by a combination of events, have placed many providers in the position of deferring doses and having patients in for multiple visits. There are now shortages, or significant delays in shipping, associated with the following vaccines: DTaP, Td, DT, Conjugated Pneumococcal vaccine, MMR, and Varicella vaccine. The shortages and delays are affecting both the private and publicly purchased vaccine systems. Based on information provided to the Immunization Program and CDC, we are able to make some estimates regarding when the supply situation will return to a more normal state. The individual vaccines are discussed below. Where applicable any restrictions put in place on the use of VFC vaccines are included.

The shortage of DTaP and Td has been an ongoing problem for over a year. Wyeth-Lederle's abrupt withdrawal from the market started the problem. In 2001, Aventis decreased production of DTaP as they transitioned to a thimerosal-free product. Aventis reduced the amount of vaccine they are shipping to physicians and temporarily suspended sales off the CDC contract. This was especially significant in Tennessee as approximately 60% of infants and children in the state are immunized with publicly purchased vaccines. The supply of DTaP, Td, and DT will be significantly improved by late spring or early summer. Smith-Kline continues to supply virtually all the publicly purchased DTaP and is working with CDC and the states to avoid distribution inequities. Aventis is increasing their production of DTaP (Tripedia) and has petitioned the FDA to allow use of the DTaP product the company distributes in Canada. If all goes as expected, DTaP vaccine would be available at normal or near normal levels by late spring or early summer. Aventis will begin allowing routine vaccine purchases through the CDC (VFC) contract, in the summer. The VFC program has restricted use of the VFC vaccine to primary doses only for both private and public providers.

The MMR vaccine is in short supply due to Merck's voluntary interruptions of production in the fall of 2001. These stoppages were partly a response to issues raised by the FDA and partly the

result of scheduled modifications to their facility. This information was not communicated to CDC for several weeks after the stoppage. To help address the shortfall of MMR vaccine, the CDC loaned Merck 700,000 doses from the national emergency stockpile. Merck states they are now filling orders for MMR, but it is taking approximately 60 days for vaccine to be delivered. Delivery of MMR is expected to return to normal by the summer of this year. The VFC Program will restrict the use of program-supplied MMR vaccine to the first dose only for private and public providers effective in mid-February.

The situation with varicella vaccine has not been clarified, and significant delays are expected at least into the summer. Varicella vaccine orders take 60 days or more to be shipped. Representatives of Merck are evaluating their production and shipping capacity for varicella vaccine. At this time, there are no restrictions on the use of VFC purchased vaccine.

The demand for the conjugated S. Pneumonia vaccine (Pneumovax) has completely outstripped production forcing most physicians and clinics to limit the number of doses children receive. Wyeth is attempting to increase production and expects to be able to supply sufficient vaccine to return to the routine schedule in the spring or summer. The requirement for Pneumovax for day care attendance was suspended and will not be put into effect until January 1, 2003. The VFC program has restricted the use of program supplied vaccine to two doses for children under age 12 months. Children with high-risk medical conditions can continue to receive four doses of the vaccine.

HIB vaccine is generally available, especially the four dose vaccines (ActHIB and HIBTITER). Hepatitis B vaccine supplies are adequate, although the choice of brands may be limited. IPV vaccine is available without any restrictions. DT vaccine is available through local health departments. Td vaccine usage is indicated for wound management and for people who have never had a primary series of tetanus containing vaccine. This shortage is expected to abate by late spring or early summer.

2002 Calendar

Jun 21-23	FL-AAP Annual Meeting	Lake Buena Vista, FL
Sep 13-14	TNAAP Annual Meeting Open Forum	Knoxville
Sep 14	TNAAP Board Meeting	Knoxville
Sep 14	TNAAP Awards Dinner	Knoxville

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

The Voice of a Pediatrician

Alison Asaro, MD and Buddy Creech, MD
Pediatric Residents, Vanderbilt Children's Hospital

Although we do not always realize it, we, as pediatricians, are trained to be child advocates. For many of us, this role is achieved in the office setting where we may encourage parents to stop smoking or provide better nutrition for their children. This role, however, can extend far beyond the office environment.

As part of our residency program at Vanderbilt Children's Hospital, we had the pleasure of spending February with Catherine Fenner, the Executive Director of the Tennessee Chapter of the AAP. Since the state legislature was in full swing, most of our time was spent investigating and commenting on bills that would affect the children of Tennessee. We were humbled at the response that legislators and lobbyists gave us, as they actively sought our opinions regarding medically-oriented bills and wanted us to work with them to draft legislation that was more effective and more child-friendly. As a result, we found that one or two voices really do make a difference. An example of this was a bill which would allow trained teachers to administer glucagon to diabetic students in the event of profound hypoglycemia. Without our input regarding the dangers of hypoglycemia in diabetic children and the ease of glucagon administration by trained persons, the legislators were prepared to vote on something they knew nothing about. We



2001 Legislator of the Year, Rep. Kim McMillan, with TNAAP Executive Director Cathy Fenner (left) and pediatric resident legislative interns, Dr. Alison Asaro and Dr. Buddy Creech (right).

we were also able to work on issues such as vision screening, child-care ratios, and TennCare.

We encourage you, as we were by Cathy, to realize your full potential as child advocates, particularly within state and local government. Please use your voice to support the well-being of Tennessee's children and pediatricians.

THE NEWBORN OFFICE VISIT - How to Code

Joel F. Bradley, MD, FAAP, CPT Coding Advisor
(w) 615-936-6053

Many pediatricians now follow the AAP recommendation given in this year's preventive medicine guidelines (found on the AAP website under Policies) to see all breastfeeding babies within 2-3 days of discharge. This, coupled with the existing recommendation to see all babies back by 48 hours who had an early discharge from the nursery, creates a need to know how to properly code for these visits.

TennCare- These visits, if comprehensive in nature, are coded just like the subsequent well baby visits at two weeks and two months - a 99391 (established patient, 0-1 year of age) or 99381 (new patient, 0-1 year of age). These are then counted as an EPSDT visit, and as discussed on page 8 are usually reimbursed at a higher rate than routine problem-oriented office visits (i.e., 99213 etc). Even though most of these visits will be comprehensive in nature, if a patient is seen for a problem or illness only, use the office visit outpatient codes letting the level of history, physical, and medical decision-making decide the code level, not the age.

Private Payers- Coding should be as stated above, although some plans have not yet incorporated these visits into their schedule of preventive medicine benefits, and unlike the TennCare MCO's, may limit the total number of well visits in the first year. If one decides to code this visit as an office visit, usually in order to be reimbursed, a diagnosis code that is not a V code will need to be used (i.e., 99214 linked to a code for jaundice-774.6). If one uses the preventive medicine code, then the V codes are appropriate.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN



This Year's National AAP "Outstanding Large Chapter"

Tennessee Chapter
P.O. Box 159201
Nashville, TN 37215

PRSRT STD
U.S. POSTAGE
PAID

Nashville, TN
Permit No. 2539