

# the Tennessee Pediatrician

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TENNESSEE PEDIATRIC SOCIETY

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## A Month on the Hill: the Ducklings' Perspective

Pilar Levy, MD, Melanie McGraw, MD,  
and Kristin VanHook, MD\*

"Advocacy rotation." Sounded interesting, and it would mean a month working outside the hospital. Needless to say, we were sold, but little did we know this would be an experience that would completely change the way we looked at our role in the community as pediatricians.

As we followed Cathy around Legislative Plaza on our first day, many questions came to our minds. What is this place? Will we ever find our way around here alone? We were overwhelmed by the crowded hallways, the fast-paced search for committee calendars and the introductions to senators, representatives and lobbyists. Cathy did a great job getting us to understand what was going on, and more important, what our role was going to be throughout the month. In just a couple of days, we felt comfortable in our new environment, and we were now a part of the lobbying team for some very important bills. Our team became very popular on the Hill, as we became known as Cathy's ducklings amongst lobbyists and legislators alike, always flocking behind her in an effort to keep up. I guess we certainly stood out, because we also had our own cameraperson following us around as part of a Learning Channel documentary on the life of a resident. That certainly opened some doors for us!

Our biggest lobbying effort during the month was the car seat safety bill, the purpose of which was to define clearer limits on weight and height for the restraining systems for children. Passing a bill whose only purpose was to protect children would seem an easy objective to accomplish, but we soon learned that lawmaking is not a simple process. First, we had to speak with senators about our bill and try to gain their support.

After that, we met with lobbyists representing other interest groups and compromised on certain aspects of the bill in order to avoid opposition. Finally, our



Vanderbilt pediatric residents (l-r) Pilar Levy, MD, Kristin VanHook, MD and Melanie McGraw, MD each spent a month at the state legislature with TNAAP Executive Director Cathy Fenner.

bill was presented in the Senate Transportation Committee. At this time, we heard the different points of view of the senators, and listened to their suggestions to make a bill that would be more fair and easier for their constituents to comply with. Because of the lack of consensus, the bill was rolled to be heard at a later date; so even after a month of time invested, we were not able to see the bill meet a success. The process seemed very frustrating at times, especially for us who had no previous experience in this arena. It was an eye-opening experience, without a doubt. It taught us that in order to be a true child advocate, being involved in and aware of the legislative process is of utmost importance. *Continued on page 4...*

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## President's Report

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I am trying to write this column on Father's Day, late for the editors once again and more blocked than usual in identifying something that I really want to say to you. Father's Day has become much less of a "Hallmark Holiday" for me since the death of my father two years ago, and I find myself thinking today of his hopes for me, my hopes for my children, and how my life as a pediatrician is intertwined with those two considerations.

Toward the end of my second year in medical school, I was required to choose a "track", i.e. a specialty-oriented group of courses, complete with an advisor, which would guide the remainder of my studies at the "Big State U". I recall that there were probably eight tracks from which I could choose and, with the exception of the MD-PhD track, there was so much overlap that it actually didn't make much difference what choice I made. After great deliberation, I chose "Pediatrics". (It is one of the choices I have made in my life that has made better sense with the passage of time, but that's another story.) I told my Dad what I had chosen to do, and he received this news with delight; having no medical background of his own, I am certain that he was just delighted I was moving along with the process of becoming a physician, a goal he enthusiastically supported. A few days later, however, he approached me, the son and grandson of bankers, with a long face and asked me whether I had seriously considered the economic ramifications of my choice. I assured him that such matters were of no importance to me whatsoever and that any financial constraints I might encounter as a consequence of my career choice were insignificant compared to the rewards of caring for children. Dad told me later that it was then he began to think of me as "the most downwardly mobile person I know."

What is the point of this reminiscence? I need to make sense of what we do professionally, in order to understand how and why we should continue to do it. It is clearly not about the money. The age of the physician entrepreneur has, blessedly, drawn to an end and, one might argue, it never really began for the pediatrician. It seems not to be about professional regard, either. Our physician colleagues, indeed, our society as a whole, continue to focus their attentions elsewhere; witness our difficulties in establishing a common pediatric formulary or reference the last television program you saw featuring a "real pediatrician", not George Clooney on "ER" opening a child's chest. I think the point lies in our mission statement, where we pledge our professional actions to realize the full growth and developmental potential of every child.

It is no longer sufficient for us "merely" to practice good medicine. In many ways, our ability to practice "good medicine" for our individual patients is determined by larger societal issues: access to quality care; injuries and violence; poverty and poor education. The Tennessee pediatrician of the third millennium must engage in the political process writ broadly, a process that extends far beyond the partisan arena of state government. Dr. Harvey Fineberg, the president of the Institute of Medicine, identified healthcare providers as having a particular responsibility to educate their fellow citizens as to what needs to be done. Pediatricians, given their traditional expertise as educators and their recognizably altruistic commitment to the common good, have a crucial role to play in awakening society's interest in the future of their children, an interest that I simply must believe is present in all of us

**Continued on page 3...**

## More Exciting Expansion of the Chapter to Report!



**Executive Director's Report**  
**Catherine M. Fenner**  
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I am thrilled to report two wonderful advancements for TNAAP and one huge legislative success. First, a report on two initiatives that have been a year in coming to fruition.

Most exciting, the Charter and Bylaws and all other necessary paperwork

have been filed with the IRS to create our 501(c)(3) arm called the Tennessee Pediatric Society Foundation. TNAAP will remain a 501(c)(6) tax entity for its professional membership and lobbying capabilities, while our new Foundation will allow us to apply for more grant opportunities to fund statewide programs ranging from asthma education, dental health, injury prevention-- you name it. The monies are out there, and this Foundation will give us the tax status to acquire them. Our Program Director, Patrice Mayo-Ligon, will oversee the Foundation. TNAAP will "parent" the Foundation, but the two will be separate corporate entities with separate Boards. Look for a plea for donations in the mail soon, since contributions to the Foundation are tax-deductible, and we will require "seed money" to start the process of identifying grant opportunities and matching them with the advocacy interests of our members.

### ***President's Report, continued from page 2...***

and only awaits development. Resources are available at the state and the national Academy level to help us with this work; the FAAN and the LKCC represent two good places to start.

Robert Bolt, in his play, "A Man for All Seasons", presents a fictional conversation in which Sir Thomas More encourages a fellow citizen, Richard Rich, to become a teacher, in the interests of the common good:

More Why not be a teacher?  
Rich And if I was, who would know it?  
More You, your pupils, your friends, God.  
Not a bad public, that.

I think my Dad and my sons understand and appreciate the work.

Personally exciting to me is the addition of our 5th staff person. Albeit very part-time initially, Cathy Jolley of Nashville is our new Financial Manager. Our finances have become more time-consuming going from one staffer to four (now five) in the last two years, along with the addition of our EPSDT contract with the TennCare Bureau. Our financial structure will become even more complex with the Foundation in place, as every penny must be kept separate between each grant we acquire and time spent on TNAAP versus Foundation labor. Cathy is going to be a huge help to me, especially as we move to more sophisticated accounting software to handle our new complex nature.

Finally, Tennessee passed one of the most strict child car seat laws in the country this year. This bill was spearheaded by Vanderbilt Children's Hospital and successfully passed with the combined efforts of TNAAP, the Comprehensive Regional Pediatric Centers, the Departments of Health, Safety, and Human Services, the American Automobile Association, and the Rural Health Association. It took four months to do it, but now we have on the books a law that mandates children up through age 8 sit in the back seat (if available) and use some sort of child restraint system. The law does not go into effect until July 1, 2004, in order to allow time to educate parents. For more details on this and the many other pieces of legislation we were following throughout the 2003 legislative session, please access my full report on our website at [www.tnaap.org](http://www.tnaap.org), or contact me if you require it to be mailed or faxed.

While on our website, please be sure to check out our Annual Chapter Report for FY03. This report, submitted annually to the national AAP at the end of our fiscal year (June 30) is a condensed compilation of all activities conducted by the Chapter over the course of the year. It's a great way to see where your dues are going and how children and pediatricians in the state are actually benefiting!

You should have received your dues billing statement for FY 04 last month (if not, please let me know). Thank you in advance for continuing your support of our work!



TNAAP members Marty Herman, MD (left) and Steve Riley, MD (right) with state Representative Rob Briley, House sponsor of the child restraint bill. Drs. Herman and Riley shadowed Fenner on the Hill for a day.

## Clarification of Requirements for HBV and Menomune for College Students

Message from Jerry Narramore  
Director of Immunizations, State of TN

The legislature passed this session two laws regarding hepatitis b vaccine and meningococcal vaccine for college students. The laws do not mandate students have the vaccines. The requirements are:

All newly enrolled students will be provided information about Hepatitis b and the vaccine. The student will then decide whether or not to get the vaccine and sign a form documenting their decision. This form will be kept in the student's record. The college will supply the form to document this decision.

All newly enrolled students who will be living in on-campus housing will be provided information about meningococcal disease and the vaccine. The student will then decide whether or not to get the vaccine and sign a form documenting their decision. This form will be kept in the student's record. The college will supply the form to document this decision.

The law does not mandate that either the health department or the college has to provide either vaccine. Further, the law in its final form does not require any action regarding Hepatitis A vaccine.

### *A Month on the Hill, continued from page 1...*

We greatly enjoyed and felt very proud representing the TNAAP and the children of Tennessee during our short time in the legislature. We hope that in the near future, more residents—and practicing pediatricians—can participate in such an enlightening experience. Cathy was a great and enthusiastic guide through the whole month. After seeing her in action, we know that the rights of our children are being safeguarded and fought for by a very passionate and professional individual. We await the day we finish our training so that we may commit ourselves to a more politically active role in our communities and become faithful advocates for our children.

*\*Drs. Levy, McGraw, and VanHook, along with Dr. Jennifer Roy are pediatric residents at Vanderbilt who each spent a month with Fenner at the state legislature in order to fulfill their advocacy requirement.*



*TNAAP strategizes with coalition partners at Legislative Plaza on the child restraint bill. L-R: Gary Zelizer from the Dept of Health; pediatric residents Melanie McGraw, MD, Kristin VanHook, MD, and Pilar Levy, MD; and Rhonda Phillippi from Vanderbilt's Injury Prevention Program.*

## WANTED

### Program Committee Members

The Chapter's Program Committee is seeking TNAAP members who would like to be active in program development, assessment and execution. The Chapter's educational, and entertainment programs often require the Program Committee's organizational, fund seeking, and networking skills. If you are interested in learning more about and/or being a member of the Program Committee, please contact Program Chair, Bob Lembersky, MD at rlembersky@pol.net.

## Future Changes in this Newsletter? You tell us

As you may have noticed, this newsletter is a compilation of spring and summer events and news. While there has been much to report since the fall edition, the time and funds needed to produce this publication seem fewer and more difficult to find, not to mention the timeliness of the news after it works its way through the 4-6 week long publication and distribution process. During the Board's annual planning retreat in April, a number of options were discussed: continuing 3-4 editions per year, but having more advertisements throughout, cutting back on the number of newsletters per year to one or two, posting it only on our website, or even moving altogether to more frequent 1-2 page "blast faxes" (with no photos). Naturally, we are very interested in what our members would prefer. Please email, call, or write to the Chapter office with your feedback. PO Box 159201, Nashville 37215, 615-383-6004, tnaap@aol.com.

## DCS Scheduling EPSDT Exams at Health Departments

The Department of Children's Services (DCS) case managers began scheduling all Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings for children in state custody with local health departments in June of this year. This decision was made by the Administration in a continuing effort to comply with federal EPSDT guidelines and John B. Consent Decree requirements.

TNAAP leaders and staff were taken aback by this decision and have expressed our deepest concern. We have explained at length how this is a further degradation of the medical home concept and how it will lower the level of care to one of our most medically vulnerable groups of children. Our concerns have been expressed to multiple TennCare officials, the special master appointed by the court, and the Commissioner of Finance and Administration. It appears this decision was made to help improve DCS "numbers". We have been repeatedly assured that ***this policy does not preclude the primary care practitioner from performing and receiving payment for preventive visits or any other type of office visit.***

As we go to print we continue to be in dialogue with the state about the possibility of reversing this decision. The following information, provided by the Best Practice Network (BPN), explains how PCPs will be notified about these exams and where to direct any questions.

When the health department completes any portion of an EPSDT screening, a one-page form letter is completed and forwarded to the DCS case manager and the child's assigned primary care practitioner (PCP). The letter documents which screens were completed and notes any needed follow-up care. When the need for additional services is determined, the child is referred to his/her assigned PCP for those services.

The State of Tennessee Department of Children's Services Administrative Policies and Procedures: 20A.7 reflecting this change can be viewed from the State of Tennessee's Web site at: [www.state.tn.us/youth/policies/chapter20A.htm](http://www.state.tn.us/youth/policies/chapter20A.htm). Again, this policy does not preclude the primary care practitioner from performing and receiving payment for preventive visits or any other type of office visit. Questions regarding this change may be directed to the Best Practice Network Unit at 1-800-451-9147 Monday through Friday, 8 a.m. to 6 p.m. EST.

If you do not receive timely reports on EPSDT screens conducted at Health Departments, please contact TNAAP's EPSDT Director, Ruth Allen, at 865-927-3030.

## HIPAA Call Center

The Office of Civil Rights (OCR) has a toll free number for callers with questions about the HIPAA privacy rule. The number, 866-627-7748, is staffed by a call center. If the staff cannot answer the question, it is sent to OCR where someone will respond within two days.

## Implementation Team Assist At Risk TennCare Children Accessing Mental Health Services

One aspect of John B. law suit concerning EPSDT services for children involved plaintiff concerns that there were TennCare-covered children entering state custody because they could not access appropriate behavioral/mental health services.

The State created an Implementation Team (IT) to review cases in which the TennCare behavioral health organization (BHO) has placed a child at risk by denying or delaying a provider requested mental health service. After receiving a referral, the IT gathers clinical/social data by interacting with those involved in the child's case. This might include family, providers, court, DCS, schools, advocates, etc. The IT then attempts to liaison with BHO to secure appropriate services in the least restrictive environment that is acceptable to family and provider. If the IT is not able to arrange services by negotiation with the BHO, it has the authority to issue an authorization letter to provider guaranteeing payment for the requested service.

A primary care physician who has a TennCare patient placed at risk due to BHO denial of behavioral or mental health services can contact the IT by calling toll free 877-580-6896.

## 2003 Calendar

Aug 16, 2003	TNAAP Board Meeting* Nashville
Sept 12-13, 2003	TNAAP and CECA Conference: "Advancing the Frontiers of Pediatric Emergency Care in TN" Memphis
Nov 15, 2003	TNAAP Awards Presentation and CME Meeting: "Common Pediatric Heart Defects" Nashville
Nov 16, 2003	TNAAP Board Meeting* Nashville

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

# TennCare Committee Report

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**D**uring the past six weeks, the Chapter has begun to make some advances in working with the present administration on TennCare. This began with a meeting with the Special Master during our spring strategic planning retreat in which we had a lengthy discussion about TennCare and his view of his duties. While the role of the Special Master was initially described as one to affect major changes in TennCare, his current duties focus on measuring what has been done to date in order to place the state in compliance with federal EPSDT rules.

The TennCare Committee met with the new Commissioner of Finance & Administration, Dave Goetz, to discuss our viewpoint on TennCare, our perceptions of the problems, and our suggested solutions to them. We found him to be very knowledgeable about TennCare and willing to listen to our input. We were assured TNAAP would have a representative on the TennCare Pharmacy Committee, and this was confirmed when the legislature passed the bill authorizing this Committee. We left him with the following list of suggestions.

1. Single MCO for all Medicaid population children under 19. Do this as fee-for-service with the exception of a few large urban groups. Assign all children to a Pediatric or Family Practice group as their medical home.
2. Determine how many of the total children on TennCare are Medicaid eligible at present percentage of poverty levels. Most of us feel that a significant number who are not on TennCare under the Medicaid eligibility category probably should be.
3. Develop a single Formulary with a Preferred Drug List that includes medicines that are appropriate for children.
4. Reinvestigate SCHIP as a source of funds for children coming onto TennCare when federal funds start dwindling next year.
5. Renegotiate EPSDT. The present agreed to numbers are impossible to do based on the numbers of practitioners in this state who are qualified to do these. The present practice of having the Health Department do them "willy-nilly" is only adding to the cost.
6. Continue to develop the Centers of Excellence concept.

7. Work with the Pediatric subspecialists to have a few specific codes for each subspecialty for which they get a reimbursement on par with their private insurers. Pay TennCare rates for the rest. By allowing this increased payment of those codes, it should increase provider participation.
8. Make TennCare data available to non-TennCare Bureau M.D./researchers for unbiased Quality Improvement research
9. Continue BlueCare's practice of "no referral needed" when referring to in-network providers.

The general feeling of our Committee was that this administration is knowledgeable about TennCare and its problems and is willing to look at suggested solutions, including ours. Commissioner Goetz stated unequivocally that if the state cannot find a way for TennCare to work this year (both for the state and those it covers), it will be done away with, probably to be replaced by a Medicaid program.

The state closed both Xantus and Universal MCOs leaving TennCare Select as the only MCO in middle Tennessee. This, in effect, puts Blue Cross in charge of administering the care to well over half the people on TennCare again. While TennCare Select pays less than the other TennCare plans, Blue Cross does have the ability to handle claims and pay them promptly (something that neither of the other two MCOs were able to do). In a discussion that I had with Manny Martins, TennCare Bureau Chief, when the closure of Universal was announced, he indicated that there would be an increase in reimbursement for TennCare Select providers but did not say when. Universal is suing the state to rescind the closure of the company. According to the Medical Director of Universal, they are suing to regain control of the company in order to get the federal money that they can then pay to providers and make up the 10 million dollar loss of their owner.

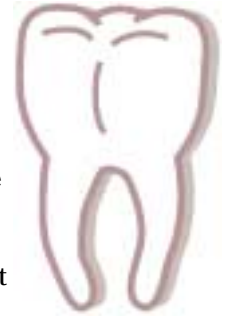
On a positive note, the Chapter was informed that our contract to help with EPSDT was approved for another year, including the services of Jacque Clouse, our Coding Educator. Please make use of her expertise, I found it to be VERY helpful when she came to my office. A few things that I do, I simply have not charged for, since I have found no way to code for them. She was able to help me find the appropriate codes; now we will see if I get paid for them!

# Dental Disease——A Pediatric Silent Epidemic

George A. Adams, DDS, MSD, President, Tennessee Society of Pediatric Dentists

*"What amounts to a silent epidemic of dental and oral diseases is affecting some population groups. This burden of disease restricts activities in schools, work, and home, and often significantly diminishes the quality of life."*

Surgeon General David Satcher, Ph.D., M.D.



## Oral Health

- 18% of 2-4 year olds have visually evident cavities
- Profound disparities exist in U.S. children's oral health
- 25% of children have 80% of the disease
- Lowest-income groups have 4-5X the levels of untreated disease
- Despite tremendous declines in childhood cavities, tooth decay remains the single most common chronic disease of childhood.
- By ages 6-8 years, 52% of U.S. children have experienced tooth decay—making it 5-8X more common than asthma, which is often cited as the most common chronic condition of childhood (Source: NHANES III, 1988-94)
- More than 80% of the adolescent population is affected by age 17.

## Oral Health and Learning

- Early tooth loss caused by dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem.
- Students ages 5 to 17 years missed 1,611,000 school days in 1996 due to acute dental problems—an average of 3.1 days per 100 students.
- Children from families with low incomes had nearly 12 times as many restricted-activity days (e.g., days of missed school) because of dental problems as did children from families with higher incomes.

## Guideline on Infant Oral Health Care

- The infant oral health care visit should be seen as the foundation on which a lifetime of preventive education and dental care can be built to help assure optimal oral health into childhood.
- Oral examination, anticipatory guidance including preventive education and appropriate therapeutic intervention for the infant can enhance the opportunity for a lifetime of freedom from preventable oral disease.
- At the infant oral evaluation visit, the dentist should:
  1. Record a thorough dental and medical history covering the prenatal, perinatal and postnatal periods

2. Complete a thorough oral examination
3. Assess the patient's risk of developing oral and dental disease and determine an appropriate prevention plan and interval for periodic reevaluation based on that assessment
4. Discuss and provide anticipatory guidance regarding dental and oral development, fluoride status, non-nutritive oral habits, injury prevention, oral hygiene and effects of diet on the dentition

## Definition and Scope of Pediatric Dentistry

Pediatric dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence including those with special health care needs.

To become a pediatric dental specialist, a dentist must satisfactorily complete a minimum of 24 months in an advanced education program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA). Such programs "must be designed to provide special knowledge and skills beyond the DDS or DMD training . . ." The curriculum of an advanced program provides the dentist with necessary didactic background and clinical experiences to provide comprehensive primary oral health care and the services of a specialist. Pediatric dentists provide care, conduct research and teach in a variety of clinical and institutional settings, including private practice and public health. We work in coordination with other health care providers and members of social disciplines for the benefit of children.

Speaking as a pediatric dentist who has practiced in Nashville for the past twenty-six years, I see dental disease on a daily basis that rivals what I saw coming out of the jungles of Vietnam in 1975. As the above information indicates, these children are being robbed of the chance to succeed in school and ultimately life. The only solution to this silent epidemic is prevention through early examinations and appropriate counseling and treatment. Pediatric dentists working together with pediatricians can significantly reduce dental disease. Our patients deserve our best efforts regarding optimal oral health for all children.

# Coding Clues

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## USEFUL V CODES

### V codes for Well Exams

- V70.5 Employment Exam
- V70.3 Sports Exam
- V20.2 Well Infant/Child
- V70.0 Well Exam Young Adult  
18+ years

### V codes for Other Services

- V40.3 Behavior Problems
- V50.2 Circumcision
- V65.1 Conference with Parent
- V65.5 Feared Illness/None Found
- V67.9 Follow up Exam
- V40.0 Learning Problems
- V72.84 Preoperative Exam
- V58.3 Suture Removal



## REMOVAL OF IMPACTED CERUMEN

ICD-9-CM	CPT
380.4	69210

If the insurance company has been denying reimbursement for an office visit and cerumen removal on the same date of service, the denial is in contrast to the explicit language of the CPT manual on this issue. Cerumen removal is a separate procedure and can be coded in addition to an office visit. Use a modifier -25 with the E/M visit code in this case with the office visit code to alert the insurance company that a separate service was provided. In addition, a diagnosis code of 380.4, impacted cerumen, should be included to support (link) the CPT procedure code of 69210.

Note: In general, the quick removal of a small amount of wax from an ear canal, to aid in the examination of the ear, would not ordinarily be coded as removal of impacted cerumen. Also if attempts were made for cerumen removal, without success, again it would not ordinarily be coded as removal of impacted cerumen.

## AEROSOL TREATMENT (94640) AND AEROSOL/INHALER INSTRUCTION (94664) AND OTHER SCREENING/TESTING CODES

- 94060** Is used to report spirometric evaluation of bronchospasm, before or after bronchodilator therapy or exercise.
- 94010** Graphic record and measurement of vital capacity and expiratory flow rates.

- 94150** Vital capacity screening test
- 94014** Is used to report patient-initiated spirometry to include recording and physician review and interpretation. This code covers 30 days of recording and review.
- 94015/94016** Is used if the two components need to be separated to identify the elements of recording only and physician review and interpretation, respectively.
- 94760-94762** Peak expiratory flow rate is part of PFT and not separately reimbursable, it is considered part of the E/M service. Pulse oximetry (94760-94762) is now bundled in to the E/M service and is not paid separately. If doing a pulse ox (94760-94762) and nothing else, it can be reported and paid for the procedure only.
- 94640** Is used to report a patient receiving a "neb" as treatment for wheezing or other obstructive respiratory conditions and bill the number of "units" if more than one treatment is needed for response.
- 94664** Is used to report the time needed for the teaching or "initial demonstration."
- 94665** Is used if the same patient requires another treatment and additional teaching. If no further teaching is needed, but other nebs are needed prior to the patient being safe for returning home, the physician can use the 94664 for the first treatment when the teaching was done, and use the 94640 for the other treatments.

## REPAIR (CLOSURE) SKIN

- 12001-13160** Are used to report wound closure utilizing sutures, staples, or tissue adhesives either singly or in combination with each other, or in combination with adhesive strips. Wound closure utilizing adhesive strips, as the sole repair material should be coded using the appropriate E/M code.

## Welcome New Members

Daniel Rudolph Duzan, MD	Newbern
Chris M. Frost, MD	Memphis
Matthew Williamson Good, MD	Chattanooga
Brinders Jones, MD	Memphis
Nehali D. Patel, MD	Memphis
Sarah R. S. Stender, MD	Memphis
Julia Whitefield, MD	Signal Mountain
Diane L. Woodall, MD	Memphis

# WELCOME!!!

## New AAP Guidelines for Vitamin D Intake

Elizabeth M. Andrew, MD, FAAP, Chair,  
TNAAP Healthy Lifestyle Committee  
Memphis, 901-795-9193

Many of you are probably already aware of the recent AAP (Section on Breastfeeding and Committee on Nutrition) recommendations for vitamin D intake, published in the April 2003 issue of PEDIATRICS. In brief, it is now recommended that by the age of two months, all infants and children receive at least 200 IU of vitamin D daily, either from food or vitamin supplementation. Reliance on sun exposure to attain adequate vitamin D nutrition is no longer considered appropriate, given several factors including:

- (1) increased risk of skin cancer in children exposed at an early age to direct sunlight;
- (2) decreased vitamin D production in skin protected by sunscreen or of darker pigmentation; and
- (3) possible decreased sunlight exposure secondary to environmental factors, lifestyle or cultural practices.

Practically speaking, 200 IU of vitamin D can be obtained from taking in 500 ml (approximately 17 ounces) per day of vitamin D-fortified formula or milk. Alternatively, vitamin supplements can be used.

These recommendations were formulated in response to reports of children developing nutritional rickets in the United States. This certainly has been the case in West Tennessee where my colleagues and I have seen a number of children with nutritional rickets. Most are infants or toddlers with darker skin pigmentation who have been breastfed or who do not ingest dairy products. Some present with bowed legs, others with failure to thrive or anemia or incidentally when X-rays are done during an acute illness. One infant required ICU admission for heart failure. Even after treatment, lower extremity bowing can persist.

*\*Formed in 2003, the TNAAP Healthy Lifestyle Committee has embraced as its mission the promotion of "optimal nutritional status and physical fitness of the infants, children and adolescents of the state of Tennessee, addressing specific issues related to undernutrition, overnutrition and physical activity."*

## "Medical Passports" are Back in Circulation

The Tennessee Department of Health has re-ordered the blue "medical passports" for use as a portable record of documentation of immunizations and other health services. Plastic sleeves for carrying the passports are also available. The information on the front includes the primary care physician and a place to document EPSDT screens. The back provides a record of immunizations.

To order a (free) supply of the forms and plastic covers, please contact: Jenny Bilbro at: jenny.bilbro@state.tn.us or call her at 615-532-8511.

## Special Thanks to the Sponsors of the Pediatric Practice Managers' Network Meeting May 9, 2003

**Gold Level:** GlaxoSmithKline, Inc.

**Silver Level:** LeBonheur Children's Medical Center  
MedImmune, Inc.\*

**Bronze Level:** Cumberland Heights  
ProAssurance, Inc.

\* Also thanks for Medimmune's generous support of the Board's Annual Planning Retreat in April, held at Montgomery Bell State



*Lunch roundtables at our 3rd Pediatric Practice Managers' Network meeting, held in Franklin in May.*

## Free Fax Back Service

The CMS Southern Consortium's Achieving Compliance Together Team has developed a HIPAA resource in an effort to reach those without internet/email access! Have your fax number handy and call this number: 800-874-5894

Select Option 1 for the starter set: HIPAA information, resources, and transactions checklist, then follow the prompts. It's that easy! Other documents are also available (for example, information on Medicare's free billing software and a HIPAA glossary).

If you have questions or need additional information, contact Ruth Allen, TNAAP's EPSDT Director, at 865-927-3030.

# TNAAP Staff Hit the Road:

Ruth and Jacque bring EPSDT and Coding Education to our Members' Doorsteps



*Dr. James Hanley of Lebanon works with Jean McIver*

*of TennCare during a collaborative feedback session regarding the TennCare EPSDT audit process.*



*Families enjoy the children's puppeteer at the Chattanooga Pediatric Society Picnic. TNAAP staff also gave a presentation on pediatric coding.*



*Dr. Tom Voychekovski kicks up his heels at the Chattanooga Pediatric*

*Society Picnic prior to the EPSDT and Coding training session.*



*Dr. Mark Gaylord addresses the Knoxville Pediatric Society*

*over dinner at the Maple Grove Inn in Knoxville. TNAAP staffmembers also attended to discuss statewide Chapter initiatives.*



*UT Knoxville residents receive an update from TNAAP EPSDT Director, Ruth Allen.*



*TNAAP staff discusses EPSDT mock audit results with pediatricians at East TN State University.*

**Continued on page 11...**



Staff at Athens Pediatrics welcomed the coding and documentation education offered by TNAAP staff.



Athens Pediatrics participates in an EPSDT and coding "Lunch & Learn" with TNAAP Coding Educator, Jacques Clouse (left).

## Influencing Change, or Simply Rolling with the Punches?

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

**T**he agenda of the national AAP continues to change almost from day to day. Pediatricians are in control of some of this agenda, but are just doing the best they can to help children, families, and pediatricians survive much of what ends up on our plates. Residency work-hour changes, competency in neonatology, Preferred Drug Lists, vaccine administration CPT codes, recertification, "family pediatrics," mental health, obesity, and the possible need to change the periodicity schedule—these were some of the topics discussed at the recent AAP Districts IV and X Meeting in Louisville, Kentucky.

It appears that residents are adjusting to the work-hour changes but that residency program directors are having difficulty meeting curriculum guidelines and adequately staffing acute care units. Neonatologists are convinced that the quality of neonatal stabilization in rural hospitals is declining because many of today's residents do not master and maintain NICU competencies. District IV will submit a resolution to the upcoming Annual Chapter Forum that asks the AAP to carefully study these issues and to suggest solutions to problems created by the new resident work-hour guidelines.

Steve Edwards, M.D., F.A.A.P., AAP President, and Carden Johnston, M.D., F.A.A.P., AAP Vice President, attended the District Meeting and updated us on the progress being made to establish a separate CPT code for pediatric vaccine administration. This could increase the Medicare payment for vaccine administration to around \$14.00, from the \$3.98 figure that was implemented last year when the federal government decided there was a "zero" physician Relative Value Unit for the Medicare vaccine administration code; and, although this is a Medicare code, it will be filtered down to Medicaid and private insurance plans. It seems that federal government administrators cannot understand that there is a

difference between giving vaccines to children under the various bureaucracies in place, and giving flu shots to the elderly. Tennessee's Joel Bradley, M.D., F.A.A.P., a speaker for the District Meeting, has been instrumental in AAP efforts to convince the federal government to pay pediatricians fairly for participating in the national effort to immunize all our children.

Paul Miles, M.D., F.A.A.P., Vice President of the American Board of Pediatrics, addressed the District Meeting attendees on the current status of recertification. It appears that all 24 Medical Specialty Boards in the US are requiring proctored exams for recertification, and the Medical Board in Texas has passed a resolution asking the legislature to require all physicians to recertify every 10 years to maintain licensure. This could mean that "grandfathered" pediatricians may have to recertify soon to maintain state medical licensure. Stay tuned.

Ed Schor, M.D., F.A.A.P., Chairperson of the AAP Taskforce on the Family, gave a very thought-provoking presentation on the importance of family support in assuring optimal child growth and development. Look for a Report from the Task Force as a Supplement to the June issue of *Pediatrics*. Dr. Schor alluded to the tremendous volume of mental health problems in children and parents and the effects this epidemic is having on child outcomes. He suggested that the AAP consider revamping the Periodicity Schedule for preventive child health services so that pediatricians are encouraged to address psychosocial issues, and to practice "family pediatrics," from prenatal care to adulthood, during office visits. The AAP Board of Directors will spend a block of time during the October Board Meetings discussing mental health issues in pediatrics.

Needless to say, we practice medicine in challenging times. The AAP is trying its best to serve all children, families, and pediatricians. To be successful, the AAP needs the input and support of all pediatricians. I welcome your comments on any child health topics.

## Call for Nominations of Chapter Officers

The Nominating Committee is conducting its search for candidates to fill the following positions whose terms will begin on January 1, 2004:

- Vice-President (two-year term, followed by two years as President)
- Secretary-Treasurer (two-year term)
- Three Fellows At-Large (one from each of the Grand Divisions, two-year term)
- Nominating Committee member from Middle TN (three-year term)

Anyone 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 5, 2003.

**TNAAP Awards Presentation:**  
**Saturday, November 15, 2003 during lunch of our CME Conference on pediatric heart murmurs. Look for your Conference program in the mail soon or download it from our website ([www.tnaap.org](http://www.tnaap.org)).**

## Obtaining Results of Newborn Metabolic Screens

Some pediatricians have been experiencing difficulty obtaining newborn metabolic screens for children if they were not the pediatrician present at birth. If you have difficulty obtaining these records, you may obtain the lab results on newborn screens directly from the state. To do so, fax a consent form that includes mother's name, infant's name, and date of birth to: 615-262-6458. The state will fax or mail the results to the provider (whichever is preferred). If immediate results are needed, call 615-262-6304.

## 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 15th. Please send your nominations in writing to the Chapter office by September 5, 2003. Include reasons why you think the candidate would be a good recipient for the award. There must 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.

**Check out our two Fall CME conferences on the Calendar!! See our website for more information on both ([www.tnaap.org](http://www.tnaap.org)).**

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