Notes from the Chair

By Carol C. Weitzman, MD, FAAP

Warm greetings to all our section members! We have had a busy 2015-16 and have many accomplishments and activities to share with all of you.

This has been a year of transition for the Section on Developmental and Behavioral Pediatrics (SODBP)! We welcomed 3 wonderful new section members—David O. Childers, Jr from Jacksonville, FL; Jack Levine, from Kew Garden Hills, NY; and Myriam Peralta-Carcelen from Birmingham, AL—who have already rolled up their sleeves and are working hard on many different projects. We also welcomed Michelle Curtin as the liaison from the Section on Pediatric Trainees. Sadly, we bade farewell to 2 executive committee members, Carolyn Bridgemohan and Ed Goldson, who contributed so much to the work of the section but thankfully are continuing work on behalf of the SODBP and the American Academy of Pediatrics (AAP). Michelle Macias, who completed her tenure as immediate past chair of the section, is now serving on the AAP Section Forum Management Committee.

Over the past few years, our section has increasingly focused attention towards advocacy and training section members to support children with developmental-behavioral issues and for the viability of our field in these changing times in medicine. In 2014, we sponsored an Advocacy Day at the AAP Department of Federal Affairs in Washington, DC.

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DC (special thanks to Tamar Magarik Haro and Jamie Poslosky) that was so well received we decided to expand our efforts this year. Through our innovation and collaboration with the Department of Federal Affairs, we became the first section, committee or council in the AAP to have a subspecialty track at the AAP Legislative Conference and sponsored 13 applicants to attend. Our attendees have been busy implementing the advocacy skills that they learned during this intensive conference and we will be highlighting those efforts on our Web site and within this newsletter.

The workforce survey, led by the efforts of Drs. Carolyn Bridgemohan, Nerissa Bauer, Nancy Roizen, Britt Nielsen and Anne Debattista, and a collaboration between the AAP/SODBP and Council on Children With Disabilities (COCWD), the Society for Developmental and Behavioral Pediatrics (SDBP) and the Developmental Behavioral Mental Health Special Interest Group of the National Association of Pediatric Nurse Practitioners, (NAPNAP) has begun to bear fruit. There was a poster showcasing findings at the 2016 Pediatric Academic Societies meeting in Baltimore and there are 2 more at the SDBP annual meeting this fall. For those attending the AAP National Conference, these posters will be on display at the SODBP business meeting.

The section, in collaboration with the COCWD, the Autism Subcommittee, and the Autism Treatment Network Clinical Coordinating Center at Massachusetts General Hospital for Children, sponsored Periodic Survey #93 on developmental and autism screening practices. Initial results of the survey also were presented at the SDBP meeting in September and will be on display at the SODBP business meeting.

The section has become more involved in authoring policy statements and clinical reports. In collaboration with the Committee on the Psychosocial Aspects of Child and Family Health, Dr. George Cohen and I have authored the updated report on Divorce and Separation, which will be published later this year. We are collaborating with the COCWD and the Autism Subcommittee to revise the developmental screening and autism clinical reports and we are also working with Council on Early Childhood on the upcoming report, Evidence-based Interventions to Address Behavioral Problems in Young Children. Ed Goldson was our lead on this report.

As the consequences of Zika virus continues to grip our nation, the AAP has partnered with the Centers for Disease Control and Prevention to understand the potentially devastating developmental and behavioral effects of this virus on children. Section members Timothy Brei, Susan Hyman, Michael Msall, Georgina Peacock, Sydney Rice, and Susan Wiley were participants at this initial meeting.

Education remains an important priority of our section. We continue to co-sponsor, along with the SDBP, the DB:PREP® Board Review Course, which will be held November 30-December 4, 2016 in Anaheim, CA. Registration just opened and will feature many nationally acclaimed speakers that will ensure this is one of the most dynamic DB:PREP® courses to date. Bob Voigt has assembled a great program for the section at the 2016 National Conference on addressing anxiety in children and adolescents. You will certainly not want to miss it or the other wonderful sessions that are sponsored by the section. Michael Reiff, Becky Baum and I are involved in developing new sections of the Mental Health Residency Curriculum that will expand to include modules on attention/impulsivity and low mood/depression.

And of course, Lynn Wegner continues her tireless efforts to improve reimbursement by supporting the AAP Committee on Coding and Nomenclature and advocating for coding and payment efforts to help the field (see more under Coding Conundrums).

Most of all, we want to create new ways to involve section members and to hear from you. We are developing subcommittees so members can get involved in large or small ways.

And let us hear from you! What is important to you? What would you like your section to focus on? Send me an email, say hello to me or other executive committee members at the National Conference, and let us know what is on your mind and ideas for section growth.

Best regards,

Carol Weitzman, MD

Carol.weitzman@yale.edu

About the author:

Carol C. Weitzman, MD, FAAP is a Professor of Pediatrics at the Yale School of Medicine and the Director of Developmental-Behavioral Pediatrics (DBP) there. She directs the fellowship program in DBP at Yale. In addition to serving as the Chair of the SODBp Executive Committee, she is the course director for DB:PREP®, the chair of the SDBP Research Scholars Symposium, and the SDBP Program Committee Co-Chair.
What Do We Do About Contact Sports?  
By Thomas M. Talavage, PhD; Eric A. Nauman, PhD; and Robert E. Hannemann, MD, FAAP

Contact Sports and Chronic Traumatic Encephalopathy

With the unexpected admission before Congress on March 14, 2016, by Jeff Miller, National Football League (NFL) senior vice president of health safety policy, that there does exist a connection between football and chronic traumatic encephalopathy (CTE)—as has been advocated for more than a decade by neuropathologists and neuroimaging researchers—it is to be expected that many parents will now be asking about the risks to their children from past or future participation in sports that involve repetitive head impacts. More importantly, this development provides an opportunity to shift interactions with the patients and their parents from an understanding of the time associated with return-to-play/return-to-academics, after an injury, to methods to prevent the injury in the first place.

To provide historical context, Dr. Omalu’s discovery of CTE in football players1 was a crucial first step. It had been observed in boxers2, but never in any other sport. Anne McKee and co-workers have observed CTE in more than 30% of former football athletes at the NFL, collegiate, and high school levels, but have also reported not finding CTE in any of a large sample of individuals with no exposure to contact sports.3 Interestingly, their data indicate that the degree of CTE does not correlate with an athlete’s history of diagnosed concussions.4 This result is important because it suggests that there are additional factors beyond whether someone simply played football at a given level or received a particular number of diagnosed concussions.

In this context, the long-term neurodegenerative diseases that have been observed to have a higher incidence rate in collision-sport athletes (ie, CTE; early-onset dementia; early-onset Alzheimer’s Disease) are likely developing from neurochemical imbalances brought about through primary injury to neurons, glial cells, and associated coupling to the vascular system. These injuries also produce secondary effects including release of neurotoxins (eg, acrolein) or impairment to the homeostatic chemical balance often resulting in a glial scar.5

The Effects of “Subconcussive” Hits

Since 2010 the Purdue Neurotrauma Group (PNG) has been the first group to document statistically significant changes in brain structure, function, and chemistry in living football and soccer players who were not diagnosed with a concussion.6–9 There were 2 important features of these observed changes. First, they affected a large fraction (60-100%) of players on the teams studied to date.10–12 Second, they were generally correlated with the number of hits and cumulative exposure.13 Taken together, it is clear that head impacts that do not result in concussion can still cause cellular-level injuries that accumulate over time. Once biochemical cascades have been initiated, it may yet be possible to intervene and prevent subsequent damage—eg, Shi (2015)14—but these cascades ultimately are not the root of the problem.

There are a variety of ways that head accelerations can cause damage to the central nervous system. Damage is ultimately caused by the dissipation of energy which, at the level of the brain, must occur through deformation of tissue (ie, stretch and compression, typically quantified by strains), fluid movement, and mechanical disruption (eg, cell rupture, myelin de-bonding, and synaptic derangement). It is possible for a single large blow to the head to cause any or all of these effects and result in symptoms. Fortunately, these types of head impacts are relatively rare.15 It should be noted, however, that even small head accelerations can produce these consequences within a localized region and, if the rate of healing does not keep up with the rate of damage accumulation, the athlete may eventually experience symptoms even in the absence of any particularly large hits. Even more critically, a direct head impact is not required. Impacts to the body may cause the head to whip forward or backward, yielding essentially the same effect. Every head impact or whiplash event would be expected to produce a unique spatial pattern of strains. Repeated exposure to such events increases the chance that the locations of maximum strains will overlap, resulting in these locations being progressively damaged over time. Eventually, the local tissue will have its resistance to injury reduced, or the small tears will preclude normal operation of the cells, much the same way in which overuse injuries may lead to stress fractures.

As is well-documented in the functional neuroimaging literature, damage or alterations in functional capacity at a single location in the brain need not produce corresponding changes in behavior.16 Rather, provided that the flow of information through the brain is not wholly impeded, normative behavior should be expected, albeit possibly being considered more strenuous. For example, speech perception normally involves 2 pathways from the auditory cortex to the frontal lobes, with the faster pathway dominating in good listening conditions, and the slower pathway being relied upon in the “more difficult” case of poor sound quality.17 Therefore, even if a location within the brain has been impaired such that information cannot pass through it, there may not be any symptoms evidenced by the individual. Instead, the entire communication process must be interrupted or significantly delayed for a “system failure” to occur. This potential for hidden damage is what makes repetitive brain injury so insidious, and is what has confounded past investigations into the causes and consequences of “concussion.”

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The Path to Prevention

While there will always be some risks (ie, it is never a good idea to hit your head), a number of straight-forward approaches exist that may be evaluated for efficacy in preserving brain health, and subsequently implemented with minimal impact on the positive aspects of participation in team sports, instead possibly increasing enjoyment due to potential for broader participation.

Based on our application of structural health monitoring to the problem of cumulative strain injuries in the brain, we propose the keys to safer participation are (1) improved education of coaches, officials, and parents regarding what may be regarded as “safer” levels of head acceleration events and how to avoid inducing such events during practices, (2) improved protective equipment that is more effective in preventing energy transmission to the skull and brain, (3) automated monitoring of athletes for exposure to head accelerations that are likely to contribute to brain injury, and (4) improved training of athletes to minimize head acceleration (ie, collision and whiplash) events. As detailed in our paper, the use of structural health monitoring allows not only a means to detect and characterize changes as a function of mechanical loading (ie, exposure), but also provides a framework in which prevention may be evaluated. Therefore, we will here primarily focus on above items (1) and (2), but hope to provide insight into how (3) and (4) may additionally be achieved.

(1) Educating coaches, athletic directors, officials, and parents so that they understand the mechanisms by which athletes expose themselves to large head accelerations, is an important step forward. Based on our data, eliminating tackling from practice (as per the recent Ivy League mandate) dramatically decreases the average number of head impacts and concomitant damage. Even if contact activities are not eliminated, providing more days off between such activities is likely to be beneficial due to the potential for natural repair processes to mitigate the cumulative damage.

(2) Beyond reducing the total number of head impacts, it is reasonable to expect engineers to improve safety equipment, including designing padding and helmets that absorb more energy than current models thus reducing the total energy delivered to the brain. In fact, this is not a difficult problem to solve, but 2 particular issues have slowed progress. First, the certification board, the National Operating Committee on Standards for Athletic Equipment (NOCSAE), has focused since its inception on mitigating skull fractures and other major trauma, as opposed to concussion. Current helmet designs prevent massive trauma, primarily by spreading the force out over a larger area, but this does little to reduce the energy transferred to the brain. Using structural health monitoring approaches, it is possible to develop new design criteria for helmets and standards that, when combined with the current NOCSAE protocol, will both eliminate massive trauma and dramatically decrease the energy transferred through the helmet to the brain. The second issue is the relatively high cost of producing helmets, but modern technologies, including 3-dimensional printing, are rapidly reducing the overall costs associated with this type of manufacturing.

(3) One of the more important outcomes of our study was the demonstration that there can be substantial changes in brain function without presentation of (obvious) symptoms and that these changes can accumulate over time. Consequently, improvement of diagnostic protocols—starting with telemetry-based monitoring of head impact number and magnitude, and with clinical follow-up possibly including blood and neuroimaging biomarkers, and neurocognitive testing—has the potential to dramatically increase sensitivity and specificity of clinical assessments, and should be expected to do so in the near future.

(4) Active correction of poor technique in athletes may be achieved based on adoption of the telemetry argued for in (3), above. Low-cost sensors that monitor the number, magnitude, and location of head impacts will provide feedback to athletes and coaches, allowing them to prevent risky practice and game techniques in real-time. If improper tackling, heading, etc, techniques can be identified rapidly and appropriately corrected, athletes will be able to participate more safely. Combining these data with findings from studies in contact sports in which head collisions are less emphasized (eg, rugby), will ultimately make it possible to reduce the average magnitude of the head impacts in all contact sports.

Concluding Thoughts

The application of functional, structural, and biochemical neuroimaging has proven to be a powerful tool, both providing insight into the mechanisms of injury and also redefining what we must consider to be injury. As we continue our study, we seek to address issues related to gender, individual variation (ie, avoiding a one-size-fits-all solution), developmental conditions (eg, ADHD), and how these subconcussive injuries may influence social and intellectual development.

Based on our findings that lesser exposure corresponds to a fewer and smaller changes in brain function, we argue for increases in preventative approaches to brain injury. Effecting these approaches points to an increased role for the pediatrician in the athletic process. The pediatrician has a platform to advocate for measures that will further the prevention of brain injury, including reduction of exposure to head impacts, introduction of adequate rest periods between contact activities, and education of parents, athletes, and coaches. In conjunction with the further advancement of the science, this joint effort between researchers and clinicians has the greatest potential for improving the overall safety of youth, with long-term positive consequences for our health care system.

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References:


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Robert E. Hannemann, MD, FAAP, is a Past President of the American Academy of Pediatrics (1997-98) and practiced general pediatrics and adolescent and sports medicine for 38 years. He was a high school team physician for 31 years. He is currently a Visiting Professor in Biomedical and Chemical Engineering and Child psychology at Purdue University where he is also a member of the Neurotrauma Research Team.

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Integration of Behavioral Health and Care Coordination in a Pediatric Medical Home

By Michael W. Yogman, MD, FAAP

In 2013, Yogman Pediatrics Associates decided to create an integrated behavioral health and primary care program because of the high incidence of behavioral health concerns in the pediatric population and the general lack of access to behavioral health treatment for this population. The epidemiology of pediatrics in the United States has shifted dramatically in the past 20 years. For the first time in the more than 30 years of tracking, the top 5 disabilities affecting children in the US are mental health concerns instead of physical concerns. One in 5 children has a diagnosed mental health or substance abuse disorder. If children do not receive necessary behavioral health care treatments, they are more likely to underachieve academically and to perform poorly in the workplace as adults. The most common current model of care for children with behavioral health concerns emphasizes referrals to outside mental health providers, psychopharmacological treatments, and, in severe instances, hospitalization. There are multiple structural and attitudinal barriers to accessing mental health care, including stigma, lack of providers, long wait times, and insufficient insurance payment for behavioral health services. Referrals outside the medical home remove the patient from their primary care provider, which contributes to the stigma around receiving mental health care. Few behavioral health providers accept insurance because the payment rates are quite low, which increases the barrier to accessing needed mental health care for patients. These barriers to care mean that nearly half of all children in need of care do not receive it, and that many who do receive care are not receiving appropriate, evidence-based care from a properly trained provider. One way to improve access and treatment for pediatric mental health disorders is by bringing mental health care and primary care pediatrics together in one place so that patients are able to receive timely and effective care in a familiar and comfortable setting.

Integration of behavioral health care in the primary care pediatric setting removes multiple barriers to mental health care access by reducing stigma, wait-times for appointments, and improving physical access to providers. Studies have also shown that it improves pediatric access to care and treatment outcomes for common behavioral health diagnoses. Integration relies on a partnership between the physician and the mental health care provider that focuses on embracing different approaches to patient care. Co-location of a behavioral health care provider in the primary care setting re-frames the mental health/physical health dichotomy as a unified concept of whole-person health and reduces the stigma around seeking and receiving mental health care for patients. Integration also emphasizes coordination of care between providers, so that patients receive well-rounded and non-redundant services. Our private practice in Cambridge, Massachusetts applied for and received a grant to fund a full time co-located Licensed Clinical Social Worker (LICSW) trained in child behavioral health care into the practice along with a parent navigator/care coordinator. This project was created with a plan to evaluate the outcome of the project using Triple Aim metrics: improving patient and provider experience, population health, and health care costs.

This project is grant funded through the Harvard Pilgrim Healthcare Foundation Quality Grant Program, which aims, “To improve the quality and value of health care for the people and communities we serve.” (www.harvardpilgrim.org). The practice applied for 1 year of funding in 2013 and has been awarded funding each year since then, concordant with a small expansion of the project each year. The original grant provided funding for hiring and training an LICSW and Data Manager. The second year of funding enabled the LICSW and data manager to stay on at the practice, as well as funding the creation of 2 parent psycho-educational groups and one support group. The third year of funding allowed the practice to hire a parent partner who performs care coordination duties for patients, especially those with special health care needs co-morbid with behavioral health needs. Current funding seeks to grapple with creating a tool kit to facilitate dissemination of this model more widely.

The LICSW and parent partner provide services to families and work with physicians to ensure all patients and families receive needed services. The LICSW works closely with the physicians to assess, triage, provide short term treatment and coordinate referrals to outside behavioral health specialists for families needing longer term treatment. The parent partner also works with the physicians to provide care coordination and care plans for patients with complex special health care needs. The LICSW and office physicians also worked together with local experts to create psycho-educational groups for parents centered on attention-deficit/hyperactivity disorder (ADHD)/executive functioning coaching and family wellness and obesity prevention. Daily activities center on referral services and behavioral therapies being provided by the LICSW and the care coordination and care plan creation done by the parent partner. The data manager organizes and records data about each patient encounter with the LICSW and parent partner, as well as organizing, distributing, and collecting data on patient experience from families who have worked with the LICSW, and on quality outcomes of our patient population organized by registries [ADHD, autism, serious emotional disorder, anxiety, depression, substance abuse, children with special health care needs (CSHCN), preschool behavior problems, Early Intervention (EI)/Individualized Education Program (IEP) and co-morbid behavioral health issues in CSHCN]. Total medical expenditure data was collected from claims data for every patient by our independent practice association.

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Data collection is ongoing but preliminary findings are that both patients and providers are highly satisfied with care, and referrals are much more efficient with warm handoffs and the lack of stigma associated with care in a pediatric office. Most surprising is that preliminary data comparing total medical expenditures in 2013 and 2014 showed marked cost savings in the group with co-morbid behavioral health and complex health care needs. Case examples illustrate possible reasons such as the prevention of ER visits, and less utilization of lab and imaging tests for underlying parental anxiety or somatization.

The challenge going forward is sustainability.\textsuperscript{11} In the current fee for service environment, billing by the social worker and/or the care coordinator covers less than a third of their actual cost/time since payment rates are quite low and much of the work involves non-billable services such as collateral care, case consultation, and phone consultation. The presence of mental health carve-outs continues to be a disincentive for coordinated care even when cost savings can be projected. Meetings with commercial payers have resulted in hopes that Accountable Care Organizations (ACOs) will eventually be created that will allow more flexible funding of innovative models of care. Hopefully these ongoing discussions and the work on developing a tool kit for dissemination will lead to some options for sustainability but this is the biggest current challenge.

References:


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ASHA Connections:
Educating Families About the Risks of Overusing Personal Technology

By Anne Oyler, AuD, CCC-A, Associate Director, Audiology Professional Practices, ASHA
Deborah Dixon, Director, MA, CCC-SLP, Director, School Services, ASHA
Diane Paul, PhD, CCC-SLP, Director, Clinical Issues in Speech-Language Pathology, ASHA

The American Speech-Language-Hearing Association (ASHA) recently conducted 3 surveys to elicit feedback about technology overuse and its implications from parents of children 0–19 years of age, teens 13–19 years of age, and ASHA members who are speech-language pathologists and audiologists. This topic is not new. The overuse of personal technology has become pervasive in family life and threatens to have long-term sequelae in the form of attention, communication, and academic and physical challenges for children of all ages and their families.

ASHA is very concerned about the impact of high-level noise from the overuse of earphones attached to a variety of devices. A 2010 study published in The Journal of the American Medical Association (JAMA) compared data collected between 1988 and 1994 and between 2005 and 2006 and showed an increase in the prevalence of high-frequency hearing loss in teens ages 12–19 years old. This type of hearing loss is consistent with that caused by long-term exposure to high-level noise.

ASHA also has concerns that excessive use of technology may interfere with conversation and human interaction and may affect the quality and effectiveness of communication. Healthy parent–child interactions are critical for the development of listening, talking, reading, and social skills.

It’s important to note that people with communication disorders who rely on technology as their primary mode of communication should have access to their communication devices at all times.

Summary of the 3 ASHA Surveys

1. **Teens depend on technology to communicate.** Teens average nearly 6 hours a day on a personal technology device, often (a) using these devices to communicate with their friends instead of talking face to face with them and (b) checking their phone while spending time with their families—even when directly communicating with their parents in person.

2. **Headphone and earbud use is common among teens.** Teens frequently use devices with accompanying earbuds or headphones, logging 3 hours a day, on average. This raises concerns about their hearing health, as noise-induced hearing loss may result from listening to devices for too long and at volumes that are too loud.

3. **Parents depend on technology, too.** Teens appear to be following their parents’ lead. Parents report using their devices as much as their children. All 3 studies revealed that an overwhelming majority of adults often use these devices at the dinner table, during family leisure time, and while speaking in person with their children.

Technology also plays a major role in how parents manage their own time and daily responsibilities. All 3 studies showed that the majority of parents permit their children to use personal technology as a form of entertainment to prevent boredom. Parents use the time that children are occupied with technology to get their own chores or work done and to find time for themselves.

4. **Technology use interferes with communication.** Many parents see technology undermining basic communication skills and abilities in their children: in all 3 studies, the majority of parents say that personal technology devices are making it harder for their children to pay attention when someone is talking, engage in meaningful conversations, and focus on their schoolwork. Many parents show interest in decreasing technology use in their households. Nearly half say that they use their own devices too much, and nearly as many say that their children use their devices too much.

5. **Rules work, but only if parents set them.** Only 2 in 5 teens say that there are rules in their household governing technology use. This represents a missed opportunity: 93% of teens who have rules say that those rules are fair.

There is also a disconnect between parents and teens regarding whether rules exist in the household. In stark contrast to the survey results from teens, more than two-thirds of parents report implementing some household guidelines regarding their children’s use of technology. Again, parents report that the rules are working: more than 90% of families that set rules say the effort is successful.

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6. **Information results in healthy behavior.** After reading short descriptions about the potential harm to hearing and communication development that technology overuse can cause, both parents and teens indicated a strong willingness to change how they use their personal technology devices. Almost all parents embrace implementing new rules in their home and, in recognition of their own overuse, leading by example with more responsible use. Teens express concerns about their own health, and in all surveys, the majority of teens say that they are likely to turn the volume down, start communicating with their friends more in person, and use their devices less.

7. **Millennial parents are using technology more but are also more willing to implement healthy rules.** On average, parents under the age of 40 use some sort of personal technology device more than 6 hours a day outside of work—an hour and a half longer than parents older than 40. This overuse extends to family time, with millennial parents being more likely than parents in all other age brackets to acknowledge that they use these devices at least “sometimes” when spending time with their children, speaking with their children, and eating together at the dinner table.

Although they are more likely to spend more time on their devices, younger parents also are more self-conscious of their behavior, including the two-thirds that recognize they use their devices too much. After hearing more information about threats to hearing health, 46% of millennial parents say that they are much more likely to implement stronger guidelines around technology use in their household—only 22% of older parents say the same. Similarly, 54% of younger parents and 30% of older parents say that they are very likely to set stronger guidelines after hearing more about potential risks to communication development.


**The Good News!**

Although many of these findings are concerning, there are a few significant bright spots. The first is that both parents and teens indicate a strong willingness to change behaviors once they learn more about the potential repercussions of technology overuse to their communication health. The second bright spot is on teens’ receptivity to rules. Findings from these polls indicate that 93% of teens whose parents set technology usage rules at home felt that the rules were fair. In addition, 96% of parents who set rules about technology usage said that these rules were successful. So, there is an opportunity to educate families and help establish change.

**How Can You Help?**

As pediatricians, you provide positive, supportive, and comprehensive primary care for your patients and their families. Part of this care includes screening for hearing loss, monitoring communication development, and making appropriate referrals to audiologists and speech-language pathologists as concerns arise. Early detection of and intervention for hearing loss and for communication delays and disorders is critical to positive outcomes. Through ongoing surveillance and conversations, you have excellent opportunities to educate families regarding the healthy use of personal technology, thus minimizing potential risks to hearing or to healthy communication development.

ASHA has compiled a list of tips to help families limit their technology use. Check out *A Digital Diet: Managing Technology in Tweens and Teens*.

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Children with Specific Phobias

By Edward Christophersen, PhD, FAAP (Hon) and Susan Mortweet Vanscoyoc, PhD

Conflict of Interest Statement: The authors declare that no conflict of interest exists.

Anxiety disorders are one of the most prevalent mental health challenges across the lifespan. Parents or patients may report concerns about separation anxiety, social worries, or general worries about many topics. Children also may present with Specific Phobias which are excessive reactions to the presence or anticipated presence of a specific situation or object. Common specific phobias for children include fear of animals, storms, mascots, crowded places, and medical procedures. By definition, a specific phobia requires that the fear must be excessive, recurring over at least a 6 month period, and causes significant distress or impairment. The child does not have to recognize or agree that the fear is irrational; he or she may try to avoid the stimulus or may react by excessively crying, clinging, or having a tantrum when facing the feared stimulus. Examples of significant impairment include parents being unable to attend sporting events or take the child to businesses where a mascot may be lurking, a child refusing to attend school if the weather is threatening, or a child who cannot go to a playmate’s home if a dog is there, even if the pet stays outside. Of course many children have fears that do not reach the level of a diagnosable phobia but cause the parent enough concern to discuss the issue with the health care provider. If a parent is worried about a child’s reaction to a specific event or situation, it is worthwhile to assess for the presence of a specific phobia using the criteria above and summarized in Table 1. It is also important to remember that children with anxiety often have comorbid mood disorders, such as other types of anxiety disorders, providing further support for a thorough evaluation of all mood issues even if the only parent comment is, ‘he’s afraid of dogs.’

<table>
<thead>
<tr>
<th>Table 1. Diagnostic Criteria for Specific Phobia</th>
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<td>Excessive fear cues by presence/anticipated presence of specific situation</td>
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<tr>
<td>May not recognize as irrational/excessive</td>
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<td>Situation is avoided or endured with intense distress</td>
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What options does the health care provider have when a parent is concerned about a Specific Phobia? Although the immediate answer may be to refer every child who appears to suffer significantly from anxiety symptoms to a mental health provider, there are steps that a health care provider can take before making such a referral, or to assist the family while they wait for their mental health appointment. First, there are several, relatively simple anxiety screening or assessment tools in the public domain that parents and patients can complete in the exam room, including:


- **Screen for Child Anxiety Related Disorders (SCARED)** is available in the public domain to assess anxiety in children aged 8 or older and has parent and self-report forms. For children ages 8 to 11, the clinician should explain all questions or have the child answer the questions with an adult in case they have any questions. ([www.wpic.pitt.edu/research](http://www.wpic.pitt.edu/research) under tools and assessments).

- **Anxiety and Depression Association of America** offers a “Screening for Specific Phobias” on their Web site ([http://www.adaa.org/living-with-anxiety/ask-and-learn/screenings/screening-specific-phobias](http://www.adaa.org/living-with-anxiety/ask-and-learn/screenings/screening-specific-phobias)) that can be completed and shared with the health care provider. Children age 9 and under, may need adult assistance to complete the measure.

**Treatment for Specific Phobias.** The American Academy of Child and Adolescent Psychiatry Practice Parameter on Anxiety suggests that treatment of childhood anxiety disorders of mild severity should begin with psychotherapy (AACAP, 2007). Medication may be considered if symptoms or impairment are moderate to severe, or if response to therapy is suboptimal. The risks and benefits of long-term use of medication for anxiety in children has not been studied, however. Given the AACAP’s position that therapy is first line treatment, this article will focus on this treatment option for children.

As a therapy modality, Cognitive Behavioral Therapy (CBT) has been studied for children with specific phobias as a primary diagnosis, typically separate from treatment research that focuses on other anxiety disorders (Carr, 2009). The cognitive and behavioral strategies used are focused on breaking the connection between the specific fear (eg, spiders, storms, heights) and feelings of anxiety, as well as to remove the association between the escape behaviors and the resulting feelings of relief (Leahy, Holland, & McGinn, 2012). Davis and Ollendick (2005), considered reinforced practice and participant modeling to be well-established treatments for specific phobia. Reinforced practice is described as graduated, controlled exposures with feedback and reinforcement from the therapist for overcoming continued on page 11

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AAP Section on Developmental and Behavioral Pediatrics Newsletter, Fall 2016
avoidance behaviors (Christophersen & VanScoyoc, 2013). To some researchers, graduated exposure or reinforced practice is considered the most important element in successful therapy for Specific Phobias despite its relative disregard for the physiological or cognitive symptoms associated with the feared situation (Davis & Ollendick, 2005).

Graduated exposure refers to starting with the least fearful or anxiety provoking event and gradually exposing the child to just a little bit more fearful or anxiety provoking event. The rationale is that it is much easier for a child to learn to be comfortable if what he is being exposed to has very little threat to it. Then, as the child adapts to the least threatening event, the child is presented with a slightly more threatening event. Examples of some threat hierarchies for typical childhood specific phobias are offered below:

<table>
<thead>
<tr>
<th>Specific Phobia</th>
<th>Least Threat</th>
<th>Moderate Threat</th>
<th>Most Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weather</td>
<td>Picture of storm</td>
<td>Gentle rainfall</td>
<td>Thunderstorm</td>
</tr>
<tr>
<td>Insects</td>
<td>Charm bracelet insect</td>
<td>Tiny fake ant</td>
<td>Actual insect</td>
</tr>
<tr>
<td>Dogs/Cats</td>
<td>View pets from car</td>
<td>Small caged puppy</td>
<td>Gentle puppy</td>
</tr>
<tr>
<td>Mascots</td>
<td>Mascot on TV</td>
<td>Picture of local mascot</td>
<td>Small event with mascot</td>
</tr>
</tbody>
</table>

It is very important that each exposure to a feared stimulus terminate with the child relaxed and comfortable, not anxious. If the child is exposed to a small charm of an insect and is able to play comfortably with it, the anxiety is reduced ever so slightly. Within about 5 minutes of a comfortable exposure, the child can be exposed to a slightly more anxiety provoking stimulus, for example, a larger, plastic insect. In this fashion, the child is exposed to gradually more anxiety provoking stimuli only as she is able to relax in the presence of each stimuli. Obviously the rate of exposure would vary from child to child and parents should be advised to err on the side of moving slowly through the hierarchy of fears versus pushing too quickly and reinforcing the child’s fear or escape response.

If an individual child has some anxiety symptoms but does not meet criteria for an anxiety disorder using a standardized screening tool, including Specific Phobias, the health care providers might be comfortable recommending one of the Web sites, apps, or popular press books that provide a good deal of education about anxiety including:


**GoZen.com.** A subscription-based Web site with multimedia materials for caregivers including a video series for children to learn about the biology of anxiety. [www.gozen.com](http://www.gozen.com)

**Anxiety and Depression Association of America.** This website has extensive patient information on anxiety disorders including simple written tests that potential patients can complete and take to their primary care provider. [https://www.adaa.org/](https://www.adaa.org/)

**Virtual Reality Exposure.** Virtual reality exposure therapy uses a computer program to simulate the phobic situation that creates anxiety in the person. The best developed virtual reality therapy appears to be for flying anxiety and for height phobias that are difficult to practice repeatedly (Powers & Emmelkamp, 2008). With virtual reality exposure, the patient sees and hears the anxiety provoking situation (eg, an airplane taking off) and is coached to engage in the therapeutic strategy employed by their therapist, for example, relaxation training, while they are repeatedly exposed to the anxiety provoking stimuli.

**iOS Apps That Focus on Anxiety / Teaching Relaxation:**
- MindShift
- Inner Peace for Kids
- Breath2Relax
- Smiling Minds

**Popular Press Books:**
- *Freeing Your Child from Anxiety: Revised and Updated* by Chansky (2014, New York: Broadway Books)
What Doesn’t Work With Specific Phobias?
It can be tempting for parents and health care providers to treat specific phobias in children as something they should just ‘get over’ or that they will grow out of them so no thoughtful intervention is needed. For many children, however, this mindset and disregard for their fear, no matter how irrational it seems to adults, can be counterproductive and can inadvertently reinforce the very fear caregivers are trying to eliminate. Strategies that should be avoided with respect to addressing specific phobias include:

• **Forced exposure.** When forced to be close to, for example, a feared dog, and the child cries and screams for the duration of the exposure, and then is allowed to get away from the dog, his fear is actually strengthened. Each time the child is forced to be near a dog and escapes while upset, the fear gets worse.

• **Punishment.** When a caregiver punishes a child for acting fearful, it increases the fear’s intensity by adding unnecessary negative emotions to the situation. Each subsequent exposure can make the fear worse as the child now adds worry of punishment to her fear of the specific situation.

• **Reassurance.** Although well meaning, reassurance can inadvertently reinforce the child’s fear by placing too much focus on its intensity. Typically coupled with avoidance or forced exposure, reassurance does not provide the opportunity for the child to experience the feared situation in a neutral way–each attempt at reassurance represents another unsuccessful exposure, with the reassurance just reminding the child of the intensity of his fear. Although it is reasonable for parents and providers to provide some reassurance, it is not a substitute for actually treating the specific phobia.

• **Reasoning.** Lectures about how unreasonable it is to be afraid of storms or Aunt Ruby’s dog may simply make the child feel worse about his worry and will not necessarily reduce the fear. Older children may be able to consider rational information such as the probability of a plane crash while flying, but this does not mean they can use that information to guide their decisions while in fear.

• **Medications.** The American Academy of Child and Adolescent Psychiatry (2007) took the position that the first line of treatments should be Cognitive Behavior Therapy and that, “when anxiety disorder symptoms are moderate or severe or impairment makes participation in psychotherapy difficult, or psychotherapy results in a partial response, treatment with medication is recommended.”(p. 276) But the same Practice Parameter states that, “Whereas controlled trials have established the safety and efficacy of short-term treatment with SSRI’s for childhood anxiety disorders, the benefits and risks of long-term use of SSRI’s have not been studied.” (p. 277) And, “At this time, there are no specific dosing guidelines for children and adolescents with anxiety disorder.” (p. 277)

A good rule of thumb when considering ways to help a child with a specific phobia is to ask oneself if the strategy would be successful with an adult who is deathly afraid of flying. It would likely not be helpful to drag the adult onto an airplane. Doing so may result in a full-fledged panic attack. Similarly, punishing the adult or repeatedly reminding them of how safe air travel is, could merely add to his fear of flying. It is understandable that caregivers can become impatient with a child whose specific phobias are irrational and impairing to family functioning. Health care providers can help parents understand that a thoughtful, systematic way of approaching such fears will ultimately result in a more successful outcome for the child than forcing exposures, punishing, or inconsistently allowing escape behaviors.

References:


Children with Specific Phobias continued from page 12

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Highlights on Advocacy

Editor’s Note: The articles in this section describe the strong and ongoing commitment of the SODB to advocacy from the points of view of 2 SODB members who attended the 2016 Legislative Conference, April 3-5, 2016 in Washington, DC.

How I Became Another Voice on Capitol Hill

By Doug Waite, MD, FAAP

I am one of the fortunate recipients of an American Academy of Pediatrics scholarship through the Section on Developmental-Behavioral Pediatrics, recently returned from the 25th AAP Legislative Conference in Washington, DC. At the conference, I not only met leaders of the AAP and people who share my special interests (I have advocated for children with fetal alcohol neurodevelopmental disorder), but also dedicated members of our Federal Affairs department, who work in Washington as lobbyists for children. For years I have been a key contact to emails from the Department of Federal Affairs, by which through a simple click, I sign a series of emails to my senators and congresswoman, and so feel I help add to our profession’s voice within the drowning noise of our nation’s government.

But over the course of those 3 days, multiple experts in child advocacy (mostly pediatricians just like you and me) taught us skills in communication when meeting with members of Congress. This culminated on the final day, with 120 pediatricians gathering on Capitol Hill to meet with senators and legislators to advocate for child nutrition programs. As pediatricians it’s hard to imagine a world without WIC, yet WIC, school nutrition and summer food programs are up for reauthorization and we have an opportunity to not only sustain, but improve coverage for children under The Improving Child Nutrition Integrity and Access Act of 2016. What was most surprising was how easy and informal those meetings were (in one case, we met with our senator’s staff member in the hallway of the Senate Building because no rooms were available). We had, quite literally, become lobbyists (one who frequents the lobbies of the House of Representatives in order to influence members in the exercise of their legislative function, Oxford English Dictionary.), taking esteem by standing among colleagues of the profession we practice every day in vastly different places from New York to Montana and California.

A common task brought us together: our love of pediatrics and caring for children. It was not grandiosity that made us feel we could make a difference, even in the halls of Congress that were driven by private interests with far more money and lobbying power than we had; but a cause we knew to be just, simply because we were experts on the outcomes of social injustice, racial prejudice, poverty and food insecurity, apparent in the lives of children we had seen over so many years. This was the culmination of our wish to make society a little more just, safe and nurturing for those children we had grown to love. We had witnessed their birth (one of my patients was born in Central Park and taken to the hospital by the police after her mother stumbled away drunk), cared for them in sickness and times of chronic illness, but mostly watched them grow in health over those most important early years that form the person who will carry on long after we have retired. Some destinies seem brighter than others. Yet all children should have the opportunity to become as bright as their potential decrees.

That kind of experience—one each of you reading this has been given the gift of being a part of—few on the Hill in Washington share. Legislators must be educated and taught the urgency we see in the lives of our children today as well as those who may come to the world tomorrow. This need to advocate for vulnerable children is a central tenet that sets pediatrics apart from other medical professions. Full circle, in those special 3 days, I found that the calling that brought me to pediatrics 30 years ago, had now led me to our Capitol, to advocate, to lobby, for a cause that was not only a part of me, but the greater testament of all my patients.

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About the author:
Doug Waite, MD, FAAP is medical director of The Keith Haring Clinic at Children’s Village, a community foster care agency and residential treatment center established in 1851, located in New York City and Dobbs Ferry, New York. He is Assistant Clinical Professor of Pediatrics at Mount Sinai Hospital, a member of the Section of Developmental-Behavioral Pediatrics and the National Mental Health Advisory Board of the Child Welfare League of America.

Being More Than Just a Band-Aid and Having Fun Doing It
By Barbara S. Saunders, DO, FAAP

“I’m just a parent. I’m just a doctor. I’ve never done this before. They’ll think I’m stupid. I’m just one person. How can I make a difference? Will this visit really even matter?” These are all thoughts that went through my mind just before I sat down for my very first meeting on Capitol Hill with Senator Wicker’s staffer in February 2014. Law, policy, and politics in general are things I’ve never really had a desire to be a part of, and honestly, things I never planned on becoming involved in. But...as I began my career as “a real doctor” (as some would call me), fresh out of my developmental-behavioral pediatrics fellowship and now an attending physician, the reality of how broken our systems were hit me like a ton of bricks. Family after family came into my clinic and voiced frustration with not being able to obtain the services, equipment, and/or medications their child needed because of insurance and/or accessibility issues. As I listened to these parents, having walked this very road myself as a parent of a child with special needs, I came to the realization that the only way these broken systems would ever get fixed is if I did something about it. I’d seen how the right health care and educational and therapy services could help a child succeed and allow that child and his/her family to have a better quality of life. I’d also seen children fall short of their potential, have a poorer quality of life, and create additional emotional and financial stress for their families because of health care and educational systems that didn’t adequately and appropriately support them. I knew that appropriate health care, nutrition, and educational and therapeutic services were of utmost importance in ensuring children are able to reach their full potential, and I’d seen that far too often children were placed on the back burner by politicians so they could tend to “more important” matters. So, I could sit there and complain about how bad things were and how my patients couldn’t get what they needed, or, I could get involved in advocacy and try to change the systems so that they actually worked for those they were put in place to support.

Saying I was going to get involved in advocacy and actually doing so were 2 very different things. I didn’t really even know how or where to start. I didn’t receive any formal instruction in advocacy during my residency or fellowship training, so it wasn’t something I’d ever been exposed to. As luck would have it, I was made aware of a one-day federal advocacy training opportunity being put on by the SODBP in February 2014. Having just started my career, finances were tight, so I decided to apply for one of the scholarships being offered. “If I got a scholarship, I’ll go, and if not, no big deal” I thought. I was fortunate enough to be awarded a scholarship to that training session, so I packed my bag and headed to Washington, DC. It was a whirlwind of a day with training in the morning and meetings on the Hill in the afternoon. And while it was a great day and a wonderful opportunity, I left with an even bigger desire to advocate for my patients but feeling like there was so much more I needed to know in order to be an effective advocate. After returning to Jackson, I began to get involved with our state chapter of the AAP and was asked to join the legislative committee. Gradually, I got more and more exposure to the legislative system but still felt like I could and should do more.

When the AAP decided to offer a subspecialty track at this year’s Legislative Conference, I was beyond excited to learn that they’d selected developmental-behavioral pediatrics be the very first subspecialty track. I felt like this was an opportunity that I couldn’t pass up, so I again applied for a scholarship being offered by the SODBP and crossed my fingers that I would be selected. The section was generous enough to award me a scholarship, and I am forever grateful that they did. Being able to spend several days in Washington, DC, learning about the various aspects of advocacy and specific issues that affect our nation’s children, was an invaluable experience. Getting to learn from other physicians, law and policy makers, and other various speakers opened my eyes to the multiple ways that one can become involved in the federal and state policy making processes. The added benefit of being able to network with other developmental-behavioral pediatricians from around the country (and even a few from outside the US) was the icing on the cake. As each day of the conference progressed and I participated in workshops and listened to speakers, my confidence as an advocate began to grow, and I began to see that I could be more than just a Band-Aid placed on a gaping wound. I could actually make a difference in the lives of my patients and their families. And, I could have fun doing it!

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Being More Than Just a Band-Aid and Having Fun Doing It continued from page 14

There are 2 specific experiences I was blessed to have as a participant at this year’s Legislative Conference that truly changed my life. The first was hearing Dr. Mona Hanna-Attisha speak about the water crisis in Flint, MI. Her zeal for her patients was tangible, and her boldness and determination were contagious. Seeing what a huge impact one physician made and how many lives will likely be saved and/or made better because she refused to sit there and do nothing fueled the fire within me to do the same. The second experience I had was meeting Julie Beckett, the mother of Katie Beckett. Her advocacy years ago is the very reason I am able to adequately care for and support my own son and his special needs and the reason so many of my patients are able to get the care and services they need. Without her tenacity and fight for Katie’s right to be cared for at home, the “Katie Beckett waiver” would never have existed. This Medicaid waiver program allows families to give their children what they need and do so at home rather than in a residential facility. Unfortunately, not all states offer this waiver, which is a matter for another article. Seeing how one mother refused to give up on her child and the broken system that was supposed to care for her was inspiring to say the least. If I can make half the difference that Mona and Julie have made, I will feel like I’ve truly accomplished something. I have seen over and over that advocacy is the key for ensuring that the next generation of leaders, doctors, teachers, politicians, service men and women, business men/women, mothers, and fathers is healthier and more successful than we are today, and it is because of the generosity of the SODBP and the AAP that I am better equipped to effectively advocate for my patients and our nation’s children. Thank you just doesn’t seem like enough to say, but “Thank you SODBP and AAP! You help me make a difference.”

About the Author:
Barbara S. Saunders, DO, FAAP, a developmental-behavioral pediatrician, is on faculty at the University of Mississippi Medical Center as an assistant professor of pediatrics and the director of resident and medical student education for the Division of Child Development. Dr. Saunders serves on the legislative committee for the Mississippi Chapter of the AAP and participated in the state medical association’s first Physician Leadership Academy.” She can be contacted at bsaunders@umc.edu.

Coding Conundrums

By Lynn M. Wegner, MD, FAAP

Dear Coding Maven,

I know it has been over 10 years since the Current Procedural Terminology® (CPT®) codes for developmental screening (96110) and extended developmental testing (96111) were published with valued relative value units (RVUs), but I’m increasingly confused about what standardized tools to use with these—and other—assessment codes. Can you shed some light on my dim understanding?

“Perplexed in Peoria”

Dear Perplexed,

Rest assured, you are in very good company! I get questions all the time about “Which code do I use for this new tool my practice just purchased?” Let’s start this explanation with a review of the pertinent codes:

96110: “Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.”

96110 was formerly described as “Developmental testing, limited. This code documents the administration and scoring of a standardized developmental screening instrument. This code has no physician work relative value units (RVUs) published on the Medicare physician fee schedule—only practice expense and professional liability insurance RVUs.

According to Centers for Medicare and Medicaid Services, CPT code 96110 is reported for screening healthy, physical development (speech and language development, physical growth). That is, there does not have to be the presumption of developmental delay to appropriately screen.

Here are requirements for reporting this code:

• The instrument must have been developed with validation and norming to assure the accuracy of identifying truly developmentally...
Coding Conundrums continued from page 15

discrepant behaviors. This would not include informal checklists.

• This code may be used for broad-band developmental screening (several areas included, such as language, gross and fine motor skills, social skills, memory, etc.)
• This code also may be used for more domain-specific screening such as language development screening.
• The code anticipates the cognitive work of the professional would be included in the accompanying Evaluation and Management code (E/M code.) The cognitive work will include: reviewing the results, integrating this information into what is already known about the child, and making a decision of what will be the appropriate actions to take as a result of the screening.

Here are some additional points to remember:

• If the assessment service does not include the use of a standardized instrument (ie, informal checklist), this information will be considered part of the patient’s history and thus included in the E/M service during which the checklist is completed.
• While the code describes the service as ‘per standardized instrument’ –it is appropriate to report as many units of 96110 as the number of standardized screening instruments administered, interpreted, and documented at the encounter.
• Payers may have their own policies on the payment for more than one developmental screening instrument administered per encounter.
• If the developmental screening instrument is not completed during the encounter, a code should not be reported on that date of service. For example, if the screening tool is sent home with one parent to be completed by the other parent (or family member), that instrument should be billed at the next encounter with the interpretation and documentation performed at that visit. The code may then be appropriately reported on that date of service.

### Examples of Current Standardized Developmental Screening Instruments

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Age Range</th>
<th># of Items</th>
<th>Time Required for Completion</th>
<th>Public Domain or Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages and Stages</td>
<td>One month-5 years 6 months</td>
<td>6 items each of these domains: Communication, Gross motor, Fine motor, problem solving</td>
<td>10-15 minutes</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Pediatric Evaluation of Developmental Status</td>
<td>Birth-7 years 11 months</td>
<td>Receptive and expressive language, fine and gross motor skills, learning, behavior, and social interactions</td>
<td>5-10 minutes</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Modified Checklist of Autism in Toddlers-Revised with Follow-up</td>
<td>16-30 months</td>
<td>Social interactions and communication</td>
<td>5 minutes</td>
<td>Public domain</td>
</tr>
<tr>
<td>The Safety Word Inventory and Literacy Screener (SWILS)</td>
<td>6-14 years</td>
<td>29 items</td>
<td>Literacy screening for practical daily living words</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

96111: Developmental testing, extended: This code documents the administration, interpretation and documentation in the medical record of a standardized developmental testing instrument. This code has physician work RVUs in addition to only practice expense and professional liability insurance RVUs. This code does not specify the typical time of the testing session.

Here are requirements for reporting this code:

• This testing is done face-to-face with the child and the professional. The informal observations made of the child’s behavior accompanying the testing should be included in the summary of the testing if they appear to have affected the child’s performance on the test.
• The instrument must have been developed with validation and norming to assure the accuracy of describing developmental skills performance in comparison with same-age peers. This will not include informal checklists, non-standardized informal tasks (eg, drawing a picture of the family) or standardized instruments whose normative data is so old as to be considered needing revision by professionals.

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• This code may be reported for broad-band developmental testing instruments (several areas included, such a language, gross and fine motor skills, social skills, memory, etc).
• This code also may be reported for more domain-specific testing instruments such as language or motor development.
• This code will include standardized instruments focusing on social problem solving and pragmatics skills.
• The code made be reported in addition to an Evaluation and Management code (E/M code) if that service was provided during the same encounter. [Payers may require the appropriate modifier(s)]. The cognitive work of the E/M will include: reviewing the results, integrating this information into what is already known about the child, and making a decision of what will be the appropriate actions to take as a result of the testing.

Also remember these additional points:

• If the assessment service does not include the use of a standardized instrument (ie, non-standardized drawings), this information will be considered part of the patient’s exam and thus included in the E/M service during which the checklist is completed.
• Only one unit of 96111 may be reported on a single date of service. All testing is bundled into the single unit of this code.
• Payers may have their own policies on the payment for developmental testing by a primary pediatrician. Additionally, they may restrict this to specialty professionals.
• If the developmental instrument is not completed during the encounter and the technical manual written for the instrument states the test may be done over multiple sessions, 96111 may be reported again at another encounter to complete the testing.

Examples of Standardized Developmental Testing Instruments: Please note, this is not an exhaustive list and inclusion in this list should not be interpreted as endorsement by me, the SODBP Executive Committee, or the AAP to the exclusion of other currently psychometrically sound measures. Furthermore, this list in not suggesting that developmental testing should be a part of general pediatric practice. This list is being provided for examples of standardized tests.

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Age Range</th>
<th>Domain(s)</th>
<th>Public Domain or Proprietary</th>
<th>Time for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Battelle Developmental Inventory-Second Edition</td>
<td>0-95 months</td>
<td>Various domains</td>
<td>Private</td>
<td>10-15 minutes</td>
</tr>
<tr>
<td>Bayley Infant Neurodevelopmental Scales</td>
<td>3-24 months</td>
<td>10-13 items Neurologic processes, neurodevelopmental skills, developmental accomplishments</td>
<td>Private</td>
<td>10-30 minutes</td>
</tr>
<tr>
<td>Beery-Buktenica Developmental Test of Visual-Motor Integration: Sixth Edition</td>
<td>2:0-99:11 years</td>
<td>Fine motor, visual spatial</td>
<td>Private</td>
<td>5-10 minutes</td>
</tr>
<tr>
<td>Brigance Screens-II</td>
<td>0-90 months</td>
<td>Speech, language, motor, readiness, general knowledge (younger ages) and reading and math @ older ages</td>
<td>Private</td>
<td>10-15 minutes</td>
</tr>
<tr>
<td>Clinical Evaluation of Language Fundamentals-Fifth Edition Screening test</td>
<td>5:0-22:11 years</td>
<td>Expressive, receptive language and pragmatics</td>
<td>Private</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Comprehensive Inventory of Basic Skills-Revised Screener</td>
<td>1st-6th grade</td>
<td>Reading comprehension, math computation, sentence writing</td>
<td>Private domain</td>
<td></td>
</tr>
</tbody>
</table>

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**Coding Conundrums continued from page 17**

<table>
<thead>
<tr>
<th>Test</th>
<th>Age Range</th>
<th>Description</th>
<th>Provider</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaufman Brief Intelligence Test: Second Edition</td>
<td>4:0-90:0</td>
<td>Verbal composite, performance score and Combined IQ</td>
<td>Private</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Preschool Language Scales-5 Screening Test for Early Educators</td>
<td>Birth-6:11 years</td>
<td>Pass/fail scores—emerging interaction and language and speech skills in infants and toddlers; Pass/fail scores for articulation, language, social/interpersonal communication skills, stuttering, and voice for children ages 3:0 to 6:11.</td>
<td>Private</td>
<td>5-10 minutes</td>
</tr>
<tr>
<td>Wide Range Achievement Test-Revised</td>
<td>5-94 years</td>
<td>Reading and math skills, spelling and comprehension</td>
<td>Private</td>
<td>Approximately 15-25 minutes for ages 5 – 7; approximately 35-45 minutes for ages 8 and up</td>
</tr>
</tbody>
</table>


96127: Brief emotional/behavioral assessment (for example, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

This code, first published on January 1, 2015, was created, according to the American Psychological Association Web site www.apapracticecentral.org: … in response to the Affordable Care Act’s federal mandate to include mental health services as part of the essential benefits that must be included in all insurance plans offered in individual and small group markets. The mandate covers services such as depression screening for adults and adolescents, alcohol misuse in adults, alcohol and drug use in adolescents, and behavioral assessments in children and adolescents.

Until this code was published, many of us had used CPT code 96110 to describe these services (emotional rating scales) to payers. That is no longer necessary and this new code permits accurate tracking of emotional and behavioral rating scale use from a public health standard.

Keep the following points in mind:

• This code has no physician work RVUs—only practice expense and professional liability insurance RVUs.

• The code anticipates the cognitive work of the professional will be included in the accompanying Evaluation and Management code (E/M code.) The cognitive work will include: reviewing the results, integrating this information into what is already known about the child, and making a decision of what will be the appropriate actions to take as a result of the screening.

• This code, like the other 2, has the requirement of a standardized instrument. Informal checklists will not pass muster.

• This code may be used for broad-band behavioral/emotional screening (several areas included, such attention, over-activity, anxiety, depression, oppositional defiant disorder, conduct disorder.) Note, however, when this type of broad band tool is used, and the condition questions are interspersed throughout the instrument, only one unit of 96127 may be reported for that encounter.

• This code also may be reported for more domain-specific tools such as anxiety scales, depression inventories, substance use scales and validated structured standardized substance-use interviews such as the CRAFFT.

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### Examples of Current Standardized Behavioral/Emotional Rating Scales

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Age Range</th>
<th>Domains Covered</th>
<th>Public or Private Domain</th>
<th>Time for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaires: Social-emotional (ASQ:SE)</td>
<td>6-60 months</td>
<td>30 items Self-regulation, compliance, communication, adaptive functioning, autonomy, affect and social interaction</td>
<td>Private</td>
<td>5-15 minutes</td>
</tr>
<tr>
<td>Brief-Infant-Toddler Social-Emotional Assessment (BITSEA)</td>
<td>12-36 months</td>
<td>42 items Behavioral/social-emotional problems and delays in competence</td>
<td>Private</td>
<td>5-7 minutes</td>
</tr>
<tr>
<td>Patient Health Questionnaire-2, 9, 16</td>
<td></td>
<td>Depression w/suicide question</td>
<td>Public domain</td>
<td></td>
</tr>
<tr>
<td>Pediatric Symptom Checklist PSC-17, PSC-35</td>
<td>4-16 years</td>
<td>17 and 35 items Internalizing, externalizing and attention scales</td>
<td>Public domain</td>
<td>Approximately 15-25 minutes for ages 5 – 7; approximately 35-45 minutes for ages 8 and up</td>
</tr>
<tr>
<td>Picture Anxiety Test</td>
<td>5-7:11 years</td>
<td>17 items Anxiety</td>
<td>Dubi K, Schnieder S. <em>The Picture anxiety Test (PAT): a new pictorial assessment of anxiety symptoms in young children.</em> Journal of Anxiety Disorders, 2009; 23: 1148-1157</td>
<td></td>
</tr>
<tr>
<td>Screen/Self-report for Anxiety and Emotion Related Disorders (SCARED)</td>
<td>≥8 years</td>
<td>35 items 5 anxiety types</td>
<td>Public domain</td>
<td>10-15 minutes</td>
</tr>
<tr>
<td>Vanderbilt ADHD Scales</td>
<td>4-18 years</td>
<td>Parent-55 items Teacher-43 items</td>
<td>Public domain</td>
<td>5-10 minutes</td>
</tr>
</tbody>
</table>

**About the author:**

**Lynn M. Wegner, MD, FAAP,** is professor emerita, University of North Carolina, past chairperson Section on Developmental and Behavioral Pediatrics, past member Committee on Coding and Nomenclature and member of the Council for Children with Disabilities.
Congratulations to the 2016 SODBP Awards Recipients

Dale Richmond/Justin Coleman Award Recipient: Dennis Drotar, PhD

Dennis Drotar, PhD, is a professor in the Division of Behavioral Medicine and Clinical Psychology, Center for Adherence and Self-Management, at Cincinnati Children's within the UC Department of Pediatrics.

A nationally recognized leader and teacher, Dr Drotar is a past president of the Society of Pediatric Psychology (SPP) and Society of Developmental Pediatrics (SDBP) and is a past editor of the Journal of Pediatric Psychology (JPP). Among his many professional honors, Dr Drotar has received the Distinguished Service Award, and the Martin P. Levin Mentorship Award from the SPP.

Dr Drotar's research focuses on understanding the factors that influence psychological outcomes of children and teens with chronic physical illness, including cystic fibrosis, diabetes, asthma, and cancer. He is currently the principal investigator and co-investigator of several NIH-funded studies and is the author of more than 328 publications, including several books, such as "Psychological Interventions in Childhood Chronic Illness" (2006).

C. Anderson Aldrich Award Recipient: Lynn Mowbray Wegner, MD, FAAP

Lynn M. Wegner, a developmental/behavioral pediatrician, is professor emerita at the University of North Carolina (UNC), where she served as Professor of Pediatrics and Division Chief of the Developmental/Behavioral Pediatrics Division. Prior to her UNC appointment in 2005, she had a private developmental/behavioral pediatrics practice from 1999-2006 and a general pediatrics practice from 1989-1993.

Dr. Wegner has been actively involved in AAP activities. She is a past chairperson of the AAP Section on Developmental and Behavioral Pediatrics (SODBP), past member of the AAP Task Force on Mental Health, and past member of the AAP Committee on Coding and Nomenclature. Dr. Wegner also served as co-chair of the SODBP/Society for Developmental and Behavioral Pediatrics Committee on Coding. She is a regular contributor to Developmental and Behavioral News, the SODBP newsletter: Coding Conundrums. She is the AAP liaison to the American Academy of Child and Adolescent Psychiatry Committee on Healthcare Access and Economics.

Dr. Wegner has been a strong proponent for coverage and payment of developmental services within primary care and specialty settings and has been committed to educating pediatricians about correct coding for developmental and mental health services. She has been the champion for Current Procedural Terminology© (CPT©) codes 96110-developmental screening; 96111-developmental testing, extended; 96127-brief emotional/behavioral assessment; and the most recently, 96161-administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient.

From procedure conceptualization through the code proposal development process and advocating for adoption by the American Medical Association and payment by Centers for Medicare and Medicaid, each code can take up to 5 years of persistent effort (eg, 96161). Successful championing requires vision and dogged effort.

Dr Wegner also served as a consultant to the American Psychiatric Association (APA) Diagnostic and Statistical Manual-Fifth Edition (DSM-5) workgroup on Somatoform Disorders, member of the APA DSM-5 Pediatric Advisory Committee, advisor to the APA DSM-5 Psychiatric-General Medical Interface Study Work Group and advisor to the Pediatric Topic Advisory Group (TAG) - International Classification of Diseases–Eleventh Edition Revision Project.

Dr. Wegner was trained in pediatrics at Children's Hospital in Oklahoma City and the UNC where she also completed her developmental/behavioral fellowship.