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DEDICATED TO THE HEALTH OF ALL CHILDREN™

California Chapter 2, the Los Angeles County, Inland Empire and Central Coast Chapter

"CATS MAKE ME REALLY HAPPY!"

By Mary Doyle, MD, FAAP
President, AAP California Chapter 2

I usually don't get a sense of dread when I receive email announcements about national or world days dedicated to raising awareness about diseases. But, I must admit that I had trepidations when I got the one announcing World Autism Awareness Day on April 2nd. I feared that the media attention on that day would focus mostly on those few, now infamous celebrities, who have an agenda to push: an agenda that detracts from the united effort needed to address the causes of this disease and to support those directly affected by autism.

What I really wanted on that day was hope, because I, like millions of others, have a family member with autism – my driving buddy in the convertible, my twelve year old niece, Miss Darcy Stockel. So, to cheer myself up, I called Darcy and her mother on April 2nd: "Hi, Karen, happy Autism Awareness Day!" to which my sister replied, "What?! Am I bad?! I have a kid with autism and I didn't even know it was Autism Awareness Day." To which I replied, "No, you are not bad. You are busy." I went on to explain that I was interested in what an autistic pre-teen or her mother would want pediatricians to be aware of if either had a chance to address a captive audience.

My sister's answer came fast and wasn't directed at pediatricians at all. She wanted to address those parents of autistic children who speak of autism as a "label" and worry about the stigma and threat to self-esteem that such a label carries. Her advice: recognize autism for the medical diagnosis it is and use that exact word. A label invites embarrassment and carries no responsibility to intervene. A diagnosis demands treatment and a commitment toward cure or amelioration. As to the question of how an autistic child feels when hearing the word "autism" we turned to Darcy. When asked if she had ever heard of the word, she said she didn't know and when offered a simple explanation, she thought it applied to her friend, Elijah, and not to her. She also didn't really know if she was "different" from her friends or classmates.

Though Darcy could not directly craft a message for us pediatricians on World Autism Awareness Day, she did prove through her answers to my questions that there is cause for our families to have hope. I wondered if she could do something better than anyone else. She replied, "Understanding animals." I wondered if she had a goal for the future. Her answer, "Be a dolphin trainer or animal veterinarian." I wondered if anything made her really happy. Her response, "Cats make me really happy!" These were the answers from a pre-teen, who nine years earlier was not communicating with anyone and whose family could not imagine

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Coming up in 2010

SAVE THE DATE!

AAP CA2's CLINICAL PEDIATRICS CONFERENCE

Hilton Palm Springs Resort
February 11 – 14, 2010

AAP CA2's ADVANCES IN PEDIATRICS CONFERENCE

The Flamingo Hotel, Las Vegas
April 22 – 25, 2010

Program information and registration flyers are mailed 3 months prior to each meeting and are available on the Chapter website at **www.aapca2.org.** For more detail, contact **chapter2@aap-ca.org.**

COMMITTEES AND TASK FORCES 2008 – 2010

American Academy of Pediatrics, California Chapter 2
(Appointed Positions, except Nomination Committee)

Committees and Task Forces are the lifeblood of a successful organization. They focus on specific areas of interest and thrive on the interest and dedication of its members in accomplishing its goals. Listed below are the current committees and task forces of California Chapter 2

CHAPTER 2 COMMITTEES	CHAIRPERSONS TELEPHONE / EMAIL
• Adolescent Committee	• Curren Warf, MD 323/361-4759 cwarf@chla.usc.edu
• AIDS Committee	• vacant
• Breastfeeding Committee	• Touraj Shafai, MD 909/689-9220 shafaidocs@yahoo.com
• Bioethics Committee	• vacant
• Child and Spousal Abuse Committee	• vacant
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• Electronic Communications Committee	• Oved Fattal, MD 818/375-4457 ofattal@verizon.net
• Environmental Health Committee	• Cyrus Rangan, MD 213/240-7785
• Fetus and Newborn Committee	• George Franco, MD 310/459-7773
• Foster Care and Adoptions Committee	• Kerry English, MD 310/668-4872 kerrydoc@ca.rr.com
• Infectious Disease Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Injury and Poison Prevention Committee	• Appointment Pending
• L. A. Care – Children's Health Committee	• Curren Warf, MD 323/660-2450 cwarf@chla.usc.edu
• Legislative Committee	• Damodara Rajasekhar, MD. drakasekhar@charter.net
• Membership Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Nominating Committee	• Elliot Weinstein, MD 909/621-0973 elstwein@charter.net
• Pediatric Practice Committee	• Christopher Tolcher, MD 818/340-3822. ctolcher@sbcglobal.net

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• Program Committee (CME)	• Robert Adler, MD 323/361-4523 radler@chla.usc.edu
• Quality Improvement Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Resident Advocacy Committee	• Eyal Ben-Isaac, MD 323/361-2110 ebenisaac@chla.usc.edu
• Scholarship Committee	• Edward Curry, MD 909/427-5477 Edward.s.curry@kp.org
• School Health Committee / Mental Health Task Force	• Michele Roland, MD 323/361-2153 mrolandk@chla.usc.edu
• Substance Abuse Committee	• Trisha Roth, MD 310/452-9782 trisharoth@aol.com
• Violence Prevention Committee	• Vacant
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when told of Darcy's autism that they had a future dolphin trainer in their midst.

Aside from showcasing the personal messages of a family affected by autism, I want to highlight AAP-CA Chapter 2 activities addressing this disease. On February 12-15, 2009, Chapter 2 held its annual Clinical Pediatrics meeting in Palm Springs where Dr. Douglas Vanderbilt, assistant professor of Clinical Pediatrics at Childrens Hospital of Los Angeles, spoke on separating myth from fact in autism spectrum disorder and addressed the primary care approach to language delay and how to screen and refer children with global delay and autism spectrum disorder. Dr. Vanderbilt is also going to speak to the pediatricians of Santa Barbara County at a future townhall meeting on parental concerns regarding autism and vaccines and help address the growing rate of personal belief exemptions for state-mandated immunizations at kindergarten entry.

Dr. Paula Whiteman, member-at-large and co-chairperson of the Chapter Committee on Pediatric Emergency Medicine, educates paramedics, nurses and adult emergency physicians on the unique issues affecting the care of the autistic child in the emergency room. She authored an article in the Fall 2008 issue of Emergipress on the approach to patients with autism spectrum disorder during transport. *Emergipress* is the quarterly newsletter of the LA County Department of Health Services-Emergency Medical Services Agency.
Chief of the Division of Infectious Diseases at CHLA and immediate Chapter past president, Dr. Wilbert Mason, continues to promote sound immunization practices and accurate information about vaccines through multiple roles. He serves as the Chapter 2 representative to the California Coalition for Childhood Immunization, has spoken at several regional townhall meetings on the subject and regularly provides expert media content to the Los Angeles Times, most recently on the HIB vaccine.

The Chapter Committee on School Health, under the direction of Chairperson Dr. Michelle Roland, and the Committee on Children with Special Health Care Needs, under the leadership of Dr. Susan Igdaloff, are re-defining their missions and building the infrastructure needed to assume projects or solicit grants to address issues of care in the school setting and for the special needs child. Obviously, both Committees can serve the child with autism but both need additional Chapter member participation to devote to this effort.

So, while World Autism Awareness Day may have passed, it did not go unnoticed by AAP CA-Chapter 2. But, awareness without action is inexcusable. Consider joining your Chapter's efforts in a more formal way on as we all work toward a cure for autism and for better services until such a cure is found.

The child was in the front seat for picture-taking purposes only. She was secured in the back seat before we set out in search of the "biggest doughnut with lots of sprinkles".

THE PEDIATRIC COUNCIL: OUR DIALOGUE WITH INSURANCE PAYERS CONTINUES

Christopher Tolcher, MD, FAAP
Vice Chair, Pediatric Council, District IX

The fourth meeting of the Pediatric Council for the state of California took place on March 20, 2009. Representatives of three of the four A.A.P. chapters in the state and the Pediatric Subspecialty Coalition met with medical directors of most of the major insurance payers to discuss several issues important to pediatricians. This is part of our effort to develop constructive working relationships with the health plans to address problem areas in pediatric care.

The health plan representatives were presented with the joint principles supporting the medical home initiative (as agreed to by the A.A.P., the American College of Physicians, and the American Academy of Family Physicians). We discussed the basic tenets and advantages of a truly comprehensive and coordinated medical home for children, and heard about some pilot projects happening around the country within some health plans—though these are largely in the adult medicine arena. We highlighted the point that for the medical home concept to be successful and hopefully reduce overall health care expenditures and improve outcomes, it has to be supported and adequately reimbursed by payers. At this point, there is no agreement from the plans to fully implement proper reimbursement for providing the medical home model of care for children. But the dialogue will continue.

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Vaccines were discussed once again. Specifically, we stressed the importance of payers adjusting their reimbursement rates quickly to account for recent price increases instituted by Sanofi Pasteur, so that providers are not again forced to bear the burden of paying higher prices without appropriately increased reimbursement. We asked them to commit to the notion that new vaccines be covered after they are approved by ACIP and not waiting for the official CDC and AAP recommendations, which often occur many months after a vaccine is commercially available. We also asked them to be more transparent about their influenza vaccination coverage with providers ahead of the flu vaccination season, particularly with respect to FluMist (the live attenuated intranasal influenza vaccine). We shared with them the general prediction that FluMist is likely to become more the "standard of care" for influenza prevention for patients for whom it is indicated, given that it's price has dropped, it is more popular with families, and that it might be somewhat more effective than the injectible vaccine. Thus, better plan coverage of this vaccine will become more important.

The subspecialty coalition discussed the growing problem of adequate access to pediatric-trained subspecialists, and the importance of health plan support of these providers to have the best outcomes for our patients needing specialty care.

The difficulty of providing confidential services to adolescents in the private sector was discussed. We gave the medical directors the task of helping us to find a way for us to see an adolescent for a confidential visit (for which they are legally entitled to confidentiality and for which they have the right to consent to care, like with pregnancy and STD screening and care) and obtain reimbursement without alerting the parents by generating paperwork to them alerting them to the visit. This subject is being looked into.

We also discussed the importance of proper reimbursement for formal but limited developmental screening that we are all mandated to do under A.A.P. recommendations. Progress has been made on a national level for reimbursement for our M-CHAT autism screens, ADHD questionnaires, post-partum depression screens (using the 96110 procedure code). But reimbursement is inconsistent and at times inadequate, and we informed them that the 2009 Medicare Fee Schedule includes a value assigned to this code that amounts to a Medicare payment of $12.98 for 96110 (which reflects "nurse work" and not physician work in performing this service). Since this screening is now standard-of-care, it should be properly reimbursed.

Finally, Blue Cross announced to us that they are making some important changes to their claims management software beginning this May and fully implement in October. This has important implications for all of us in that if we do not bill for services according to standard AMA and CMS (Center for Medicare and Medicaid Services) coding procedures (especially involving proper use of code modifiers and procedure codes), we will see changes in their denial patterns and potentially reduced reimbursement. For more information on this, see article by Dr. Laura Mabie on this subject in this newsletter. This is yet another reason that we must all code well in order to collect well.

ANTHEM BLUE CROSS MAKING CHANGES TO CLAIMS MANAGEMENT

Laura Mabie, MD, FAAP
Vice President, Chapter 2 Representative, Pediatric Council, California District IX

At the March meeting of the Pediatric Council, the representative from Anthem Blue Cross gave an inservice about a new billing initiative in response to coding errors. The purpose of the initiative is to promote correct billing, provide accurate reimbursement and increase provider payment efficiency.

The goal of the company is to be consistent with other health plan billing practices. Many other health plans in California are currently using the same coding systems (the McKesson's Claims Performance Solutions). The changes will begin to take place on 5-1-09 with complete implementation expected by late October.
Pediatricians need to be aware of a small piece of this initiative. The first is the use of the "-25 modifier" code. This can be used when a significant, separately identifiable E/M visit occurs with the same provider on the same date of service of another procedure or service. The example given is the child brought in for a routine well child visit who is also found to have an otitis media and given an antibiotic

prescription. The diagnosis codes would be V20.2 (well child exam) and 382.9 (otitis media, acute). The correct billing codes would be 99213-25 AND 99391.

The second change that affects pediatricians is the use of the "-57" edit code. This is used to identify the separate reporting of E/M services when a substantial diagnostic or therapeutic procedure is performed on the same day. An example of this might be a child who comes in for an 'infected bug bite' that turns out to be a localized abscess which the provider then drains. The correct coding would be 99213-57 AND 10060.

Please feel free to contact me if you have questions.

HOW TO NEGOTIATE WITH PAYERS FOR ADEQUATE VACCINE REIMBURSEMENT

Glenn S. Schlundt, MD, MPH, FAAP
Member-at-Large

It is important to realize that you can successfully negotiate with payers over vaccine prices. Many pediatricians feel uncomfortable with the prospect of negotiating with payers, both because they prefer to avoid appearing confrontational and because they are unsure of how to proceed. While the prospect of negotiations may appear daunting, in many instances the result is a substantially improved relationship with the payer with whom you negotiated.

Step one: Mine your data

As discussed in the last newsletter, the first step is to see what you are actually being reimbursed for the vaccines you provide, and to relate these to your costs. This is easily done by developing a spreadsheet. To begin, identify any payers who are not reimbursing fairly for any vaccine, especially those who are paying below invoice cost. These will be the payers with whom you are negotiating first.

Step two: Build consensus within your group over how to proceed.

Decide with your colleagues who will be the negotiator for the group, and develop consensus on how to proceed. It is important that all members of the group agree that the present reimbursement from the carriers identified is unacceptable, and further agree that the status quo may not be allowed to continue. Many pediatricians appear to believe – wrongly, in my opinion – that it is their responsibility to provide vaccines to their patients even if the reimbursement is less than the physicians' costs. It is important to make decisions based on sound fiscal planning and reasonable business acumen. Buy-in from members of the group is important to avoid potential issues with office politics going forward. If some in your group voice concerns or objections to re-negotiating vaccine reimbursements, or express doubts over their willingness to go along with actions that may compel the payer to take your group seriously, these issues should be identified and addressed before the call to the payer is made. In the case of vaccines for which you are being reimbursed at less than your cost, consider running a report to determine exactly how much you are losing per physician or as a group over the course of a year. You may want to use the AAP's Business Case for Vaccine Pricing as a guide to compare your observations with what you would expect if you were paid at the 17-28% over invoice value that the AAP has established represents the true actual costs of administering vaccines[1]. Staring at the cold, hard numbers may help to strengthen a group's resolve, as may the notion that while the patient has actually purchased vaccines at a fair price in terms of the insurance premiums that have been paid, this is not reflected in the amounts you or your group may be receiving. Moreover, by reducing your medical group's resources, underpayment for vaccines also reduces a group's ability to provide *pro bono* or other services to other patients who may be more deserving than the insurance company who is presently usurping the benefit of the group's administrative largesse.

Step three: Make contact with the payer.

Review your contract to re-acquaint yourself with any specifics regarding renegotiation. Some carriers will only renegotiate during certain months of the year. Read the contract carefully. Carefully note what the contract does and *does not* say. Clinicians are well advised to retaining counsel in such instances if any doubt exists as to how your contract allows one to proceed.

Next, determine the correct person

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with whom to begin discussions. This may be difficult and time consuming. Do not allow yourself to become discouraged. Bear in mind that the payer is happy with the way things are and will likely behave administratively in a fashion that allows this fiscal behavior to continue. While some argue that it makes sense to work their way up the ladder, speaking first to lower-level contracting personnel, and finally talking to someone with decision-making authority (usually a VP or equivalent in the Contracting department), I would argue that it makes more sense to simply identify the head of the contracting department and deal with them directly. Your time has value too, after all. You will have successfully completed this stage when you get the name, title, and *street mailing address* (not a post office box) for the individual with whom you will be discussing your group's requirements. While some advocate meeting with carrier face-to-face, I prefer keeping things in writing to begin (not email). All letters are sent certified, return receipt requested, with restricted delivery. After the initial formalities, the remainder can usually be handled over the phone.

Step four: Brass tacks.

OK. You and your group are finally here. You have identified a vaccine for which you are being underpaid, your colleagues have agreed that it is too costly for this to continue, and you have identified the correct individual who can help you resolve this problem and you have located them in space by determining a mailing address. Using the AAP's Business model for vaccine pricing as a guideline, write a letter to the carrier stating that the amount you are being reimbursed for the vaccine(s) you have identified needs to be increased to an amount that you and your colleagues have agreed is reasonable. You may want to include a blinded spreadsheet showing what other insurers are reimbursing you for the same vaccine. Do not identify the other carriers by name.

Here comes the tough part. In order for any carrier to take you seriously, you are likely to have to put some teeth into your request. It is unwise to expect any carrier to simply increase their remuneration just because you ask. Some business-savvy pediatricians would argue that the best way to get an insurer's attention is to send them a termination notice. If you choose this approach, the letter should include a termination date that allows reasonable but not excessive time to reach an agreement, bearing in mind you want to leave yourself enough time to a) notify patients who may be affected by your termination; b) notify any *employers* who use this insurer of your intent to terminate, and c) allow the negotiator in your group ample time to think about alternatives that the insurer may present, and to discuss and debate these with other members of the group so that all decisions remain collegial, internally diplomatic, and universally agreed to. I usually give myself six months. Notifying the payer that you intend to inform *employers* who use this payer of your intention to terminate within thirty days (or whatever time frame you choose) of receipt of the letter may be helpful. One down side to the termination notice is that theoretically you could sever your relationship with the carrier, so clearly this strategy is not recommended if you do not want this to take place. If the "termination maneuver" appears too drastic, one can think of alternatives that establish effective limits on what is an unacceptable behavior on the payer's part. In some parts of the country, primary care physicians write prescriptions for vaccines that their patients then bring back to their offices to have administered. Others send patients to the health department. Both strategies can be criticized for having logistical constraints, but one can argue, perhaps convincingly, that without some degree of inconvenience the payer is unlikely to feel compelled to change its behavior.

Conclusion

Chirelstein writes:

"Contracts are voluntary arrangements created by the parties themselves to carry out their own particular aims. People exchange things with one another because they want to not because they have to, and in fashioning the terms of exchange – who is obligated to do what for whom – they are likewise free, within broad limits, to invent their own rules of conduct and to structure their relationship in a way that best suits their personal interests"[2]

And continues:

"The trading process is *not a poker game* in which one player wins what another loses; rather, it is a kind of joint undertaking which increases the wealth of both parties and from which both emerge with a measure of enhanced utility…The act of making an exchange will lead not only to individual but to *mutual advantage despite a thoroughly self-centered outlook* on the part of the traders (italics mine)."[3]

The fact is that insurers expect (though do not necessarily welcome) physicians to re-negotiate their contracts. They know, but are unlikely to share, that legally both parties are viewed equally. While an insurer may have a staff of thousands, and you may be a solo practitioner, under the law each of the two parties have equal rights to "create their own rules by explicit contractual provision."[4] Physicians occasionally worry that the payer might browbeat them with the contract they've already signed, without appreciating that contracts are living documents that are routinely modified and

updated as circumstances change. I have never had an insurer tell me they would not modify a contract because they were holding me to a fee schedule (which was often incomplete) that was several years old. It is in the payer's best interest to keep their physicians happy enough not to leave. Remember that without you they have nothing to sell. They may tell you that there are several other groups in their area that their patients could see should you leave, but they also know that with every physician or group that is lost, their strength in the marketplace relative to other insurers is diminished.

The AAP has many resources for its members to help with issues such as these. Those with increasing interest in these and related topics would do *well* to consider joining the AAP Section on Administration and Practice Management, which has an active and very knowledgeable listserv and a range of web based information. The AAP's Pedialink module "Contract Negotiation with Payers," (http://practice.aap.org/content.aspx?aid=1924&nodeID=2000) by Edward Zissman is another excellent resource.

In my experience, the hardest part of negotiations occurs at the beginning. Once the correct individual has been determined and a trusting relationship established, the remainder of the exercise tends to become less difficult. Data, determination, and a sense of fairness are mandatory components of any discussion. The results can be a happier ending for you and your practice.

References:

1. www.aap.org/securemoc/reimburse/BusinessCase.pdf
2. Concepts and Case Analysis in the Law of Contracts. 5th ed. Chirelstein, M.A. Foundation Press, 2006. Page 3
3. IBID page 9
4. IBID page 55

FIRST ANNUAL CONFERENCE ON HEALTH AND HUMAN RIGHTS IN SOUTH LOS ANGELES TO BE HELD ON JUNE 5, 2009

There is a fundamental crisis of health and human rights in south Los Angeles. South L.A. has the poorest health outcomes and indicators in the County of Los Angeles, mirroring the health status in some developing nations. Homelessness, slum housing, violence, food disparity and lack of resources reflect the underlying epidemic in the social determinants of poor health.

South Los Angeles, formerly known as South Central Los Angeles, encompasses nearly 100 square miles. It includes the communities located south of the Santa Monica Freeway, east of La Brea, and north of the Century Freeway. With more than one million residents, South Los Angeles is home to many historic neighborhoods, including Leimert Park, the Crenshaw District, Morningside Park, West Adams, Watts, Willowbrook, Compton, Baldwin Hills, Inglewood and Lynwood.

While data fail to fully convey the health and human rights situation in south Los Angeles, the following statistics help illustrate the degree of inequity and burden of disease in the community.

In South Los Angeles:

- There are only 11 pediatricians per 100,000 children, less than one fifth the LA County average. This contrasts with 190 /100,000 in West Los Angeles
- 30% of adults are uninsured
- 37% of households are overcrowded
- 64% of schools lack adequate staff, resources and do not provide a clean, safe and functional learning environment
- 91% of homeless residents are unsheltered
- Homicide is the leading cause of premature death; 40% of LA County homicides occur in South LA
- Five South LA emergency rooms have closed since 2000. Only one full-scale ER/trauma center remains to serve over one million residents in a nearly 100 square mile area
- There are 0.11 school-based health centers per 1000 uninsured children

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This groundbreaking conference will advance the understanding of health and human rights in south Los Angeles and develop a call to action to improve the health of residents at home and beyond. Colleagues from across the world will share their experiences and examples of the international health and human rights movement.

Confirmed speakers include:

- Supervisor Mark Ridley-Thomas, Los Angeles County, 2nd District
- Congressman Dennis Kucinich, Chair, Domestic Policy Subcommittee
- Dr. Violeta Menjivar, Former Mayor of San Salvador, El Salvador
- Robert K. Ross MD, President & CEO, The California Endowment
- Carolina Reyes MD, Executive Director, Los Angeles Best Babies Collaborative
- Helen Potts, JD, PhD, Chief of Health Programs, Physicians for Human Rights
- Anja Rudiger, PhD, National Economic Social Rights Initiative/National Health Law Program

This conference is sponsored by The California Endowment, LA Care Health Plan, St. John's Well Child and Family Centers, Los Angeles Best Babies Network and the California School Health Centers Association. It is endorsed by the American Academy of Pediatrics Chapter 2, the Society for Adolescent Medicine, Charles Drew University of Medicine and Science, Physicians for Human Rights, Physicians for Social Responsibility, Southside Coalition of Community Health Centers, UCLA Program in Global Health among many others.

The conference will be held on June 5 at the Museum of Natural History in Exposition Park located at Exposition Blvd. and Figueroa Ave.

For more information and to register for the conference please go to: http://www.southlahealthandhumanrights.org/index.html or call 323.541.1600 x 4000
Registration is free.

SCHIP/MEDICAL EXPANSION: BE CAREFUL WHAT YOU WISH FOR

Jeffrey Penso, MD, FAAP
Past President, Chapter 2

Hope and change have arrived along with a new climate for reform of our medical system. It is not yet clear how change will be structured, but it is likely that American pediatrics will be impacted significantly by recent expansion of the SCHIP program.

SCHIP will bring opportunities and challenges in California, where it is called the Healthy Families program. Healthy Families started in the heady nineties, when prosperity seemed permanent. The program was the product of a historic compromise between Democrats wanting to expand health care to uninsured children and Republicans who pushed expansion via the private sector.

Voila- Healthy Families, a state sponsored program, but administered by private plans, such as Blue Cross. The name reflected initial optimism, that not only could the Golden state cover needy kids, but their parents as well. The program had a quick start, with significant outreach to immigrant children. Gov. Pete Wilson, a moderate, advocated that all resident children (i.e. immigrants) get full benefits at minimal cost.

California budget realities have prevented coverage of parents, at least for now. Like Medi-Cal, the program is underfunded, which has caused Blue Cross (now Anthem) to withdraw from administration in 12 counties. And the peculiar method of vaccine procurement makes the program anathema to some primary care doctors (more on this below.)

The new SCHIP law increases the threshold for coverage to 200 percent of poverty income, and advocates assert that many previously uninsured kids can be signed up. However the size of the uninsured pediatric population is debatable. Recently the state of Hawaii expanded its state program to cover uninsured children. There was initial fanfare. As the program progressed it became clear that it was costly and duplicative. Instead of enrolling new kids, there was a transfer of already insured kids from pri-

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vate insurance into the state program. This process, called 'crowd out' threatened the solvency of Hawaii health care and led to the elimination of the program.

Does it matter that children may switch from private to state sponsored programs, like Healthy Families? In the world of real economics it does. About fifty percent of primary care pediatricians and FPs contract to cover SCHIP kids, which may provide enough Primary care physicians. However specialty care, e.g. neurology, orthopedics is in short supply. Most of these services are provided by specialty physicians at academic centers. Already overburdened and short staffed, parents soon find that these centers of excellence are effectively rationing care, by delays in appointments and follow up.

How can we get specialists in the community to cover impacted kids? There are two ways. One is to significantly increase payment rates. A young orthopedist after completing a decade of education may be 300 to 400 thousand dollars in debt. She cannot afford to see SCHIP patients in her office at current payment rates. Specialists prefer patients with excellent coverage, and some are reluctant to deal with any insurers, private or state programs. The alternative is to force physicians to work for the government a la Canada - a monumental political change for Americans.

Then there is the vaccine issue, which could kill SCHIP in California. While Medi-Cal provides free vaccines to patients through the Vaccine For Children program, Healthy Families treats vaccine purchase and reimbursement as a private service. This means that PCPs who participate in Healthy Families will have to purchase and store vaccines, and then seek reimbursement from plans or administrators. Most of the public and many physicians (other than pediatricians) are not aware that:
-the number and cost of vaccines for children have increased geometrically in the past 15 years.
-the monthly outlay for vaccine purchases is the costliest component of a practice expense, well over the margin of profit for a practice. It now costs $1200 to immunize one child. (Stephenson, M. Inf. Dis. Child. Jan. 2007)
-administration expenses are not adequately reimbursed, according to American Academy of Pediatrics; leaving many practices at a loss in the vaccine 'business'.
Vaccines have become the loss center of primary care. Some pediatricians will serve Medi-Cal patients, administer free vaccines provided by the state and accept a small profit margin. But these same physicians cannot accept large numbers of Healthy Families kids as long as there is a vaccine burden linked to the program.

So be careful what you wish for.

Healthy Families is worthy of expansion and promotion. But success will require funding reforms. Primary care doctors cannot participate unless and until Vaccine For Children plan program is allowed to cover Healthy Families patients. And specialists cannot afford to participate until there is improved funding of pediatric specialty care.

HOUSE STAFF AWARDS PROJECT

Al Yusin, MD, FAAP
Chair, Committee on Service, Education and Mentoring

The Southwestern Pediatric Society [SWPS] was established in the late 1930s as a resource for continuing education and the exchange of information for practicing Pediatricians in the Southern California area. In addition to providing this service, they introduced a novel program for Pediatric House staff., whereby house staff members could submit abstracts of research papers or case presentations to SWPS. A SWPS committee evaluated the abstracts and accepted three of them for presentation before the society at one of their meetings. The group heard the papers and voted on which they thought was the best one. The other two papers were identified as "runner ups". Each presenter received a cash award for their presentation, the "best" paper receiving more than the other two.

As a result of declining membership SWPS was unable to sustain itself and disbanded three years ago. However, it was felt that the Pediatric House Staff award program was a unique and exciting program that should be continued if possible,

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as it stimulated house staff research and careful case analysis. Therefore, as a former member of SWPS, I approached our local chapter of the American Academy of Pediatrics to assess their interest in picking up this activity. They were interested in doing so with some modification in the previous format.

Two papers were chosen for presentation at the Palm Springs Conference by Chapter 2 in February 2009, with each presenter receiving the same financial award.

The presented papers are being printed in the Chapter Newsletter for the first time. I am sure that the membership will find them well written and informative.

"ORBITING" THE DIAGNOSIS: CASE PRESENTATION AND LITERATURE REVIEW

Anita Gupta, MD
Pediatric Resident, Childrens Hospital Los Angeles

Susan Wu, MD
Assistant Clinical Professor, Division of General Pediatrics, Childrens Hospital Los Angeles and Keck School of Medicine at University of Southern California

Case presentation: *A 10-year-old previously healthy female presents to the Emergency Department with right eye swelling, blurry vision, and eye pain.*

For the past two months, she has had intermittent right upper eyelid swelling and erythema, without fevers, viral illnesses, joint pain, other rashes, or facial trauma. Her primary physician initially treated her with antibiotic ophthalmic drops without improvement. She was referred to an ophthalmologist, who prescribed two courses of oral antibiotics (clindamycin and dicloxacillin) without complete resolution, although the swelling did wax and wane.

On the day prior to admission, the edema spread to the right lower eyelid and she had pain with eye movements. She denied headaches, upper respiratory symptoms, vomiting, or diarrhea. There is a dog at home, but no cats. No recent travel was noted.

On physical exam, she had right upper and lower eyelid tense swelling with erythema. She had an upward gaze palsy, ptosis, proptosis, and photophobia. She raised her chin to improve her binocular vision and noted pain with downward gaze. Lateral gaze was intact without nystagmus. No conjunctivitis or gross visual field deficits were noted, but she did report blurry vision. Fundi were sharp and pupils were equal, round, and reactive to light and accommodation. The rest of her physical exam was within normal limits.

CBC showed white blood cell count of 8.19 K/uL. CRP was 2.8 mg/dL and ESR was 60 mm/hr. A head CT showed preseptal and postseptal cellulitis with lacrimal gland involvement, and maxillary sinusitis. No abscess was seen. She was admitted for orbital cellulitis, presumed to be secondary to sinusitis, and was started on vancomycin and ampicillin/sulbactam. The swelling and pain initially improved after 1-2 days of IV antibiotics, but then she developed a low grade fever and worsening swelling, with CRP increasing to 4.3 mg/dL. Further lab testing and studies revealed the diagnosis.

Discussion: Due to persistent upper eyelid swelling despite antibiotics, the diagnosis of orbital pseudotumor was considered. Rheumatology was consulted to assist in evaluation of possible non-infectious inflammatory etiologies of orbital pseudotumor. Anti-neutrophil cytoplasmic antibody (ANCA) testing was performed. C-ANCA (anti-proteinase-3) was normal at < 6 Units/mL, and p-ANCA (Units/mL) was elevated at 58 Units/mL (normal < 6). IgG, IgM, and IgE levels were elevated. Urinalysis showed microscopic hematuria with no proteinuria. Chest x-ray was normal. ACE level was normal.

Neurosurgery was consulted to biopsy the inflammatory mass in the orbit (fig. 1). Bacterial, fungal, and AFB cultures from the tissue were negative. However, histopathology (fig. 2) showed chronic inflammation with granulomas leading to the diagnosis of orbital Wegener's granulomatosis (WG).

Her swelling improved with methylprednisolone IV 30 mg/kg/day for 3 days, followed by a prednisone taper. Remission was maintained with methotrexate (20 mg) weekly plus a leucovorin (5 mg) rescue. Her most recent chest and orbital CT scans were normal, and she is reportedly doing well!

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The condition: WG is a necrotizing small vessel vasculitis of presumed autoimmune origin. Multisystem granulomas can form, especially in the lungs and kidneys. The orbits can be affected either from primary inflammation or contiguous extension from the sinuses in the limited form of the disease.[1] Positive p-ANCA (myeloperoxidase) has a 10% sensitivity and 12% specificity for WG, while positive c-ANCA (anti-proteinase-3) has a 91% sensitivity and 99% specificity.

Orbital pseudotumor is an ophthalmologic condition characterized by idiopathic inflammation and swelling of tissues within the orbit. Generally, only one eye is affected, and it occurs more commonly in females. Eye pain typically dominates the presenting symptoms, but associated epiphora, injection, proptosis with vision loss, diplopia, and ophthalmoplegia are also seen.[2] On CT images, an inflammatory mass is seen.

Differential diagnosis: Bacterial or fungal infection, lymphoma of the orbit, sarcoidosis, Graves orbitopathy can cause an orbital mass.[3] Small vessel vasculitidies associated with orbital inflammation include WG, polyarteritis nodosa, Crohn's disease, Churg-Strauss, microscopic polyangitis, and sarcoidosis. Orbital pseudotumor is a diagnosis of exclusion, but also responds to systemic steroid treatment. The pathologic triad of parenchymal necrosis, vasculitis, and granulomas are seen in 50% of orbital biopsies and 91% of open lung biopsies in patients with WG.

Treatment: Therapy for orbital WG includes glucocorticoids and cyclophosphamide with the addition of methotrexate to maintain remission.

Lessons for the clinician: If presumed orbital cellulitis does not improve with conventional therapy, think about other possible causes of inflammatory changes. Biopsy and ANCA testing may help lead to a definitive diagnosis. Subspecialist consultation is often helpful if available. Because early aggressive treatment of orbital WG has been shown to prevent blindness[4], it is important to identify patients with this condition.

References:

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PRIMARY CARDIAC OSTEOSARCOMA WITH METASTASIS TO THE THYROID: CASE REPORT

Bryan Mitton, MD, Ph.D. and Noah Federman, MD
University of California, Los Angeles, Department of Pediatrics
Division of Hematology-Oncology

Primary cardiac neoplasms are rare occurrences, with an incidence of approximately 0.002%; the majority of these tumors are benign and are associated with an excellent prognosis. In contrast, primary cardiac malignancies such as angiosarcomas and leiomyosarcomas are associated with poor prognosis, as their location often precludes wide excision and their rarity precludes the utilization of large controlled trials to establish the efficacy of various chemotherapeutic regimens. Primary cardiac osteosarcomas, which comprise less than 10% of primary cardiac neoplasms; to date, only 37 have been reported in the literature. These tumors are aggressive, and often elude detection until their growth exceeds cardiopulmonary reserve.

A previously healthy 19-year-old Hispanic male presented with a two week history of progressive fatigue, dyspnea, cough, and chest pain. A chest radiograph showed bilateral diffuse infiltrates, and he was treated with a 2 week course of amoxicillin for presumptive pneumonia. His symptoms continued to progress and he presented three weeks later with intermittent peripheral cyanosis upon even mild exertion, with associated chest pain and respiratory distress. A repeat chest radiograph showed worsening bilateral infiltrates. An echocardiogram performed showed a large multilobular mass nearly filling the left atrium and obstructing left ventricular inflow with extension into the superior left atrium and pulmo-

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nary veins. There was significant pulmonary hypertension with estimated pulmonary artery systolic pressures of 70-75 mmHg.

Due to the extensive nature of the mass and progression of symptoms, open heart surgery was performed to debulk and attempt total resection of the tumor. Tumor remained on the posterior and lateral aspects of the left atrium and within the pulmonary vein making further dissection impossible at that time. Pathology was consistent with the diagnosis of high-grade cardiac osteosarcoma showing spindle-cell lesions with plump pleomorphic cells, a high nuclear-to-cytoplasmic ratio, and widespread lace-like osteoid deposition.

A metastatic evaluation was then undertaken, which revealed several pulmonary nodules. Whole body positron emission tomography (PET) with 18-fluoro-2-deoxyglucose (FDG) showed hypermetabolic uptake within the known cardiac mass and, surprisingly, a hypermetabolic thyroid nodule. Initial CT scan of the neck, performed simultaneously, was unremarkable. Technetium 99m bone scan demonstrated no evidence of bony metastases. Chemotherapy was initiated three weeks post-operatively with a regimen of cisplatin, plus ifosfamide and etoposide alterating with doxorubicin. Blood cell counts were maintained with filgrastim and erythropoietin post chemotherapy. He tolerated this chemotherapeutic regimen reasonably well with minimal toxicity.

Repeat cardiothoracic surgery was performed after four cycles of neoadjuvant chemotherapy. The tumor was based on the posterior and lateral wall of the left atrium with near occlusion of the left superior pulmonary vein; it was resected with a 5mm margin of atrial tissue. The left upper lobe of the lung was dissected from the left lower lobe and removed en bloc with the tumor and the posterior wall of the left atrium. Tumor pathology again showed high grade osteosarcoma with approximately 40% necrosis. All of the surgical margins were negative for tumor, and the lung parenchyma was not involved. The left thyroid lobe was also later surgically removed, and pathology showed a malignant neoplasm consistent with metastatic osteosarcoma.

Whole body PET/CT scans and cardiac MRI were negative for recurrent disease after completion of chemotherapy and surgery. Unfortunately, 6 months later, the patient began to complain of numbness and tingling in his right fingertips. An MRI of his brain revealed a 2 cm mass in his posterior pons consistent with metastatic disease. He was treated with stereotactic radiosurgery, but later developed right facial paresis, and right facial dysesthesia, dizziness and poor balance. His symptoms progressed and he passed away 22 months following initial diagnosis from progressive CNS disease.

SHOULD THE STATE PURCHASE VACCINES FOR ALL CHILDREN IN CALIFORNIA?

Christopher Tolcher, MD, FAAP
Chair, Pediatric Practice Committee

When it comes to fulfilling our obligation to vaccinate all children, there is no doubt that pediatric providers are hurting. This is "issue #1" for pediatricians practicing in the private sector, where most of the state's vaccines are given. Many of us simply cannot continue to eat the profit loss of vaccinating our patients and still expect to remain in a financially viable practice, so it is clear that something has to change. This problem must be attacked on several fronts. First and foremost, pediatricians need to be empowered to renegotiate better contracts with payers to recoup proper reimbursement (see article by Dr. Glenn Schlundt in this newsletter). The A.A.P. has to advocate for the practitioner with insurance payers and our government to find remedies for this crisis. Fortunately, much of this is happening, but progress takes time. But time is not something we have a lot of when it comes to the situation many practices find themselves in. We need to consider all of our options in addressing this problem.

One of the options on the table for solving this problem is instituting some form of "universal vaccine purchase" for the state of California. California is one of 21 states that provide vaccines to VFC-eligible children only. Currently eight states have truly universal vaccination programs whereby the state purchases vaccines for all children in the state (instead of just those covered under the VFC program). Twenty nine other states have programs that supply vaccines beyond only the VFC-enrolled children, including providing

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some or all vaccines for children who are insured but remain under-insured for vaccinations. Each of these states has the purchasing power of a very large group, so this has the benefit of saving money overall on the purchase price of vaccines. Whether these programs are a success in these states is not easy to determine, since the results of these programs are not being studied or are rarely reported on in the literature. The program centralizes the distribution system and removes what is currently the largest budgetary expense of most pediatric practices. In states that have such a program, there are both advocates and opponents of such a program. As you might guess, those who tend to suffer the most financially from vaccinating tend to "love it", while those who could make money and also want to have more control over vaccine purchasing do not. And like any other government-run program, there are some disadvantages that are not trivial.

In states with such universal purchase programs, transferring the financial burden to the state has been proven to be very burdensome to state budgets. Federal funding (through what's known as "Section 317" discretionary grants) has been limited and has not been increasing with the increasing cost of vaccinating in recent years. This has led to delays in providing some of the newer and more expensive vaccines and in some cases has led to states rethinking and limiting their programs such that they do not provide the newer vaccines. (One potential solution to this is to have insurance payers pay the state for the cost of vaccinating children covered under their plans, while the state funds vaccines for the uninsured, and payers would be required to financially support all recommended vaccines for all "covered pediatric lives"). There have been problems with providers not having all recommended vaccines in stock due to supply and distribution problems. On a national level, there has been opposition from the vaccine industry due to reduced profits when more vaccines are provided at bargain prices to these governments. This has led to claims that reduced profits would hamper research and development of new vaccines. Having a universal purchase system makes it even more important that providers are reimbursed properly for the administration fee to cover the costs of stocking, supporting, and providing vaccines (and this is often legislated as part of the program to ensure uniform reimbursement for this).

What effect switching to universal purchase will have on the rate of completely vaccinated children in the state is not entirely clear. In the case of North Carolina, a study showed that the vaccination rate increased somewhat after the implementation of a universal purchase program (this program covered the uninsured and those underinsured for vaccines in the state and did not affect those who are insured for vaccinations, so perhaps that explains the improvement). When one considers the rate of successfully vaccinating with newer vaccines, the picture may not be so rosy, since most states have been unable to fund the newer vaccines. Given recent evidence that providers are having trouble keeping all vaccines in stock due to the financial cost—as well as those who are considering not providing vaccines due to cost, which seems to be more likely among family practitioners given some recent surveys—it is reasonable to think that vaccination rates will only continue fall if something is not done soon. Of course, this is in addition to the falling vaccination rates we are currently seeing due to growing vaccine refusal by parents.

In order to gain more financial freedom from the growing burden of purchasing vaccines, pediatric providers would stand to lose the control that comes with being independent purchasers. Sometimes fixing one problem means creating others, and we are left choosing between the least offensive alternative. In the end, we need to determine what approach will improve our ability to continue our mission to vaccinate all children yet remain financially successful by having a margin of profit. Currently, the A.A.P. does not have an official position on advocating for or against universal vaccine purchase. *What do you think?* If you want to have a voice in this debate, go to a local A.A.P. Town Hall Meeting which happen periodically throughout our chapter and get involved in the discussion. Let your A.A.P. Area Representatives hear your opinions and they can funnel them to our Pediatric Practice Committee and the Pediatric Council. If you wish you can even send your comments directly to me at ctolcher@sbcglobal.net.

In keeping with the notion that this is "issue # 1" for those of us in community practice, there are other articles in this newsletter about the other approaches we are taking to tackle this problem—helping you to go about getting better reimbursement, advocating with payers at the Pediatric Council, and advocating via the state legislature to mandate improved reimbursement for vaccines. We have to do all that we can so that children are no longer vaccinated for the public good on the financial backs of those of us just doing our best to do the right thing for our children.

A BILL ON ADEQUATE VACCINE REIMBURSEMENT

Damodora Rajasekhar, MD, FAAP
Legislative Committee

The California Medical Association along with American Academy of Pediatrics/California, and California Academy of Family Physicians co-sponsored bill **AB 1201** (authored by Manuel Perez, D-Coachella) to address the issues related to adequate vaccine reimbursement. This bill was introduced in March of this year.

AB 1201 will:

1) require health plans and insurers to fully reimburse physicians for the direct and indirect costs to acquire and administer recommended vaccines that are already required to be covered;

2) prohibit health plans and insurers from charging co-payments, deductibles or other out-of-pocket expenses that deter parents from immunizing their children; and

3) prohibit health plans and insurers from including the cost of immunizations in a policy's dollar limit provision.

On April 14th, 2009 physicians from different counties of California went to Sacramento and met with their state senators and assemblymen/women and presented the facts related to vaccine financing and asked for their support for Assembly Bill AB1201. The final details are being worked out on this bill, so stay tuned for more information as it works its way through the California state legislature.

CHAPTER 2 GOES TO SACRAMENTO

Susan Wu, MD, FAAP *Member-At-Large* **Roberta Kato, MD** *Pulmonary Fellow, Childrens Hospital LA*

On April 14th, in the midst of the California budget crisis, pediatricians and pediatric residents traveled to the state's capitol in Sacramento to advocate for child health legislation and funding. The California AAP District IX (AAP-CA) collaborated with the California Medical Association (CMA) in their 35th Annual Legislative Leadership Conference. Chapter 2 was well represented, including many pediatric residents and fellows from Kaiser Sunset, Harbor-UCLA, and Childrens Hospital Los Angeles. Funding for travel was provided for pediatric residents by the California Endowment, through the California Community Pediatrics and Legislative Advocacy Collaborative, with the leadership of Lisa Chamberlain of Stanford and Nancy Graff from UC San Diego.

The night before the Legislative Conference, UC Davis and AAP-CA sponsored an educational program at the UC Davis M.I.N.D. Institute. Speakers included AAP Executive Director Kris Calvin, UC Davis faculty Elizabeth Miller, AAP State Government Affairs representatives Marc Lerner and Shannon Udovic-Constant, and Lisa Chamberlain. The agenda included discussion on key issues and legislation, a workshop on how to represent the AAP, and a role-playing session to practice speaking with legislators.

At the Leadership Conference, a comprehensive policy overview was presented by Dustin Corcoran of the CMA including a review of A.B.1201 (Perez) co-sponsored by the AAP-CA, CMA and AAFP. A.B. 1201 will require payers to adequately reimburse for vaccines and the administrative costs (staff time, supplies, storage, etc) making it possible for pediatricians to continue the best possible care for patients. The keynote speaker was Senate President pro-Tem Darrell Steinberg. Pediatricians received additional training through AAP-CA including information about policy related to children's health and well-being. In addition to the top priority of supporting AB 1201, the AAP-CA's agenda including ensuring continued support of matching funds for Healthy Families. Lauren Kagan, MD, a first year pediatric resident from Childrens Hospital Los Angeles, presented information to connect the need for early intervention programs to ensure optimal development and medical treatment to success in school. Training also included how to approach legislators and staffers during meetings, how to get messages across effectively and concisely and most importantly, how to continue long-term relationships with our elected officials.

During the afternoon, AAP members met with Legislators and staffers in private meetings. Chapter 2 members met with the staff of Senator Gilbert Cedillo (D-22) and Senator Carol Liu (D-21). About 50 people also attended a special meeting with Senator Marc Leno (D-3), who spent time discussing his proposed single healthcare payer bill, SB 810. It was an opportunity to ask hard questions as the AAP-CA has not yet determined a position on the bill. Residents also sat in on the Assembly Health Committee meeting where bills were presented, discussed and parties presented their testimony, support or opposition. By the end of the day residents returned to their home institutions with an understanding of the legislative process and felt empowered to put their new advocacy to work.

UPCOMING EVENTS!

AAP-CA2 TOWN HALL MEETING

Organized By Ken Saul, MD, FAAP
Maggiano's, 6100 Topanga Canyon Blvd.
Woodland Hills
6:30 PM, Wednesday, June 3, 2009
Topic: *"Update on HPV Vaccines"*
Speaker: Lawrence A. Ross, M.D.
Professor of Clinical Pediatrics,
University of Southern California, Department of
Infectious Diseases & Virology
Childrens Hospital of Los Angeles
RSVP: call Ken Saul at (805) 494-1948

FIRST ANNUAL CONFERENCE ON HEALTH AND HUMAN RIGHTS IN SOUTH LOS ANGELES

L.A. Care-Children's Health Committee
Endorsed by AAP-CA2
June 5th, 2009
Topic: *Educating on the health conditions of children and adults in the South Los Angles area to develop a better course of action to serve residents' health needs.*
To register, and for more information, go to http://www.southlahealthandhumanrights.org/index.html
or call **(323) 541-1600 x 4000**
Registration is free.

AAP-CA CHAPTERS 1, 2, 3 AND 4

31ST ANNUAL LAS VEGAS SEMINARS

Pediatric Update
Caesars Palace, Las Vegas, NV
November 19-22, 2009
Program information and registration available on the District website: www.aap-ca.org

Coming up in 2010
SAVE THE DATE!

AAP CA2's CLINICAL PEDIATRICS CONFERENCE

Hilton Palm Springs Resort
February 11 – 14, 2010

AAP CA2's ADVANCES IN PEDIATRICS CONFERENCE

The Flamingo Hotel, Las Vegas
April 22 – 25, 2010

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