EXPERT OPINION

Developmental-Behavioral Screening Saves

To help judge effectiveness in identifying children with developmental and behavioral problems, physicians should ask themselves this question: "What is my referral rate?"

If that rate is less than 16% (1 out of 6), such problems are being missed. This figure may seem high, but the Centers for Disease Control and Prevention states that the prevalence of such disabilities is 16% to 18%. Our national high school dropout rate is close to 20%, according to the U.S. Census Bureau. Many developmental disabilities can contribute to school failure, as do psychosocial risk factors. But interventions are available that can greatly improve a child's chance of success at school. Early identification and intervention are therefore essential, not only for those with disabilities but also for children at risk for dropping out for other reasons, such as poverty or parents' limited education.

BY FRANCES PAGE GLASCOE, PH.D.

Why do physicians fail to detect so many children with developmental and behavioral problems? The answer lies in the detection methods they use. Many practices still use informal milestones checklists or key items from the Denver II or Prescreening Developmental Questionnaire II (PDQII), which simply don't work. Informal questions to parents don't work either. We don't put a hand to a forehead to detect fever. We measure. In the same way, accurate screening tools are required to sort developmental-behavioral problems requiring referral from those that can be addressed by in-office counseling.

The American Academy of Pediatrics (AAP) Section on Developmental and Behavioral Pediatrics has a Web site that describes and lists accurate screening tools designed for use in primary care (www.dbpeds.org). Several are workable for busy clinics because they use information from parents, and the screens can be deployed in waiting or exam rooms, or even online before the visit. These instruments are as effective as lengthier measures requiring providers to elicit skills directly from children.

By having information about parents' concerns and/or children's skills before the actual encounter, physicians can save time for more valuable services such as parent education or referrals. It also helps focus the visit, enhance the teachable moment, and reduce those "oh, by the way" concerns that could take up additional time.

But to implement quality screens, physicians must consider the cost of these tools and whether reimbursement will be forthcoming.

Often, correct coding is all that is needed to recover all costs. It is important to know that when a quality screening test is performed along with any evaluation and management service such as preventive medicine or office outpatient, the modifier "–25" should be appended (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). The procedure code, 96110, is used to indicate that screening occurred. If two screens were administered, then add "X 2."

In 2005, the Centers for Medicare and Medicaid Services published a total relative value unit (RVU) of 0.36 for 96110, which amounts to a Medicare payment of $13.64. RVUs only cover staff time, so it is critical to help office staff appreciate the value of early identification and of managing work flow.

None of this can guarantee that a valid claim will be accepted, so the AAP is willing to help with denied claims either by phone (call the Coding Hotline at 800-433-9016, ext. 4022) or on its site, www.aap.org (search Coding Hotline).

The material cost of screening, after purchasing tools, is about $0.50 per visit or less (either for materials purchased from publishers or from photocopying costs, when permitted). Quality screening tests are expensive to develop, maintain, and translate, hence the price. But the costs are more than offset by the savings in provider time and from improved reimbursement.

Some providers are reluctant to screen because they aren't sure services are available. In fact, early intervention programs of good quality and proven effectiveness are mandated by law and are available throughout the United States. (See box.)

Most children do not outgrow developmental problems. When a delay is detected, the most cautious and careful approach is not to defer, but rather to refer and to refer promptly. ■

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Resources to Have Ready

Intervention takes many forms. Here are some helpful links:

► **www.aap.org/referral** For locating developmental-behavioral, neurodevelopmental, and specialty pediatricians.

► **www.nectac.org** For links to state, regional, and local early intervention and testing services for young children.

► **www.ehsnrc.org** For information about Head Start programs.

► **www.childcareaware.org** and **www.naeyc.org** For locating preschool and day care programs.

► **www.patnc.org** and **www.kidshealth.org** For information about parent training classes.

These links have useful information on tools, training, billing, and coding:

► **www.dbpeds.org** AAP's Section on Developmental-Behavioral Pediatrics Web site has information on implementing the new policy on early detection, and more. Providers can post questions on a discussion list.

► **www.pedstest.com** For slide shows offering training on screening tests, downloadable parent education handouts, and a list of questions and answers about screening, services, and referral.

► **www.developmentalscreening.org** This site helps busy practices with implementation of screening tools.

Source: Dr. Glascoe

Long-Term Benefits of Eating Disorder Therapy Found Mixed

BY SUSAN LONDON
Contributing Writer

SEATTLE — Initial improvements in anorexia nervosa and bulimia nervosa achieved in an intensive residential treatment program are largely sustained an average of 4 to 5 years later, researchers reported.

"Data on long-term follow-up of individuals with anorexia nervosa and bulimia nervosa following intensive inpatient or residential treatment are limited," said Dr. Timothy D. Brewerton, a psychiatrist at the Medical University of South Carolina, Charleston.

Dr. Brewerton and his colleagues surveyed patients with eating disorders who had received at least 30 days of treatment in the Monte Nido Residential Treatment Program, in Malibu, Calif. Dr. Brewerton reported that he was paid as a consultant by Monte Nido to collate, analyze, and present the survey data.

Outcomes on the Eating Disorder Inventory-2 (EDI-2), Beck Depression Inventory (BDI), and a structured eating disorder assessment were evaluated at admission, discharge, and the most recent of 13 postgraduate follow-ups (range from 1 to 10 years).

The analyses were based on 85 patients with anorexia and 71 patients with bulimia. The mean time between discharge and postgraduate follow-up was 4.5 and 4.1 years, respectively. On average, the patients in each group were aged about 30 years (range, 17-57).

In the anorexia group, mean body mass index (BMI) scores increased significantly between admission and discharge (from 16 to 18 kg/m^2), Dr. Brewerton said at an international conference sponsored by the Academy for Eating Disorders and cosponsored by the University of Mexico. Moreover, a further significant increase was seen from discharge to postgraduate follow-up (from 18 to 19).

By discharge, anorexia patients had significant improvements in 9 of 11 EDI-2 subscales, with further significant improvements in five of the subscales—body dissatisfaction, drive for thinness, interoceptive awareness, immaturity fears, and asceticism—between discharge and postgraduate follow-up.

The percentage of anorexia patients with a good outcome, defined as a return of BMI to at least 18 and normal menses, increased between discharge and postgraduate follow-up (from 19% to 41%). There also was a decrease in the percentages with an intermediate outcome, defined as restoration of BMI or normal menses (from 48% to 46%), and a poor outcome, defined as restoration of neither BMI nor menses (from 33% to 12%).

The frequency of 3 of 10 eating-disordered behaviors—bingeing, laxative use, and vomiting—was significantly higher at postgraduate follow-up than at discharge, and the values remained significantly or marginally lower than those at admission.

Scores on the BDI decreased significantly between admission and discharge, and remained so at postgraduate follow-up. About 85% of patients reported they were improved or significantly improved at the latter assessment.

Patients in the bulimia group had significant improvements in all 11 EDI-2 subscales by discharge, and the benefits persisted to postgraduate follow-up, reported Dr. Brewerton, who also is in private practice in Mt. Pleasant, S.C. Their BMIs were in the normal range at all three assessments.

Between discharge and postgraduate follow-up, there was a decrease in the percentage of bulimic patients with a good outcome, defined as complete cessation of bingeing, purging, and other compensatory behaviors (from 97% to 62%) and an increase in the percentages with an intermediate outcome, defined as a reduction in those behaviors by at least half (from 3% to 19%) and a poor outcome, defined as a reduction of less than half (from 0% to 19%).

The frequency of 7 of the 10 eating-disordered behaviors decreased significantly by discharge and remained at that level at the postgraduate follow-up. BDI scores in this group also fell by discharge and remained steady. About 85% of patients said they were improved or significantly improved.

Receipt of therapy during follow-up is still being analyzed, said Dr. Brewerton. ■