TESTIMONY OF THE AMERICAN ACADEMY OF PEDIATRICS

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

STATEMENT FOR THE RECORD

PRACTICING PHYSICIANS ADVISORY COUNCIL

ON BEHALF OF

THE AMERICAN ACADEMY OF PEDIATRICS

February 10, 2003

The American Academy of Pediatrics is pleased to be able to present its testimony before the Practicing Physicians Advisory Council. I am Dr. Julia Pillsbury, a Board-certified Pediatrician in private practice from Dover, Delaware.

The Academy is an organization of 57,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents, and young adults. The topic on which I have been asked to focus is the proposed rule for the 2004 Medicare Physician Fee Schedule.

IMMUNIZATION ADMINISTRATION

Immunizations are a cornerstone of both public health and the future of children's health. In the 2003 Medicare Physician Fee Schedule CMS acknowledged that the model of immunization administration may be different in the pediatric population than it is in the Medicare population. The Academy commends CMS for recognizing this. CMS noted that it will consider whether the amount of counseling of the patient and/or family is different for childhood immunizations than

for the typical Medicare service. It will also consider whether coding changes to reflect these differences would be appropriate. The Academy feels strongly that pediatric immunizations do require more counseling. We took the first step in implementing such coding changes this past weekend (February 7-9, 2003) during the CPT Editorial Panel meeting by presenting a proposal for new pediatric-specific immunization administration CPT codes. If approved by the Panel, the new codes will go to the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), where recommendations will be developed for relative value units (RVUs). The RUC-recommendations emanating from that meeting will be forwarded to the CMS for consideration for the 2004 Medicare Physician Fee Schedule. While the current practice expense and professional liability insurance RVUs assigned to the service of immunization administration are reasonable, CMS has never published the RUC-recommended physician work RVUs. However, given that CMS recently agreed that the model of immunization administration may be different in the pediatric population than in the Medicare population, it would be appropriate that it publish the RUC-recommended physician work RVUs for the new codes on the 2004 Medicare Physician Fee Schedule.

In the past, CMS has suggested that the physician work involved in immunization administration is already accounted for within the work RVUs of the preventive medicine codes. This, however, is not the case. The vignettes used to value the preventive medicine services make no reference to the physician work of counseling and obtaining informed consent during the administration of immunizations. Additionally, since children receive more vaccines than adults do, pediatricians must not experience any "missed opportunities" to immunize a patient. This means that many vaccines are administered during the course of an otherwise "sick" visit, rather

than just exclusively during well child exams. Over the past few years, CMS has asked for "real" evidence as to why physician work values should be published for the service of immunization administration. The primary charge of the RUC is to determine the existence of work and practice expense for each code presented. The RUC has agreed on several occasions that immunization administration does require physician work. We believe that the validation process utilized by the RUC should be sufficient to assuage CMS' concern that the work involved in the administration of immunizations is "real" work.

The administration of immunizations to children is a very different service than the administration of immunizations to adults. Both medical ethics and federal and state law demand that pediatricians provide information and counsel parents/guardians about the risks and benefits of the immunizations that their children are scheduled to receive. The National Childhood Vaccine Injury Act requires that physicians explain the benefits to the patient and the community as well as the possibilities of adverse reactions to vaccines at the time each dose is administered. In some cases, children may also receive vaccines from a variety of sources such as a public health department or a community health clinic). This further complicates the pediatrician's task of trying to form a comprehensive vaccine history using scattered records to piece together one child's medical history.

With the increase in the amount of misinformation disseminated by anti-vaccine groups, the time that physicians spend on education and cognitive discussion has increased. If CMS does not publish the RUC-recommended work RVUs, it will in essence be unilaterally determining payment policy for the service of pediatric immunization administration. And, since work RVUs

typically make up close to 55 percent of a code's total RVUs, this means that pediatricians who provide immunizations to their patients will be losing out on 55 percent of the reimbursement for that service.

It is incongruous that other branches of the federal government call for greater recognition of the importance of immunizations, especially in these uncertain times. The Centers for Disease Control and Prevention (CDC) urges physicians to increase the rate of vaccinations in order to decrease and eliminate many diseases, such as measles and polio. It is also anticipated that the threat of bioterrorism will only increase the CDC's push for greater rates of vaccination. If it decides not to publish work values for this service, CMS will further devalue this basic requirement of pediatric health maintenance.

The Academy urges the Council to support the development of these codes and the assignment of the RUC-recommended physician work RVUs. The Academy would be pleased to share with the Council the specific descriptors for these codes and the appropriate RUC-recommended values.

NON-FACE-TO-FACE SERVICES

CMS has been hesitant to publish any values on the Medicare Physician Fee Schedule for those services deemed to be "non-face-to-face." While it has recently started to reimburse for very select types of telemedicine services, CMS remains skeptical about the true value of many services that are provided when the patient is not physically present. As pediatric practice

evolves to serve many working families and a growing population of children with special needs, non-face-to-face medical services, and especially telephone care, are an increasingly important component of health care for children. Telephone care is safe and effective, and reduces health care expense. Patients enjoy the convenience of getting advice in a timely manner without the need for an office visit. Health plans enjoy the cost savings incurred by reducing office and ED visits through protocol based telephone triage and advice that ensures an appropriate level of care. However, despite the fact that telephone care involves physician work, practice expenses and medical liability, the CPT codes within case management and care plan oversight services that cover telephone care have no RVUs assigned. As a result, most physicians do not report or receive any reimbursement for telephone care that is provided outside part of pre- and post-visit work or case management. The AAP membership, through its Chapter Forums, has repeatedly called for reimbursement for non-visit care, including telephone care. To ensure continued access to telephone services, and reimbursement for the providers of that care, we support an approach to revise the current CPT codes for telephone care including a survey process and assignment of relative values for this important service.

Non-face-to-face services effectively maintain the patient's medical home because they allow the primary care physician to maintain a role in coordinating all aspects of that patient's care. The AAP believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of

mutual responsibility and trust with them. These characteristics define the "medical home." In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective. The need for an ongoing source of health care -- ideally a medical home -- for all children has been identified as a priority for child health policy reform at the national and local level. The US Department of Health and Human Services' *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a "medical home" and multiple federal programs require that all children have access to an ongoing source of health care[i]. Inadequate reimbursement for services offered in the medical home remains a very significant barrier to full implementation of this concept.

DEVELOPMENT OF HCPCS LEVEL II CODES

CMS has attempted to make Medicare policy coverage decisions through the development of Healthcare Common Procedure Coding System (HCPCS) Level II codes. Given that the development of HCPCS Level II codes involves only representatives from CMS, Blue Cross Blue Shield Association, and the Health Insurance Association of America, there is no opportunity for organized medicine to have routine input into the creation of these codes. The HCPCS Level II code development process allows CMS to avoid the input of organized medicine that is required of both the CPT and RUC processes. Further, CMS has continued to develop and/or maintain HCPCS Level II codes even though an equivalent CPT code may exist.

G codes are HCPCS Level II codes defined as "temporary codes for procedures and services being reviewed prior to inclusion in CPT" that are removed once CPT codes for such services and procedures are assigned. However, the G codes for immunization administration of influenza, pneumococcal, and hepatitis B vaccines (G0008, G0009, and G0010) continue to be maintained by CMS even though codes 90471 and 90472 exist in the CPT code set. In the 2003 final rule CMS stated that it "will maintain these G codes…in order to closely monitor patient access." In a similar vein, CMS attempted to create 3 HCPCS Level II codes for all hepatitis B vaccine products in an effort to simplify Medicare payment for the vaccine. While this action was rescinded, it was another example of how CMS attempted to use HCPCS Level II codes to circumvent the CPT and RUC processes in an effort to enforce Medicare payment policies. In order to ensure that this does not continue to happen in the future, we recommend that the HCPCS Level II code development process be modified to allow primary involvement by organized medicine. In the interim, CMS should not develop new HCPCS Level II codes for services accurately represented by CPT codes and it should delete HCPCS Level II codes that are duplicative of codes in the CPT nomenclature. We strongly urge the Council to recommend these revisions with regard to the development and utilization of HCPCS Level II codes.

MEDICAID PROGRAM, BENEFICIARY ACCESS, AND PREVENTIVE CARE

On behalf of the AAP, I would like to sincerely thank the Council for its recent recommendation regarding the development of a National Medicaid Payment Advisory Commission. We would also like to thank the Council for presenting CMS with important Medicaid questions during its December meeting. It is my understanding that CMS has announced that the Council will not

address Medicaid issues in the future. This is unfortunate since it will eliminate any chance of federal oversight for the Medicaid program. In the absence of a separate National Medicaid Payment Advisory Commission, we encourage the Council to continue to include Medicaid on its agenda.

Thank you and I would be pleased to answer any questions now or at a time you have designated.

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[i] AAP Policy Statement, "The Medical Home," *Pediatrics* (Vol. 110, No. 1), July 2002, p. 184-186.