

TARA CENTER LLC
STATEMENT TO THE PRACTICING PHYSICIANS
ADVISORY COUNCIL

CODE SETS TO REPORT VACCINES UNDER HIPAA
September 23, 2002

TARA CENTER is an independent consulting service under which I have worked since returning to private life in 1996. I worked for Medicare as a Medical Director for Part B in Wisconsin for 3 years and then as Medical Officer at CMS, then HCFA, for 4 years. I am currently working in association with SMT, Inc, a private consulting firm in New Jersey which is working with Merck Sharp and Dome on a range of vaccine issues, such as educational outreach programs.

This particular project began 2 years ago with the goal of educating Medicare carriers on two AMA CPT™ code changes for Hepatitis B vaccines and assist contractor staff in identifying products that match the two codes so they could apply the reimbursement rules. After 2 years, most contractors have matched products with code descriptors and arrived at similar reimbursement levels while the reimbursement consortium (affecting 19 states) continues to overpay for one of the codes.

The proposed resolution of the program reimbursement inconsistencies for those 2 codes has created a much broader, long range public health concern and brought the issue to your door. Today, the question has become part of the debate about which code set should be adopted as the standard for vaccinations under HIPAA.

With the May 31, 2002 Federal Register notice, the initial selection of NDC codes for drugs and biologicals as the standard codes set for use in the office setting was ruled out. In that Notice, the public was asked to comment on which set of codes should be used. The options are to adopt one of the existing code sets (AMA CPT™ Codes, HCPCS, ICD-9) or to wait for the development of a new set.

I would suggest that for vaccines, the question goes far beyond what specific codes will report vaccines for payment purposes. Our immunization success with children is a public health success story – achieved by public and private clinics, schools, state legislatures and CDC working together. As we

look to achieving the healthy 2010 goals, the task is to maintain our success of 90% with children while addressing the pockets still not meeting the goal – and to turn our attention to the adults.

Going from less than 68% to 90% immunization rates in adults in 8 years will require major public and private commitment of time and money. It will require money to pay for the vaccines and their administration – which will link the public health goal with the payers and the code sets under discussion. The “keeper of the code set” for vaccines will become a vital player in the public health goal of increasing immunization and reducing vaccine-preventable morbidity and mortality. The “keeper of the codes” must understand that link and demonstrate its commitment to these goals.

SUMMARY OF RECOMMENDATIONS:

I. Increasing immunization of children AND adults is a public health priority (Healthy 2010).

A. We have the most work to do for adults to reach the goal of 90%

- 1. < 67% of adults over 65 and those institutionalized are immunized for pneumococcal and influenza.**
- 2. < 40% are immunized in high risk groups and for Hepatitis B**

B. Achieving this goal will require public and private commitment to remove the barriers that presently exist

- 1. Ensure adequate reimbursement for the vaccines and their administration**
- 2. Development and use of efficient of tracking systems to avoid missed opportunities – systems that function within clinics and allow for networking with population-based registries.**

C. Tracking systems, such as immunization registries, require standardization of data elements to support HL7, which is currently being addressed by CDC and other entities.

- 1. Data is reported to the immunization registries in one of two ways:**

a) CDC system – includes vaccine and manufacturers code and other data elements for some vaccines.

b) AMA CPT™ codes

(1) *These are preferred by providers and are the source of 50-70% of the current data submitted to some registries*

(2) *CDC has been working with the AMA CPT panel to increase the level of detail in the AMA CPT™ codes*

D. The entire data system and complex algorithms used by immunization registries and the CDC are being standardized for HL7 as part of the HIPAA initiative

E. The standard code set for vaccines adopted under HIPAA should continue to meet the needs of payers and tracking systems including immunization registries.

II. CMS should adopt the AMA CPT™ code set for vaccines and administration for the following reasons:

A. The existing AMA CPT™ codes

1. Aren't broke and don't need replacing

2. Demonstrate the “keeper of the codes”

a) **ability to understand the issues associated with vaccines and improving immunization rates and**

b) **Be responsiveness to the needs of other users of the codes, including purposes other than reimbursement.**

3. Are in place and currently used to report vaccines for all ages, including those used predominantly in the non-Medicare population: children and adults under 65 years of age.

4. Have been developed in conjunction with major providers and concerned parties, including Medicare

5. Have been refined in recent years, at the request of CDC, to include more detail.
6. Provide sufficient detail to be useful to providers in developing internal reminder systems and improving immunization rates
7. Are one of the two coding options being standardized to report immunizations data to HL7 and are used in their algorithms to report immunizations and prompt reports from registries as to when immunization is due
8. As part of the tracking systems, they are an integral to the Healthy 2010 goals to increase immunization rates.
9. If a problem develops with the existing AMA CPT™ codes, the process is in place for all players, including Medicare, to participate in the process and have their concerns addressed.

III. THE HCPCS code set should not be selected as the standard code set for reporting biologics such as vaccines for the following reasons:

A. There is no existing code set within the HCPCS system for vaccines for children, adults and adults over 65 years.

1. The only existing HCPCS codes that relate to vaccinations are 3 G codes which allow Medicare to pay for the administration of vaccines covered under the Medicare law.

B. Switching from the existing AMA CPT™ codes which are already an integral part of other public health data tools is unnecessary and costly in dollars and morbidity and mortality

1. Changes in the code set will require major education and system changes in clinics, software vendors and over 200 immunization registries and CDC – diverting limited resources
2. Changes in codes will create a disruption in the data set, making reports less useful until reporting accuracy and consistency is restored.

3. **Disrupted data set and tracking results in missed opportunities for vaccination- which translates into increased morbidity and mortality as well as health care costs.**

C. Changing the “keeper of the code set”, to create a new code set would not be consistent with the HIPAA requirement that changes result in reduced administrative cost.

D. CMS as the “keeper of the codes” for HCPCS

1. **Medicare’s focus and expertise is limited to those over 65.**
2. **In testimony on May 30, 2002 before the Subcommittee of the National Committee on Health and Vital Statistics, T. Gustafson and Dr. Feinberg**
 - a) **emphasized the importance of the HCPCS coding system in meeting Medicare’s programmatic and policy needs and**
 - b) **expressed concern about creating a uniform set of codes with implementation guidelines that would compromise the Medicare reimbursement program.**
3. **CMS management of immunization of adults**
 - a) **Is to be commended for its public education and awareness efforts with beneficiaries**
 - b) **Leaves much to be desired in its coding and payment policy for the vaccine and its administration**
 - (1) ***Its payment for administration of vaccines is inadequate and based on incomplete understanding of the need for tracking and reminder systems in addition to inventory control and counseling***

IV. Specific recommendations regarding planned changes in vaccine codes planned for January 1, 2003: to add 3 local Q codes and delete 5 existing AMA CPT™ codes for Hepatitis B vaccines for Medicare use.

A. Summary of the code changes (for actual language – see p.16)

- 1. Combine codes into 3 age groups**
- 2. Delete delineation of vaccines by dosing schedule, which reflects different formulations and concentrations of vaccine**
- 3. Adds “per dose” to the descriptor**

B. The need to change the codes to address programmatic issues

- 1. Adding “per dose” – All of the vaccine codes are presumed to be “per dose”. That is the long standing position which has been communicated to payers and providers.**
- 2. Unilateral creation of new codes: Prior to the announcement at the August meeting, the AMA CPT Panel was not aware of Medicare’s need to change the codes.**
- 3. Other options are available to communicate “per dose” to contractors: e.g. the November Federal Register notice or in a Program Memorandum.**
- 4. Other programmatic issues specific to contractor inconsistency in payment levels for the codes, could be addressed by other means such as education and/or Program Memorandum.**

C. Impact of the change to Q codes

- 1. Do not contain sufficient detail to be used for monitoring purposes - they would require chart review or additional documentation to trigger reminders**
- 2. Disrupt the crosswalk to HL7, making the information unusable for the adolescent (2-dose) and immunocompromised populations. Will require CDC and CIRSET convene to**

address how clinics currently using billing data for submission can submit needed data compatible with HL7

- 3. Represent a reversal of the current public action: instead of finding existing codes to replace thousands of local codes, Medicare is adding to the existing list of local codes for the Hepatitis B vaccines.**
- 4. Combining vaccines with differing concentrations and dosing schedules into one code for reimbursement purposes creates a financial barrier to the clinical use of vaccines which may be preferred because of higher compliance and rates of seroconversion.**

V. In summary, it is requested the Practicing Physicians Advisory Council recommend that the Department of Health and Human Services and CMS

- A. Name the AMA CPT™ codes for vaccines as the standard code set under HIPAA and***
- B. Withdraw its creation of local Q codes to report Hepatitis B vaccine in lieu of the existing 5 AMA CPT™ codes for Medicare use only***
- C. Work with the AMA CPT Editorial Panel to make revisions to the existing codes***
- D. Explore other means, such as internal education or clarification of reimbursement policy instructions, to resolve its program inconsistencies in reimbursement for the Hepatitis B vaccine codes***
- E. Initiate discussions with the CDC staff on vaccination and registries to better understand vaccines and their use***
- F. Increase the reimbursement level – either delete its local G codes for reimbursement for the administration of vaccines and use existing AMA CPT™ codes or change its reimbursement crosswalk to the AMA CPT™ codes for vaccine administration.***

END SUMMARY

Background and Discussion: Selection of Code Set for Vaccines Under HIPAA

I. Increasing immunization of children AND adults is a public health priority.

Routine immunization has been a public health success story. Yet, for the last 3 decades, it has been known that 100 times more adults die from vaccine-preventable conditions than children. Between 30,000 and 50,000 adults continue to die each year from complications related to influenza and pneumococcus.

The alarm was first raised in the 1994 National Vaccine Advisory Committee report: “we should remind ourselves that our nation’s programs for childhood immunization have reduced the costs of health care and improved the well-being of all our children. We can and should expect no less from our efforts to immunize adults”

This was followed by the report prepared by Gregory Poland, MD and Suzanne Miller for the IOM in March 2000 entitled: “A Call to Action: The Crisis in Funding and Infrastructure Needed to Improve Adult Vaccine Coverage in the United States”

Healthy 2010 contains 23 specific objectives for immunization – including raising the adult immunization rates. Current rates for different populations are included in the appendix.

Recommendations for action begin with the need for federal planning and funding. At the physician level, recommendations include

- Increasing demand by improving provider and public awareness
- Increasing awareness: e.g. Healthy 2010 goals, Inclusion as HEDIS measures
- Providing adequate funding for vaccines and costs of administering the program
- Removing barriers: lack of awareness, safety and efficacy concerns and missed opportunities and (from The National Vaccine Advisory Committee, 1994).
- Missed opportunities are systems failures: opportunities to immunize that are not recognized and unintended barriers which prevent timely delivery of vaccines.

ADDRESSING MISSED OPPORTUNITIES - TRACKING SYSTEMS

Tracking systems are required to improve immunization rates. Pediatric and Family Practice clinics know this. School systems have them – even parents try to keep track. Now that we are close to achieving our goal of 90% immunization, the focus with children has turned to ways to maintain that rate.

Nationally, we are embarking on a major effort to create a network of community/state population – based immunization registries that are capable of sharing information

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necessary to achieve our 2010 objectives. As a network, it is essential that data elements be standardized. Whenever possible, these registries capitalize on data already being collected and used in providers' practices for billing or other purposes (NVAC Report, January 1999). When fully functioning, these registries return reports to the clinics about vaccinations due, allowing the clinic to flag the chart for a reminder and/or action at the next visit. They will provide on-line information about vaccination status. CDC provides significant staff support and direction to these efforts.

The success of the registries will depend on the ability of the local/state registries and clinics to share information. The American Immunization Registry Association (AIRA) and the Committee on Immunization Standards for Electronic Transaction (CIRSET) are working with practice management software vendors to address issues of data exchange between billing systems and immunization registries. CIRSET is made up of over 40 immunization registry projects, CDC, All Kids Count (Project funded by Robert Wood Johnson) and vendors. Their task is to develop a guide to standardize the implementation of HL 7 immunization messages for registries, to build HL7 specifications in the vendors information systems. Their work with vendors will address barriers providers may face when reporting to and querying registries.

As clinics prepare to participate in registries for children, they will be creating the infrastructure needed for improving immunization in the adult population, in fee-for-service and managed care, as well. By applying the programs across the board, HealthPartners of Minnesota increased its pneumococcal vaccination coverage to 85% in patients > 65 years of age.

CODE SETS USED IN IMMUNIZATION REGISTRIES

The CDC began work on this in 1994 and developed their own system of coding vaccines that is part of the HL7 data transmission. The CDC system is based on a CVX code for the vaccine and the manufacturer's code. On occasion, they need additional information such as age or dose schedule.

CDC and others have found that many providers prefer to use systems already in place in the clinic – the AMA CPT™ codes. Recognizing that this increases data submission, CDC has worked with the AMA CPT Editorial Panel since 1997 to increase the specificity of the CPT Codes used to report vaccines.

A complex crosswalk and algorithm has been developed to create reports which can then be sent to the family and clinic about vaccinations due. When available on-line, it would allow any provider to access the data and determine what is due and when. This is invaluable when patients go between systems or travel.

Although no one has actual numbers on the extent of CPT code submission, informal conversation with established registries in Oregon (considered a Best Practice in registries) and Michigan suggests that 70% and 50-60%, respectively, of the data submitted to these two registries is in the form of AMA CPT™ codes.

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CPT/CVX Code Crosswalks

The AMA CPT™ code can be cross-walked to the CDC CVX system. Parts of the cross-walk, available on the CDC website has been reproduced here. Additional information needed for the CDC algorithm may be obtained from another required data element (date of birth) or another code (e.g. age or dose schedule). Examples of vaccines with more than one product and multiple codes are provided here. At present, there is only one manufacturer for some of the vaccine types currently available.

Collapsing the AMA CPT™ codes results in lost data when the clinic is relying on submission of AMA CPT codes for the dual purpose of billing and transmission to a registry. The data is valuable for monitoring vaccine types, doses and schedules for effectiveness, complications and adverse events. It should be noted that it is not generally possible for payers and programmatic staff to match products to the CVX or the AMA CPT™ code directly from the Redbook of available products. It requires basic clinical information as well. Crosswalks such as this one obtained from the CDC website provide a valuable service to providers and payers.

Influenza virus vaccines (2000-2001 formulations)

CPT	CVX*	Formulation	Dosage	Appropriate for	Brand name	Manufacturer*
90657	15	Split virus	0.25 ml	6-35 mo.	Fluzone®split Fluvirin® Fluogen® Flushield®	Aventis Pasteur Inc. PowerJect Parkedale Wyeth-Ayerst
90658	15	Split virus	0.5ml	≥ 3 yrs	Fluzone®split Fluvirin® Fluogen® Flushield®	Aventis Pasteur Inc. PowerJect Parkedale Wyeth-Ayerst
90659	16	Whole virus	0.5 ml	>12 yrs	Fluzone®whole	Aventis Pasteur, Inc

Haemophilus influenzae type b (Hib) conjugate vaccines

CPT	CVX*	Formulation*	Schedule	Brand name	Manufacturer*
90645	47	HbOC Diphtheria CRM 197 protein/oligosaccharide	4 doses	HibTITER®	Wyeth-Ayerst
90646	46	PRP-D (diphtheria toxoid)	Booster use only	ProHIBiT®	Aventis Pasteur Inc.
90647	49	PRP-OMP (outer membrane protein)	3 doses	PedvaxHIB®	Merck & Co., Inc.
90648	48	PRP-T (tetanus toxoid)	4 doses	ActHIB® OmniHIB®	Aventis Pasteur Inc. GlaxaSmithKline

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Hepatitis B vaccines

CPT	CVX*	Formulation	Dose*	Schedule		Brand	Manufacturer*
90744	08	Pediatric adolescent dose	10 mcg/0.5 mL	3 dose	All infants children, adolescents	Engerix-B®	GlaxoSmithKline
90744	08	Pediatric adolescent dose	5 mcg/0.5 ml	3 dose	All infants children, adolescents	Recombivax HB®	Merck & Co, Inc
90743	42	Adolescent/high-risk infant	10 mcg/0.5 ml	2 dose	High risk infants Adolescents 11-15	Recombivax HB®	Merck & Co, Inc
90746	43	Adult	20 mcg/1.mL mg/1 ml	dose	Adult > 19 yo	Engerix-B®	GlaxoSmithKline
90746	43	Adult	10 mg/1 ml	3 dose	Adult > 20 yo	Recombivax HB®	Merck & Co, Inc
90740	44	Dialysis or immunosuppressed, 3 dose	40 mcg - 2 doses of adult dose	3 dose	Adult predialysis/dialysis	Recombivax Dialysis HB®	Merck & Co, Inc
90747	44	Dialysis or immunosuppressed	40 mcg – 1 ml of dialysis formulation	4 dose	Adult predialysis/dialysis	Engerix-B®	GlaxoSmithKline

II. Impact of changing the Code Set for Vaccines from the AMA CPT™ codes

A. If the change is superficial, e.g. replacement of numbers/letters -- retaining the present vaccine groupings and detail, impact of such changes

1. **On the crosswalk, CDC and registry informatics – the cost of substituting new codes into the algorithms and crosswalks**
2. **On vendors, clinics and CDC – the cost of revising the systems educating staff and creating crosswalks for billing software**
3. **Other impact - time to educate, lost data as systems are updated and education completed. This is significant for clinics and the registries.**

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4. The bigger question would be whether a change would be justified under HIPAA. Increased costs of change would not realize simplification and/or reduced administrative costs overall.

B. If codes are modified so that clinical information in the descriptor is expanded and/or increased number of codes, it would

1. Increase the value to the registries of the AMA CPT™ codes and the amount of overlap with the CVX system.
2. Increase the ability of the clinics to collect and enter only one type of data which would be used for billing purposes and subsequent transfer to the registry
3. Have cost associated – all of the costs identified for a superficial change would apply.

C. If the codes are reduced in descriptors and/or collapsed into fewer codes, the impact can be significant.

1. All the costs associated with changing codes identified in A would apply.
2. Clinics will no longer have sufficient data in the AMA CPT™ code to meet the Registry needs – they will need to create another system of data entry or submit information by paper and have the registries do the data entry.
3. Clinics will need to introduce chart audits or separate data entry systems to obtain information necessary for monitoring and tracking immunization status and reminder notices.
4. Registries relying on CPT data will lose valuable pieces of information to determine when doses are due and create reports for clinics and families
5. Population- and clinic-level studies to determine effectiveness of types of vaccines, dosing schedules and complications reporting vaccine adverse events will require chart review to obtain necessary details. The time and cost will prove prohibitive.

III. Change to the HCPCS System as the Standard Code Set for Vaccines with CMS as the “Keeper of the Codes”

A. In general, the HCPCS system is a system developed for Medicare program purposes.

- 1. Under HIPAA, its role will be expanded and standardized for much of the Durable Medical Equipment and Supplies.**
- 2. The majority of the vaccines are for children, which is considered outside the expertise and purview of the Medicare program.**
- 3. The National Committee for Health and Vital Statistics, main advisor to DHHS on HIPAA and code sets, has been holding hearings on Code Sets and the ability of the “keepers of the codes” to expand beyond their own parochial programmatic needs -- to involve all participants and create codes that meet the needs of all payers and populations and uses of the codes, including public health and outcome studies.**

B. Immunizations relevant to Medicare: influenza, pneumococcal, tetanus and Hepatitis B.

- 1. How Medicare handles coverage and payment of vaccines impacts the adult immunization rate.**
- 2. 95% of those receiving influenza and pneumococcal vaccination are beneficiaries.**

C. Covering the cost of administration

- 1. Beginning in 1994 Medicare created 3 G codes to pay for administration costs when there was not a physician visit associated.**
- 2. Medicare pays these codes by crosswalking the codes to the AMA CPT™ Code – 90782 - Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular**
- 3. In 2001, AMA RUC recommended that the reimbursement for immunization administration be increased to cover the expense of administration, which includes counseling and storage.**

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4. In November 2001 Federal Register, CMS rejected the AMA recommendation and reiterated its position that they believe the work of administration of vaccines is basically the same as administration of a therapeutic or diagnostic injection.
5. In June 2002 Federal Register notice, CMS proposed administrative changes which would increase the reimbursement for the vaccine administration codes.
6. There have been no proposed changes in the crosswalk code for payment of administration by Medicare.
7. Despite a higher RVU for CPT codes for immunization administration, if the June recommendations were implemented, Medicare would still pay providers the same old rate because of the internal crosswalk to CPT Code™ 90782.

		Current RVUs	Proposed June 2002	RUC Recommendation, November 2001
AMA CPT™ codes				
90471	Immunization administration	0.11	0.21	0.17
90472	Immunization administration, each additional	0.11	0.09	0.15
G codes (created in 1994 and used only by Medicare) – cross-walked to AMA CPT™ code 90782.				
G0008	Administration of influenza virus vaccine	0.11	X	X
G0009	Administration of pneumococcal vaccine	0.11	X	X
G0010	Administration hepatitis B vaccine	0.11	X	X
90782	Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular	0.11	X	X

D. Medicare uses the AMA CPT™ Codes to report vaccines used by and covered for Medicare beneficiaries: influenza, pneumococcal, tetanus and Hepatitis B.

1. Historically, there have been no HCPCS codes to report vaccines for Medicare purposes only. (G codes are used only to report the administration.)
2. In the November 2001 Federal Register notice, a single Q code for Hepatitis B was announced with a crosswalk to some of the

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specific AMA CPT™ codes. Some contractors published newsletter articles informing providers of the pending change.

3. The 2001 Federal Register notice was incorrect. The Q code for Hepatitis B vaccine had been withdrawn prior to the FR publication.
4. Concerns about the impact of the proposed Q code and implications for registries were conveyed to CMS staff, as well as names of CDC contacts on the matter.

E. In August 2002, Medicare has communicated its intention to change codes used for some vaccines.

1. It was announced at the August AMA CPT meeting that Medicare would be making changes for Hepatitis B vaccines.
2. In correspondence to me, CMS has stated that as of January 2003, Medicare will delete the 5 AMA CPT codes for Hepatitis B vaccine for Medicare purposes and will substitute 3 HCPCS codes (in fact increasing the number of codes in the system for Hepatitis B vaccines.)
3. The rationale for the changes has not been provided. The language change is primarily of deletion of information, although the term “per dose” is added.
4. The crosswalk presented here is presumed. There has been no formal communication of the crosswalk to be used.

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PROPOSED Q CODES		EXISTING AMA CPT™ Code	
Code	Description	Code	Description
??? 1	Injection, Hepatitis B vaccine, Pediatric or Adolescent, per dose	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
		90743	Hepatitis B vaccine, adolescent dosage (2 dose schedule), for intramuscular use
??? 2	Injection, Hepatitis B vaccine, Adult, per dose	90746	Hepatitis B vaccine, adult dosage, for intramuscular use
??? 3	Injection, Hepatitis B vaccine, Immunosuppressed Patients (Including Renal Dialysis Patients), per dose	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
		90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

5. The impact of this change on the immunization registry is significant. It includes

a) Loss of data, combining CVX categories so that the information will be clinically useless.

(1) It will be impossible to separate analysis and reports for

- (a) the adolescent, 2 dose series (which is adult dosage) versus the pediatric dosage and 3 dose schedule.
- (b) The different schedules and formulation for immunocompromised/dialysis patients.

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COMBINED CROSSWALKS – Q Codes/AMA CPT™ Codes/CDC System

Hepatitis B vaccines

Q	CPT	CVX*	Formulation	Dose	Schedule	Appropriate for	Brand	Manufacturer*
--- 1	90744	08	Pediatric adolescent dose	10 mcg/ 0.5 mL	3 dose	All infants children, adolescents	Engerix-B®	GSK
	90744	08	Pediatric adolescent dose	5 mcg/ 0.5 ml	3 dose	All infants children, adolescents	Recombivax HB®	Merck
	90743	42	Adult	10 mcg/ 0.5 ml	2 dose	High risk infants Adolescents 11-15	Recombivax HB®	Merck
--- 2	90746	43	Adult	20 mcg/1.m Lmg/1 ml	3 dose	Adult > 19 yo	Engerix-B®	GSK
	90746	43	Adult	10 mg/1 ml	3 dose	Adult > 20 yo	Recombivax HB®	Merck
--- 3	90740	44	Dialysis Formulation	40 mcg - 1 ml Dialysis Formulat ion	3 dose	Adult predialysis, dialysis	Recombivax Dialysis HB®	Merck
	90747	44	Adult	40 mcg- 2 doses of adult dose	4 dose	Adult predialysis, dialysis	Engerix-B®	GSK

IV. Impact and Implications of Medicare's Creation of Q Codes (HIPAA perspective)

A. Creating local Medicare codes to replace existing AMA CPT codes is counter to the work and direction of the entire health industry and HIPAA – which has made significant progress in reducing local codes and using codes already available whenever possible.

- 1. Medicaid, Medicare's sister agency, has reduced over 30,000 local codes to less than 500 codes and modifiers.**
- 2. In one instance, Medicaid reduced 3000 codes to just 3.**
- 3. Medicare's action will *increase* the number of codes for Hepatitis B vaccines.**

B. Medicare's action creates changes which will require CDC and CIRSET to decide how to address for the Immunization Registries across the country.

- 1. It creates complications, not simplification**
- 2. It loses valuable data from a public health data base.**
- 3. Software vendors will need to modify the information collected and transmitted to HL7 for immunization.**
- 4. Clinics may need to submit additional data, use the CDC system or stop submitting data to the registry.**

C. Vendors, clinics, and secondary payers will need to create crosswalks, reimbursement levels and educate staff on changes in the system.

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D. As a potential “keeper of the codes” for vaccine codes, the current changes in Q codes and its position on payment for administration of vaccines suggests that Medicare would need

- 1. to seriously expand its perspective on the role of the “keeper of the codes” and its vital link to improving immunization rates.**
- 2. to ensure that its process of code development**
 - a) included all payers and providers, including other government agencies;**
 - b) addressed needs of all age groups, including children;**
 - c) created HCPCS codes for vaccines that were needed by other payers even though they may have not direct programmatic use for Medicare; and**
 - d) was open and easily accessible to participants.**

V. Impact of Creation of New Q codes for Existing, Functional CPT Codes - Impact on Clinics and Clinical practice

A. The new codes combine into single codes vaccines that were previously reported separately because they have different formulations, concentrations and dosing schedules.

B. Combining vaccines into one code changes the reimbursement level for the products in the code group.

C. The reimbursement policy will create a financial barrier for clinics to provide access to vaccines requiring fewer doses because of higher concentration or different formulations

**VI. In summary, it is requested the Practicing Physicians
Advisory Council recommend that the Department of
Health and Human Services**

- A. Name the AMA CPT™ codes for vaccines as the standard code set under HIPAA and***
- B. Withdraw its creation of local Q codes to report Hepatitis B vaccine in lieu of the existing 5 AMA CPT™ codes for Medicare use only***
- C. Work with the AMA CPT panel to make revisions to the existing codes, such as adding the language “per dose” if needed.***
- D. Explore other means, such as internal education or clarification of reimbursement policy instructions, to resolve its program inconsistencies in reimbursement for the Hepatitis B vaccine codes***
- E. Initiate discussions with the CDC staff on vaccination and registries to better understand vaccines and their use***
- F. Change its crosswalk for reimbursement for the administration of vaccines to the AMA CPT™ codes for vaccine administration.***

ADDITIONAL CONTACT INFORMATION

CIRSET (Committee for Immunization Registry for Electronic Transactions: Jeff Wehl, Chair
Michigan Public Health Institute. P: 517: 324-8325, jwehl@mphi.org; www.circet.org

National Immunization Program, CDC: Wm Atkinson, MD; Susan Abernathy P: (404) 639-8177.
Saa6@cdc.gov; www.cdc.gov/nip/registry.

AIRA (American Immunization Registry Association) www.immregistries.org

President-elect and Chair of the Technical Work Group: Barbara C. Canavan, Director,
Oregon Immunization ALERT; P: 503-731-4988.
Barabara.C.Canavan@state.or.us

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REFERENCE LIST

National Vaccine Advisory Committee (NVAC) Report: Development of Community- and State-Based Immunization Registries. January 1999. From www.immregistries.org website. Downloaded September 12, 2002.

Poland, Gregory and Miller, Suzanne, Prepared for IOM (Institute of Medicine). A Call to Action: The Crisis in Funding and Infrastructure Needed to Improve Adult Vaccine Coverage in the United States. 2000 Mar.

HEALTHY 2010 Data – Status and Goals of Immunization in the US

CHILDREN	Baseline – 1998 %	2000 %	Target – 2010 %
Diphtheria-Tetanus-Pertussis	84	82	90
Haemophilus influenzae type b	93	93	90
Hepatitis B	87	90	90
Measles-mumps-rubella	92	90	90
Polio	91	90	90
Varicella	43	68	90

(data from www.health.gov/healthy people)

ADULTS	Baseline – 1998 %	2000 %	Target – 2010 %
Pneumococcal			
> 65yo (Noninstitutional)	46	53	90
High Risk (18-64 yo)	13	16	60
Institutionalized (1997)	59	66	90
Influenza			
> 65 (Noninstitutional)	64	65	90
High RISK (18-64 yo)	26	28	60
Institutionalized (1997)	25	38	90
Hepatitis B			
Long term hemodialysis	35		90
Men who have sex with men	9		60
Occupationally exposed workers	71		98

(data from www.health.gov/healthy people)

Note: estimates of Hepatitis B immunization are obtained from survey of ESRD facility staff regarding how many current patients have completed 3 doses of a series. The majority of ESRD patients are receiving the vaccine that requires 4 doses for completion.

Background and Discussion: Selection of Code Set for Vaccines Under HIPAA

For nonwhites, the rates of immunization in adults are even worse.

	Percent Vaccinated - year 2000		
	Whites	Blacks	Hispanic
Influenza Vaccine			
> 65 yo	66	48	56
High risk (18-64 yo)	29	25	25
Pneumococcal Vaccine			
> 65 yo	56	31	31
High Risk (18-64 yo)	16	15	10

(data from www.health.gov/healthy people)