December 4, 2013

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Difficulties in billing for immunizations in conjunction with well child visits

Dear Secretary Sebelius:

Childhood immunization has been called our society's greatest health care achievement. The development and widespread use of vaccines has led to the reduction or eradication of once common childhood diseases. Making it easy for children to access immunizations is an important component of keeping health costs down and ensuring the strength of our nation's future. Children and families also depend on well child check-ups as listed in the AAP/*Bright Futures* Periodicity Schedule. During a well-child check-up, a child and his or her family are evaluated for their unique needs and the child's healthy development is gauged. Historically, well child check-ups and immunization administration have occurred during the same visit, decreasing inefficiencies for families and keeping the medical home cohesive.

Nevertheless, the Centers for Medicare and Medicaid Services (CMS) has undermined the connection between well-child check-ups and immunization administration through a technical billing rule that is impacting medical homes across the country. CMS eroded this connection by publishing a National Correct Coding Initiative (NCCI) edit applicable to all evaluation and management (E/M) service codes (including well child visit codes, 99381-99395) when reported with any immunization administration code (90460 and 90461 and 90471-90474), effective January 1, 2013. Children's access to care has been seriously undercut by this ruling, and we respectfully request that you urge CMS to withdraw it.

While seemingly minor, the impact of the change is particularly significant to the care of children. In 2011, nearly 40 percent of all claims submitted with pediatric "Preventive Medicine Services" (eg, well-child) Current Procedural Terminology (CPT) codes (ie, 99391, 99392, 99393) were submitted in conjunction with pediatric immunization administration codes (90460 and/or 90461) (Source: TruvenHealth's January – September, 2011 Market Scan).

Child health advocates have been in continuous contact with CMS staff, who have been gracious with their attention to child health advocates' concerns, but who refuse to deactivate the edits at the national level. CMS argues that payment would be made for both essential health services by reporting with the appropriate modifier. While in theory that is how it should work, in reality that has not been the case as we seen many clean claims denied for payment.

Child health advocates take issue with CMS's interpretation of CPT rules, which do not require the use of a modifier for a routine event. Per CPT rules, "a modifier provides the means to report

or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." The AAP/*Bright Futures* Periodicity Schedule specifically notes that immunizations should be provided in conjunction with a comprehensive well child visit. Providing immunizations during preventive medicine visits should never be considered unusual or out of the ordinary, and therefore is clearly outside of the definition for a modifier use.

Child health advocates acknowledge and appreciate that CMS has extended some flexibility by allowing each state Medicaid program to deactivate these edits for 2013, and 13 state Medicaid programs have deactivated the edit. Unfortunately, a series of documented miscommunications between CMS and Medicaid agencies has led to at least one state deciding not to deactivate the edit due to the erroneous belief that doing so would result in a fiscal penalty to the state. While that information was determined to be untrue and the issue eventually clarified through welcome reassurance from CMS, this state refuses to deactivate the edits due to a continued expressed fear of a fiscal penalty. We are concerned that other states may have also been misinformed leading to the lower rate of deactivation.

Other problems have also been uncovered in relation to the edit. First, many private health plans have adopted the edit or soon plan to. Second, physicians and other health care providers report that even with a proper modifier appended, claims are still being denied due to the confusing nature of the edit by private payers. Third, some Medicaid plans are advising practices to append modifier 59 to the claim, which is not appropriate. Fourth, some Medicaid plans are denying clean claims -- even with proper modifier placement. Fifth, a single state fee-for-service Medicaid plan has instituted a different policy than some Medicaid Managed Care Organizations, causing even further confusion and billing complications.

The proposed solution directly impacts those who provide care for children by greatly enhancing the likelihood that the normal course of child health care will trigger expensive and burdensome audits. Historically, the use of modifier 25 has been the leading trigger of Office of the Inspector General (OIG) audits as well as private payers. Because of the frequency with which child health care providers bill for immunization administration in conjunction with well child check-ups, if every claim involving both services requires modifier 25, the volume of modified claims would increase significantly, triggering numerous audits and exacerbating paperwork burdens on pediatric practices.

The state-by-state nature of the option that CMS created for annual deactivation of the edits is also in itself problematic. In fact, states report that CMS has told them that even if they had decided to deactivate these edits they will now be forced to re-activate them effective January 1, 2014, creating further uncertainty and variation across the country and continue to cost practices time and resources.

Finally, it should be noted that these edits fundamentally undermine the goal of the Affordable Care Act's §1202, which requires improvements to immunization administration and other preventive services payment in order to encourage participation in the Medicaid program. Congress recognized that the hassle factors of low payment and paperwork burden disincentives

full participation in the Medicaid program. Adding an additional practice level burden whose solution vastly increases a care provider's chance of an audit does not support this policy.

For all the reasons stated above we again urge CMS to deactivate the edit as soon as possible, but no later than January 1, 2014. We greatly appreciate your attention to this matter and stand ready to work with you to improve the care of children in our country. We look forward to receiving your timely response.

Sincerely,

AIDS Alliance for Women, Infants, Children, Youth & Families
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Assistants
American College of Obstetricians and Gynecologists
Association of Family Practice Physician Assistants
BIO
Every Child By Two
Immunization Action Coalition
New Jersey Chapter of the American Academy of Pediatrics
Pennsylvania Chapter of the American Academy of Pediatrics
Pediatric Infectious Disease Society
PKids
Society of Physician Assistants in Pediatrics

cc: Howard Koh, Assistant Secretary for Health
Thomas Freiden, Director, U.S. Centers for Disease Control and Prevention
Marilyn Tavenner, Administrator, CMS
Cindy Mann, Director, CMS Center for Medicaid and CHIP Services
Jonathan Blum, Director, CMS Center for Medicare