1. **AAP monitoring payer implementation of new immunization administration (IA) codes**

   While many practices in several states have reported enhanced or adequate payment for the new immunization administration (IA) codes, there are implementation issues by public and private payers. The AAP is monitoring reported issues with implementation of the new codes and remains in contact with other stakeholders to advocate for timely resolution of the problems as well as developed resources to assist practices in addressing some of the issues. For an overview of the new codes and answers to specific coding questions, please visit the FAQ Fact Sheet for the 2011 Pediatric IA codes: [http://practice.aap.org/content.aspx?aid=2980](http://practice.aap.org/content.aspx?aid=2980)

   Below is a summary of frequently reported issues and AAP follow up to-date:

   **1. New IA codes are loaded and recognized by payer claims systems but the actual payment schedule is not known.** Several of the largest national and regional carriers (Aetna, Cigna, Humana, UnitedHealthcare, and several Blue Cross plans) responded to letters from the AAP assuring that their claims systems would recognize the new IA codes. Carriers are updating their fee schedules and payment methodologies for the new IA codes. Some AAP members have reported that payments are enhanced and some are reporting that payers have not determined actual payment. For example,
Aetna, CIGNA, UnitedHealthcare (UHC) are reported by AAP members to be processing claims and paying at a percentage of billed charges until fee schedules are updated later in the year.

The AAP has contacted UHC regarding denials for multiple reported units for the IA codes. UHC acknowledges that this is an error and reiterated its intent to pay for the new multiple component vaccine administration codes without denials of multiple submissions as duplicates. Pediatricians experiencing claim denials by UHC for the new IA codes should contact their local UHC physician advocates to have the claims promptly readjusted.

2. **Inadequate payment including bundling** The 2011 Medicare Resource-Based Relative Value Scale (RBRVS) non-geographically values for the new IA codes are $23.10 for CPT code 90460 and $11.55 for CPT code 90461. However, some carriers are developing their own fee schedules below the Medicare rates. The AAP and chapter pediatric councils are working to educate state payers about the need for adequate payment. The AAP has a template for members and chapters to send to payers along with the Business Case for Pricing Vaccine Administration. These documents are attached and can be downloaded to share with payers at the following links:

Letter to Payers Regarding Inadequate Payment for Immunization Administration
http://www.aap.org/securemoc/reimburse/InadequatePayIA.pdf
AAP Business Case for Pricing Immunization Administration

3. **Not recognizing the new IA codes.** There are few reports of payers not recognizing the new IA codes, as it is a violation of HIPAA federal law. There are, however, several reports of clearing houses, some of which are owned by payers, not recognizing the new codes. To report any HIPAA violations such as non recognition of CPT codes, access the Administrative Simplification Enforcement Tool at: https://htct.hhs.gov/aset/ or http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. AAP members are also encouraged to report any payment issues on the AAP Hassle Factor Form so that the Academy can follow up. The Hassle Factor Form can be accessed on the AAP Member Center home page http://www.aap.org/moc.

4. **Public payer issues** The primary issue reported in the public sector has been non-recognition of the new immunization administration (IA) CPT codes (90460 and 90461) by state Medicaid programs. Members in Florida, Texas, and Tennessee have reported that their Medicaid programs are not adding the new IA codes to their claims systems until a rate hearing process is completed and are advising pediatricians to use the deleted CPT codes (90465-90468). The AAP is working with the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS), to encourage immediate use of the new codes.

The AAP has been in discussions with the CDC about billing combination vaccines within the Vaccines for Children (VFC) program, and the CDC issued an updated Q&A document on December 27, 2010, providing guidance on billing with the new codes in VFC. The VFC maximum regional charge, established by federal regulation in 1994 for each state, sets the maximum payment by any payer for the administration of VFC vaccine in the state. The CDC indicates in its updated Q&A document that as the maximum regional charge was established on a per-vaccine (and not per-component) basis, physicians in the VFC program are to use only new code 90460 (first vaccine component). Until such time that the federal maximum regional charge regulations are revised, physicians will not be able to be paid for code 90461 (each additional component) for VFC-supplied vaccine. Both CDC and the AAP realize this has detrimental effects on the immunization of VFC and
Medicaid eligible children. CMS has indicated that changes to the maximum regional charge regulations are in progress, which would require publication in the Federal Register for comment before implementation. The AAP is advocating to CMS for timely action to address these concerns.

The AAP continues to monitor problems and work with the chapters and pediatric councils to address them. Despite these implementation issues there have been numerous reports of payment for IA increasing in pediatric offices that are using the new IA codes. The AAP still has confidence that these new codes will help pediatricians receive appropriate recognition for the work they do administering combination vaccines.

2. Opportunity for pediatrician input to international payment study

The AAP is sharing information on an international study on payment for pediatricians to consider participating. The Catholic University Leuven, Ghent University and University of Antwerp in Belgium are currently organizing a survey study across the US, Canada, Australia and Europe to shed light on payment issues. Physicians, policy makers, and other stakeholders are invited to express their preferences for payment systems and payment effects. It will take about half an hour to fill out the survey. In exchange survey respondents will receive a detailed study report explaining the study findings, with comparisons across health systems and across stakeholder groups. Pediatricians interested in completing the survey may access the survey online as follows:

(When your surname begins with the letter A – I)

(When your surname begins with the letter J – R)

(When your surname begins with the letter S – Z)

3. AAP Coding Webinars – live and archived webinars available

The AAP has developed webinars on key coding topics. These events are open to physicians, care providers, coders and practice management staff for a fee. For more information visit http://aap.org/webinars/coding

The next AAP Pediatric Coding Webinar will be broadcast live on February 17, 2011 at 12:00 pm CT. Chip Harbaugh, MD, FAAP will be presenting RBRVS and RVUs - Everything You Always Wanted To Know But Were Too Busy to Ask! This informative session will introduce the basics of Resource-Based Relative Value Scale (RBRVS) and show how RBRVS can benefit your practice. Also, learn how relative value unit (RVU) components are developed and maintained. For more details on this upcoming webinar, visit http://aap.org/webinars/coding

Check out these topics as well:
Don’t Risk Denials! Keep up to Date! New/Revised CPT and ICD-9 Codes for 2011
Archived event available until February 18, 2011

Everything You Always Wanted To Know About RBRVS and RVUs But Were Too Busy to Ask!
Live event on February 17, 2011. Archived event available until May 17, 2011

Navigating Neonatal Concurrent Care Concerns
Live event on April 21, 2011. Archived event available until May 17, 2011

How to Code When the Kid Isn’t There
Live event on June 7, 2011. Archived event available until September 3, 2011

For more details on these webinars, to view an archived event, or to register, visit http://aap.org/webinars/coding

4. AAP News articles related to private payer advocacy issues
The following articles related to private payer issues were published in the January 2011 AAP News

AAP: Loss of copays should not fall on pediatricians’ shoulders
http://aapnews.aappublications.org/cgi/content/full/32/1/10

Improving care, reducing costs • Why some experts have high hopes for Accountable care organizations
http://aapnews.aappublications.org/cgi/content/full/32/1/1-c

Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement
http://aapnews.aappublications.org/cgi/content/full/32/1/1-e

AAP joins 3 other specialty societies in releasing Joint Principles for Accountable Care Organizations (ACOs)
The AAP, together with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) released the Joint Principles for Accountable Care Organizations to reflect those attributes they believe are essential for the effective implementation of the ACO model within the health care system. The new joint principles define key characteristics of effective accountable care organizations and provide 21 principles describing important aspects to consider when building the administrative structure of ACOs, as well as how payment should be facilitated. For more information go to:
http://practice.aap.org/content.aspx?aid=2987
December 20, 2010

Dear Medical Director:

The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists providing medical care to over 72 million children and adolescents. The AAP’s goal is to ensure that all infants, children, adolescents and young adults receive all recommended immunizations on time. Inadequate payment for administering vaccines serves as a barrier to providing cost effective immunizations, and therefore is also a barrier for patients to access immunizations. Payments for immunization administration must be at a sufficient level to cover all direct and indirect costs, as outlined in the enclosed AAP Business Case for Pricing Immunization Administration.

To adequately recognize the work done by physicians for providing vaccines, specifically combination vaccines, new immunization administration (IA) CPT codes have been published and are effective as of January 1, 2011. It has been brought to the Academy’s attention that some payers are not paying adequately for immunization administration, either by bundling payments with the vaccine product or the office visit, or paying less than the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule. Physicians cannot be expected to subsidize carriers by providing immunizations at a loss.

Some carriers mistakenly believe that costs for immunization administrations can be covered by payments for the vaccine product. However, immunization administration is a separately reportable service and entails its own additional costs. There is also an incorrect belief that the RBRVS relative value units assigned to the Preventive Medicine Services (PMS) codes (99381-99397) include all or most of the resources (i.e., physician work, practice expense, and professional liability insurance expense) expended in the service of vaccine counseling. All vaccine counseling services beyond the general vaccine history are included in the immunization administration (IA) codes (90460-90474). This includes, but is not limited to:

- Obtaining information on potential contraindications to receiving a particular vaccine(s)
- Reviewing/discussing the relevant CDC Vaccine Information Statement(s) (VIS)
- Reviewing/discussing risks and benefits of specific vaccine(s)
- Obtaining informed consent for each vaccine(s) administered
- Addressing all other patient/parent concerns and questions related to vaccines and immunization administration
Dear Medical Director,

December 20, 2010
Page 2

For this reason, when vaccines are given at the time of a PMS, the IA code(s) must be separately reported from the PMS code so that the provider can be appropriately paid for the work involved in vaccine counseling.

Payments at or below the RBRVS value discriminate against children and pediatricians. It is more difficult to immunize children than adults. Pediatricians must spend time convincing parents of the importance and value of immunizations because of misguided information in the media concerning vaccine safety. Additionally, federal and state law and medical ethics demand that pediatricians provide information and counsel parents/guardians about the risks and benefits of the immunizations that their children are scheduled to receive. In some cases, children may also receive vaccines from a variety of sources (i.e., public health departments, community health clinics). 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. Unless the administration fee is paid at a minimum of the current RBRVS rate, pediatricians and others who care for children cannot afford to provide this service.

Pediatric practices are the public health infrastructure for the nation's childhood immunization program. Eighty-five percent of all childhood immunizations are delivered through the private sector, the vast majority of those being provided in pediatricians' offices. (Centers for Disease Control and Prevention. National Immunization Survey 2008. Available online at http://www.cdc.gov/vaccines/statistics/data/tables_2008.html#facility.)

Pediatricians are in the best position in the child's medical home to both deliver the vaccines and to ensure accurate recordkeeping while educating parents about the importance of immunizations. The AAP recognizes that schools and other non-traditional locations may be utilized as vaccination sites in some states, but accessing immunizations in the medical home leads to higher rates of on-time immunization. Also, children ages 6 months to 5 years must have access to immunizations in their medical home.

Appropriate payment for vaccines and immunization administration will enhance access to this cost effective medical service. Should you have any questions or need additional information, please contact Lou Terranova at lteranova@aap.org or at 847/434-7633. I look forward to your response.

Sincerely,

O. Marion Burton MD

O. Marion Burton, MD, FAAP
President

OMB/It
The Business Case for Pricing Immunization Administration

One of the goals of the American Academy of Pediatrics (AAP), shared by the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) is to promote maximum immunization coverage for all infants, children, adolescents, and young adults. To achieve this goal, physicians must be paid for the full costs (direct and indirect) of vaccine product-related expenses and vaccine administration expenses as well as the margin for overall overhead expenses. Because the private physician practice is the backbone of the immunization delivery infrastructure, payors must recognize that a pediatric practice is really a business entity and must run on sound, generally accepted business principles to remain viable. Vaccines are among the top overhead expenses for the pediatric practice. Therefore, payments must ensure reimbursement for the total direct and indirect practice expenses and a margin for both the vaccine product and the vaccine administration office costs and the time spent counseling families on the indications for and potential side effects of each vaccine product.

Immunization Administration Expenses: This service is separately reportable from the vaccine product. Some payers mistakenly try to maintain that inadequate vaccine payments can be made up by nominal immunization administration fees. However, these are two separate expenses and both need to be appropriately covered by payers.

Several studies published in the Pediatrics supplement, "Financing of Childhood and Adolescent Vaccines," underscore the need for appropriate payment to cover the total costs for immunizations. In one study on variable costs for immunizations by pediatric practices in Colorado it was determined that the variable costs of vaccine administration exceeded reimbursement from some insurers and health plans.

The Centers for Medicare and Medicaid Services (CMS) uses its Medicare Resource-Based Relative Value Scale (RBRVS), which assigns relative value units (RVUs) to services based on the resources utilized. The RVUs of a Current Procedural Terminology (CPT) code take into account the physician work, practice expenses, and professional insurance liability expenses associated with that service. For immunization administration, these components are detailed below.

1. Physician Work Component: The total value of physician work contained in the Medicare RBRVS physician fee schedule includes:
   • Physician time required to perform the service
   • Technical skill and physical effort
   • Mental effort and judgment
   • Psychological stress associated with the physician's concerns about the iatrogenic risk to the patient

2. Practice Expense Component: Medicare RBRVS uses both direct and indirect practice expenses to determine practice expense RVUs, including the resources used within the facility or physician's office (or patient's home) in providing the service. The practice expense component of the immunization administration fee includes: 1) clinical staff time (RN/LPN/MA blend, including time for vaccine registry input, refrigerator/freezer temperature log monitoring/documentation, and refrigerator/freezer alarm monitoring/documentation). 2) medical supplies (1 pair non-sterile gloves, 7 feet of exam table paper, 1 OSHA-compliant syringe with needle, 1 CDC information sheet, 2 alcohol swabs, 1 band-aid) and; 3) medical equipment (exam table, dedicated full size vaccine refrigerator with alarm/lock [commercial grade], and refrigerator/freezer vaccine temperature monitor/alarm).

3. Professional Liability Insurance Expense Component: The professional liability insurance RVUs assigned to
Effective 01/01/2011

a code are based on CMS historic malpractice claims data.

These three components are combined to create total RVUs (see Table below).

<table>
<thead>
<tr>
<th>CPT code and description</th>
<th>Physician Work RVUs</th>
<th>Practice Expense RVUs (Non-Facility)</th>
<th>Professional Liability RVUs</th>
<th>Total RVUs (Non-Facility)</th>
<th>Total RVUs x 2011 Medicare conversion factor (92.3.9764) = Medicare Amount (Non-Facility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional, first vaccine/ toxoid component *</td>
<td>0.17</td>
<td>0.50</td>
<td>0.01</td>
<td>0.68</td>
<td>$23.10</td>
</tr>
<tr>
<td>90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional, each additional vaccine/toxoid component *</td>
<td>0.15</td>
<td>0.18</td>
<td>0.01</td>
<td>0.34</td>
<td>$11.55</td>
</tr>
<tr>
<td>90471 Immunization administration, each injection **</td>
<td>0.17</td>
<td>0.50</td>
<td>0.01</td>
<td>0.68</td>
<td>$23.10</td>
</tr>
<tr>
<td>90472 Immunization administration, each additional injection **</td>
<td>0.15</td>
<td>0.18</td>
<td>0.01</td>
<td>0.34</td>
<td>$11.55</td>
</tr>
<tr>
<td>90473 Immunization administration by intramuscular route, first administration **</td>
<td>0.17</td>
<td>0.50</td>
<td>0.01</td>
<td>0.68</td>
<td>$23.10</td>
</tr>
<tr>
<td>90474 Immunization administration by intramuscular route, each additional vaccine **</td>
<td>0.15</td>
<td>0.18</td>
<td>0.01</td>
<td>0.34</td>
<td>$11.55</td>
</tr>
</tbody>
</table>

* CPT codes 90460 and 90461 are reported for patients under 18 years of age and when counseling is performed on the patient by the physician or other qualified health care professional. It should also be noted that the following codes are reported per vaccine component rather than per injection/administration and make no distinction between routes of administration (i.e., injectable versus oral/intranasal).
**These codes are reported for older patients (i.e., those 19 years and older) or if there is no counseling performed on the patient or the healthcare professional counseling does not meet state requirements for an "other qualified healthcare professional". It should also be noted that the following codes are reported per injection/administration and allow distinction between routes of administration (i.e., injectable versus oral/intranasal).

As a separately reported service, payments for immunization administration need to adequately cover those costs to the practice which are separate from the direct and indirect costs associated with the vaccine product. Insurers understand business principles including the concept of return on investment and expect it in their business. There is no reason physicians should accept carrier refusal to pay separately and adequately for the vaccine product and the administration. Viable businesses pass on their increased costs to their purchasers to maintain profitability. The pediatric practice has a legitimate business case to make for separate and adequate payment for vaccines and immunization administration and carriers need to provide adequate payments to cover the total direct and indirect expenses for both the vaccine product and the administration.

Pediatric practices are the public health infrastructure for the nation's childhood immunization program. It is imperative to incentivize pediatricians to participate in immunization efforts by appropriate payment for immunization administration.

References
1 Financing of Childhood and Adolescent Vaccines; Pediatrics Supplement 2009. Available at: http://pediatrics.aappublications.org/content/vol124/Supplement_5/0
2 Judith E. Glazier, MS, Brenda Beaty, MSPH and Stephen Berman, MD Cost of Vaccine Administration Among Pediatric Practices Pediatrics 2009; 124:S492-S498 Available at: http://pediatrics.aappublications.org/cgi/content/abstract/124/Supplement_5/S492

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