On behalf of [Practice name], a primary care pediatric medical home providing \_\_\_\_\_\_\_\_\_\_ outpatient visits annually, we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies published in the August 14th, 2019 Federal Register (Vol. 84, No. 157 FR, pages 40482-41289). While the Medicare PFS represents only a small number of pediatric patients directly, it has significant impact on the majority of pediatric patients indirectly through its policies being adopted by other public and private health plans.

CMS’ decision to reflexively reduce the practice expense (PE) for pediatric Immunization Administration (IA) codes 90471/90460 because these codes were initially valued by a crosswalk to code 96372 has had significant impact on our ability to continue providing vaccines. The recent measles crisis in the US spotlights the importance of immunization administration being appropriately valued. One-third of pediatric visits include immunizations making appropriate IA payment essential to ensure access to vaccines provided in the medical home, where studies have shown immunization rates are higher.

Code 90460 was reviewed by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in October 2009. Rather than accepting the RUC recommendations, CMS crosswalked code 90460 from code 90471 (*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*), which is crosswalked from code 96372 (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*) (formerly code 90772 and then 90782).

Maintaining the crosswalk from code 96372 to codes 90471/90460 and the related reduction in PE is not appropriate as the clinical staff documentation requirements are significantly more robust for IA than they are for the service of therapeutic injection:

*Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered. Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log.*

Furthermore, the crosswalk has brought about a 60% reduction in PE relative value units (RVUs), resulting in payment substantially lower than current CDC regional maximum charges for IA. Since 90460 is among the most commonly reported codes in our practice, the impact to providing childhood immunizations is significant and without adequate payment to offset costs, we risk being unable to offer vaccines.

Historically, CMS typically only uses a crosswalk for work values, not PE values. Additionally, when the RUC makes crosswalks, it disconnects the codes after the initial crosswalk – so that changes to the source code no longer affect the crosswalked code. CMS also has this option – because once the crosswalk is used, the codes no longer need to stay linked.

Finally, it should be noted that CMS has already validated the RUC-recommended values for code 90460. CMS used the RUC-recommended values for code 90460 to value the fast-tracked H1N1 IA code (90470) for 2010 – as both codes were reviewed during the same RUC meeting (October 2009).

**We respectfully request that CMS utilize the RUC-recommended direct PE inputs for code 90460 to publish PE RVUs for CPT codes 90471 and 90460.**