



HOW MEDICAL CLAIMS SIMPLIFICATION CAN IMPEDE DELIVERY OF CHILD DEVELOPMENTAL SERVICES

Anne Markus, Sara Rosenbaum, Alexandra Stewart, and Marisa Cox
George Washington University
School of Public Health and Health Services

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ABSTRACT: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) seeks to achieve greater efficiency and effectiveness in the health care system by requiring payers and providers to use standardized procedure codes for payment claims. HIPAA has a significant impact on the translation of benefit designs into medical claims payment standards. This presents challenges for children with Medicaid coverage, since the Medicaid program employs a unique definition of medical necessity that ties coverage to childhood growth and development. To comply with HIPAA, state Medicaid agencies must eliminate local payment codes, a process that may result in reduced levels of coverage for children, particularly for primary health and support services such as mental health services, early intervention, physical and speech therapy, home care, case management, and transportation. To avoid unintentional reduction of child development services, the authors suggest revising HIPAA to allow states to customize payment coding to their unique coverage standards.

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CONTENTS

About the Authors	iv
Acknowledgments	v
Executive Summary	vi
Introduction	1
Early Child Health Care, Insurance Coverage, and Claims Reimbursement	1
HIPAA Administrative Simplification and Its Impact.....	11
Medicaid Changes Following HIPAA Implementation.....	21
Discussion.....	29
Notes.....	31
Appendix. Preliminary HIPAA-Compliant Coding Taxonomy for Effective Developmental Services in a Primary Care Setting.....	37

LIST OF FIGURES AND TABLES

Figure 1 Publicly Insured Children Are More Likely than Privately Insured Children to Have Routine Well-Child Visits.....	4
Table 1 A Comparison of Benefits for Infants and Young Children: Medicaid and the FEHBP Standard Option Blue Cross/Blue Shield Plan.....	9
Table 2 HIPAA Standard Code Sets	13
Table 3 Structure of HCPCS Before and After HIPAA	14
Table 4 Types of HCPCS Level II Codes	16
Table 5 Entities Responsible for Modifying HCPCS	18

ABOUT THE AUTHORS

Anne Rossier Markus, J.D., Ph.D., M.H.S., is associate research professor in the Department of Health Policy at the George Washington University (GWU) School of Public Health and Health Services, where she teaches and researches topics related to the financing and organization of health care and access to quality care, with a particular emphasis on managed care, Medicaid/SCHIP, health centers, and how they address the needs of women and children. Prior to joining the department, she was a research associate at the GWU's Intergovernmental Health Policy Project, where she tracked, researched, and analyzed health care legislation and issues on health care reform, managed care, access to care, and bioethics. Previously, she worked for the Washington Business Group on Health, a national organization of Fortune 500 employers that has worked to restructure health care financing and delivery since 1974. Ms. Markus holds a law degree from the University of Lausanne School of Law in Switzerland, a master's degree in health policy from the Johns Hopkins University School of Hygiene and Public Health, and a Ph.D. in public policy from GWU Columbian College and Graduate School of Arts and Sciences.

Sara Rosenbaum, J.D., is the Harold and Jane Hirsh Professor of Health Law and Policy and chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services. Ms. Rosenbaum also directs the Hirsh Health Law and Policy Program and the Center for Health Services Research and Policy. She has focused her career, which began as a legal services attorney for the poor, on health care for low-income, minority, and medically underserved populations. Over the years, she has played a major role in the design of federal and state legislative and regulatory health policy related to Medicaid, private health insurance and employee health benefits, health services for medically underserved persons, maternal and child health, civil rights, and public health. In 1993–94, Ms. Rosenbaum worked for the White House Domestic Policy Council, where she directed the drafting of the Health Security Act for President Clinton. She has been named one of America's 500 most influential health policymakers and has been recognized by the U.S. Department of Health and Human Services for distinguished national service on behalf of Medicaid beneficiaries. Ms. Rosenbaum received her law degree from the Boston University School of Law.

Alexandra M. Stewart, J.D., is assistant research professor in the Department of Health Policy at the George Washington University School of Public Health and Health Services. Ms. Stewart has performed research in two areas: 1) the intersection of immunization law and health policy, and 2) the community integration of persons with disabilities. Ms. Stewart

directs an initiative on the epidemiology of U.S. immunization law, funded by the Centers for Disease Control and Prevention. Ms. Stewart has drafted model statutes addressing state private insurance law for immunization coverage; establishment of state immunization registries; data sharing among immunization registries; and establishment of perinatal and infant hepatitis B testing and vaccination programs. She earned her law degree from the George Washington University Law School.

Marisa Cox, M.A., is a research associate at the Department of Health Policy at the George Washington University School of Public Health and Health Services, where she is currently assisting department staff in an extensive CDC-sponsored project focused on access to and financing of vaccines for various populations. Ms. Cox has engaged in policy-related internships at the Lehigh Valley Hospital Ethics Committee, Women Work!, and the American College of Nurse Midwives. She has completed a master of arts degree in philosophy and social policy at the George Washington University.

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EXECUTIVE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is intended to foster greater efficiency and effectiveness in the health care system by requiring payers and providers to use standardized procedure codes for payment claims. Although HIPAA's goal is to decrease costs and increase health care quality, the law may have unintended consequences on the ability of Medicaid agencies to preserve special rules of coverage. In particular, Medicaid-covered services related to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program present challenges in adapting claims and payment codes. If the standardized codes are not adopted or adapted to fulfill special coverage standards, states can lose significant coverage for developmental services for Medicaid-enrolled infants and young children, who as a group have higher-than-average health needs.

This report examines HIPAA administrative standardization and the process of modifying the standardized codes. It assesses the implications of HIPAA standardization for payment of Medicaid-covered early childhood preventive and developmental services, drawing on findings from a 50-state, point-in-time review of readily available state HIPAA compliance documents conducted in December 2004.

Key Findings

- HIPAA has a significant impact on the translation of benefit designs into medical claims payment standards. HIPAA standardization relies on a national coding scheme, which public and private health insurers have little discretion to adapt to their own coverage standards. This presents challenges for children's Medicaid coverage. Not only does Medicaid cover types of benefits not found in private health insurance, but the program also has a unique definition of medical necessity that ties coverage to childhood growth and development.
- While HIPAA sets coding standards and has a strict process for modifying codes once they are established, individual insurers can choose which of the standardized billing codes to recognize for reimbursing covered services. Few insurers recognize the full set of national billing codes.
- All state children's health insurance coverage programs are expected to launch a HIPAA-compliance process, including standardization of codes and communication of new codes to participating providers. Only a slight majority of state Medicaid agencies (n=26) take part in this process via Web posting ("study states"). Study

states either: 1) maintain the same level of coverage by “cross-walking” their pre-HIPAA local codes to existing national billing codes deemed equivalent by the agency; 2) reduce the level of coverage by eliminating local codes and not replacing them with national codes, or by replacing local codes with national codes that in effect reduce coverage; or 3) expand coverage by recognizing national codes for which they had no corresponding local code or that they had previously recognized only for a different purpose.

- HIPAA’s national coding system, which is rooted in discrete procedures, may have shortcomings for pediatric care. The system only recently began to take into account child health and developmental services that are nonprocedural in nature. In addition, HIPAA either excludes or fails to appropriately capture a number of behavioral health services, particularly services to follow up on initial detection of a condition.
- HIPAA’s coding system may result in lower levels of service for Medicaid enrollees. Across the 26 study states, changes made to local Medicaid codes tend to affect primary health and patient support services furnished in settings other than private practices, such as county and local agencies. Mental health services, early intervention, physical and speech therapy, home care, case management, and transportation appear to be particularly affected.

Conclusion

To the extent that HIPAA has inadvertently resulted in reduced Medicaid coverage for child development services, it is important to reverse this trend. The findings demonstrate that HIPAA reduces, but by no means eliminates, variation in payment coding. Since some variation among insurers is inevitable, HIPAA should allow payment coding to be customized to accommodate unique coverage standards. State Medicaid agencies could learn from one another about how to modify payment rules to cover child development services.

The continued involvement of pediatric health experts in HIPAA standardization is essential. It is particularly important to include professionals with special expertise in child development and care for children with unique needs related to poverty, culture, language, or other factors. It may be valuable to create a pediatric consensus panel to identify and refine standards of care for preventive and developmental services and translate these standards into HIPAA-compliant codes. Finally, additional research is needed to illuminate distinctions between what health insurance covers and which payment codes apply and to measure the impact of standardized codes on the types of developmental services pediatric physicians choose to provide.

HOW MEDICAL CLAIMS SIMPLIFICATION CAN IMPEDE DELIVERY OF CHILD DEVELOPMENTAL SERVICES

INTRODUCTION

This report examines the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and assesses their implications for coverage of early childhood preventive and developmental services by state Medicaid and State Children's Health Insurance Program (SCHIP) agencies.¹ HIPAA aims to increase the efficiency of the health care system by requiring payers and providers to follow standardized procedure codes for payment claims.

In trying to reduce administrative costs, the law may have unintentionally curtailed the ability of payers, particularly Medicaid agencies, to customize their policies to pay for developmental services for young children. Before the implementation of HIPAA, there was enormous variation among the states in terms of what developmental services they reimbursed providers for delivering. This variation still exists today, but to a much lesser extent. However, the HIPAA-compliant national coding system may have serious shortcomings for the delivery of developmental services. The system is rooted in discrete procedures and cannot be sufficiently customized to cover childhood health and developmental services that are nonprocedural in nature.²

This report discusses how health insurers' coverage and payment policies affect the quality of care for young children. It provides an overview of HIPAA and its administrative simplification provisions, reviews the federal standards on electronic transmission of patient information and payment codes, and outlines the process by which public and private insurers standardize their coverage and payment policies for child development services. It then presents findings of an analysis of activities in all 50 states and a review of state HIPAA compliance records that illustrate the changes that state Medicaid and SCHIP agencies have made in order to comply with HIPAA. We then discuss the implications of these changes for coverage and payment of early childhood preventive and developmental services.

EARLY CHILD HEALTH CARE, INSURANCE COVERAGE, AND CLAIMS REIMBURSEMENT

Definition of Preventive and Developmental Services

Early childhood preventive and developmental services play a crucial role in promoting the healthy development of children from birth to age 5, a period during which children develop neurologically, physically, socially, and cognitively.³ In order to monitor this

development, children should receive age-appropriate medical, psychological, and other support services. If developmental problems are diagnosed and treated during these early years, it may be possible to avoid detrimental consequences to children's health, well-being, social attainment, and educational achievement.⁴

Although there is no consensus on the content of developmental services, these services generally include an array of screenings and interventions aimed at the prevention, detection, and treatment of physical, cognitive, and behavioral delays or conditions. Examples of services include vision, hearing, and dental assessments; health education and anticipatory guidance; mental health counseling; and physical examinations.

For this analysis, we rely on a typology of early childhood preventive and developmental services developed by a research team from the University of California at Los Angeles. The team examined the available scientific evidence documenting the effectiveness of these services and categorized those found to be effective into four main categories:⁵

1. Assessment services, such as assessments of parental concerns about a child's health and development, developmental tests, psychosocial risk screenings, observations of the parent-child relationship, and assessments of child behavior problems and temperament;
2. Education services, such as anticipatory guidance (e.g., on sleep habits, discipline) and parent-support groups;
3. Intervention services, such as office counseling and home visits; and
4. Care coordination services, such as follow-up for office interventions, monitoring of sub-specialist or program referrals, and implementation of an office tracking system.⁶

Relationship Between Coverage, Payment, and Quality of Care

To our knowledge, no research has examined the potential impact of HIPAA standardization on the breadth of coverage available to children enrolled in public health insurance coverage programs. Our review of the literature reveals that all of the pertinent research published to date presents findings from data collected prior to the implementation of HIPAA. This section summarizes these findings, which can be used as a baseline to measure the impact of federal changes in payment policy on coverage of pediatric care.

We found two types of studies related to our examination of billing codes. The first type documents the relationship between type of coverage and quality of care. The second type of research, which is still in its infancy, explores the relationship between payment levels and quality of care. Payment codes are the link between these two lines of research since they are used both to implement coverage and to form the basis of the fee schedule used to pay providers.

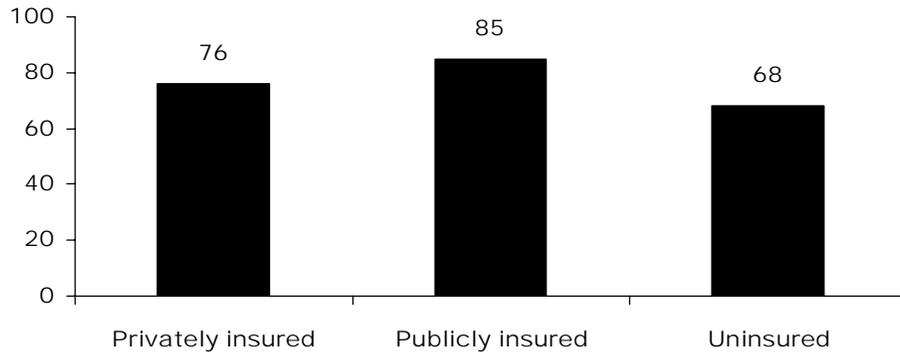
Research has shown that children covered by health insurance, whether public or private, have better access to preventive, screening, and therapeutic services, and that being insured is associated with better health outcomes as measured by mortality and disability rates.⁷

Privately insured children usually fare slightly better than publicly insured children on a number of access and quality measures. Overall, however, public insurance has narrowed the gap in access to and quality of care between the uninsured and the privately insured.⁸ Poor and low-income children are more likely to have public insurance.⁹ They are also more likely to be in fair or poor health and have asthma, learning disorders, or medical conditions that require regular treatment with prescription drugs.¹⁰ For these children, Medicaid or SCHIP may be the only sources of coverage for preventive and developmental services.

Analyses of existing data on the rate at which children see their doctor for a routine check-up at age-appropriate intervals provide somewhat conflicting results. Household survey data from the National Survey of America's Families (NSAF), in which parents report on use of routine check-ups for their children, show that publicly insured children generally surpass privately insured children on this measure. In a study of 1999 data, 85 percent of publicly insured children ages 3 to 17 received age-appropriate well-child visits, compared with 76 percent of their privately insured counterparts (Figure 1).¹¹ In a study of 1999 and 2002 data, receipt of well-child visits among children ages 17 and younger generally increased over time, with publicly insured children still receiving one or more well-child visits at a higher rate than privately insured children (75% vs. 70%).¹²

Figure 1. Publicly Insured Children Are More Likely than Privately Insured Children to Have Routine Well-Child Visits

Percentage of children ages 3-17 who received an annual well-child visit at recommended ages, 1999



Source: S. Leatherman and D. McCarthy, *Quality of Health Care for Children and Adolescents: A Chartbook* (New York: The Commonwealth Fund, 2004).

The two NSAF studies used different definitions of children (i.e., children ages 3 to 17 vs. all children ages 17 and younger) and well-child visits (i.e., age-appropriate visits vs. one or more visits in the past year). The studies also use different statistical approaches to control for factors apart from health insurance coverage that influence service use, such as health and socioeconomic status. These differences may explain the variation between the two studies' findings. Yet, both find that publicly insured children are more likely than their privately insured counterparts to have routine check-ups, a finding that may seem surprising since Medicaid is known for its low reimbursement rates.¹³

Self-assessed and audited 1999 Health Plan Employer Data and Information Set (HEDIS) data from Medicaid and commercial managed care plans, on the other hand, show that Medicaid-covered children fared worse than their commercially insured counterparts in terms of number of well-child visits received, particularly during the first 15 months. Overall, compliance rates were low for publicly insured children compared with privately insured children (31% vs. 53% for children under 15 months; 50% vs. 55% for children ages 3 to 6; and 29% vs. 27% for adolescents 12 years and older).¹⁴

Unlike NSAF household survey data, which are representative of the population as a whole, HEDIS data do not represent the entire population. Health plans report HEDIS measures on a voluntary basis and thus measures from a number of plans usually go unreported (in 1999, one-quarter of all plans did not provide this information and small

plans were underrepresented). For example, HEDIS data focus on a more limited number of childhood years and on children who are continuously enrolled in the same managed care plan in the prior 12 months. In addition, the data do not control for individual differences in health status and socioeconomic factors among enrolled children. There are other differences in how HEDIS and NSAF data are gathered and analyzed, which may explain the poorer performance of the managed care delivery system.

Apart from immunization rates, there are limited data comparing the content of care provided during office visits for publicly and privately insured children.¹⁵ The American Academy of Pediatrics (AAP) recommends that a number of developmental services be performed during well-child visits, including dental, hearing, and vision screens, developmental assessments, and anticipatory guidance.¹⁶ Providers typically give parents some level of guidance about what to expect in terms of their child's development, though they may not perform more resource-intensive blood tests to check lead levels or comprehensive developmental assessments.

Data from the National Survey of Early Childhood Health (NSECH), a household survey conducted in 2000 in which parents reported use of care by children ages 4 to 35 months, show that insurance status did not affect receipt of a number of preventive services, including: developmental assessments; injury prevention guidance on car seats, sleeping positions, and dangerous situations; smoking history; and parental guidance on reading.¹⁷ Overall, approximately two-thirds of children received four or more of these services, regardless of whether they had private or public insurance. These findings seem to indicate that once children "get in the door," physicians are able to provide high-quality care.

Some researchers have hypothesized that there is a link between payment levels and quality of preventive services for children, but the research in this area is just beginning.

For example, recent research has attempted to detect a relationship between capitated payment levels paid to pediatricians by commercial managed care plans and their adherence to the AAP well-child visit and immunization recommendations.¹⁸ Specifically, one study of 2002 HEDIS data found similar well-child visit and immunization rates for infants, young children, and adolescents as the study of 1999 HEDIS data mentioned above. In both cases, rates were low across the board. Yet, states with higher reimbursement levels had higher immunization and well-child visit rates. The study also found that pediatrician supply was a mediating factor: a higher proportion of pediatricians

were located in higher-paying states, which in turn had increased rates of visits and immunizations. The authors hypothesized that, because pediatricians have specialized education and training, they are more likely to perform these services themselves and to adhere to the AAP periodicity schedule.¹⁹

Researchers did not analyze Medicaid HEDIS data in a similar fashion, but it is possible to hypothesize that states with lower Medicaid payments may deter practitioners from providing the full array of developmental services (although the NSAF studies indicate that children receive better care under Medicaid despite lower reimbursement levels).²⁰ In addition, due to low reimbursement levels, there have historically been shortages of physicians, including pediatricians, willing to serve Medicaid enrollees. As stated above, there may be a link between pediatrician supply and rates of immunization and other services. These factors may help explain some of the disparities found in previous research, such as the study of 1999 HEDIS data described in this section.

Research findings to date seem to support our assumption that different coverage designs determine which services primary care providers will actually be paid for providing and ultimately the quality of care.²¹ Researchers who examined the NSAF household data hypothesized that more comprehensive public coverage may account for higher rates of preventive visits among publicly insured children compared with privately insured children.²² This assumption may hold particularly true for children enrolled in Medicaid because of key differences in insurance design between Medicaid and SCHIP programs.²³ However, more research is needed to determine the relationships between coverage designs, payment levels, and quality of care. In addition, a comparison of pre- and post-HIPAA patterns would be valuable in order to detect the actual impact of standardization.

Reimbursement for Preventive and Developmental Services in Public and Private Coverage

The nation's health care financing system involves a complex web of publicly and privately sponsored group and individual health insurance plans. Under these plans, each insurer may use its own marketing, billing, and claims procedures. Together, these insurers process more than 5 billion payment claims annually, according to the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, and SCHIP.²⁴

In terms of claims payment, state Medicaid programs act much like any group health plan. Although state Medicaid programs are subject to federal standards, they have historically had the flexibility to use their own claims protocols. As Medicaid programs

increasingly have moved to managed care, their contracts either mandate continuation of their own claims protocols or permit the adoption of procedures used by their contractors. This also has been true in state SCHIP programs.

The cost of a vast, multi-payer claims processing and plan administration system is considerable; one frequently cited estimate places it at one-quarter of total health care spending.²⁵ Administrative costs appear to be as much as three times higher for private insurers and health care corporations than for public agencies such as state Medicaid programs or CMS.²⁶ For this reason, the evolution of Medicaid and SCHIP from publicly administered programs into programs that buy managed care services from the private sector has likely led to increased claims administration costs.

Health care providers shoulder heavy burdens under multi-payer claims administration. As a condition of participation, providers must comply with the billing and claims procedures imposed by each insurer or plan. The Commonwealth Fund Survey of Physician Experiences with Managed Care found that, in 1997, one-half of the physicians surveyed participated in five or more separate plans and one-quarter had contracts with 10 or more plans, with a mean number of eight contracts per physician.²⁷

Some of the variation in billing procedures and codes may result from idiosyncratic choices made by insurers and health plans regarding how they recognize and pay for the same procedures. In other cases, variations may be attributable to real differences in plan coverage. This is particularly true in Medicaid, which has fundamentally different coverage rules than private insurers. The implications of this are important for children, who have a unique level of coverage under Medicaid.

Billing Codes and Coverage Designs

Insurers recognize a set of billing codes, which providers use to implement insurers' coverage designs. A coverage design or certificate of benefits consists of an insurer's terms of coverage, which determine the extent of coverage, including classes of benefits, exclusions and limitations, and standards for determining medical necessity. In Medicaid and SCHIP, the extent of coverage is described in federal law and regulations; state Medicaid and SCHIP plans, as approved by the federal government; state policies and manuals; and any managed care contracts. Group and individual policies, members' handbooks, and other internal documents describe the extent of coverage for private insurers.

Medicaid’s coverage design for children is the most comprehensive of all insurers. Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children under age 21, Medicaid provides children with a comprehensive set of screenings, interventions, and other support services. The benefit covers services for young children with potential developmental problems who need preventive care as well as short- and longer-term therapies to reach their full potential.

State SCHIP programs have the option of designing similar developmental benefits, but most states do not choose to provide such comprehensive coverage. Rather, they typically offer coverage that meets a minimum standard set by other commercial insurers in the state and that is more limited in scope.²⁸ For example, SCHIP programs tend to limit speech, occupational, and physical therapy and exclude private duty nursing and other long-term services, which are covered by Medicaid if they are deemed to be medically necessary.²⁹ Yet, SCHIP benefit packages still are typically more generous than those found in the private market. Federal law requires SCHIP programs to offer well-child care as a basic benefit.³⁰ The majority of states provide SCHIP-enrolled children with some level of vision, hearing, and dental care—benefits that often are extremely limited or completely excluded from private insurance packages.³¹

Compared with Medicaid and SCHIP, private insurance offers the least comprehensive developmental coverage. This is true even for the Standard Option Blue Cross/Blue Shield Plan offered to federal employees under the Federal Employees Health Benefits Program (FEHBP). Put simply, private insurers do not cover interventions for children at risk for developmental disabilities and delays. Table 1 illustrates the differences between children’s coverage in Medicaid and the FEHBP Standard Option Blue Cross/Blue Shield plan.³²

Table 1. A Comparison of Benefits for Infants and Young Children:
Medicaid and the FEHBP Standard Option Blue Cross/Blue Shield Plan

Benefit	Medicaid	FEHBP Standard Option Blue Cross/Blue Shield Plan
Comprehensive assessment of physical and mental growth and development (developmental assessments)	Covered	Limited to “healthy newborn visits,” “routine screening,” “routine physical examinations,” “neurological testing,” and initial examination of a newborn needing “definitive treatment,” when the infant is covered under a family enrollment.
Anticipatory guidance	Covered	Not explicitly covered
Physical, speech, and related therapies	Covered without limitations other than medical necessity; no “recovery” requirements; therapy covered for conditions identified through early intervention and child care programs.	Limited to inpatient coverage. “Maintenance therapy” expressly excluded. Also excluded are “recreational and educational” therapy and “any related diagnostic testing except as provided by a hospital as part of a covered inpatient basis.” All services billed by schools or school staff members are excluded.
Hearing services	Covered without limitations, including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development.	Testing covered only when “related to illness or injury.” Routine hearing tests excluded other than as standard part of “routine” screening for children; hearing aids excluded along with testing and examinations for the prescribing or fitting of hearing aids.
Eye examinations and eyeglasses	Covered without limitations, as medically necessary.	One pair of eyeglass replacement lenses or contact lenses to “correct an impairment directly caused by a single instance of accidental ocular injury or intraocular injury;” eye examinations for specific medical conditions; nonsurgical treatment for amblyopia and strabismus from birth through age 12. Eyeglasses and routine eye examinations specifically excluded, as are eye exercises, visual training and orthoptics except in connection with the specific diagnosis of amblyopia or strabismus.
Durable medical equipment (DME)	Covered without limitations, as medically necessary.	Certain DME covered but only if prescribed for the treatment of “illness or injury.”
Home nursing	Covered without limitations, as medically necessary; home visits can cover health educators, therapists, health aides, and others.	Covered for 2 hours per day, 25 visits per year, when furnished by a nurse or licensed practical nurse and under a physician’s orders.

Sources: S. 1905(r) of the Social Security Act, 42 U.S.C. 1396d(r); Part 5, Section 5122 of the State Medicaid Manual; OPM, FEHBP Blue Cross and Blue Shield Service Benefit Plan, 2005.

Billing Codes and Reimbursement Policies

Not only are billing codes used to implement coverage policies, they are also used to determine the actual payment levels providers will receive for their services. Billing codes, however, are only one aspect of payment policies. More specifically, reimbursement policies include 1) recognized billing codes, which are combined into a fee schedule, 2) payment rules, 3) adjustments for cost-sharing, and 4) claims analysis software. In practice, these payment policies may limit the coverage for services that are included in the benefit design.

First, insurers use billing codes to identify procedures that are either part of covered benefits, medically unnecessary, or excluded from the benefits. The codes recognized by each individual insurer vary from insurer to insurer and rarely capture the broad terms of coverage. For example, Medicaid covers hearing screenings as part of well-child visits, but a state agency may or may not allow providers to bill separately for that service.

Second, insurers impose a number of rules on payment. These payment rules also vary from insurer to insurer because there are no national standards.³³ Insurers may, for example, require providers to submit claims within a certain time period or meet prior authorization requirements.

Third, insurers may require patients to contribute to the cost of their care through copayments or coinsurance. Providers may have to collect this part of the payment at the point-of-service and bill the insurer for the remainder of the allowable fee.

Finally, insurers often use claims analysis software, which automatically rejects certain combinations of diagnosis, procedure, and visit codes.³⁴ For example, some insurers will reject certain procedures administered on the same day and billed separately from each other, such as a physician-administered objective developmental test performed during, or on the same day as, the periodic preventive well-child visit. The software also systematically groups, or “bundles,” related services into a single payment code or categorizes certain codes as incidental to another procedure, thus in effect limiting payment. These policies are usually found in insurers’ provider manuals and fee schedules. In the private sector, these documents are considered proprietary, and insurers may not allow physicians to view their fee schedules before signing a contract and usually do not allow them to review their coding and bundling practices.³⁵ In the public sector, Medicaid and SCHIP provider manuals and fee schedules are in the public domain, even though they are sometimes incomplete.

HIPAA ADMINISTRATIVE SIMPLIFICATION AND ITS IMPACT

Where Does HIPAA Administrative Simplification Come into Play?

The HIPAA administrative simplification requirements affect reimbursement policies by dictating which sets of billing codes insurers may recognize to effectuate their coverage design and by eliminating local codes used by insurers to tailor payment to their coverage policy. This approach is akin to an insurer imposing a poorly designed drug formulary that substitutes more effective brand-name drugs with less-expensive generics, or fails to provide a satisfactory substitute for a drug that is eliminated altogether.

Children enrolled in Medicaid may be most affected by the HIPAA changes. Medicaid covers many classes of benefits not found in standard commercial policies, including comprehensive developmental assessments for children with suspected delays in physical and mental development and anticipatory guidance for families. It also covers long-term therapies for infants and young children with speech, movement, and language delays. In addition, for conditions such as cerebral palsy, the program covers therapies intended to prevent deterioration in function. In contrast, private insurance typically excludes therapies that are not related to the treatment of a specific illness or injury. In many cases, treatment is limited to “recovery” periods and maintenance therapy for permanent conditions is excluded.

There are also important differences between Medicaid and private insurance in terms of the definition of “medical necessity.” All insurers use this standard to measure when a covered medical service is actually reimbursed. Medical necessity determinations may be made on a case-by-case basis or written into the definition of a service itself. In Medicaid, a service is considered medically necessary if it “ameliorates” a child’s physical or mental “condition.” For private insurers, medical necessity frequently is limited to treatments that “restore or improve” functioning following an “illness or injury.” This narrower concept of medical necessity eliminates coverage for long-term developmental and maintenance therapies.

Medicaid’s benefit classes and medical necessity standard make a significant difference in the extent of coverage for infants and young children. These features expressly require coverage of certain interventions and mandate greater, earlier, and longer-term coverage of others.

In creating the HIPAA payment coding system, policymakers eliminated a coding subset that included local codes for certain procedures. While this affected any insurer that had made use of such codes, it greatly affected Medicaid because its breadth of coverage

requires the most local customization. To the extent that the eliminated codes have no counterpart in the current HIPAA system, Medicaid agencies have lost the ability to pay for certain covered procedures. Although opportunities for creating new codes or modifying existing codes still exist, it may be more difficult to customize the national codes than it had been to customize the local codes.

Overview of the HIPAA Administrative Simplification Requirements

Congress enacted HIPAA in August 1996 “to improve . . . the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.”³⁶ Congress required the Department of Health and Human Services (HHS) to adopt national standards for certain electronic health care transactions, code sets, and provider, employer, and health plan identifiers and to ensure the security of health information.³⁷ CMS, which is responsible for implementation and oversight of the transaction and code set standards, anticipated that, upon full implementation, “HIPAA . . . [would] streamline and standardize the electronic filing and processing of health insurance claims, save money and provide better service for providers, insurers and patients.”³⁸ CMS envisioned that the cost of health care would decrease and the quality of care would increase through simplification of administration and management of health information.³⁹ HHS estimates from 2002 put total net savings at \$29.9 billion over 10 years.⁴⁰

Federal HIPAA regulations implementing the administrative simplification requirements are complex. Since HIPAA’s enactment, seven sets of implementing rules have been published, proposed, or placed under development. HHS issued the first rules governing electronic health care transaction and code sets on August 17, 2000.⁴¹ The rules became effective on October 16, 2003, for public and private health insurers that conduct electronic referral authorizations, claim transactions, and other financial and administrative transactions (with the exception of small health plans).⁴² In addition, CMS guidance relaxes the 2003 compliance date for entities that make “a good faith” outreach and testing effort to achieve compliance, allowing them to implement contingency plans using non-standard transactions in order to maintain operations and cash flow.⁴³

HIPAA is enforced using a voluntary compliance approach that depends on “a complaint-driven” process.⁴⁴ Providers may continue to use paper transactions but the Medicare and Medicaid programs will ultimately require electronic transmission of all transactions (except in some limited instances) and other payers are expected to follow suit.⁴⁵ Other businesses may voluntarily comply with the standards.⁴⁶

Federal Standards on Electronic Transactions and Code Sets

HIPAA regulations provide four federally recognized code sets covering inpatient services, pharmaceuticals, dental care, and outpatient services (Table 2). Distinct organizations, such as CMS and the American Medical Association (AMA) are responsible for maintaining specific code sets, which are valid within the dates specified by these organizations (Tables 2 through 5).⁴⁷ Specifically, HIPAA turns on the following code sets:

1. ICD-9-CM, International Classification of Diseases, 9th edition, Clinical Modification (Vol. 3);
2. NDC, National Drug Codes;
3. Code on Dental Procedures and Nomenclature;⁴⁸ and
4. HCPCS, Health Care Financing Administration Common Procedure Coding System, and CPT-4, Current Procedural Terminology, Fourth Edition.

Table 2. HIPAA Standard Code Sets

Federally Recognized Code Sets	Diagnoses/Procedures/Services/Items
ICD-9-CM, Volumes 1, 2 and 3 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by the Department of Health and Human Services (HHS)	Volumes 1 and 2: Diseases, injuries, impairments, other health problems and their manifestations, and causes of injury, disease, impairment, or other health problems. Volume 3: Prevention, diagnosis, treatment, and management procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients, reported by hospitals.
National Drug Codes (NDC), as maintained and distributed by HHS, in collaboration with drug manufacturers	Drugs and biologics
Code on Dental Procedures and Nomenclature (the Code), as maintained and distributed by the American Dental Association (ADA)	Dental services
Combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA)	Physician and other health care services (e.g., physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services, including ambulance). All other substances, equipment, supplies, or other items used in health care services (e.g., medical supplies, orthotic and prosthetic devices, durable medical equipment).

Source: Fed. Reg. 50370; 45 C.F.R. Subpart J § 162.1000, 162.1002, and 162. 1011.

Notably, the law excludes DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, maintained by the American Psychiatric Association, as a federally recognized

code set. Many diagnostic codes used in the delivery of behavioral health services are not captured adequately in the ICD-9-CM’s definitions. The implications of this exclusion for behavioral health providers has been discussed in-depth elsewhere.⁴⁹

For providers of preventive and developmental services, the standard code set that combines the existing HCPCS and CPT-4 coding systems maintained by HHS and AMA, respectively, known as Level I codes, is the most important. The HCPCS coding system is an amalgam of the department’s original coding system for Medicare claims administration augmented by additional codes developed by selected health professions societies.⁵⁰ It incorporates the AMA’s CPT-4 coding system as Level I codes as well as the American Dental Association Code on Dental Procedures and Nomenclature CDT-4 coding system as Level II dental codes.⁵¹ CMS considers this resulting amalgam the overall standard for services delivered in an outpatient setting, even though it does not encompass all professional procedures, particularly those unique to mental and developmental conditions.

While HHS developed HCPCS for the Medicare program, Medicaid agencies and other insurers have also adopted HCPCS, or parts of HCPCS, for their own coding system.⁵² Recognizing the need for a procedure to augment, modify, or delete existing codes, CMS maintains an updating process, discussed below.⁵³

Prior to enactment of HIPAA, the HCPCS was divided into three levels of codes—Level I, Level II, and Level III codes (Table 3). Today, only two levels are used.

Table 3. Structure of HCPCS Before and After HIPAA

HCPCS Subsystems	Coding System	Procedures/Services/Items
<i>Before HIPAA</i>		
Level I codes	CPT-4 (AMA)	Medical services and procedures
Level II codes	HHS-developed	Medical services, supplies, equipment, and other items NOT included in CPT-4 coding system, e.g.: ambulance services; durable medical equipment; prosthetics; orthotics; supplies
Level III codes	Locally developed	Services without a Level I or Level II code
<i>After HIPAA</i>		
Level I codes	CPT-4 (AMA)	Medical services and procedures
Level II codes	HHS-developed	Medical services, supplies and equipment NOT included in CPT-4 coding system, e.g.: ambulance services; durable medical equipment; prosthetics; orthotics; supplies

Source: CMS, 2004, at <http://www.cms.hhs.gov/medicare/hcpcs>.

Level I codes (those drawn from the AMA’s CPT-4 coding system) date back to 1966 and are updated annually. Level I offers a uniform, numeric coding system consisting of descriptions of medical services and procedures provided by physicians and other health care professionals, each of which is paired with a five-digit number that uniquely identifies these services and procedures. For example, a pediatrician performing a “well-child” exam for a three-year-old child would use CPT-4 code 99392, which covers “an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures.”⁵⁴ One code bundles together many different procedures. Assuming that the procedure represents a covered service under a particular health insurance plan and all other reimbursement policies are fulfilled, the insurer would pay the claim at the dollar level assigned to the code.

Level II codes, established for Medicare and other public and private insurance program administration in the 1980s and updated annually, is a standardized, alpha-numeric coding system that identifies medical products, supplies, and services that are not included in the CPT-4 coding system. Level II codes represent procedures furnished outside a physician’s office and billed regularly by suppliers other than physicians. Level II codes consist of an official treatment and procedure definition and a single alphabetical letter followed by a four-digit number. For example, a dentist furnishing a “prophylaxis” for a five-year-old child would use HCPCS Level II code D1120. Assuming coverage under the child’s insurance plan and fulfillment of other reimbursement rules, the insurer would pay at the code’s dollar value as determined in the fee schedule.

Within Level II codes, there are several sub-categories of codes (Table 4). These sub-categories include: 1) permanent national codes, 2) dental codes, 3) miscellaneous codes, and 4) temporary national codes, developed for i) professional procedures and services that normally would be coded in CPT-4 but for which no CPT-4 code exists, ii) services, supplies, and equipment not included in CPT-4 and for which no national Level II code exists, and iii) drugs, services, and supplies used by private insurers. Medicaid and SCHIP agencies may use any of these four types of Level II codes and, in addition, are able to develop Medicaid-specific temporary codes necessary to run the program and for which no permanent national code exists (known as T codes) and to reimburse certain mental health services (known as H codes). For example, since November 2004, Illinois reimburses “prenatal care, at-risk assessment” Level II temporary national code H1000 for the screening of prenatal depression in primary care settings as part of the mental health services covered by the state Medicaid program.

Table 4. Types of HCPCS Level II Codes

Level II Codes	Purpose	Entity Responsible for Additions, Deletions, Modifications
Permanent National Codes	For use by all private and public health insurers for medical services, supplies and equipment NOT included in CPT-4 coding system	HCPCS National Panel, which includes representatives from America’s Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), and CMS, and requires unanimous consent of all three parties.
Dental Codes	Separate billing of dental services	American Dental Association, which makes unilateral decisions.
Miscellaneous/ Not Otherwise Classified Codes	Billing of services for which there are no existing national code; claims are manually reviewed, must clearly describe the item or service, and must provide pricing information as well as documentation of medical necessity	Not applicable. Supplier should check with payer if another code can be used before using a miscellaneous code. If a supplier believes a permanent code is needed, it may submit a request to modify HCPCS to the National Panel.
Temporary National Codes	For use by insurers who need codes before the annual update of permanent codes or until consensus on permanent codes can be reached (35% of Level II codes are temporary codes). There are 7 types of temporary codes: <ol style="list-style-type: none"> 1. C codes: Medicare claims by hospital outpatients only 2. G codes: Professional procedures and services that would be coded in CPT-4 but for which no CPT-4 code exists 3. Q codes: Services, supplies, and equipment NOT included in CPT-4 and for which no national Level II code exists 4. K codes: Claims submitted to one of the four durable medical equipment regional carriers (DMERCs) only 5. S codes: Private sector claims for drugs, services, and supplies which are used by private insurers and can be used by Medicaid but are not payable by Medicare 6. H codes: Medicaid claims for mental health services when state law mandates Medicaid agencies to establish separate codes for these services 7. T codes: Medicaid claims necessary to administer the Medicaid program but for which no permanent national code exists. Can be used by private insurers but are not payable by Medicare 	CMS (HCPCS workgroup), AHIP, and BCBSA maintain their own series of temporary codes and make unilateral decisions about the type and number of codes considered temporary. CMS temporary national codes may be used by other insurers, if desired. National Panel may decide to replace temporary codes with permanent codes; in other cases, temporary codes may exist on an indefinite basis.

Source: CMS, 2004, at <http://www.cms.hhs.gov/medicare/hcpcs>.

Level III codes, which were local codes established by state Medicaid programs, Medicare contractors, and private insurers in their local jurisdictions, are no longer recognized under HIPAA. These codes either were replaced with similar CPT-4 or Level II codes or else were completely eliminated within the timeframe given for compliance.⁵⁵ Level III provided a local, alpha-numeric coding system that identified services without a Level I or Level II code, which would have otherwise been identified with a “miscellaneous or not otherwise classified” code. Level III codes consisted of a single letter followed by a four-digit number. For example, a Utah health professional participating in the Child Health Evaluation and Care (CHEC) program (Utah’s version of the Medicaid EPSDT program) would have been able to submit a claim for “physical therapy for EPSDT once a month” provided to a four-year-old child, using HCPCS Level III local code Y0013, developed and covered by the Utah Medicaid agency. The Utah Medicaid program eliminated this code in order to comply with HIPAA. No precisely equivalent code exists under Levels I or II.

In addition to codes, HCPCS uses a system of national code modifiers, which insurers may instruct providers to use in conjunction with a HCPCS code in order to provide additional information about the service or item being billed (e.g., type of provider other than a physician who furnished the service). These modifiers are alpha-numeric or consist of two letters and are placed after the billing code. For example, the Alabama Medicaid agency requires a pediatrician participating in the state’s EPSDT program, in submitting a payment claim for a periodic EPSDT assessment for a three-year-old, to add the modifier “EP” to the CPT-4 code 99392 (i.e., 99392-EP) to indicate that the well-child exam was provided in the context of an EPSDT visit. In this way, the agency can distinguish between a visit during which all federally mandated screens were performed and other preventive visits with partial screens.

In sum, HIPAA standardized code sets are an outgrowth of earlier coding systems but with certain notable differences that have implications for children’s care. To a substantial degree, the HIPAA sets are an amalgam of preexisting coding arrangements used by CMS, AMA, and ADA. At the same time, the amalgam is by no means all-inclusive. In addition, in creating the HIPAA coding system, policymakers eliminated a coding subset that contained important local codes applicable to certain procedures and claims used by Medicaid. To the extent that these eliminated claims codes have no counterpart in the current HIPAA coding system, Medicaid programs have lost the ability to pay for some covered procedures in EPSDT benefit classes.

Furthermore, the HIPAA coding system is built on preexisting Medicare policy—geared to the disabled and older adult population—as well as on coding systems developed by national professional organizations that may not have expertise in child health or Medicaid. It is unlikely that members of AMA or ADA, for example, would be familiar with children’s developmental health care or with the distinctive aspects of Medicaid’s coverage design. As described above, procedures central to the Medicaid program are commonly excluded from private health insurance because of limitations related to the “illness and injury” and “restoration” coverage standards. Thus, coding systems that emanate from a commercial market and Medicare (which closely follows private insurance principles in coverage design) may not account for the full breadth of coverage under Medicaid’s EPSDT. While HIPAA permits some modification of codes, the phased-out elimination of the prior “Level III” coding system may limit the extent to which this actually occurs.

National Procedures for Code Modification

The process of adding, eliminating, or modifying HCPCS codes is independent of the initial benefit design process and quite complex. Depending on the specific HIPAA coding system involved, modification responsibilities are assigned to different entities (Table 5). Thus, for Level I codes, the AMA maintains modification responsibilities. In the case of Level II codes, different entities are involved: a national HCPCS review panel that advises CMS, ADA, and national insurance organizations, such as America’s Health Insurance Plans (AHIP) and Blue Cross and Blue Shield Association (BCBSA).

Table 5. Entities Responsible for Modifying HCPCS

HCPCS Subsystems	Coding System	Entities	Type of Action
Level I codes	AMA’s CPT-4 coding system	AMA (CPT-4 Editorial Panel)	Additions, eliminations, modifications
Level II codes	HHS-developed coding system	Permanent National Codes: HCPCS National Panel, composed of representatives from America’s Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), and Centers for Medicare and Medicaid Services (CMS) Dental Codes: American Dental Association (Code Revision Committee) Temporary National Codes: CMS (HCPCS workgroup), AHIP and BCBSA independently from each other	Additions, eliminations, modifications
Level III codes	Locally developed coding systems	State Medicaid agencies, Medicare contractors, and private insurers	Phasing out, with total elimination required by the federal HIPAA compliance date

Source: CMS, 2004, at <http://www.cms.hhs.gov/medicare/hcpcs>.

MODIFICATION PROCESS FOR LEVEL I, HCPCS CODES

CPT-4 codes. The AMA is authorized to add, eliminate, or modify existing Level I, CPT-4 codes. Updates and publications occur annually, in October of each year. In its revision efforts, the AMA is informed by a CPT-4 editorial panel, which reviews requests for coding modifications throughout the year and makes coding decisions by June.⁵⁶ A CPT advisory committee, consisting of specialists, allied health professionals, and organizations concerned with performance measures, provides expert advice.⁵⁷ Any interested entity (e.g., medical specialty societies, state medical associations, individual physicians, hospitals, third-party payers) can submit a request to AMA staff members, who, in turn, make recommendations to the committee.

If advisors unanimously conclude that no change is needed, the AMA informs the requestor on how to use existing codes to report the procedure. If members all agree that a change should be made or if two or more members disagree, then the request is referred to the panel for final resolution. The standard of review for modification requests is crucial, because it delineates the substantive bases on which modification may be granted or denied.⁵⁸ Under the review standard, the AMA has broad discretion to grant or deny requests that may bear significantly on clinical practice and the extent to which compensable procedures mirror actual coverage design.

New codes hinge on a finding that a request meets all of the following distinct criteria, thus placing the bar for approval at a high level.⁵⁹ The request must document: 1) FDA approval for the specific use of a drug or device; 2) that the procedure or service is a distinct service performed by “many” physicians or practitioners in multiple locations in the United States.; 3) the clinical efficacy of the service or procedure as documented in the U.S. peer-reviewed literature; 4) that the suggested procedure or service does not represent the “fragmentation” of an existing service or procedure and is not currently reportable by one or more existing codes; and 5) that the service or procedure is not a means of reporting extraordinary circumstances related to a service or procedure that already has a specific CPT code.⁶⁰ The panel may add a new code or revise existing nomenclature, postpone or table an item to obtain further information, or reject a request.

The rules permit written appeals of the panel’s decisions to the CPT executive committee of the panel for a decision to reconsider.⁶¹ If the executive committee rejects a proposal to reconsider, a second proposal to reconsider may be submitted immediately to the committee, if it is based on new information that has recently become available. Otherwise, the “appellant” must wait at least 12 months before resubmitting a request to reconsider. No further appeals are permitted, either to CMS or the courts.

CONVERTING LEVEL I, CPT-4 CODES INTO PAYMENTS

Following the modification of codes, the AMA CPT-4 editorial panel submits the new, approved codes into the Resource Based Relative Value Scale (RBRVS), which is Medicare's physician fee schedule, enacted in 1986 and fully implemented in 1992. There is some dialogue between CMS, AMA, and AAP about how to apply the RBRVS payment system—which was developed for adults—to pediatric services.⁶² This translation of a new code into the RBRVS allows for the recognized procedure to be given a dollar value. Like the coding system, the RBRVS system is updated annually.⁶³

MODIFICATION PROCESS FOR LEVEL II, HCPCS CODES

Permanent national codes. The HCPCS national panel, composed of representatives from AHIP, BCBSA, and CMS, is authorized to add, eliminate, or modify existing Level II codes, an annual process with results published in January. As with Level I CPT-4 codes, the process follows a number of steps but is conducted directly under CMS authority. A HCPCS workgroup reviews modification requests annually and submits recommendations on behalf of CMS to the HCPCS national panel.⁶⁴ The standard of review allows for the addition of codes if three criteria are met: 1) the product or item has received FDA approval to be marketed in the U.S.; 2) the product has been on the market for a minimum of six months; and 3) the product represents 3 percent or more of the outpatient use for that type of product in the national market.⁶⁵ The workgroup can recommend the addition of a permanent or temporary code to cover an additional procedure for changes representing large volume, the use of an existing code, the use of an existing “miscellaneous” code to cover an additional procedure for changes representing small volume, or the elimination of an obsolete code. The panel's recommendations to add, modify, or eliminate must be unanimous and the decision cannot be appealed.

Dental codes. The ADA holds the rights to add, eliminate, or modify existing codes, a process that is conducted biannually.⁶⁶ The ADA's code revision committee reviews requests for coding modifications periodically, and requests can be made in accordance with ADA guidelines.⁶⁷

Temporary national codes. The HCPCS workgroup, AHIP, and BCBSA are authorized to add temporary national codes or eliminate or modify existing codes, and each has its own review process.⁶⁸ Updates take place every quarter and new temporary codes typically take four to six months to be fully implemented.⁶⁹

In sum, the process for updating codes is multilayered, allocated to national organizations that operate under broad grants of authority, and non-reviewable in the courts. (Similarly, a health plan beneficiary may challenge the denial of a covered benefit.

But in terms of challenges to the fact of coverage or lack of coverage, courts eschew interference.) As long as the process follows basic principles of procedural fairness, final decisions are allowed to take effect. For this reason, requests to customize coding procedures to take into account the unique aspects of a particular benefit plan's coverage design may not receive full consideration. The process does not necessarily take into account the extent to which coding patterns affect the fundamentals of a particular insurer's coverage design. This "below the radar" system for translating coverage into actual medical practice is a vital and yet unseen aspect of health policy.

Elimination Process for Local Codes

HIPAA simplification means that the Level I CPT-4 coding system is the official language used by pediatric professionals to claim payment for covered services. HIPAA required state Medicaid and SCHIP agencies, as part of simplification, to review their existing code sets and use a process known as "cross-walking" in order to determine whether a local code was similar to an existing Level I or Level II code, multiple Level I or Level II codes, or a portion thereof. The outcome of this process was the elimination of local codes and their replacement with an existing Level I CPT-4 or Level II code or multiple codes, where appropriate. Local codes deemed unnecessary because they were no longer used were not replaced at all. Similarly, local codes with no comparable, existing Level I or II codes were to be eliminated, at least temporarily, until a process known as "gap filling" is initiated.

The Net Effect of Standardization

Despite the HIPAA move toward standardization, there continues to be great variation in the range of codes that insurers recognize. Few, if any, recognize the complete set of CPT-4 codes.⁷⁰ In fact, this variation among insurers is a hallmark of Medicaid and SCHIP programs, as will be examined in a forthcoming study of interstate variation in Medicaid and SCHIP procedure payment policies.⁷¹

MEDICAID CHANGES FOLLOWING HIPAA IMPLEMENTATION

While HIPAA is intended to standardize payment for health services, individual insurers retain considerable discretion in adopting specific codes that define their coverage. Following HIPAA implementation, insurers have three choices. First, they can maintain the same level of coverage by "cross-walking" their local codes to existing CPT-4 and/or Level II codes deemed equivalent. Second, they can reduce their level of coverage either by eliminating their local codes and not replacing them with national codes or recognizing less extensive coverage through existing CPT-4 or Level II codes. Third, they can expand their level of coverage by recognizing CPT-4 or Level II codes they did not recognize

before (e.g., CPT-4 codes 96110-111, developmental testing) or codes they recognized before but for different purposes (e.g., CPT-4 code 99420, health risk assessment for mental health and substance abuse services, expanded to include screening for perinatal maternal depression performed during post-partum and well-child visits).

This section presents our findings regarding the types of changes undertaken by state Medicaid and SCHIP agencies following the implementation of the HIPAA administrative simplification requirements.

Methodology

We undertook a point-in-time descriptive study, relying on publicly available documents that were readily accessible online. State Medicaid agencies either have sections of their Web sites devoted to HIPAA and implementation issues or have HIPAA information included with other information for providers. The 35 separately administered SCHIP agencies either link to HIPAA information on Medicaid or managed care contractors' sites or do not provide any specific information.

Because HIPAA documents were generally more available from state Medicaid agencies than SCHIP agencies, our analysis focuses on changes in the Medicaid program.⁷² We also reviewed the Medicaid fee-for-service provider manuals for EPSDT services to identify language that would explain the payment coding changes to participating physicians. We did this to verify the information provided in HIPAA documents online or in lieu of these documents to gather information about states that had not posted HIPAA information online.

We gathered information about changes in coding made to comply with HIPAA, particularly those related to the provision of EPSDT and other child development services. The results are summarized below and represent information as of December 2004. We provide specific examples to illustrate the types of changes in payment policy that appear to disproportionately affect child development services. More research is needed to determine the actual impact of these changes on the provision of these services.

Findings

For 24 states, we could not locate explicit HIPAA-related documentation to explain changes in Medicaid coding policies. These 24 states may have transmitted written instructions to providers through means other than Web postings, or may still be in the process of becoming HIPAA-compliant.

Twenty-six states posted information about HIPAA-related coding changes on their Web sites. The information generally included tables of codes showing how the agency had “cross-walked” local codes to existing, federally recognized codes, where available. Some states explicitly stated how HIPAA would affect providers. For example, North Dakota documents say that the state “cannot accept electronic claims that contain local codes, as they are not HIPAA compliant.”⁷³ The documents also “strongly encourage all providers to use electronic transactions to increase efficiency in the exchange of health care information and timely processing and payment of claims.”⁷⁴ They indicate that providers who use paper claims can still use local codes and modifiers, but changes in submission requirements affect these providers in the same manner as they affect providers who submit electronic claims.⁷⁵

The 26 states made one or more of the following changes to their coding system following the implementation of HIPAA: 1) they eliminated their local codes and did not replace them; 2) they eliminated local codes and replaced them with a smaller number of existing CPT codes, and in some cases required the use of a modifier in addition to the CPT code; 3) they eliminated local codes and replaced them with an equivalent number of existing CPT codes; 4) they eliminated local codes and replaced them with a higher number of existing CPT codes; and/or 5) they did not have local codes in the first place but started recognizing an existing CPT code or added certain services to existing CPT codes. Because it is difficult to tease out the number of states that made each type of change based on the information collected, we have aggregated all categories of change.

Because the documents collected were not always comprehensive, we could not determine which categories of services were most affected by the coding changes. The examples below illustrate state-specific changes; they do not represent all the changes made by particular states or the most frequent changes across all states. In addition, some states are overrepresented because their written communications were more explicit or complete. Despite these limitations, the examples illustrate the variation among states in the payment coding changes made to specific preventive and developmental services.

EXAMPLES OF REDUCTION OR POTENTIAL REDUCTION IN COVERAGE

Eliminated Codes, No Replacement

Utah, New Jersey, Kansas, and Delaware, like many other states, eliminated a number of local codes and did not replace them at all, in effect discontinuing the provision of services previously reimbursed under these codes.

Utah eliminated hundreds of local codes, replacing 75 percent of those with equivalent HCPCS codes and eliminating the remainder. Several of those eliminated were child-specific, particularly in the case of physical therapy, durable medical equipment, and targeted case management. For example, monthly physical therapy maintenance provided to children enrolled in Child Health Evaluation and Care (Utah’s name for EPSDT) is no longer reimbursable. Similarly, the state eliminated “special manual wheelchairs” sold by a manufacturer specializing in pediatric wheelchairs, “pediatric reachers” designed for children with limited reach or strength to pick up objects, and inpatient and outpatient targeted case management for children with special health needs furnished in 15-minute increments by the agency for Community and Family Health Services. Other eliminated codes affected services such as hourly and daily respite care and portable oxygen refills for non-medical activities—services used by children with special needs.

In **New Jersey**, the Medicaid agency notified providers of services under the home- and community-based service community care waiver that they could no longer use seven of 10 local codes for the developmentally disabled and five of 13 local codes for persons with acquired traumatic brain injuries. Similarly, the state dropped about a quarter of local codes used by all physicians, nurse midwives, certified nurse practitioners, clinical nurse specialists, and independent clinics; about a third of local codes used by EPSDT providers; and all local codes used by providers of mental health services. Codes that were retained were converted to HIPAA-compliant codes.

Kansas dropped a few local codes used by providers to obtain reimbursement for behavioral management services for seriously emotionally disturbed children.

The **Delaware** Medicaid program discontinued a number of services, including EPSDT mental health counseling services consisting of family training and counseling offered through the state’s Part H/Early Intervention Program and intermittent nursing services consisting of two visits per day.

Eliminated Codes, Replacement with Smaller Number of Existing Codes

Illinois, Iowa, and West Virginia eliminated local codes and replaced them with a smaller number of existing codes without adding modifiers that would allow distinctions between the type of provider furnishing the service or the specific service provided. Nebraska used a similar “narrowing” process by substituting one national code modifier for a number of local code modifiers. This practice may make it more difficult for agencies to determine which services and procedures were actually furnished and monitor the quality of care received by children. It may also eliminate a previous financial incentive for physicians to perform the service in the first place.

The **Illinois** Medicaid program covers developmental assessments performed as part of an EPSDT visit. Prior to HIPAA, the state used individual local codes for each screening tool the program recognized as a valid instrument. Following HIPAA, the state consolidated these individual codes into a smaller number of federally recognized codes. For example, the five local codes (W7114 through W7118) used to bill separately for the McCarthy Screening Test, Early Screening Inventory, Developmental Profile II, Minneapolis Preschool Screening Instrument, and Vineland Social Maturity Scale are now billable under CPT-4 codes 96110 (Early Screening Inventory, Developmental Profile II, Minneapolis Preschool Screening Instrument) and 96111 (McCarthy Screening Test and Vineland Social Maturity Scale). Similarly, the 12 additional local codes recognized for a number of other tools (e.g., Denver II, Bayley Scales of Infant Development) are now covered under CPT-4 codes 96110-96111. The state also covers health risk assessments performed as part of an EPSDT visit. Prior to HIPAA, the Medicaid agency permitted providers to use four local codes (W7360-W7363) to bill separately for 1) a risk assessment and referral to mental health assessment/services, 2) a risk assessment for mental health services with no referral needed, 3) a risk assessment and referral to substance abuse assessment/treatment, and 4) a risk assessment for substance abuse and no referral needed. Today, all of these assessments are billed under CPT-4 code 99420.

In **Iowa**, the Medicaid program replaced the local codes used for group or family therapy provided by solo psychologists, social workers, or psychiatric nurses; therapy provided by a combination of professionals; or therapy provided by a professional working in collaboration with a psychiatrist with one CPT-4 code (90853, group psychotherapy other than of a multiple-family group). The state does not require these different providers or teams of providers to add modifiers to the code to specify their disciplines, as the local codes had.

The **West Virginia** Medicaid program previously maintained separate codes for dental and vision screening. Following conversion to HIPAA-compliant codes, the state no longer allows providers to bill for each service in addition to the CPT-4 codes used for comprehensive well-child examinations. This means that providers are expected to accept reimbursement of CPT-4 codes 99381-385 and 99391-395 as reimbursement in full without supplemental payment for the dental and vision services provided during the visit.

Nebraska collapsed 15 local modifiers into a single, nationally recognized modifier, "EP." The various local modifiers had enabled the state to distinguish between EPSDT referral types, such as follow-up by another physician, screening physician and dentist, screening physician and ear specialist or audiologist, and screening physician and

eye specialist. The new modifier only permits the state to distinguish broadly between services provided as follow-up to an EPSDT visit or those provided as follow-up to another type of visit.

EXAMPLES OF MAINTENANCE OF SIMILAR LEVELS OF COVERAGE

Eliminated Codes, Replacement with Equivalent Number of Existing Codes

Kansas and Illinois replaced their local codes with an equivalent number of existing codes. Iowa, Minnesota, and Missouri essentially maintained the same level of coverage by attaching distinct modifiers to a smaller number of CPT-4 codes.

Changes in the **Kansas** Medicaid program focused on services provided by local education agencies, children and family services, early childhood intervention programs, and behavioral management. For example, all of the local codes used by local education agencies were converted to HCPCS temporary codes. Local codes used for behavioral management, specifically one hour of attendant care and one hour of in-home family treatment, were replaced with the HCPCS temporary code for 15 minutes of personal care services and modifier HA (denotes “child/adolescent program”) and CPT-4 code 90847 (“family psychotherapy, conjoint psychotherapy, with patient present”), respectively. It is not clear how many “units” of personal care a provider can bill for but the state may specify an amount (“up to four”) that would provide the same intensity of coverage as before. The program also maintained a few local codes to use in conjunction with HCPCS Level II codes.

Illinois allows reimbursement of hearing and vision screens performed during an EPSDT visit separately from the well-child visit (CPT-4 codes 99381-385, 99391-395). Before HIPAA, it used local codes (W7020 for hearing; W7087 for vision), which were replaced with CPT-4 codes 92551 (hearing) and 99173 (vision) following HIPAA implementation.

The **Missouri** Medicaid agency combined the two local codes it used to reimburse EPSDT case management with the same national temporary code (T1016) and instructed providers to distinguish between the first visit and follow-up visits by using a modifier for the follow-up visit (TS). The new code is time specific and the state authorizes providers to “bill up to 4 units for the initial month visit and up to 2 units for each subsequent month visit.” Similarly, the state collapsed the four distinct local codes for environmental lead assessment into one code (T1029) and now uses three modifiers that enable it to distinguish between the four levels of care, i.e., assessment pertaining to lead, initial assessment, second assessment, and subsequent reassessments.

Minnesota made changes to the billing codes used by schools or school districts to bill for health services included in an Individualized Education Program, an Individualized Family Service Plan, or an Individual Interagency Intervention Plan. Each of the distinct local codes used to recognize daily sessions of physical therapy, occupational therapy, speech/language/hearing therapy, mental health services, nursing services, and personal care assistant/paraprofessional services as well as assistive technology devices and special transportation are now recognized as T1018 (HCPCS temporary code) with distinct modifiers (U1-U8) that identify each of these services.

In **Iowa**, the Medicaid program replaced the local codes used for individual psychotherapy provided by psychologists (W0844), social workers (W0845), and psychiatric nurses (W0846) with one CPT-4 code, 90804. The agency also instructed each professional to use a different modifier to identify his discipline and determine his reimbursement level, which varies by profession. As a result of these changes, a psychologist will use 90804-HP (denotes “doctoral level”), the social worker 90804-HO (denotes “masters degree level”), and the psychiatric nurse 90804-HN (denotes “bachelors degree level”) to bill for this specific service.

Deleted Codes, Replacement with Higher Number of Existing Codes

Delaware, Missouri, and North Dakota are examples of states that expanded the number of codes reimbursed for certain services in order to maintain comparable levels of coverage. In some cases the replacement of local codes with national codes may actually result in broader coverage, though determining the extent of this growth would require further research.

Delaware replaced the local EPSDT code for an annual comprehensive mental health treatment evaluation with CPT-4 codes 90801 (psychiatric diagnostic interview examination) and 90802 (interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication). It also replaced the local EPSDT code for biweekly, half-hour individual mental health treatment therapy sessions with 10 CPT-4 codes (90804, 90805, 90810, 90811, 90816, 90817, 90823, 90824, 90845, and 90875). Finally, it replaced the local EPSDT code for a biannual speech, language, and hearing screen with eight nationally recognized codes, including CPT-4 92551, 92552, 92553, 92555.

Missouri replaced the sole local code it recognized for EPSDT screening services with CPT-4 codes 99381-385 and 99391-395 and two modifiers to differentiate between an unclothed physical examination/history and full or partial medical screenings.

For certain audiology services, **North Dakota** eliminated one local code and introduced two or more existing national codes. For example, the local code used for electric acoustic analysis either for one ear or both ears was converted to CPT-4 92594 for monaural and 92595 for binaural electroacoustic evaluation for a hearing aid.

EXAMPLES OF EXPANSION IN COVERAGE

Absence of Local Codes and Addition of National Codes

In a few instances, some states, in becoming HIPAA-compliant, added national codes for services for which they had not previously had local codes.

As mentioned above, **Illinois** covers developmental assessments performed as part of an EPSDT visit. The state also now recognizes 19 tools, such as the Ages and Stages Questionnaire and Parent's Evaluation and Development, for reimbursement under CPT-4 codes 96110-96111, which did not have a local code assigned to them before HIPAA. Recently, the state began to recognize assessment for perinatal depression under CPT-4 code 99420 (health risk assessments performed as part of an EPSDT visit) and requires the use of the modifier HD to distinguish that service from other services provided under the same code.

Summary

In order to comply with HIPAA, many states made changes to their billing codes. In some cases, states appeared to find true equivalencies between the local codes they employed prior to HIPAA and the national codes they adopted. In other cases, states could not find equivalencies and/or determined that services were no longer needed and thus dropped them altogether. Finally, some states recognized CPT-4 codes they had not recognized before HIPAA or expanded the procedures reimbursable under a CPT-4 code that they had recognized previously.

It is not clear whether the use of additional CPT-4 codes with or without modifiers constitutes a perfect translation of the breadth of coverage recognized prior to HIPAA. Some of the CPT-4 codes are limited to certain time periods or differ in other ways from the local codes prescribed (as in Kansas). In addition, the modifiers may have different meanings for different codes and provider types. They may not capture some of the subtleties in services provided in the same way local codes could (as in Nebraska).

Across states, changes made to local codes often target services provided in venues other than physicians' offices. These include family support services and services to enhance access to care provided by county and local agencies. Mental health services, early

intervention, physical and speech therapy, home care, case management, and transportation seem particularly affected.

DISCUSSION

HIPAA has had a major impact on the standards and procedures used to translate the coverage design of health insurance into the actual terms of payment within each class of benefits. The implementation of HIPAA presents both opportunities and challenges for purchasers of early childhood preventive and developmental services, particularly for Medicaid, which offers comprehensive child development coverage.

HIPAA has the potential to simplify coding and payment and thus ease the administrative burdens on health plans and providers. It may also improve understanding of population patterns in the buying and selling of health care. At the same time, HIPAA standardization presents challenges for health plans, particularly Medicaid plans, that employ coverage aimed at promoting child health but that rely on services not typically included in commercial coverage. For low-income children who depend on Medicaid and SCHIP, standardization has the potential to foster or impede high-quality care.

The HIPAA standardization process is complex, involving extensive translational steps and an intricate system for revisiting and refining the codes. These translational and review activities vest broad discretion in the entities charged with their conduct, including the federal government, large insurers, and professional societies for medicine and dentistry. No specific authority is vested in an entity with expertise in developmental pediatrics. Given the modest cost of child development services and the fact that their coverage is largely confined to Medicaid, there is strong potential for these critical services to be overlooked in the drive to standardize. Although states have some ability to customize national coding to compensate for omissions and ensure that pediatric coverage meets local needs, this analysis suggests that only a portion appear to have undertaken this complex task.

In navigating the standardization process, there is opportunity for states to learn from each other. State Medicaid agencies that have made progress in implementing standard codes and modifying them to support coverage of child development services could share their experiences with other states. Pediatric providers will have to adapt the national coding system to account for the particulars of pediatric practice. In cases where states do not recognize certain national codes, providers can approach the entities responsible for modification of codes and “make the case” for their value in promoting child health. Key to this process are professional consensus on what constitutes preventive

and developmental services and the development of HIPAA-compliant billable codes to translate this standard of care into billable services. In addition, systematic documentation of the relationship between coverage design, reimbursement rules, actual payment levels, and the quality of pediatric care is essential in supporting these efforts.

This analysis suggests that more research is needed to understand the full impact of states' efforts to customize national standards. In some cases, local codes were eliminated entirely. In others, states replaced disaggregated local codes with aggregations of codes. In a few cases, states actually augmented their codes in order to promote certain services related to child development.

Over the past decade, research on brain development and early childhood experience has underscored the importance of preventive and developmental care. The Medicaid and SCHIP programs include coverage for preventive and developmental care that are not available in the commercial market. In Medicaid, these interventions are required for most enrolled children, while in SCHIP programs, equally broad interventions qualify for federal financing.

As critical as developmental services are, they are of modest cost. But their financing depends on how the unique aspects of Medicaid and SCHIP benefit designs are translated into provider payment policy. This analysis suggests that even as obscure a discipline as insurance coding can have a considerable impact on the provision of child development services. Continued research is needed to gauge the effect of HIPAA's requirement that payers eliminate local codes or substitute "equivalent" codes from standard code sets. In particular, it will be important to track whether the standardized code set is sufficiently attuned to the nuances of child development services to offer a comprehensive treatment and payment pathway.

A recent Commonwealth Fund study found that publicly covered children were more likely to receive recommended preventive health care visits than their privately insured or uninsured counterparts.⁷⁶ However, a sizable portion of publicly covered children—25 percent—did not. The study also found that the actual content of physician visits for preventive care differed among various practices/states and certain patient characteristics (e.g., poverty, race/ethnicity).

Payment codes need to be explicitly linked to preventive and developmental services in order to ensure access to and quality of pediatric care.

NOTES

¹ Pub. L. No. 104-191, Subtitle F—Administrative Simplification; 42 U.S.C. § 201 et seq.

² American Academy of Pediatrics, “Issues in the Application of the Resource-Based Relative Value Scale System to Pediatrics: A Subject Review,” *Pediatrics* 102 (October 1998): 996–98; P. White, “Access to Health Care: Health Insurance Considerations for Young Adults with Special Health Care Needs/Disabilities,” *Pediatrics* 110 (December 2002): 1328–35. Examples of nonprocedural services include: prolonged physician service without patient contact, team conferences, telephone calls, care plan oversight services, or preventive services with individual or group counseling.

³ National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Child Development* (Washington, D.C.: National Academies Press, 2000); Institute of Medicine, *Children’s Health, The Nation’s Wealth: Assessing and Improving Child Health* (Washington, D.C.: National Academies Press, 2004).

⁴ NRC and IOM, *Neurons*; IOM, *Children’s Health*; American Academy of Pediatrics, “Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years,” *Pediatrics* 100 (December 1997): 1040–41; N. Halfon et al., [Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children](#) (New York: The Commonwealth Fund, 2003); S. Rosenbaum et al., [Room to Grow: Promoting Child Development Through Medicaid and CHIP](#) (New York: The Commonwealth Fund, 2001); K. VanLandeghem, D. Curtis, and M. K. Abrams, [Reasons and Strategies for Strengthening Childhood Development Services in the Health Care System](#) (New York: The Commonwealth Fund, 2002).

⁵ Halfon et al., *Building a Bridge*; M. Regalado and N. Halfon, “Primary Care Services Promoting Optimal Child Development from Birth to 3 Years: Review of the Literature,” *Archives of Pediatrics & Adolescent Medicine* 155 (December 2001): 1311–22; M. Regalado and N. Halfon, [Primary Care Services: Promoting Optimal Child Development from Birth to Three Years](#) (New York: The Commonwealth Fund, 2002).

⁶ [See Appendix](#) for more details.

⁷ J. Hadley, “Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income,” *Medical Care Research and Review* 60 (June 2003): 3S–75S; Kaiser Family Foundation/Kaiser Commission on Medicaid and the Uninsured, *Children’s Health—Why Health Insurance Matters* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2002), <http://www.kff.org/uninsured/4055-index.cfm>; B. Starfield, “Social, Economic, and Medical Care Determinants of Children’s Health,” in *Health Care for Children—What’s Right? What’s Wrong? What’s Next*, ed. R. Stein (New York: United Hospital Fund, 1997), 39–52.

⁸ S. Leatherman and D. McCarthy, [Quality of Health Care for Children and Adolescents: A Chartbook](#) (New York: The Commonwealth Fund, 2004).

⁹ L. Ku and S. Nimalendran, *Improving Children’s Health: A Chartbook About the Roles of Medicaid and SCHIP* (Washington, D.C.: Center on Budget and Policy Priorities, 2004).

¹⁰ *Ibid.*

¹¹ S. M. Yu et al., “Factors That Influence Receipt of Recommended Preventive Pediatric Health and Dental Care,” *Pediatrics* 110 (December 2002): e73, in Leatherman and McCarthy, *Quality Chartbook*.

¹² G. M. Kenney, J. M. Haley, and A. Tebay, “Children’s Insurance Coverage and Service Use Improve,” in *Snap Shots of America’s Families III* (Washington, D.C.: The Urban Institute, 2003).

¹³ Medicaid pays, on average, 63 percent of the Medicare physician fees, which are below what commercial insurers customarily pay providers (White, “Access to Health Care”).

¹⁴ J. W. Thompson et al., “[Quality of Care for Children in Commercial and Medicaid Managed Care](#),” *Journal of the American Medical Association* 290 (September 17, 2003): 1486–93.

¹⁵ Both 1999 HEDIS data and 2000 household survey data (National Immunization Survey and National Survey of Early Childhood Health) found disparities between privately insured and publicly insured children (Thompson et al., “Quality of Care”; J. M. Santoli et al., “Insurance Status and Vaccination Coverage Among U.S. Preschool Children,” *Pediatrics* 113 (June 2004 Suppl.): 1959–64). However, when controlling for other factors such as sociodemographic and socioeconomic factors, insurance status was no longer a predictor of up-to-date vaccinations (Santoli et al., “Insurance Status”).

¹⁶ American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, “Recommendations for Preventive Pediatric Health Care,” *Pediatrics* 96 (August 1995): 373–74.

¹⁷ B. Zuckerman et al., “Prevalence and Correlates of High-Quality Basic Pediatric Preventive Care,” *Pediatrics* 114 (December 2004): 1522–29.

¹⁸ T. K. McInerney, W. L. Cull, and B. K. Yudkowsky, “Physician Reimbursement Levels and Adherence to American Academy of Pediatrics Well-Child Visit and Immunization Recommendations,” *Pediatrics* 115 (April 2005): 833–38.

¹⁹ *Ibid.* Other factors not examined in the study, but with potential mediating effects, include regional practice patterns and concentration of technology, general community awareness about the benefits of preventive and primary health care, and level of system accountability, monitoring, and enforcement.

²⁰ White, “Access to Health Care.”

²¹ McInerney, Cull, and Yudkowsky, “Physician Reimbursement Levels.”

²² Leatherman and McCarthy, *Quality Chartbook*.

²³ S. Rosenbaum, A. R. Markus, and C. Sonosky, “Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP,” *Suffolk Journal of Health and Biomedical Law* 1 (2004): 1–47.

²⁴ Centers for Medicare and Medicaid Services (CMS), *Medicare Program; Procedures for Coding and Payment Determinations for Clinical Laboratory Tests and for Durable Medical Equipment* (Washington, D.C.: CMS, 2004), <http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp>.

²⁵ U. E. Reinhardt, P. S. Hussey, and G. F. Anderson, “U.S. Health Care Spending in an International Context,” *Health Affairs* 23 (May/June 2004): 10–25.

²⁶ *Ibid.*

²⁷ K. S. Collins, C. Schoen, and D. R. Sandman, [The Commonwealth Fund Survey of Physician Experiences with Managed Care](#) (New York: The Commonwealth Fund, 1997).

²⁸ S. Rosenbaum et al., *Policy Brief #2: State Benefit Design Choices Under SCHIP—Implications for Pediatric Health Care* (Washington, D.C.: Center for Health Services Research and Policy, George Washington University, 2001), http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/SCHIP_brief2.pdf; Title XXI §2103(a)(1); 42 U.S.C. 1397cc.

²⁹ Rosenbaum et al., *State Benefit Design*.

³⁰ *Ibid.*

³¹ *Ibid.*

³² Available at <http://www.opm.gov/insure/05/brochures/pdf/71-005.pdf>.

³³ T. Doran, American Academy of Pediatrics, *Testimony Before the Federal Trade Commission on Health Care and Competition Law and Policy*, February 27, 2003, http://www.aap.org/advocacy/washing/Doran_2_27_testimony.htm.

³⁴ A. Gawande, “Medical Dispatch: Piecemeal—Medicine’s Money Problem,” *The New Yorker* (April 4, 2005): 44–53.

³⁵ Doran, *Testimony*.

³⁶ 42 U.S.C. § 261. Purpose.

³⁷ U.S. Department of Health and Human Services, *Fact Sheet—Administrative Simplification Under HIPAA: National Standards for Transactions, Privacy and Security* (Washington, D.C.: DHHS, 2003), <http://www.hhs.gov/news/press/2002pres/hipaa.html>. HIPAA was also designed to 1) improve the accessibility of health insurance by guaranteeing the portability of health insurance under certain circumstances, and 2) protect medical records and other personal health information by comprehensively regulating health privacy.

³⁸ U.S. Department of Health and Human Services, *News Release—CMS Named to Enforce HIPAA Transaction and Code Set Standards; HHS Office for Civil Rights to Continue to Enforce Privacy Standards* (Washington, D.C.: DHHS, 2002), <http://www.hhs.gov/news/press/2002pres/20021015a.html>.

³⁹ Centers for Medicare and Medicaid Services, *Health Insurance Portability and Accountability Act (HIPAA)—Administrative Simplification* (Washington, D.C.: CMS), <http://www.cms.hhs.gov/hipaa/hipaa2/default.asp?>.

⁴⁰ B. Kamoie, *Issue Brief #22: HIPAA’s Electronic Transactions Rule: Implications for Behavioral Health Providers* (Washington, D.C.: Center for Health Services Research and Policy, George Washington University, 2002). Available at: http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/behavioral_health/bhib-22.pdf.

⁴¹ 65 Fed. Reg. 50312. HHS adopted modifications to some of these standards in final regulations published on February 20, 2003. See DHHS, *Fact Sheet*.

⁴² The original effective date was October 2003; this date was delayed by a year as a result of the Administrative Simplification Compliance Act, enacted in 2001, which extended the compliance date for all covered entities (including small health plans). H.R. 3323 signed into law by President Bush on December 27, 2001. See also DHHS, *Fact Sheet*.

⁴³ See DHHS, *Fact Sheet*.

⁴⁴ *Ibid*.

⁴⁵ See Kamoie, *HIPAA’s Rule*.

⁴⁶ *Ibid*.

⁴⁷ Fed. Reg. 50370; 45 C.F.R. Subpart J § 162.1000, 162.1002, and 162.1011.

⁴⁸ Also called “the Code,” which can be found within the American Dental Association’s publication titled CDT-4, Current Dental Terminology, Fourth Edition. The newest version is available within CDT-5, which became effective January 1, 2005.

⁴⁹ See Kamoie, *HIPAA’s Rule*.

⁵⁰ See CMS, *Medicare Procedures for Coding*.

⁵¹ CMS incorporated the AMA’s CPT-4 coding system as Level I codes within HCPCS in 1983.

⁵² In fact, in 1986, CMS required state Medicaid agencies to use HCPCS in the Medicaid Management Information System. See American Medical Association, *CPT Process—How a Code Becomes a Code* (Chicago: AMA, 2004), <http://www.ama-assn.org/ama/pub/category/print/3882.html>.

⁵³ See CMS, *Medicare Procedures for Coding*. See also 65 Fed. Reg. 50376; 45 C.F.R. § 160.104, in Kamoie, *HIPAA's Rule*.

⁵⁴ American Medical Association, *Current Procedural Terminology CPT 2004* [Professional Edition] (Chicago: AMA, 2003).

⁵⁵ See page 15. In addition, the elimination of local codes was postponed until December 21, 2003, as a result of § 532(a) of the Medicare+Choice Benefits Improvement Protection Act of 2000 (BIPA). See CMS, 2004, *supra*.

⁵⁶ The Panel is composed of 17 members, all physicians, the majority of whom are nominated by the AMA and four of whom are nominated by BCBSA, AHIP, American Hospital Association, and CMS. All members are appointed by the AMA board of trustees. See AMA, *CPT Process*.

⁵⁷ Organizations concerned with performance measures include the Agency for Healthcare Research and Quality (AHRQ), AMA, CMS, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA), and the Physician Consortium for Performance Improvement. See AMA, *CPT Process*.

⁵⁸ 45 C.F.R. §162.1002(e) and §162.1011.

⁵⁹ Written electronic communication with AMA staff, March 9, 2005.

⁶⁰ Other codes considered for review are tracking codes used for performance measurement, which are optional and cannot substitute for regular codes, and temporary tracking codes used for new and emerging technologies, which are intended to help with data collection or to substantiate widespread usage needed in the FDA approval process. Different evaluation criteria separate from those used for regular codes apply to these two types of codes. See AMA, *CPT Process*.

⁶¹ Five members of the panel serve as the executive committee and are elected by the entire panel. See AMA, *CPT Process*.

⁶² Many third-party payers other than Medicare, including state Medicaid/SCHIP programs, Blue Cross Blue Shield carriers, and other private carriers, use variations of the RBRVS to determine physician reimbursement and capitation rates. Because RBRVS was originally created for Medicare, it did not include pediatric CPT-4 codes and pediatric practice expense valuations. The American Academy of Pediatrics (AAP) has been working with the AMA's Specialty RVS Update Committee (RUC), which develops and assigns a relative value unit to a new or revised CPT-4 code, and CMS to rectify the content of RBRVS so that it reflects pediatric care more accurately. It has initiated the process with the AMA CPT editorial panel to add needed pediatric CPT-4 codes, some of which have been accepted and incorporated into the CPT-4 manual (e.g., most recently in 2004, developmental testing CPT-4 codes 96110-96111). It also has initiated the process with the AMA RUC to provide recommendations to CMS on the valuation of physician work involved in providing services to children for the approved pediatric CPT-4 codes. While CMS has approved and assigned values to these pediatric codes in RBRVS, it has not assigned a reimbursement level for services that are commonly and uniquely pediatric in nature, such as vision screening, so that payment levels for these services are left to carrier discretion. In addition, the AAP is pushing for the recognition of added physician work for non-pediatric specific CPT-4 codes used to provide care to children, which take more time when provided to children than when they are provided to adults. In some cases, state Medicaid/SCHIP agencies have recognized these issues and adjusted payment levels at a higher level than called for in RBRVS for some pediatric services or created separate fees (e.g., case management fee) to increase physician payment

for pediatric services. See AAP, “Issues in Application of RBRVS.” Still, many Medicaid/CHIP agencies have yet to reimburse all of the services listed in RBRVS (e.g., developmental testing CPT-4 codes 96110-96111).

⁶³ The RBRVS updating process is led by the AMA’s Specialty RVS Update Committee (RUC), which develops and assigns a relative value unit to a new or revised CPT-4 code. The RUC was created in 1991 and consists of 29 members, the majority of whom are appointed by national medical specialty societies. The remaining six seats are held by the RUC chair, the chair of the AMA’s Practice Expense Advisory Committee, the co-chair of the AMA’s Health Care Professionals Advisory Committee (an advisory committee representing non-physician health professionals who use CPT coding to report the services they provide independently), and representatives from the AMA, American Osteopathic Association, and CPT editorial panel. The RUC process is distinct from the CPT editing panel process described in this report. It consists of two main components. First, a RUC Advisory Committee and its individual members (appointed from each of the 98 specialty societies seated in the AMA House of Delegates) make recommendations to the RUC. The RUC also advises a separate Health Care Professionals Advisory Committee (HCPAC) Review Board, which then makes recommendations to CMS on relative values for new and revised codes used mainly by non-physician professionals. The Review Board includes all members of HCPAC, which represent organizations of physician assistants, chiropractors, nurses, occupational therapists, optometrists, physical therapists, podiatrists, psychologists, audiologists, speech pathologists, registered dietitians, and social workers, and three physician members of the RUC. Upon receiving RUC recommendations, CMS typically convenes a meeting of health plan medical directors to review the RUC recommendations. The product of this review is published in the Federal Register along with a 60-day public comment period. These CMS-approved relative values remain interim values for one year, with modifications by “refinement” by a separate panel convened by CMS in light of timely submitted comments. The whole RUC process follows on average a two-year cycle, and initial RUC recommendations tend to prevail. See AMA, *History of RBRVS and the RUC* (Chicago: AMA, 2004), <http://www.ama-assn.org/ama/pub/category/print/10559.html>; AMA, *Update Committee: RVS Updating Committee and Members (RUC)* (Chicago: AMA, 2005), <http://www.ama-assn.org/ama/pub/category/print/3108.html>; and AMA, 2004. *Two Illustrations of RUC Recommendations* (Chicago: AMA, 2004), <http://www.ama-assn.org/ama/pub/category/print/3142.html>.

⁶⁴ The workgroup is composed of representatives from CMS, the Veterans Administration, state Medicaid agencies, and the Statistical Analysis Durable Medical Equipment Carrier (SADMERC), which is responsible for providing suppliers and manufacturers with assistance in determining which HCPCS code should be used for a given piece of durable medical equipment, prosthetics, orthotics, and supplies, and participates in the workgroup as a representative of the four durable medical equipment regional carriers. See CMS, *Medicare Procedures for Coding*.

⁶⁵ CMS, *Medicare Procedures for Coding*.

⁶⁶ American Dental Association, *Requesting a Change to the Code* (Chicago: ADA, 2004), <http://www.ada.org/prof/resources/topics/cdt/change.asp>.

⁶⁷ Ibid.

⁶⁸ See previous description of the process used by the HCPCS workgroup for CMS decisions; no information was readily available on the AHIP and BCBSA Web sites but we assumed a similar process is used internally.

⁶⁹ CMS, *Medicare Procedures for Coding*.

⁷⁰ AAP, “Issues in Application of RBRVS.”

⁷¹ A. R. Markus et al., *Fulfilling the Promise: A 50 State Compendium of How State Medicaid and SCHIP Programs Invest in Child Development Services* [working title] (forthcoming).

⁷² Note that for 13 of the 35 separately administered SCHIP programs—Arizona, Delaware, Illinois, Indiana, Kentucky, Maine, Massachusetts, Nevada, New Jersey, North Dakota, Oregon, Washington, and West Virginia—the Medicaid agency is the administering agency and thus, changes affecting Medicaid would also affect children enrolled and physicians participating in SCHIP.

⁷³ North Dakota Department of Human Services, Medical Services Division, “HIPAA Electronic Transaction Update,” *Medicaid Bulletin* 56 (Bismarck, N.D.: NDDHS, 2004), 1, <http://www.state.nd.us/humanservices/services/medicalserv/medicaid/docs/medicaid-bulletin-200409.pdf>.

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ Leatherman and McCarthy, *Quality Chartbook*. [See Figure 1 on page 4.](#)

**APPENDIX. PRELIMINARY HIPAA-COMPLIANT CODING TAXONOMY FOR
EFFECTIVE DEVELOPMENTAL SERVICES IN A PRIMARY CARE SETTING**

Assessment

Service	Available/Used/Reimbursed Code(s)
<i>(a) Parental Concerns</i>	
Parental concerns assessment	<ul style="list-style-type: none"> • Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) • Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined)
<i>(b) Developmental Screening</i>	
Developmental history	<ul style="list-style-type: none"> • Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) • Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined)
Developmental screening test	<ul style="list-style-type: none"> • Developmental testing (96110-96111)
<i>(c) Psychosocial Risk Screening</i>	
Psychosocial history	<ul style="list-style-type: none"> • Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) • Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined)
Psychosocial risk assessment	<ul style="list-style-type: none"> • Administration and interpretation of health risk assessment instrument, e.g., health hazard appraisal (99420) • Health and behavior assessment, nonphysician provider (96150-96151)
Stress management interview	
Home environment screening	

Assessment (cont.)

Service	Available/Used/Reimbursed Code(s)
<i>(d) Parent-Child Relationship</i>	
Parent-child interaction observation	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined)
<i>(e) Behavior Concerns</i>	
Child behavior problems assessment	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined) – Administration and interpretation of health risk assessment instrument, e.g., health hazard appraisal (99420) – Health and behavior assessment, nonphysician provider (96150-96151)
Temperament assessment	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) – Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined)

Education

Service	Available/Used/Reimbursed Code(s)
<i>(a) Anticipatory Guidance</i>	
Optimizing parent–child interaction	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Preventive medicine counseling and/or risk factor reduction, separate encounter (99401-99404)
Temperament-based counseling	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Preventive medicine counseling and/or risk factor reduction, separate encounter (99401-99404)
Sleep habits counseling	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Preventive medicine counseling and/or risk factor reduction, separate encounter (99401-99404)
Promoting children’s learning	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Preventive medicine counseling and/or risk factor reduction, separate encounter (99401-99404)
Discipline practices counseling	<ul style="list-style-type: none"> ● Initial comprehensive preventive medicine, new patient (99381-99385, well-child, age-determined) ● Periodic comprehensive preventive medicine, established patient (99391-99395, well-child, age-determined) <ul style="list-style-type: none"> – Preventive medicine counseling and/or risk factor reduction, separate encounter (99401-99404)
<i>(b) Parent Education/Support Groups</i>	
Developmental behavioral brochures	<ul style="list-style-type: none"> ● Educational supplies (99071)
Audio-visual materials	<ul style="list-style-type: none"> ● Educational supplies (99071)
Parenting classes/training	
Group well-child care	<ul style="list-style-type: none"> ● Preventive medicine counseling and/or risk factor reduction (99411-99412)

Intervention Services to Help Manage Developmental
and Behavioral Concerns, Including Counseling

Service	Available/Used/Reimbursed Code(s)
<i>(a) Problem-Focused Intervention</i>	
Office counseling	<ul style="list-style-type: none"> • Office or other outpatient visit, new patient (99201-99205, problem-oriented, time-determined) • Office or other outpatient visit, established patient (99211-99215, problem-oriented, time-determined) • -25 modifier • Office or other outpatient consultation (99241-99245) • Prolonged physician services in office or other outpatient setting, direct patient contact (99354-99355, time-determined, used in conjunction with 99201-99215, 99241-99245) • Health and behavior intervention performed by a nonphysician provider to improve health and well-being using cognitive, behavioral, social, and/or other psychophysiological procedures designed to ameliorate specific disease-related problems (96152-96155)
Telephone advice line	<ul style="list-style-type: none"> • Telephone calls (99371-99373) • Prolonged physician services in office or other outpatient setting, without direct patient contact (99358-99359, time-determined) • Services requested after office hours (99050, 99052, 99054, 99056, 99058)
Home visitation	<ul style="list-style-type: none"> • Home visit, new patient (99341-99345) • Home visit, established patient (99347-99350)

Care Coordination for Children with Developmental
and Behavioral Concerns Within the Primary Care Setting

Service	Available/Used/Reimbursed Code(s)
Office care coordinator/follow-up for office interventions	<ul style="list-style-type: none"> ● Team conferences (99361-99362)
Developmental passport/journal	<ul style="list-style-type: none"> ● Special reports (99080)
Monitoring of sub-specialist/program referrals	<ul style="list-style-type: none"> ● Supervision of patient under care of home health agency (99374-99375)
Developmental services resource manual	<ul style="list-style-type: none"> ● Educational supplies (99071) ● Special reports (99080)
Office tracking system	<ul style="list-style-type: none"> ● Analysis of clinical computerized data (99090) ● Collection and interpretation of physiologic data (99091) ● Special reports, such as insurance forms, agency forms, report of medical pediatric exam for surgeon (99080)

Sources: M. Regalado and N. Halfon, [*Primary Care Services: Promoting Optimal Child Development from Birth to Three Years*](#) (New York: The Commonwealth Fund, 2002); American Academy of Pediatrics, *Medical Home Crosswalk to Reimbursement* (Elk Grove Village, Ill.: AAP, 2003); American Academy of Pediatrics, *2004 Resource-Based Relative Value Scale* (Elk Grove Village, Ill.: AAP, 2004); American Academy of Pediatrics, *Top Ten Underutilized CPT Codes in Pediatrics* (Elk Grove Village, Ill.: AAP, 2003); and Society for Developmental and Behavioral Pediatrics, *Practice Issues and Financial Concerns Survey—2002, Preliminary Outcomes* (Mount Laurel, N.J.: SDBP, 2004).

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

#843 [*The Role of States in Improving Health and Health Care for Young Children*](#) (July 2005). Vernon K. Smith, Health Management Associates. The author of this issue brief argues that states, as administrators of public insurance and health care programs, are in a unique position to improve the quality of health and care for young children, but that quality improvement initiatives are often hampered by lack of coordination among programs, inadequate data and information technology, and a tendency to focus on short-term projects.

#822 [*Quality of Preventive Health Care for Young Children: Strategies for Improvement*](#) (May 2005). Neal Halfon, Moira Inkelas, Melinda Abrams, and Gregory Stevens. In analyzing data from the National Survey of Early Childhood Health, the authors say that only about half of parents of young children report ever discussing their child's development with a pediatrician.

#814 [*Using External Quality Review Organizations to Improve the Quality of Preventive and Developmental Services for Children*](#) (May 2005). Henry T. Ireys, Tara Krissik, James M. Verdier, and Melissa Faux, Mathematica Policy Research, Inc. State Medicaid agencies typically contract with external quality review organizations (EQROs) to assess the quality of health care in Medicaid managed care plans, but only a handful of states are using these organizations to improve the quality of preventive and developmental services these plans provide, this Fund report finds.

#787 [*Dialing for Help: State Telephone Hotlines as Vital Resources for Parents of Young Children*](#) (November 2004). Meg Booth, Treeby Brown, and Malia Richmond-Crum, Association of Maternal and Child Health Programs. According to the authors of this issue brief, toll-free telephone hotlines operated by the states are increasingly being used by families to obtain reliable advice on their young children's health and well-being. Originally created for prenatal-care assistance alone, these lines now cover a wide range of early-childhood issues.

#785 [*A Need for Faculty Development in Developmental and Behavioral Pediatrics*](#) (November 2004). Edward L. Schor and Caren Elfenbein. The authors of this issue brief argue that identifying and managing issues of child development and behavior is a crucial part of primary care pediatrics, yet despite its importance, many pediatricians do not receive adequate training in developmental and behavioral pediatrics.

#778 [*Early Child Development in Social Context: A Chartbook*](#) (September 2004). Brett Brown, Michael Weitzman et al. This chartbook reviews more than 30 key indicators of development and health for children up to age 6, as well as social factors in families and communities that affect these outcomes. It also offers practical implications for practitioners and parents.

#757 [*Rethinking Well Child Care*](#) (July 2004). Edward L. Schor. *Pediatrics*, vol. 114, no. 1 (*In the Literature* summary). According to this article's author, the nation's system of preventive pediatric care requires major revisions if chronic health problems and unmet behavioral and developmental needs among American children are to be addressed.

#700 [*Quality of Health Care for Children and Adolescents: A Chartbook*](#) (April 2004). Sheila Leatherman and Douglas McCarthy. The researchers use 40 charts and analyses to outline the current state of children's health care, arguing that the health care system has devoted far less attention to measuring the quality of care for children and adolescents than it has for adults.