Dear Dr. McInnes:

The American Academy of Pediatrics (AAP), representing over 62,000 pediatricians, pediatric subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, is writing to provide the Centers for Medicare and Medicaid Services (CMS) with its analysis of the appropriate use of the Primary Care Exception Rule (PCER).

As you know, the PCER is part of the Physicians At Teaching Hospitals (PATH) guidelines, which are CMS guidelines for health care provided by interns, residents, and fellows. The PCER allows teaching physicians to bill for primary care services provided by residents under their supervision who have completed at least 6 months of approved graduate medical education.

Attached please find an analysis of recent changes enacted by the Affordable Care Act which we believe set a precedent for use of the Preventive Medicine Services CPT codes under the PCER in the context of pediatrics.

Please feel free to contact Robert Hall, AAP staff, at RHall@aap.org, with any questions or concerns.

Sincerely,

Sandra G. Hassink, MD, FAAP
President

SGH/ljw
Primary Care Exception Rule (PCER)

Request

To allow consistency with current policy and rationale, we are requesting that the Centers for Medicare and Medicaid Services (CMS) provide confirmation that the pediatric CPT Preventive Medicine Services (PMS) codes (99381-99384 and 99391-99394) are included under the primary care exception rule (PCER).

Background

The PCER in the Physicians At Teaching Hospitals (PATH) guidelines (ie, CMS guidelines for health care provided by interns, residents, and fellows (referred to as “residents” in this document)) allows teaching physicians to bill for primary care services provided by residents under their supervision who have completed at least 6 months of approved graduate medical education. To qualify for this exception, services must be provided in a teaching hospital or clinic. If the services are provided outside a hospital, there must be a written agreement with the teaching hospital that includes a contract outlining the payment for the teaching services or written documentation that the services will be “donated.” In general, this exception cannot be applied in a private physician’s office.

The teaching physician must be physically present in the setting where the care is taking place, must be immediately available to the residents, and may not have other responsibilities (including supervising other personnel or seeing patients). No more than 4 residents can be supervised at a time. The teaching physician must review the care (history, findings on physical examination, assessment and treatment plan) provided either during or immediately after each visit. The documentation must reflect the teaching physician’s participation in the review and direction of the services performed.

This exception allows the teaching physician to report CPT Office or Other Outpatient Services codes 99201-99203 for new patient visits and 99211-99213 for established patient visits when the service is provided by a resident under the teaching physician’s supervision. However, if a higher-level evaluation and management (E/M) service is necessary and performed, the teaching physician must follow the teaching physician guidelines and personally participate in the care of the patient as outlined above. As always, the selection of the code is based on the E/M code descriptions and documentation guidelines.

The PCER does not explicitly address the CPT Preventive Medicine Services (PMS) codes for either new nor established patients (99381-99397). The CPT PMS codes are classified as “Noncovered” (ie, Status Indicator “N”) on the Medicare Resource-Based Relative Value Scale (RBRVS). However, these services are of primary importance in the training of pediatric physicians.

Importance of the PCER

The PCER grew out of the recognition that residents training in primary care specialties, unlike other medical/surgical disciplines, require extensive training in the continuous supervision of their own panel of patients throughout their training, both preventive (“well-child care”) and acute care visits. Residents in training benefit from this continuous patient interaction, both as a model of care they will follow in future primary care and a mechanism to excite residents to the personal fulfillment of watching children and families mature physically, emotionally and developmentally over time.

Primary care physicians follow a panel of patients for the three years of their residency. While the PCER allows the supervising physician to review each patient at the time of or after the encounter with the resident, it does
not require the supervisor to physically see each of the resident’s patients. This helps to encourage the independence of the resident as well as family attachment to the resident in training. The residents must have at least 6 months of completed training and can always ask the supervising physicians to see any patient in which they require confirmation of a finding or help in diagnostic or therapeutic advice.

Because Medicaid plans are required to follow the Medicare PATH guidelines, pediatric residents are being denied an important part of their training experience that the PCER intended to help develop by not addressing the pediatric CPT PMS codes.

**Preventive Medicine Services Included Under PCER**

CMS created HCPCS Level II PMS codes G0344, G0402, G0438, and G0439 using CPT PMS codes 99387 and 99397 as their foundation, both in terms of their descriptors and their valuation.

For services provided on or after January 1, 2005, the following HCPCS Level II code is included under the PCER: G0344 Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 6 months of Medicare enrollment

[Note: Code G0344 was deleted effective December 31, 2008 and replaced by code G0402.]

For services provided on or after January 1, 2009, the following HCPCS Level II code is included under the PCER: G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Effective January 1, 2011, the following HCPCS Level II codes are included under the PCER: G0438 Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit G0439 Annual wellness visit, includes a personalized prevention plan of service, subsequent visit

**Pediatric Precedent Established**

It is clear that CMS, through the development of the specific HCPCS Level II codes, now recognizes preventive health care as part of the Medicare mission. As with previous legislative initiatives such as the Affordable Care Act (ACA), CMS has chosen to develop new HCPCS Level II codes instead of utilizing CPT codes since the former can be developed with greater expediency than the latter. By including the HCPCS Level II preventive medicine services under PCER, CMS clearly establishes a precedent for all CPT PMS codes to be included under the PCER.

Pediatricians following the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* provide many preventive medicine service visits for children. In the younger age groups where growth and development are changing rapidly, preventive medicine service visits predominate and represent the most important educational experiences for pediatric residents in training. Unfortunately, CMS has never explicitly communicated that the pediatric Preventive Medicine Services (PMS) codes (99381-99384 and 99391-99394) are included under the PCER.

To be consistent with current policy and rationale related to HCPCS Level II preventive service codes, we request that the pediatric CPT PMS codes be included under the PCER.

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