COLLEGE of AMERICAN PATHOLOGISTS

January 4, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the revised "CMS Patient Relationship Categories and Codes". The CAP is a national medical specialty society representing over 17,000 physicians who practice anatomic and/or clinical pathology. CAP members practice their specialty in clinical laboratories, academic medical centers, research laboratories, community hospitals and federal and state health facilities.

Currently, pathologists do not generally have patients attributed to them using the current Resource Use (i.e. VBM methodology) attribution methodology, so we appreciate the need for an alternative methodology. The CAP is looking forward to continued engagement with CMS to determine how to measure the resource use appropriately of providers who typically do not furnish services that involve face-to-face interaction with patients, including pathologists. The CAP believes considerable accommodations or alternate measures will be necessary to meet this clause[1] in the Medicare Access and CHIP Reauthorization Act (MACRA) with respect to resource use measures.

GENERAL COMMENTS

As noted previously, the CAP cannot provide detailed comments on the draft patient relationship codes without fully understanding how they will be used. There may be unintended consequences of specifying these code descriptors without a clear

[1] In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—
''(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and
''(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.
In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

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understanding of their intended use. The CAP requests that the CMS provide greater detail on the use of the codes before finalizing the code descriptors.

RESPONSES TO QUESTIONS

1. **Are the draft categories clear enough to enable clinicians to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation?**

The revised codes are clearer than the previously drafted codes; however, the CAP believes that some additional revisions are needed. For example, category 5 appears to be an over simplification of the care furnished by non-patient facing clinicians. In addition, there is some overlap between Categories 4 and 5 with respect to pathology services. A particular CPT code may be coded as 4 or 5 depending on the circumstances of the care provided. The CAP questions whether the CMS intends to leave the coding decisions to the physicians or if there be specific rules outlined in the future. For those codes which will always fall under one category, the CAP suggests the patient relationship codes be automatically applied to limit the reporting burden.

2. As clinicians furnishing care to Medicare beneficiaries practice in a wide variety of care settings, do the draft categories capture the majority of patient relationships for clinicians? If not, what is missing?

Most pathology services, but not all, will fall under Category 5 or in rare cases Category 4. We believe that Code 5 would capture most pathology practices if it were revised slightly. We suggest the following edits to the description of Category 5 –

> 5. ~~*Only*~~ ***As*** ordered by another clinician: This category could include a clinician who furnishes care to the patient only as ordered by another clinician ***or incident to services ordered by another clinician***. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians.

3. Are HCPCS modifiers a viable mechanism for CMS to use to operationalize this work to include the patient relationship category on the Medicare claim? If not, what other options should CMS consider and why?

Yes, the HCPCS modifiers are a viable mechanism; however, we continue to be concerned about the burden of adding a modifier to every code. The CAP suggests that it may be easier to have a default patient relationship code based on specialty. The CAP suggests that only exceptions should be indicated on claims via the use of a CPT

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modifier. At a minimum, CMS should limit the modifier to one per claim to reduce the reporting burden.

Whatever descriptor and mechanism the CMS decides to use, the CAP recommends that the CMS perform pilot testing to assure the patient relationship codes work as intended. Thorough pilot testing would provide a clearer understanding of that burden as well as whether the codes are achieving their intended purpose.

Closing,

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Sent via email

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