COLLEGE of AMERICAN PATHOLOGISTS

August 15, 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: Request for Information Regarding Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Request for Information entitled "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

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 understanding of

[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.

Fay Shamanski
Assistant Director, Economic & Regulatory Affairs, CAP

Tc: 202-354-7113
f: 202-354-8113
fshaman@cap.org

1350 I Street, NW
Suite 590
Washington, DC 20005
800-392-9994 | cap.org

their intended use. The CAP requests that the CMS provide greater detail on the use of the codes before finalizing the code descriptors. The CAP also suggests that the CMS provide definitions of terms used in the proposal.

In general, the CAP does not believe the draft patient relationship codes are sufficient or that the categories of acute and chronic care represent the full range of relationships between patients and physicians. The CAP believes the code description needs to relate to how the codes will be applied (e.g. once per claim similar to Place of Service or different codes for each CPT code.) The CAP suggests that it may be easier to have a default patient relationship code based on specialty and only exceptions indicated on claims via the use of a CPT modifier.

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. We are concerned about the additional reporting burden associated with the use of these codes and thorough pilot testing would provide a clearer understanding of that burden as well as whether the codes are achieving their intended purpose.

RESPONSES TO QUESTIONS

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

No, the categories need to be simpler and clearer. For the most part, the categories[2] need more definite dividing lines, so as to avoid the potential confusion (i.e. II vs IV.) Many of CAP members thought IV vs. V were overlapping and confusing. It is not clear which types of practices CMS is trying to distinguish between these two categories.

[2] "(B) Development of patient relationship categories and codes.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who--
(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
(v) furnishes items and services only as ordered by another physician or practitioner.

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Pathologists would typically belong in Category V but not always. Linking this code to another code in the encounter (CPT) could simplify matters. Perhaps Category V would be a default category for pathologists and change only if necessary. It may be necessary to break Categories IV and V into two categories each – one for patient facing encounters and one for non-patient facing encounters once it becomes clearer how the codes will be used to measure resource use. The distinction between these categories may be ambiguous for non-patient facing specialties.

2. As described above, we believe that there may be some overlap between several of the categories. To distinguish the categories, we are considering the inclusion of a patient relationship category that is specific to non-patient facing clinicians. Is this a useful and helpful distinction, or is this category sufficiently covered by the other existing categories?

It is not clear how specifying non-patient facing will be used in the context of measuring resource use. Category V seems to cover pathologists, but perhaps they could specifically state it is for PRIMARILY non-patient facing clinicians. The risk of miscoding the relationship would seem greater when the pathologist isn't identifying it, but appropriate technical assistance and education as mentioned in question 6 could minimize that risk. Finally, as we understand the patient relationship codes, there would not be a single patient relationship that would accurately characterize all services provided by non-patient facing clinicians.

3. Is the description of an acute episode accurately described? If not, are there alternatives we should consider?

This is difficult to specify particularly for pathology, as pathology reports often dictate a transition from chronic to acute episodes of care (i.e. a disease relapse, a new diagnosis). It is unclear where the pathologist's service would be classified in this model.

4. Is distinguishing relationships by acute care and continuing care the appropriate way to classify relationships? Are these the only two categories of care or would it be appropriate to have a category between acute and continuing care?

We do not think acute care and continuing care cover the broad array of relationships that physicians have with patients. The CAP recommends that the CMS add a diagnostic care category, for when the patient's diagnosis is as yet unclear, and is being worked up.

5. Are we adequately capturing Post-Acute Care clinicians, such as practitioners in a Skilled Nursing Facility or Long Term Care Hospital?

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We do not think post-acute care is adequately captured.

6. What type of technical assistance and education would be helpful to clinicians in applying these codes to their claims?

It would be helpful if CMS could provide several case examples for each category. In addition perhaps codes could be tagged to certain CPT codes. For example, the performance of a fine needle aspiration CPT code would get a (iv) but its professional interpretation would always get (v) to reduce one more data entry for staff / providers. The CAP is concerned about the increased administrative burden and cost associated with adding patient relationship codes to each CPT code.

7. The clinicians are responsible for identifying their relationship to the patient. In the case where the clinician does not select the procedure and diagnosis code, who will select the patient relationship code? Are there particular clinician workflow issues involved?

Clinicians will likely be responsible for identifying the appropriate patient relationship code; however coders may be the ones adding the patient relationship codes to claims, so the educational piece is very important. Coding should be standardized for pathology, as we will usually be category V except in those (typically procedural) circumstances where it would likely be a category IV. Both are however predicted based on CPT codes.

8. CMS understands that there are often situations when multiple clinicians bill for services on a single claim. What should CMS consider to help clinicians accurately report patient relationships for each individual clinician on that claim?

The significance of multiple clinicians billing on the same claim will depend on the mechanism and granularity of the coding; if the coding is by a modifier, ideally with a default for the CPT service and clinician type, then this ought not to pose additional problems. This exercise seems redundant as the patient relationship should be clear from the specialty code and the service code, and for the most part pathologists will report that they are non-patient facing and responding to an order from another clinician, which should be well established.

Sent via email

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