



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

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August 15, 2016

Andy Slavitt

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Baltimore, MD 21244

Submitted electronically to patientrelationshipcodes@cms.hhs.gov

Dear Administrator Slavitt:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide input on *CMS Patient Relationship Categories and Codes* in the call for comments issued on April 15, 2016. ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

We recognize that the call of comments related to Patient Relationship Categories and Codes is made in the context of implementing the payment and resource use measurement provisions required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In attempting to create payment systems that better reflect the value of care, both the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) will seek to better measure resource use, and in order to achieve that goal, stakeholders have consistently called for better attribution mechanisms to ensure that the costs of care pinned to any physician are truly those over which a physician can influence utilization. We believe that the creation of Patient Relationship Categories and Codes has the potential to help develop better attribution mechanisms, and offer the following observations to assist in strengthening this proposal.

BACKGROUND

In laying out the provisions related to Patient Relationship Codes and resource use measures, MACRA provided examples of the different “relationships” Congress envisioned could be captured via Patient Relationship Codes:

- A physician or practitioner who considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time
- A physician or practitioner who considers themselves 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
- A physician or practitioner who 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
- A physician or practitioner who furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner
- A physician or practitioner who furnishes items and services only as ordered by another physician or practitioner

ACUTE VS. NON-ACUTE EPISODES

CMS believes that one approach to developing Patient Relationship Codes is to distinguish between patient-clinician relationships where items and services are furnished on an acute basis and patient-clinician relationships where items and services are furnished on a non-acute or continuing basis.

CMS proposes a draft definition of an acute episode:

Acute episodes may encompass a disease exacerbation for a given clinical issue, a new time-limited disease (e.g. acute bronchitis), a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. It may occur or span inpatient and outpatient settings.

While CMS does not separately define non-acute episodes, it states that “[c]ontinuing care occurs when an episode is not acute, and requires the ongoing care of a clinician.”

ASPS is concerned that the acute vs. non-acute distinction (which is used to create the categories outlined below) does not fully reflect the variation in patient-physician relationships that occur in the actual delivery of care. In particular, we are concerned with the language restated above suggesting that disease exacerbation and surgery are, by definition, categorically acute care. In participating in the CMS webinar related to the call for comments on Patient Relationship Categories, we specifically inquired about reconstructive plastic surgery (i.e., the restoration of appearance and function) and were provided information to suggest in that instance, the relationship would be “specialized chronic care.” Given that reconstructive surgery creates a long-term patient-doctor relationship, we agree with that assessment, however, we do not believe the CMS documentation on Patient Relationship Categories and Codes reflects that, given the mention of surgery in the definition of an acute episode.

We believe that in implementing the use of Patient Relationship Codes, this distinction could create confusion and that CMS will need to bring more clarity to several issues, including:

- How these distinctions and categories apply to clinicians involved in team-based care
- How these distinctions and categories apply to care delivered by clinicians who provide supportive care but do not directly bill the Medicare program for their professional services. (e.g. dietitians or therapists)

DRAFT PATIENT RELATIONSHIP CATEGORIES

Using the acute vs. non-acute distinction discussed above, CMS has put forward the following Patient Relationship Categories. We provide comment after each category.

Continuing Care Relationships:

- *Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care (e.g. primary care physician providing annual physical examination (outpatient); geriatrician caring for resident (Nursing Home); nurse practitioner - providing checkups to adult asthma patient (outpatient)).*

ASPS requests clarification on the inclusion of the language “primary health care provider.”

Does CMS intend for “primary health care provider” to refer only to primary care practitioners? In the alternative, is CMS attempting to develop a code to reflect the predominant clinician coordinating services for a particular condition, illness, or injury?

- *Clinician who provides continuing specialized chronic care to the patient (e.g. endocrinologist (inpatient or outpatient) treating a diabetes patient; cardiologist for arrhythmia; oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology).*

ASPS requests clarification on what the Agency defines as “chronic care.” As discussed above, we are concerned with the current proposal’s language that appears to suggest disease exacerbation and surgery are, by definition, categorically acute care.

Acute Care Relationships:

- *Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode (e.g. hospitalist caring for a stroke patient (inpatient); gastroenterologist performing a colonoscopy (outpatient ambulatory surgery); Orthopedist performing a hip replacement; urgent care practitioner caring for a patient with the flu (ambulatory); emergency room physician assistant treating a motor vehicle accident patient (outpatient), attending at a Long Term Care Hospital or Inpatient Rehabilitation Facility).*
- *Clinician who is a consultant during the acute episode (e.g. infectious disease specialist treating a patient for sepsis or shingles; gastroenterologist performing an upper endoscopy on a*

hospitalized patient (inpatient); rheumatologist performing an evaluation of an acutely swollen joint upon referral by a primary care physician; dietician providing nutritional support to an ICU patient (inpatient).

ASPS requests clarification on what the Agency defines as “acute care.” As discussed above, we are concerned with the current proposal’s language that appears to suggest disease exacerbation and referrals are, by definition, categorically acute care.

Acute Care or Continuing Care Relationships: *Clinician who furnishes care to the patient only as ordered by another clinician (e.g. non-patient facing Clinicians such as pathologists, radiologist, and other practitioners who care for patient in specific situations ordered by a clinician but have very little or no relationship with a patient).*

ASPS encourages the Agency to consider more specific relationship categories for “non-physician” practitioners if the intent is to compare resource use by provider type.

ADMINISTRATIVE ISSUES

CMS requests input on several administrative issues related to how CMS would collect data on the Patient Relationship Codes. In particular, CMS asks the following questions:

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

While we believe that these are important questions, ASPS finds it difficult to provide input given the lack of detail available at this point related to the codes and lack of proposals related to how to report Patient Relationship Codes. However, we do believe that there are several focal points for CMS to consider as it develops more detailed proposals.

First, we would find it helpful if CMS would provide, as practicable as possible, detailed proposals on the method for the data capture. In the most concrete terms, CMS should clarify how it envisions the codes to be reported on the HCFA or in an ANSI Loop. We respectfully remind the Agency that another option might be reporting this type of information via HCPCS codes or potentially to enhance POS codes to also report Patient Relationship Codes. We look forward to providing more feedback on the

efficiencies and burdens associated with CMS' intended method of data capture as more information is publicized.

In addition, after establishing more defined Patient Relationship Categories and Codes, we would encourage CMS to make clear that there will be many scenarios in which a clinician will need to choose different Patient Relationship Codes depending on the type of care delivered to a patient (i.e. surgeons will not apply the same code to every claim no matter the service delivered). Extensive CMS education will be needed.

And finally, we ask that CMS clarify how it hopes to utilize certified EHR technology to capture this type of data. To the extent that algorithms or other tools can be built into EHRs and billing mechanisms, it could result in better compliance and accuracy, but will need sufficient lead time for vendors to incorporate into EHR software.

ASPS appreciates the opportunity to offer these comments, and we look forward to providing additional input on accurate resource use measurement, including CMS' proposals for implementing Patient Relationship Codes. Given the current CMS proposal to increase the weight of the Resource Use Performance Category under the MIPS program for the reporting period expected to occur in 2018 (to be used for 2020 payment updates), we encourage CMS to issue more detailed proposals as soon as possible so the program will move away from the crude resource use measures in the Value-Based Payment Modifier Cost Composite and proposed for MIPS and toward more meaningful resource use data to plastic surgeons. Our members are committed to taking all appropriate steps to ensure patients receive care that results in the best outcomes and value.

Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Manager, at cfrench@plasticsurgery.org or at (847) 981-5401.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Song', with a long horizontal flourish extending to the right.

David H. Song, MD, MBA, FACS
President, American Society of Plastic Surgeons