August 15, 2016

Acting Administrator Andrew Slavitt
Centers for Medicare and Medicaid Services
Department of Health and Human Service
200 Independence Avenue, Southwest
Washington, DC 20201

RE: Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

Our coalition includes the following members: the American Academy of Physical Medicine and Rehabilitation (AAPMR), the American Pain Society (APS), the American Society of Regional Anesthesia and Pain Medicine (ASRA), the Society of Interventional Radiology (SIR), and the Spine Interventional Society (SIS). Our members' practices are typically limited to the treatment of patients with chronic, intractable pain. Our patients are generally referred from primary care physicians, surgeons, neurologists, oncologists or other specialties after not achieving significant improvement in quality of life with the use of other forms of treatment such as oral medications, surgery, physical therapy, chiropractic care, other non-pharmacologic, or intervention services. We strongly support the efforts of Centers for Medicare and Medicaid Services (CMS) to improve quality of care and patient outcomes.

Our coalition appreciates the opportunity to comment on the "CMS Patient Relationship Categories and Codes" draft guidance. Our comments center on the following issues:

1. Emphasizing that in the "continuing care" relationship the role of the chronic pain clinician is to provide chronic pain management and not primary care services;
2. Urging supporting establishment of a patient relationship category for "non-patient facing" clinicians;
3. Providing technical assistance and education to physicians on including patient relationship codes on administrative claims; and
4. Ensuring that physicians can clearly identify their relationship to the patient if an administrative claim reflects the services of multiple clinicians.

Our comments reflect our desire to work effectively with CMS to implement changes to Medicare physician reimbursement as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

1. "Continuing Care" Relationship Category

<u>Recommendation</u>: As CMS considers how to define the "continuing care" patient relationship, our coalition urges the Agency to recognize that a chronic pain clinician provides important and necessary ongoing chronic pain management services, but does <u>not</u> serve as the patient's primary care provider when performing these services. As such, CMS should not attribute any primary care services to the chronic pain medicine physician when defining the "continuing care" patient relationship and, accordingly, the chronic pain medicine clinician should not be measured on any quality or resources use metrics related to the patient's primary care services.

CMS proposes to create a category of clinicians who provide "continuing specialized chronic care to the patient" under the "Continuing Care Relationships" category. Examples listed in the draft guidance document include an endocrinologist (inpatient or outpatient) treating a diabetes patient; a cardiologist for arrhythmia; and an oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology. While not listed as an example in the draft guidance, chronic pain medicine physicians likely would fall under such category. Chronic pain medicine physicians play an integral role in treating and helping patients manage chronic pain (inpatient and outpatient) through a variety of care methods, such as appropriately prescribing chronic pain medications (e.g. opioids); performing procedures including nerve blocks, spinal injections and other interventional techniques; and coordinating additional care like physical and psychological therapy.

While chronic pain medicine physicians provide highly specialized treatment for a patient's ongoing pain management, chronic pain clinicians do not perform primary care services for these patients. Rather, primary care providers oversee the primary care needs of chronic pain patients. As such, CMS should attribute primary care services strictly to the chronic pain patient's primary care provider and not to the patient's chronic pain specialist.

Our coalition seeks to emphasize this distinction particularly because a chronic pain specialist often codes chronic pain management visits under Evaluation & Management codes that CMS inadvertently could misread as primary care visits, rather than chronic pain visits. For example, a chronic pain specialist following the Centers for Disease Control and Prevention (CDC) "Guideline for Prescribing Opioids for Chronic Pain" assesses a chronic pain patient "every 3 months or more frequently" to evaluate the potential benefits or harms to the patient of continued opioid therapy.[1] While coded as an E&M visit, the visit to evaluate the appropriateness of continued opioid use represents a specialized chronic pain visit rather than a primary care visit.

Because of the frequency of chronic pain visits and the typical coding of such visits as E&M visits, a patient's plurality of E&M visits may be with the patient's chronic pain specialist rather than his or her primary care provider in a given Merit-Based Incentive Payment System (MIPS) performance year. If this were to occur, under the proposed MIPS attribution methodology, CMS inadvertently and

[1] See CDC "Guideline for Prescribing Opioids for Chronic Pain – United States, 2016." https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

inappropriately could assign the chronic pain specialist as the patient's primary care provider – rather than the patient's actual primary care provider – for purposes of MIPS quality and resource use measurement.[2] To ensure that inappropriate attribution does not occur, our coalition strongly urges CMS to recognize the role chronic pain specialists provide in giving "continuing specialized chronic care" to the patient – but not primary care services – when defining the important "continuing care" relationship these clinicians have with patients.

1. Establishment of Non-Patient Facing Relationship Category

<u>Recommendation</u>: Our coalition urges CMS to adopt a "non-patient facing" relationship category to distinguish clearly the services performed by these clinicians – and the little to no control over which these clinicians have in the provision of such services – when treating a patient. Our coalition further recommends that "non-patient facing" clinicians identify themselves as "non-patient facing" on the administrative claim when identifying their relationship to the patient.

Statute requires CMS to make special considerations in MIPS for circumstances of "non-patient facing" clinicians under section 1848(q)(2)(C)(iv) of the Social Security Act. Accordingly, CMS proposes special considerations for "non-patient facing" clinicians in the MACRA proposed rule for purposes of MIPS measurement.[3] Consistent with these statutory and regulatory policies, we urge CMS to adopt a "non-patient facing" category when defining patient relationship categories. Creating a "non-patient facing" category better ensures that CMS appropriately measures "non-patient facing" clinicians based on the little to no control they have over the resource use in the care of patients requiring their services.

Furthermore, CMS requests in the draft guidance how to clearly distinguish between a "non-patient facing" clinician and a clinician who provides services in one of the following manners:

- furnishes items and services only as ordered by another clinician;
- 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; and
- furnishes items and services to the patient on an occasional basis, usually at the request of another practitioner.

CMS explains that clinicians will have the responsibility of identifying their relationship to the patient on the administrative claim. As such, our coalition recommends that CMS include a line item in the administrative claim whereby the clinician may categorize himself as "non-patient facing" for purposes of identifying his or her relationship to the patient for a specific diagnosis or procedure code. This line item will aid CMS in distinguishing a "non-patient facing" clinician from clinician in the three specified categories above who are "patient facing."

[2] 81 Fed. Reg. 28199
[3] 81 Fed. Reg. 28208

2. Technical Assistance and Education

Recommendation: Our coalition recommends that CMS create educational tutorials, preferably electronic, for clinicians in each patient relationship category on how to apply patient relationship codes appropriately to Medicare administrative claims.

CMS asks types of technical assistance and education that would be helpful for clinicians in applying patient relationship codes to their administrative claims. Our coalition recommends that CMS develop concise and easily accessible electronic tutorials for clinicians describing how to appropriately apply patient relationship codes to Medicare administrative claims. CMS should develop separate tutorials for each type of clinician defined in the patient relationship categories, including distinct tutorials for "patient facing" and "non-patient facing" clinicians within each category. Separate tutorials for each clinician group will better ensure that clinicians appropriately code their relationships to specific patients.

3. Multiple Clinicians Billing on the Same Administrative Claim

Recommendation: Our coalition recommends that the administrative claim clearly include line items where each clinician contributing to the patient's care directly states his or her relationship to the patient.

CMS recognizes in certain instances a single administrative claim may reflect services provided by multiple clinicians and asks what it should consider to ensure that physicians accurately report their distinct patient relationships on that claim. Our coalition recommends that the administrative claim include as many line items as necessary to ensure that clinicians can directly state their specific relationships to the patient for that specific diagnosis or procedure.

Our coalition further wants to emphasize that the identification of the patient relationship adds new administrative and financial burdens for providers, which can be particularly challenging for solo practitioners and small group practices. As such, in general when developing policies for implementation of patient relationship categories and codes, our coalition strongly urges CMS to minimize burden and facilitate relative ease in adoption of these new policies, recognizing that the most important goal for clinicians and the Agency is to provide high-quality care to patients.

Again, our coalition appreciates the opportunity to comment on the Agency's draft guidance entitled "CMS Patient Relationship Categories and Codes." Please do not hesitate to contact Angela Stengel at astengel@asra.com if you have any questions. We look forward to working with CMS to achieve our mutual goals of advancing high-quality care and improving patient outcomes.

Sincerely,

The American Academy of Physical Medicine and Rehabilitation,

The American Pain Society,
The American Society of Regional Anesthesia and Pain Medicine,
The Society of Interventional Radiology, and
The Spine Interventional Society