American Academy of Physical Medicine and Rehabilitation

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/754.4368
info@aapmr.org

President
Gregory M. Worsowicz, MD, MBA
President-Elect
Steve R. Geiringer, MD
Vice-President
Darryl L. Kaelin, MD
Secretary
Jonathan Finnoff, DO
Treasurer
Michelle S. Gittler, MD
Past President
Kathleen R. Bell, MD
Members-at-Large
Larry H. Chou, MD
D. J. Kennedy, MD
Robert J. Rinaldi, MD
Deborah A. Venesy, MD
Strategic Coordinating
Committee Chairs
Medical Education
Steven R. Flanagan, MD
Membership Committee
Michael Saffir, MD
Quality, Practice, Policy & Research
Peter C. Esselman, MD
Resident Physician
Council President
Stephanie Tow, MD
AMA Delegate
Leon Reinstein, MD
PM&R, Editor in Chief
Stuart M. Weinstein, MD
Executive Director
Thomas E. Stautzenbach, CAE

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1645–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Request for Information Regarding Patient Relationship Categories and Codes

Dear Mr. Slavitt:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the Request for Information: CMS Patient Relationship Categories and Codes. Physical Medicine and Rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R applauds CMS for developing a new attribution model. It is our belief that previous programs, such as the Value-Based Modifier, have serious flaws. However, we also believe that a number of changes need to be made to the Patient Relationship Categories and Codes in order for this to work.

CMS should provide additional information that explains to physicians how they plan on using relationship categories and codes to attribute cost and outcomes. There is a lack of information on how these categories and codes will interact with episode groups which were also required under the Medicare Access and CHIP Reauthorization Act (MACRA). **In order to ensure a successful launch of the patient relationship categories and codes, we urge CMS to gain physician buy-in.** This could be done by testing the categories and codes in a pilot program and sharing the results with the physician community.

AAPM&R is also concerned that an additional, new reporting requirement will create another burden for physicians when it comes to reporting. With the Merit-Based Incentive Payment System (MIPS), starting in 2017, physicians will need to learn and adapt to the changes brought forth with that final rule. If physicians need to report

new codes on each claim under the development of patient relationship categories and codes, it will create another administrative burden. **Therefore, AAPM&R suggests that CMS should consider using modifiers rather than codes to identify patient relationships.** This would require less of an adjustment for physicians and decrease the administrative burden.

Responses to Questions in the Request for Information:

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?*

The categories, as presented, are not exclusive and can change over a short period of time. A patient will often have more than one physician with a continuing care relationship. One relationship that is not captured in the categories is the physician who sees an outpatient for one or two visits in a **consulting role**. That is not a continuing care relationship. It may be a consult during an acute care episode (I.e. patient seen by a physiatrist for a chronic shoulder condition). In the latter case it is not an acute episode (disease exacerbation for a given clinical issue) but a consultation or short-term management of a chronic condition. **AAPM&R believes CMS should adjust the categories to fully account for all patient relationships.**

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?*

AAPM&R believes that non-patient facing clinicians are essential to patient care and would like to see CMS add a patient relationship category for those physicians.

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

AAPM&R does not believe the description of an acute episode is accurately described. The distinction between acute and chronic is not well defined. AAPM&R also believes that by only using the terms acute and continuing, CMS is ignoring a number of care categories and **we urge CMS to include a post-acute category.**

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?*

As stated above, **AAPM&R believes the additional category of post-acute care is needed.** The only way to capture patient relationships at a skilled nursing facility, long-term care hospital or inpatient rehabilitation facility is by creating the post-acute category.

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

As the patient relationship categories and codes are currently defined, we do not believe CMS is adequately capturing Post-Acute Care clinicians. However, as we stated above, **AAPM&R would like to see CMS add the additional category of post-acute care**. If added, then those clinicians would be captured.

6) *What type of technical assistance would be helpful to clinicians in applying these codes to their claims?*

As with any new program, AAPM&R firmly believes that CMS needs to conduct extensive outreach with all stakeholders. **CMS should work with physicians to develop examples or case studies to assist physicians and staff with choosing the accurate category. CMS will also need to create education for all levels of clinical staff and billing staff.**

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?*

As we mentioned above, **AAPM&R urges CMS to create education, not only for clinical staff, but for the billing and coding staff as well**. The amount of additional work and burden on both physicians and staff will be significant. Not only will workflow issues, need to be addressed, but CMS also needs to engage with EHR vendors regarding the requirements.

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?*

AAPM&R believes there are many logistical issues that need to be worked out before the implementation of patient relationship codes. **We urge CMS to look into using modifiers to establish the patient relationship category.** We believe that this will be the simplest way to report, however this will still add to the burden physicians are already facing with the numerous other requirements.

We appreciate the opportunity to comment on this request for information. AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Beth Radtke, Manager of Quality and Research Initiatives in the AAPM&R Division of Health Policy and Practice Services. She may be reached at bradtke@aapmr.org or at (847)737-6088.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation