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Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically: patientrelationshipcodes@cms.hhs.gov

RE: Request for Information Regarding Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

The American Society for Gastrointestinal Endoscopy (ASGE) is pleased to offer comments on the Centers for Medicare and Medicaid Service's (CMS) draft list of patient relationship categories as the Agency works to fulfill Section 101(f) of the Medicare Access and CHIP Reauthorization Act (MACRA) which requires the establishment and use of classification code sets: care episode and patient condition groups and codes, and patient relationship categories and codes.

Since its founding in 1941, the ASGE has been dedicated to advancing patient care and digestive health by promoting excellence in gastrointestinal endoscopy. ASGE, with more than 14,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education.

ASGE has taken every opportunity to offer its input on implementation of MACRA, including comments to CMS in response to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) proposed rule, and the request for information on draft episodes of care.

Need for Pilot Testing
As ASGE has expressed in past communications to CMS, we support the creation of a new attribution method for assigning resource use costs, as well as a reliable method for attributing patient outcomes to physicians. We appreciate that CMS is soliciting stakeholder feedback early in the process of fulfilling its mandate and

looks forward to an iterative process. Importantly, ASGE believes pilot testing of the patient relationship categories is vital. This pilot testing must include the submission of patient relationship codes, a period of stakeholder feedback, and an evaluation of the effect of the patient relationship categories in the calculation of physician resource use. ASGE believes that patient relationship categories should be pilot tested alongside episode groups, as we hope episode groups will supplant the current value-based cost measures. In fact, the complexity of patient relationship categories makes it more essential that CMS moves slowly and carefully toward the use of episode groups for measuring physician resource use rather than rushing to meet its initial target of episode groups that account for approximately 50 percent of Medicare expenditures under Parts A and B. Instead, we hope CMS will develop episodes that are clinically sensible and for which attribution of costs is transparent and logical to physicians.

Attributing Cost to Multiple Providers

It will be critical for patient relationship categories to accurately attribute cost when multiple physicians are responsible for a patient's care. As CMS considers how it will apportion the cost of care among physicians when they are attributed to the same episode of care, we suggest that the following potential pitfalls be considered:

- Attribution by plurality of charges may inadvertently penalize physicians who engage in high-volume, low-intensity services that may attribute a higher percentage of total cost to them due to higher volume of services.

- Attribution by percentage of total charges may inadvertently penalize physicians who perform high-quality, high-intensity, low-volume services.

- A physician specialist may be participating in the care of a patient to remediate a complication caused by the care of another acute or chronic condition treated by the primary physician. The cost of caring for this complication may exceed the cost of all other care and should not be attributed to that specialist but rather to the primary or other physician.

- Physicians may try to minimize their attribution or potential "downside" by documenting a less intensive relationship if they believe the patient is likely going to be high-risk/cost. This would suggest that the attribution assignment needs to somehow be automated and driven by claims and associated diagnoses/procedures.

  There is also the more global problem of physicians avoiding predictably high-cost cases or cases likely to have poor outcomes. Recent data on the experience of New York cardiac surgeons imply that no longer publishing individual outcomes data was associated with improved interventions and better outcomes. While CMS' proposed programs are not identical to the New York program, physicians justly fear the directions of public outcomes data and outcomes linked to reimbursement when conditions or patient characteristics not in a physician's control may lead to adverse outcomes to the physician. There are also, unfortunately, situations in which high-quality physicians practice in a peer environment of lower quality care/or higher cost care provision, and can then get "dragged down" in performance ratings and reimbursement.

Response to Questions

Question 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 five patient categories, distinguished by different categories of clinician-patient relationships that occur on an acute verses non-acute basis, proposed by CMS are as follows:

Continuing Care Relationships

(i) Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care.
(ii) Clinician who provides continuing specialized chronic care to the patient.

Acute Care Relationships

(iii) Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode.
(iv) Clinician who is a consultant during the acute episode.

Acute Care or Continuing Care Relationship

(v) Clinician who furnishes care to the patient only as ordered by another clinician.

ASGE supports the American Medical Association's (AMA) suggestion of the following possible categorization alternatives, which we believe could apply to a vast majority of physician-patient interactions: continuous/broad; continuous/focused; episodic/broad; and episodic/focused. For example, many gastrointestinal episodes are episodic/broad, such as management of a gastrointestinal hemorrhage, hospital or outpatient management of an inflammatory bowel disease (IBD) flare, or liver disease decompensation. There are also many gastrointestinal encounters that are episodic/focused, such as performing a procedure ranging from screening colonoscopy to an endoscopic retrograde cholangiopancreatography (or ERCP) to remove a common bile duct stone. In the latter situation, the surgeons and hospitalists may then manage the rest of the stay for gallbladder removal. Using an episodic/focused category allows all physicians involved in the patient's care to select the same patient relationship category if they feel they are a principal care provider.

In an effort to minimize reporting burden on the physician, especially as physicians begin participating in MIPS, we, like the AMA, support the use of a default patient relationship code. However, we prefer an approach where the physician would report a relationship code which remains the default unless a new code is self-reported (if the physician's role changes). If no code is reported, the default for primary care specialties (perhaps with the exception of gynecology) should be continuous/broad and episodic/focused for other specialties.

ASGE also offers the following comments on the five draft patient relationship categories:

- ASGE recommends that CMS avoid using the phrase "primary care provider" when describing patient relationship categories. We agree with the AMA that this phrase will cause confusion among physicians and that the term "principal" would be a more appropriate term.

- ASGE believes multiple physicians must be allowed to report the same patient relationship category for the same episode of care. In addition to having multiple physicians in the same category for the

same patient, a physician may fall into multiple categories for the same patient as his/her role may change day-to-day or episode-to-episode.

Question 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?

ASGE joins the AMA in its opposition to a category or terminology that utilizes "non-patient facing clinicians." We do not believe this is a helpful designation and, furthermore, the alternative framework suggested by the AMA would support non-patient facing relationships.

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

We believe AMA's alternative framework avoids the artificial distinction of acute or chronic and allows for the common "acute-on-chronic" type episode to be characterized.

Question 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?

ASGE believes the AMA's suggested framework of four patient relationships is enough to characterize relationships ranging from preventive through acute-to-chronic, post-acute, acute-on-chronic, etc. We believe that more categories will add undue complexity when there is already substantial uncertainty as to how the relationships interact with the episode in question and how, in turn, cost attribution differs. Nuances can be further analyzed by site of service, nature of the CPT codes, etc., but the primary determinant of a relationship is the selection of a patient relationship category or the assigning of the default relationship, per our comments above.

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

Again, we believe the AMA's suggested framework of four patient relationships is enough to characterize relationships. We agree, however, with the AMA that site of service alone should not determine the patient relationship category.

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

ASGE wishes to emphasize the importance of pilot testing the patient relationship codes. We also believe that extensive physician outreach and education will be critical. We agree with the AMA that clinical examples for each patient relationship category would assist physicians in choosing a category for each patient. We suggest the AMA CPT Editorial Panel could develop some clinical examples, similar to those that relate to CPT evaluation and management code distinctions, by specialty. Specialty societies could submit to CMS examples of relationships for common clinical situations they encounter.

Question 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?

We believe this question underscores the importance of CMS creating the simplest patient categorization method possible and using default categories, as described above. We believe it would be very difficult for a biller to determine patient relationship categories from review of documentation, except to the degree the service in question appears identical or equivalent to clinical examples as suggested in Question 6.

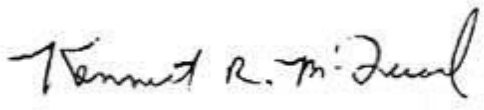
8. CMS understands that there are often situations when multiple clinicians bill for services on a single claim. What should CMS consider to help clinicians accurately report patient relationships for each individual clinician on that claim?

ASGE believes that a modifier approach may be the simplest approach to ensuring that patient relationships are accurately reported when multiple clinicians bill for services on a single claim. However, this approach could result in many encounters requiring more than one modifier, which many practice management systems and claims adjudication systems would find troublesome. Therefore, development of other HCPCS codes may be the least complicated approach, particularly if CMS accepts AMA's four suggested patient relationship categories. Furthermore, the use of patient relationship category defaults, as described above, rather than requiring indicators on every claim/claim line is important to reducing the reporting burden and error rate.

Conclusion

ASGE appreciates the opportunity to provide feedback on patient-relationship categories, and we look forward to future comment opportunities. Should you have questions or require additional information, please contact Lakitia Mayo, Director of Health Policy and Quality at lmayo@asge.org or (630) 570-5641.

Sincerely,



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