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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850
Submitted electronically: patientrelationshipcodes@cms.hhs.gov

Re: Centers for Medicare and Medicaid Services Request for Information Regarding CMS Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Request for Information (RFI) regarding CMS Patient Relationship Categories and Codes. The ACR recently submitted comments in response to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model proposed rule. We understand that this RFI is the first of several opportunities to comment on the manner in which patient relationship categories and codes, necessary for attribution of cost/resource use episode of care groups, will be developed. We also understand that MACRA provides CMS considerable flexibility on how the patient relationship categories will be implemented.

The ACR is committed to working collaboratively with other stakeholders in proposing meaningful recommendations to help CMS shape the delivery of health care services for the future with focus on value over volume. We encourage feedback from CMS on means to engage radiologists in the structure and use of these patient relationship codes.

General Comments Regarding the Role of Radiologists

Radiologists are physicians trained in the diagnostic and/or therapeutic use of x-rays (radiography, fluoroscopy, computed tomography (CT), and radiation therapy), diagnostic ultrasound (US), magnetic resonance imaging (MRI) and radionuclides (nuclear medicine and radionuclide therapy), interventional radiology, medical physics, and radiation biology. Specialization in radiology typically requires five to seven years of residency training which includes demonstrating knowledge of imaging patterns consistent with a wide variety of diseases, congenital abnormalities, metabolic and toxic conditions, infections, tumors, and trauma. Radiologists are also uniquely positioned to diagnose and/or treat many of the above conditions with minimally invasive techniques relying on image guidance technology.

The ACR and its members believe that this broad array of skills and depth of training uniquely positions us as effective care coordinators able to communicate important manifestations of diseases or complications of therapy to a full gamut of clinicians with different specialties and roles in treating patients. It is the ACR's hope that the patient relationship codes may help capture some of these valuable activities.

Policy Principles for Developing Patient Relationship Categories and Codes

Using the patient relationships categories described in section 1848(r)(3)(B) of the Act as a starting point, CMS distinguishes patient-clinician relationships by determining whether items and services are furnished on an acute basis or non-acute (i.e., continuing) basis. Using this framework, CMS further distinguishes the different categories of clinician-patient relationships that occur within each of these situations. CMS' rationale is usually within each type of acute or non-acute situation, there is a clinician who has primary responsibility for the care of the patient and a clinician who furnishes care on a consultative or supportive basis. When reviewing the relationships described in section 1848(r)(3)(B), CMS notes that there may be some overlap between three of the categories listed below because many clinicians can assist in the care of a single patient. Determining when a clinician furnishes items and services only as ordered by another clinician versus furnishes services on a continuing basis or an occasional basis may be due to the clinical situation (e.g., a pathologist who reads a breast tissue biopsy vs. a kidney doctor/nephrologist taking care of a patient receiving dialysis).

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

CMS believes that there are many ways to interpret these categories and as the operational list of categories and codes are developed, CMS would like to make it as easy as possible for clinicians to accurately identify their relationship to the patient. To distinguish between these categories, CMS is considering a category specific to non-patient facing clinicians. CMS seeks comment on the best way to distinguish between these situations and the inclusion of this category.

CMS is requesting comment on the draft patient relationship categories as well as suggestions for additional relationships or modifications to these relationships. CMS also requests comments regarding the questions included below.

Questions for Consideration

CMS seeks comment on the draft patient relationship categories as well as suggestions for additional relationships or modifications to these relationships.

The five patient categories proposed by CMS are summarized as follows:

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

General comments on the draft patient relationship categories:

The ACR previously submitted comments to CMS regarding the "CMS Episode Groups" effort. We encourage CMS to provide additional information regarding the use of these patient relationship codes to the attribution of costs to physicians. It is relatively difficult to comment specifically on these codes without a greater understanding of the context to which they will be applied.

The ACR is also concerned about the additional reporting and administrative burden these new codes could cause radiologists. We encourage CMS to implement these new codes in a manner which minimizes this burden. We recognize that MACRA requires the reporting of these codes with all claims starting in 2018 and encourage CMS to provide guidance for billing entities and physicians well in advance of their implementation.

ACR Comments Regarding Specific 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?**

Radiologists practice in a number of different settings and treat patients across the spectrum of care from prevention, to diagnosis, to management and post-acute care. As such, the ACR would expect that radiologists will report across multiple categories according to this draft, except for primary care. We would even expect that some radiologists may report different categories for the same patient on the same day. For example, a radiologist may interpret an examination in the morning, but then be the treating physician later on the same day. For example, a radiologist may determine that a diagnostic mammogram is warranted for a patient referred initially for a screening mammogram. If the diagnostic mammogram is normal, the radiologist will typically interact with the patient regarding follow-up exams; if abnormal, the radiologist will determine and perform additional testing. The radiologist is actively engaged in the diagnosis and treatment options for the patient in this example.

Accordingly, the ACR does not believe that specific categories should be applied universally to specific specialties or groups of physicians. For instance, radiologists should not be broadly classified or defaulted into one specific category, such as draft category (v). Rather, the categories should apply to specific services independent of the specialty involved. Assigning the specific relationship may prove challenging as a static category is being assigned within the context of a dynamic clinical episode.

The ACR believes the draft category (v) is overly simple and requires greater granularity. For example, the familiarity a radiologist has with a patient can vary depending on the patient's clinical situation. For example, a routine morning chest x-ray on a patient in the intensive care unit may be adequately captured by the draft category (v) language of "furnishes care to the patient only as ordered by another clinician." However, a CT scan on that same patient often requires a more in depth review of the patient's history including a review of the patient's medical record in Certified Electronic Health Record Technology (CEHRT) or discussion with the clinical team in order to protocol the study and interpret the images within the proper clinical context. This exploration phase, by definition, is a deeper relationship than the draft category (v) language allows. **As such, the ACR believes a second new category is needed which states: "Clinician who furnishes care to the patient only as ordered by another clinician, after consultation on appropriateness of the examination and determination of adequate protocol."**

The draft category (v) language fails to capture the radiologists' role in care coordination. For example, a CT scan ordered by a primary clinician may have findings beyond the scope of practice for that very same clinician necessitating a second communication event between the radiologist and a specialist. The opposite scenario is also common in which a finding on an imaging study is beyond the scope of practice of an ordering specialist, necessitating a second communication event with the patient's primary clinician. These are both examples of vital care coordination which take place daily, and yet are not recognized under the current fee-for-service system. Many other examples of radiologists' role in care coordination occur on a daily basis including face-to-face consultations between radiologists and care teams during film review and at multi-disciplinary conferences. **Accordingly, the ACR believes a third new category is needed which states: "Clinician who furnishes care to the patient only as ordered by another clinician, but requires care coordination activities."** These activities could easily be captured in the radiologist's report by documenting the results have been communicated to more than one clinician involved in a patient's care.

In summary, ACR believes that the draft category (v) is too broad and the draft category requires greater granularity. We recommend CMS create subcategories to category (v) as illustrated below:

(v) (a) Clinician who furnishes care to the patient only as ordered by another clinician. **Vignette:** A radiologist interprets a chest x-ray as ordered on an ER patient with chest pain. An interpretation is provided and communicated with no additional consultation or care coordination provided.

(v) (b) Clinician who furnishes care to the patient only as ordered by another clinician, after consultation on appropriateness of the examination and determination of adequate protocol.

Vignette: A radiologist receives an order for a CT scan of the abdomen and pelvis on an outpatient with abdominal pain. Further history is necessary for proper protocol. For example, the type and onset of pain may dictate if IV and/or oral contrast are necessary. If the pain is reproduced by palpation, a marker could be placed on the patient's skin localizing the point of origin. A patient history of renal failure would also alter the protocol either leading to performing the exam without nephrotoxic contrast or reducing the contrast dose. Additional history is often pertinent, but often not provided. This additional history can be valuable for protocol, but often even more valuable during interpretation of the images. For example, history of abdominal or pelvic surgeries can alter interpretation and/or recommendations provided by the radiologist. Increasingly, the quest for prior studies has become the hallmark of a practicing radiologist. The prior study could change the original protocol, obviate the need for the currently ordered exam, or alter the recommendations (more often than not, eliminating the need for additional follow up exam recommendations for incidental findings). All these activities require a deeper understanding of why an order has been placed for a particular patient, and therefore, a deeper relationship than the original proposed category (v) code.

(v) (c) Clinician who furnishes care to the patient only as ordered by another clinician, but requires care coordination activities.

Although most of the activities in our proposed category (v) (b) vignette could be viewed as care coordination activities occurring between the ordering clinician and the radiologist, there are additional activities not captured by this category. These activities occur daily regardless of the site of service, and include the radiologist as the communication link between multiple clinicians caring for a patient.

Vignette: A radiologist interprets a CT scan of the head on an inpatient for weakness. An unexpected recent appearing stroke is detected. The finding is communicated to the ordering provider; however, the findings are out of the scope of practice for this clinician. Pertinent information obtained about the stroke from the radiologist includes age of the stroke, and whether the stroke has associated hemorrhage or mass effect. These pertinent radiographic findings help to determine which specialist should be contacted for management. Hemorrhage in the stroke may necessitate neurosurgical intervention, while an acute non-hemorrhagic stroke may require a stroke interventionalist or stroke neurologist. The radiologist either contacts the appropriate specialist on behalf of the original ordering clinician, advises the clinician who to contact next, or often does both of these activities.

(v) (d) Clinician who furnishes care to the patient only as ordered by another clinician, but Radiologist plays a lead role in providing preventative services.

None of the proposed patient relationship codes adequately capture screening activities/preventative care in which radiologists often play a central role. Relationships not captured include screening activities occurring during mammography, CT colonography, as well as lung cancer screening-- each of which mandates a different relationship than captured in the proposed patient relationship codes.

In summary, the proposed category (v) patient relationship code could be expanded, allowing for a more in depth view of the diverse set of patient relationships clinicians furnishing care "as ordered by another clinician" encounter during a typical daily practice. In fact, to further capture these relationships, one may need to use a **combination** of proposed codes. Allowing reporting of a combination of codes would help capture the complexity and dynamic nature of relationships between clinicians and patients, and allow for tracking changes in such relationships as an episode of care evolves.

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?**

The ACR understands the intent in describing certain physicians as "non-patient-facing". However, we are concerned that this terminology mischaracterizes radiologists, who are invariably patient-centric in the care they provide. In addition to face-to-face encounters, radiologists also use diverse forms of communication, such as instant messaging and telephone conversations to discuss imaging options, the results of diagnostic tests and follow-up recommendations with their patients and referring clinicians. Radiologists' practice of medicine may appear different than that of many medical specialties; however, to promote the evolution of more patient-centric care we believe the terminology "non-patient-facing" can be removed from consideration within the context of patient relationship codes. The patient-facing/non-patient-facing terminology may be reasonable when describing a CPT code but not when describing a clinician or group of clinicians, such as radiologists.

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

The ACR is concerned that the distinction between acute versus chronic is unclear. For example, there needs to be further clarification from CMS as to when an episode is considered acute versus chronic and when the patient transitions from acute to chronic. There are often situations where an acute patient becomes chronic, if a provider is treating an acute patient who later becomes chronic, does the provider report the patient as acute or chronic? This question is relevant to radiologists who diagnose and treat patients across the spectrum of disease, from acute to chronic.

The ACR is also concerned that differentiating episodes based on acute versus chronic fails to

capture episodes which are procedure based. The ACR believes it is important to have a category that is team member-procedure based encounter as procedures are, in general, more time limited than acute and chronic patient management. For example, during many interventional radiology procedures there is interaction with the patient around the time of the procedure/encounter (pre/post), but the service is technically encounter based, not necessarily a form of on-going care. But, certainly this episode of care will involve a broader clinical team interaction from beginning to end, including the coordination of care during post procedure recovery.

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?**

CMS should consider a category related to preventive care only. A patient may utilize a physician for all preventive services and immediately transition to specialists for acute or chronic care needs. Additionally, CMS should take into consideration there are different levels of preventive care with varying costs, for example patients who are healthy versus patients who have an acute illness or multiple chronic conditions. Radiologists are engaged in preventive care at multiple levels such as screening mammography and CT colonography, so guidance for our members is relevant.

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

We do not have any comments regarding question 5 at this time.

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

The requirement to determine and assign a patient relationship code to every claim by 2018 is an ambitious undertaking. It will require extensive outreach to the physician community, similar in scope to the recent ICD-10 implementation. Medical specialty societies, such as the ACR, should be key partners in this effort to ensure proper implementation.

The ACR believes that CMS should implement a pilot program to test whether the patient relationship categories will work in practice and determine their impact on physicians' cost and administrative burden. Gradual implementation of the patient relationship codes based on practice size, such as that employed with the Value Modifier should be considered to reduce the initial burden on small and rural practices.

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 state in answer to question 6, the enormity of this task is significant and the potential for large administrative burden is real. As such, CMS will need to provide educational guidance to the billing staff and entities that will be charged with applying these codes to individual claims.

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?**

We do not have comments regarding question 8 at this time.

The ACR looks forward to continued dialogue with CMS officials about these and other issues affecting radiology. If you have any questions or comments on this letter or any other issues please feel free to contact us any time through Judy Burleson at jburleson@acr.org, Pam Kassing at pkassing@acr.org or Laura Pattie at lpattie@acr.org.

Respectfully Submitted,

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer

Cc: Amy Bassano, CMS
Robert Anthony, CMS
Ezequiel Silva, III, MD, Chair, Commission on Economics
Jacqueline Bello, MD, Chair, Commission on Quality and Safety
Gregory Nicola, MD, Chair, MACRA Committee
Mythreyi Chatfield, ACR
Judy Burleson, ACR
Pam Kassing, ACR
Laura Pattie, ACR
Angela Kim, ACR