



## The Society of Thoracic Surgeons

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August 11, 2016

Mr. Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Sent via: patientrelationshipcodes@cms.hhs.gov

## Re: CMS Patient Relationship Categories and Codes Request for Comment

Dear Acting Administrator Slavitt:

On behalf of The Society of Thoracic Surgeons (STS), I write to provide feedback on CMS' proposed physician-patient relationship categories, which are intended to more accurately attribute physicians to patient care that is in their direct control. Founded in 1964, STS is an international not-for-profit organization representing more than 7,000 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the creation of care episode groups, as well as patient condition groups, and patient relationship categories as well as corresponding codes to improve the accuracy of clinician resource use measurement under the Merit-based Incentive Payment System (MIPS). The law also requires that physicians record these codes on Medicare claim forms beginning in 2018. Per MACRA, these categories and codes also could potentially be used in Alternative Payment Models (APMs).

In its request for feedback, CMS proposes the following categories:

- Continuing Care Relationships: The clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care. Examples include, but are not limited to: a primary care physician providing an annual physical examination (outpatient), a geriatrician caring for a resident in a nursing home, or a nurse practitioner providing checkups to adult asthma patient (outpatient). It can also be the clinician who provides continuing specialized chronic care to the patient. Examples include: an endocrinologist (inpatient or outpatient) treating a diabetes patient, a cardiologist monitoring a patient's arrhythmia, or an oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology.

- Acute Care Relationships: The clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode. Examples include but are not limited to: a hospitalist caring for a stroke patient (inpatient) or a gastroenterologist performing a colonoscopy (outpatient ambulatory surgery). It can also include surgical interventions such as an orthopedic surgeon performing a hip replacement, a cardiothoracic surgeon performing a coronary artery bypass graft (CABG), or a general thoracic surgeon performing a lobectomy for lung cancer. This also could include clinicians who consult during the acute episode. Examples include: an infectious disease specialist treating a patient for sepsis or shingles a gastroenterologist performing an upper endoscopy on a hospitalized patient (inpatient), a rheumatologist performing an evaluation of an acutely swollen joint upon referral by a primary care physician, or a dietician providing nutritional support to an ICU patient (inpatient).
- Acute Care or Continuing Care Relationship: This includes clinicians who furnish care to the patient only as ordered by another clinician. Examples include: 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.

Overall, STS supports efforts to more clearly define a clinician's role in treating a patient for purposes of resource use measurement. The current set of measures used to evaluate resource use under the Value Modifier are largely irrelevant to many physicians—either because no patients are attributed to them or because the physicians have little to no opportunity to influence the costs that are attributed to them. Additionally, for inpatient episodes of care, the current VM uses a plurality approach which holds the clinician or group practice responsible for the totality of inpatient resource utilization, including the range of specialists' services which might contribute to the cost of treating a patient (e.g., testing, procedures, imaging and per diem charges using E&M codes). There is an urgent need for more properly designed resource use measures, including measures that are tied to more discrete episodes of care and that better reflect the patient-physician relationship throughout the episode of care, as well as the clinical and socio-demographic characteristics of patients that might impact their need for healthcare services. Refinement of measures in this manner will not only improve the relevance, reliability and applicability of resource measurement, but also will result in more actionable clinician feedback.

Listed below are some overarching principles that STS believes CMS should adhere to as it further refines patient relationship categories and codes:

**Balancing Administrative Simplicity with Clinical Accuracy.** Finding balance between a classification system that is clear and simple to administer but also granular enough to capture critical clinical distinctions will be challenging. The categories must be discrete enough to distinguish between the different responsibilities clinicians have with a patient at the time of furnishing a service, as well as the changing relationship that might evolve throughout the span of the episode. At the same time, CMS cannot ignore the mounting regulatory requirements facing clinicians. Just as the patient relationship reporting mandate is being rolled out, surgeons will be in the midst of learning how to comply with a plethora of new and complex requirements under MIPS and also be expected to report on an entirely new set of G-codes to track all pre-

and post-operative care provided in the 10- and 90- day global surgery periods. Most clinicians simply do not have the infrastructure (i.e., information technology, coding staff, etc.) to comply with these new requirements and only the largest systems with the most resources will be able to keep up with these mandates. To minimize burnout and avoid a situation where clinicians devote more time to regulatory compliance than direct patient care, CMS must prioritize these new mandates, implement them one at a time, and ensure that they do not impose an undue burden on practices.

**Gradual and Transparent Implementation.** Similarly, we request that CMS implement this new policy gradually and thoughtfully. It is challenging to provide meaningful feedback on patient relationship categories when CMS has not yet finalized a set of initial clinical episodes. Without that context, it is difficult to assess the adequacy of the proposed relationship categories. In fact, as CMS continues to refine the episode groups, it might become clear that different strategies for categorizing patient-physician relationships across different episodes are required rather than adopting a uniform approach. Once the categories and codes are developed, it is important that CMS pilot their use and provide clinicians with the opportunity to confidentially review the resulting data before using them to evaluate resource use performance under MIPS. Clinicians should also have the opportunity to review, question and correct inappropriately attributed resources. It is not clear from the proposal whether CMS expects clinicians to append a patient relationship code to every single claim they submit to Medicare, but in the initial years of implementing this new policy, we advise against imposing such an administratively burdensome requirement.

Similar to concerns we raised in previous comment letters about the proposed clinical episode groups and logic, we remind CMS of the importance of ensuring that these categories and codes are developed and refined based on the ongoing input of practicing clinicians and that this process take place in a fully transparent manner. Posting information on the CMS website is insufficient. We request that CMS hold listening sessions with a variety of specialties and stakeholders to generate more specific feedback on these proposals.

**Categories and Codes Must Reflect the Realities of Clinical Practice.** While STS believes that CMS' attempt to distinguish between acute and ongoing care relationships is a good start, it does not go far enough in enabling clinicians to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation. For example, it does not address how to capture a clinician's relationship with a patient who has multiple concurrent acute care episodes, all of which might occur in the context of an underlying chronic episode or disease process. One example of shifting clinical relationships could be envisioned in a patient who is admitted to the hospital with stable coronary artery disease (CAD). A cardiothoracic surgeon may be initially requested to consult on the patient by the cardiologist or emergency medicine physician. The patient's condition could worsen during the course of the hospital stay, leading to the need for urgent CABG procedure which is performed by the cardiothoracic surgeon, who will also take over the care of the patient related to the CABG. If, after the surgery, the patient exhibits signs and symptoms of severe gastrointestinal bleeding, following appropriate consultation, a general surgeon may be required to perform emergency surgery to treat the acute hemorrhage.

In this example, the role of the physicians providing care has shifted dramatically throughout the patient's hospital stay. Another possible example would be in a patient undergoing treatment for metastatic breast cancer who develops a malignant pericardial effusion. The patient would be taken to the operating room by a cardiothoracic surgeon who would surgically create a pericardial window to alleviate the dangerous condition of pericardial tamponade. The cardiothoracic surgeon assumes care for the 90 day global period associated with the pericardial window, but does not take over the overall care of patient whose treatment of metastatic breast cancer remains ongoing.

CMS will need to clearly outline the timeline for a given relationship category. Will it be dictated by the role of the clinician at the onset of an episode or can it change throughout? If it can change, how frequently would clinicians have the opportunity to adjust their roles (e.g., daily, annually, per claim, per episode)?

**Arbitrating Role Assignment.** In this proposal, CMS also does not discuss how it would address situations where multiple clinicians claim the same role in treating the patient. Nor does CMS address whether multiple specialists could share the lead responsibility over an acute and/or chronic care episode. For example: if a patient is followed for many years by a cardiologist for stable coronary artery disease but is eventually admitted to the hospital for elective coronary artery bypass surgery, how is the post-operative care assigned? Following the surgery, the patient will be in an intensive care unit. The intensive care, specific to the cardiac surgery, is administered to the patient by the cardiac surgeon. However, the patient may have multiple other conditions, such as renal failure, sepsis, etc. that would be appropriately cared for by a trained intensivist in a non-duplicative and clearly distinct manner. Similarly, issues related to the patient's underlying coronary artery disease must be addressed by the cardiologist.

CMS has not provided a workable solution to the issue of attribution of responsibilities, especially when three physicians (in the scenario above) would claim primary responsibility in the care of the patient's acute care episode. While STS supports care coordination and more team-based approaches to care, it is unreasonable to adopt a national coding policy that hinges on clinicians coordinating their responses to decide who has primary responsibility over the patient versus who plays a more supportive role. As CMS refines this reporting mandate, we hope to see (and have a chance to respond to) a thoughtful strategy for adjudicating or otherwise addressing these conflicting or overlapping interpretations.

**Additional Adjustments Will Be Necessary.** While patient relationship codes may help to improve attribution, they are insufficient in isolation. CMS must simultaneously develop better risk-adjustment methodologies that take into account the health and socio-demographic status of the patient, the clinical setting (e.g., geographic location, teaching vs. non-teaching hospital), and the physician specialty.

The ability to attribute patients to clinicians, in whole or in part, based on clinician reporting of the different relationships they have with their patients is an exciting opportunity. However, to achieve the goal of more accurate resource use measurement, it is absolutely critical that CMS implement this policy gradually, with relevant and transparent clinical input, and in a manner

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that minimizes the administrative burden on clinicians who are already struggling to make the patient a priority in the face of multiple, competing regulatory demands.

We would also implore CMS to roll this program out on a much smaller scale in selected areas as mandated in the MACRA legislation to allow for thoughtful assessment of program successes as well as failures. This would allow for modifications and adjustments to the process prior to nation-wide implementation.

Thank you for considering our comments. Should you have any questions, please contact STS Director of Government Relations Courtney Yohe at 202-787-1222 or [cyohe@sts.org](mailto:cyohe@sts.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Bavaria", with a stylized flourish at the end.

Joseph E. Bavaria, MD  
President