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August 15, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

RE: Comments on MACRA Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

On behalf of the International Society for the Advancement of Spine Surgery (ISASS), I am writing in regards to your request for comment on the proposed MACRA patient relationship categories and codes.

ISASS is a global scientific and educational society of spinal surgeons and scientists organized to provide an independent venue to discuss and address the issues involved with surgical aspects of the basic and clinical science of spinal care. Thank you for the opportunity to provide comments on the proposal.

ISASS appreciates the policy principles CMS is utilizing to develop the proposed patient relationship category framework: a clear, simple classification code set; flexibility in reporting and ease of submission; and an open and transparent development process. While our comments are not intended to create a more complex system, we feel that some of the intricacies of the spine surgeon-patient relationship are not captured by the patient relationship categories as proposed. Below, please find ISASS' responses to each of the eight specific questions listed in the proposal:

1. *A.) 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? B.) 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?*

A.) Yes, the categories are clear and concise enough to enable physicians to self-identify an appropriate patient relationship category for a given clinical situation. In order to self-identify accurately, it will be extremely important for the physician to know that the categories are not designed to be static, rather the physician's category with a particular patient may change over time based on the presenting clinical situation. It will also be useful to provide real-world patient relationship examples within the categories in order to help physicians understand the categories and self-identify accurately.

B.) In most cases, spine surgeons and their patients will fall into proposed category (iii): "Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode." We assume that the patient's decision to have spine surgery "triggers" the acute episode and that the spine surgeon would be responsible for the care of the patient during the surgery as well as managing any surgery-related issues. The draft description of an "acute episode" in the proposed framework indicates that it may "encompass a disease exacerbation for a given clinical issue, a new time-limited disease, a time-limited treatment or any defined portion of care so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare." For the spine surgeon-patient relationship, defining the acute episode by time rather than site of service makes the most sense, since the spine surgeon-patient relationship spans multiple settings during the acute episode (i.e. pre-service time in the office, intra-service time in an inpatient or outpatient surgical setting, and post-service time in an inpatient or outpatient surgical setting followed by the office).

In some clinical situations, co-surgeons or multiple surgeons may be required to treat the patient during the intra-service period (e.g. an orthopaedic surgeon and a neurological surgeon jointly performing the surgery, or for certain approaches, an access surgeon may be needed at different points during the surgery (e.g. general surgeon, vascular surgeon, cardiac surgeon or an ENT surgeon)). In these cases, we assume CMS would consider the assisting surgeon under category (iv): "Clinician who is a consultant during the acute episode," but it would be helpful to have additional guidance from CMS on this type of relationship prior to issuance of the final framework.

Depending on the practice, some spine surgeons may fall into proposed category (ii): "Clinician who provides continuing specialized chronic care to the patient." A spine surgeon may manage a patient's chronic, ongoing back pain with nonsurgical treatment options for a period of time prior to the patient becoming an appropriate candidate for surgery and making the decision to have surgery.

It would be helpful to add an "Ongoing, Intermittent Care" category to the proposed framework. After the conclusion of the acute care episode, a spine surgeon will likely continue to see the patient to check his/her progress on an ongoing, intermittent basis (e.g.

biannually, annually), but is no longer managing a chronic condition (proposed category (ii)), managing an acute episode (proposed category (iii)), nor is he/she the “primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care” as described by proposed category (i). Other surgical and non-surgical specialties may find this category useful as well.

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?*

Non-patient facing relationships seem to be covered by proposed category (v): “Clinician who furnishes care to the patient only as ordered by another clinician.” However, spine surgeons are patient-facing clinicians and as such, ISASS defers to non-patient facing specialties on the usefulness of a separate patient relationship category to describe this relationship.

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

Yes, an acute episode is accurately described. Appropriately, the description does not classify an acute episode strictly by site of service, but rather recognizes the disease, treatment, and time-limited nature of the episode as essential constructs.

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?*

Yes, distinguishing relationships by acute care and continuing care is appropriate. As mentioned above, it would be helpful to add an “Ongoing, Intermittent Care” category to the proposed framework. This category may stem from an acute episode, but would likely be classified as a continuing care relationship.

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

Spine surgeons are not post-acute care clinicians and as such, ISASS defers to post-acute care clinicians on the adequacy of capturing their patient relationships within the proposed framework.

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

Physicians are extremely busy caring for patients on a daily basis. ISASS understands that CMS is mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to implement patient relationship categories and codes. However, in addition to

implementing these new patient relationship codes, physicians will also be responsible for understanding and implementing the other payment and quality reporting changes required by MACRA, which will undoubtedly require a significant amount of time and resources. Classifying relationships is a new concept for physicians, so keeping things simple and concise is vital. Any technical assistance or education (e.g. fact sheets, webinars, trainings, email notifications, etc.) on patient relationship categories and codes should be directed not only to physicians, but also their office staff who may have the responsibility of assigning these codes to claims. It will also be extremely important that physicians understand what happens with the data once it is reported and how this information will be used by CMS.

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?*

In many cases, the spine surgeon will self-identify his/her relationship to the patient. In the cases where the surgeon does not self-identify, the surgeon's administrative staff/coding staff would select the patient relationship code. The IT systems, medical record systems, and claims forms used by surgical spine practices will need to be updated prior to implementing this proposal. Adequate time must be given to practices to make these workflow changes.

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?*

If the categories are properly constructed, concise, and easy to understand, clinicians should not have a problem accurately reporting patient relationships, even when there are multiple clinicians billing for services on a single claim.

Thank you for your time and for your consideration of our comments. Please contact Liz Vogt, Director of Health Policy & Advocacy by email at liz@isass.org or by phone at 630-375-1432 with questions or requests for additional information.

Sincerely,



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Chair, Coding and Reimbursement Task Force
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