3975 Fair Ridge Drive, Suite 400 North | Fairfax, Virginia 22033
(703) 691-1805 | Fax (703) 691-1855

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August 15, 2016

Centers for Medicare & Medicaid Services,
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013.

RE: Draft CMS Patient Relationship Categories and Codes

Submitted electronically at: patientrelationshipcodes@cms.hhs.gov

Dear Acting Administrator Slavitt:

The Society of Interventional Radiology (SIR) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding the draft document on Patient Relationship Categories and Codes.

The Society of Interventional Radiology (SIR) is a professional medical association that represents approximately 6,500 members, including most US physicians who are practicing in the specialty of vascular and interventional radiology. Interventional Radiologists consult with patients and perform procedures in a variety of care settings, admit and discharge patients, and see patients for follow up and long term monitoring in some instances, so we feel we are a specialty that on any typical day will use or cross over several of the draft codes.

General comments:

- While we understand the need under the proposed MIPS system to track resource use and attribute provider care, it seems to us that designing a coding system that is accurate is a very complicated undertaking. There are literally countless scenarios that do not fall under the draft 5 categories. We echo the American Medical Association's concern that CMS should entertain the idea of doing a **rigorous pilot program** to ensure that any patient relationship coding scheme is accurate and does not result in unintended consequences or impinge patient access to optimal care.

- While the draft enumerates five categories as a basic framework, we feel there will be a need for additional granularity in describing provider-patient interactions, and the degree over which a provider can actually impact resource use. While the five categories might suffice as a general framework, we ask CMS to consider developing a set of ***second-level modifiers*** that would add additional information and important details to the provider-patient encounter. Not unlike CPT modifiers, these modifiers

would provide additional details about the provider-patient encounter, for example, how a provider was asked to treat a patient, the level of acuity, admitting physician, clinical necessity to use a "high-cost" item, etc.

- We suggest CMS try to factor in a sharper definition of time involved in all these codes. If a patient is admitted to treat an acute episode, and seven days later develops a complication unrelated to the original admittance, which clinical episode governs? For example, in interventional radiology, the IR is often consulted for an issue or complication unrelated to the patient's primary cause for admission, and this can be days after the patient was admitted.

- Similar to trying to define an acute episode, effective codes will need to capture when a patient's care is clinically transferred from one provider to another. Again, a modifier that can be appended to the base code might be a useful way to indicate this.

- In draft code #(V), the CMS uses the text "only as ordered by another clinician." We ask that CMS exercise caution when using the term "ordered". While it might be appropriate in some instances, in the age when team care is part of the inpatient experience, patients are frequently sent to a specialist to assess a condition or complication. The specialist is asked to evaluate the patient and recommend a course of action. While this might result in a procedure, it also might result in watchful waiting or some other course of action. Even if the specialist does the procedure "as ordered", and the patient is returned to the care of the referring physician, some follow up care by the specialist is actually common.

- We ask CMS to give careful thought as to how these codes might actually be implemented and documented. Will providers self-assess their own patient-relationship code? The coding and billing departments? The MAC based on claims analysis? Will EHR systems capture and assign the codes? What sort of documentation might be required? Again, a pilot test phase might help resolve these issues as the program develops.

- What if multiple providers all claim the same patient relationship code? Will there be a method for adjudicating such scenarios?

- As CMS is aware, specialty providers make decisions every day about the supplies and equipment they use to treat patients. New devices that offer clinically superior outcomes, e.g., drug-eluting stents or antibiotic coated catheters, will often be more expensive until they become widely adopted and pricing reflects market conditions. Similar to the new technology add-on payment that can be granted by CMS, SIR recommends that CMS consider that a provider who documents clinical necessity in an atypical case (especially in Codes iii or iv) not be penalized when utilizing an item that might be considered high-cost.

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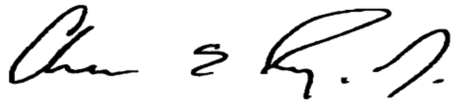
In closing, our specialty thanks CMS for your consideration of our comments. If we can be of any future assistance, please do not hesitate to contact Susan Sedory Holzer, SIR's Executive Director, at (703) 691-1805, or sholzer@sirweb.org.

Sincerely,



Charles E. Ray Jr., MD, PhD, FSIR
2016-2017 President
Society of Interventional Radiology