Hello, everyone. Thank you for joining today's CMS Patient Relationship Categories and Codes webinar. This webinar will provide guidance for clinicians and stakeholders in classifying patient relationships for which CMS has recently implemented an initial volunteer reporting period that began on January 1, 2018. Examples of the real-world clinical scenarios will be presented to illustrate how the patient relationship categories and codes work in the practice, and to review the statutory context and policy principles used in their development. Presenters will also address questions from participants following the presentation. Now, I will turn the call over to Dr. Reena Duseja. Please go ahead.

Thank you, Stephanie. I want to welcome everyone again to today's webinar. My name is Dr. Reena Duseja. I am the Director of the Division of Quality Measurement here in the Quality Measurement and Value-Based Incentives Group in the Center for Clinical Centers and Quality here at CMS. Next slide. Next slide.

So the purpose of today's webinar is to provide guidance for clinicians and other stakeholders in classifying patient relationships. We will cover the following topics here on this slide. We will explain the purpose of the patient relationship categories and codes. We will expound upon the operational list definitions. We will then illustrate the proper coding of patient relationships, the real-world clinical scenarios. And then we'll dedicate time at the end to answer questions and highlight additional resources for our participants. Next slide.

This slide goes over the agenda for the webinar today. I will give you an overview of the statutory contexts and development process for the patient relationship categories. I will then pass that presentation to Dr. Rose Do from Acumen, who will go over the five patient relationship categories and the link to the Level II HCPCs modifier codes. And she'll also discuss several real-world clinical scenarios to illustrate the application of the patient relationship categories. And then we will leave time for questions and answers at the end of the presentation. Next slide.

This slide displays a list of the acronyms that will be referenced during the presentation, and you can feel free to reference this during the presentation. Next slide. Next slide.

Now, I will go over the statutory context of the patient relationship categories and the policy principles used in the development as well as our development process. Next slide.

As context, the development of the patient relationship categories sits in the larger context of the quality payment program. The quality payment program evaluates clinicians on a range of performance areas which includes resource use. MACRA requires the development of the patient relationship categories and codes for potential use and the attribution methodology for our cost measures. Specifically, the patient relationship categories are intended to define and distinguish the relationship and responsibility of a clinician with a patient at the time of furnishing an item or service. It also facilitates the attribution of patients and episodes to one or more clinicians. And finally, it allows clinicians to self-identify their patient relationships. Next slide.

We've finalized the operational list of patient relationship categories and codes in the calendar year 2018 Physician Fee Schedule final rule. Now, the

codes are now in a voluntary reporting period. This is important from our perspective here at CMS to give clinicians adequate time to gain familiarity in the use of the patient relationship categories. And it also allows us time to collect data for our validity and reliability testing of the codes before their potential use in the attribution methodology for the cost measures. It also identifies for the audience today that, because we are in a voluntary reporting period, what and how the codes are reported will not affect Medicare payment. Next slide.

This slide emphasizes that all eligible clinicians can report on the patient relationship categories on their Medicare claims. If you are a MIPS eligible clinician, the list here is on the slide. So that includes physicians, doctors of dental surgery, doctors of dental medicine, those in podiatry, optometry, and chiropractors. It also includes physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Next slide.

We have five policy principles in the development at the patient relationship categories. This includes developing a clear and simple classification code set that captures the majority of patient relationships. We also want to ensure flexibility in and ease of submission of the codes on the claims and maintain openness and transparency. And finally, we want to make sure that we're enabling accurate and effective cost measurements. Next slide.

This slide demonstrates how CMS has had solicited extensive input from clinicians and other stakeholders. We have had three public postings of the patient relationship categories for public comment. It's included a draft list for public comments in April of 2016, then we had a modified list for public comment in December of 2016, and then the operational list was published in May of 2017. In addition to these public postings, CMS has held two listening sessions in July of 2016 and solicited comments in the rule of the physician fee schedule for calendar year 2018. Now, I will hand that over to Dr. Rose Do with Acumen to go over the operational list of the five patient relationship categories and dive into some real-world clinical scenarios. Rose?

Thank you, Dr. Duseja. Good morning, good afternoon, everyone. My name is Rose Do. I'm a cardiologist also working as a clinician researcher and policy associate at Acumen, LLC. I'm very happy to be here today and would like to go over the patient relationship categories and codes. For this section, we're going to go over several clinical scenarios and examples to help us better characterize the relationships and interactions we have with our patients. So in this slide, we're showing five different relationship categories quoted by Level II HCPCS modified codes. And the different categories are X1, continuous/broad services, X2, continuous/focused services, X3, episodic/broad services, X4, episodic/focused services, and X5, only as ordered by another clinician. In the slides that follow, we'll provide some guidance on the types of clinicians and services that may fall under these categories. And in general, it may be helpful to think of the categories in this way. So, continuous and episodic refers to the length of the length of the clinician/patient interaction. Whereas the broad/focused section refers to the level of clinical care provided in that interaction. We may refer to a patient's care as being fairly comprehensive or broad versus something that's organ or specialty based and focused.

So in this slide with X1, we talk about the continuous broad services. And this code could be used by clinicians that are providing comprehensive care for a patient no planned end point in the relationship. Many types of clinicians could fall under this category. Typically, we might see primary care clinicians or specialists that provide primary care identifying with this PRC. Next slide, please. Next slide, please.

So for X2, the continuous/focused clinicians might be focusing on a specific organ or a disease process that needs to be managed over a long period or indefinite amount of time. And examples might include specialists that are focused no a specific disease, process, or condition. Again, it's occurring over an indefinite period of time. Examples could include the endocrinologist that manages diabetes over the patient's life span; an orthopedist that manages the osteoarthritis before actually doing a replacement. They may do some of their physical therapy, prescriptions, or medications. There's pulmonologists managing asthma, infectious disease consultants that manage care for a patient with HIV. Next slide.

And for X3, the episodic/broad services, this category could include clinicians responsible for overall care and coordination for a patient during a defined period. So, this could be something like an acute hospitalization or an in-patient rehabilitation. So it might be the hospitalist that's actually managing the patient in the hospital, taking care of many aspects of the patient's experience. An intensivist who also is managing several of the patient's comorbidities and the acute reason for admission. and a physiatrist in the in-patient rehabilitation setting. Next slide, please.

For X4, the episode/focused services, this category can include clinicians providing services for a specific condition or organ system. And the treatment's time limited or discreet. This can be the clinician that treats a patient with surgery, radiation, or other time-limited intervention. This might be the surgeon that's doing the one-time procedure, so it could be the orthopedist performing the new replacement at this time. It could be the ophthalmologist performing cataract surgery. There are several other examples on this side, and we'll go over them in other clinical scenarios in the slides that follow. Next slide, please.

For X5, the code only as ordered by another clinician is used to categorize the clinician to provide important services that are furnished mainly if ordered by other clinicians. So some helpful examples could include radiologists that interpret a CT scan, a pathologist that reviews tissue samples, neurologists or other specialists such as allergists, audiologists, et cetera. Or performing diagnostic testing. Another way to think of these clinicians are that they're mainly providing diagnostic services using their expertise, but they may not necessarily initiate a treatment plan of their own. Next slide, please.

In this slide, 19, this is a recap of all the codes and the categories and the descriptions we just covered. So as you can see, there's the five different modifier codes with the categories we've described which are time-based as well as kind of interaction based, and then the definition that we provided. Next slide, please.

Look for slide 20 in the clinical scenarios. In this section, we'll just give some examples of clinical scenarios to further illustrate these definitions that I've just provided. And again, these scenarios are purely

hypothetical for illustrative purposes. So the first scenario, we'll start -- actually, the first few scenarios, we'll start with simple scenarios that are a little more straightforward. They're informed by the review of public comment, and they're intended to address these comments and further clarify things. Afterwards, we'll go over some slightly more complex scenarios to demonstrate how a range of clinicians can self-identify their patient relationship. They're not real cases. They're purely hypothetical; just illustrating. Next slide, please.

So the review of public comment. We'll begin this section with a few simple clinical scenarios. On one of the comments regarding the PRCs was that continuous and episodic were vague and open to interpretation. It was unclear if the categories captured changes in patient relationships over time. And the categories might undermine co-management and team-based care. With the simple examples or scenarios that we'd like to demonstrate, we want to show that the PRCs are specific, dynamic, and flexible, and can address these concerns. The complex clinical scenarios will also describe and show how a wide range of clinicians that are involved in patient care and doing co-management and team-based care should identify their patient relationship. Next slide, please.

So in this Simple Clinical Scenario 1, we're going to describe how the definition of episodic really depends on the clinical situation or context. So this will address the time base question. Patient Khan develops actinic keratosis and sees a dermatologist for treatment with cryotherapy. Her interaction with the dermatologist spans two visits to treat the AK. A few months later, Patient Khan undergoes a joint replacement procedure by an orthopedic surgeon. She sees the orthopedist for post-operative check-up. Next slide, please.

So, we are going to highlight the clinicians as well as how we might characterize them. As we can see, the dermatologist has an interaction that spans two visits. It's an episodic type of length, and the treatment is involving mainly the actinic keratosis. It's not really broad-based care. It's very focused on the skin condition. So this would be exemplified as episodic focused or X4. As you can see, the orthopedic surgeon, a different type of clinician, could also utilize the same PRC. In this situation, it's again -- there's some post-operative checkups, the actual surgery, making this an episodic example. And given that it's focused on the joint replacement itself, it's also a focused relationship. So this would be an X4. Because the clinical context defines episodic, the categories for continuous and episodic patient relationships are not defined as a specific number of days. It's more about the type of clinical scenario. Next slide, please.

So in this example, scenario two and the following, we will show how the patient relationship categories are dynamic and can capture changes in patient relationships over time. So the scenario here, Patient Gogol is admitted for exacerbation of COPD and is managed by a hospitalist who coordinates her care. She's never been diagnosed with COPD, and a pulmonologist is consulted to help treat her COPD exacerbation. And after being discharged, she begins following up with the pulmonologist regularly for her COPD. So the next slide, let's review the patient relationship here.

So in green, we will highlight the hospitalist who is taking care of the patient over the acute exacerbation. So, this is episodic. The hospitals will coordinate the care and discuss the treatment plan with the other

specialist using a broad-based type of interaction. So this would be an episodic broad relationship or X3. A pulmonologist, on the other hand, is the consultant treating during the COPD exacerbation or the acute episode. So it's episodic and focused on the COPD exacerbation itself or the disease process. So that makes a pulmonologist an episodic/focused clinician with an X4 category. And then finally, the pulmonologist that sees the patient post-discharge could be the same pulmonologist, could be a colleague or someone else who's following up with the patient afterwards. We'll continue care over an indefinite period of time, making this a continuous type of relationship. Again, focused on the COPD. The COPD disease process or organ system itself. That makes it continuous/focused or X2. Next slide, please.

In this third clinical scenario, we discuss Patient Ramone undergoing a colonoscopy by his gastroenterologist. The pathologist reads the biopsies and issues a report that the findings are consistent with Crohn's Disease. The gastroenterologist initiates treatment for Crohn's Disease and continues to monitor him. Let's review the patient relationships in this next slide. So in green, the gastroenterologist performs the colonoscopy and therefore has an episodic/focused relationship or an X4 relationship. And then the pathologist would introduce the X5 category which is only as ordered by another clinician. The pathologist reviews the biopsies and issues a report for the gastroenterologist. And then finally, the gastroenterologist in blue, light blue, will initiate the treatment plan over a long period of time. So this is focused on the Crohn's Disease, but continuous in nature. In that this is an indefinite amount of time for this chronic condition. So that is X2. Next slide, please.

In this scenario, Patient Ventura does not have a primary care clinician. He is admitted to the hospital for a new diagnosis of diabetes where he is treated by an endocrinologist. He begins seeing an endocrinologist as an outpatient for his diabetes. And after a few years of treatment, his endocrinologist notes that he should be on treatment for hypertension. Since she has developed a long-standing relationship with Patient Ventura, the endocrinologist begins treating his hypertension and doing regular health check-ups. You can see there's been a change in the relationship and treatment over time. Let's review the patient relationships in the next slide.

So the first mention of the endocrinologist--highlighted in green. The endocrinologist encounters Patient Ventura in the hospital setting and gives the diagnosis of diabetes. The next setting, there's an episodic element to it. It happens during the admission, and it's focused on the patient's diabetes. So that relationship is an episodic/focused relationship categorized as X4. In the outpatient setting, the endocrinologist highlighted in red starts seeing the patient regularly and over a long period of time focused on the diabetes again. It's a continuous/focused relationship, categorized as X2 in red. Many years have passed. The endocrinologist starts treating other conditions that the patient has such as hypertension and starts doing broad-based care. So it's a continuous relationship, but now we've introduced the broad relationship, as well. So the last mention of the endocrinologist in light blue would be Continuous/Broad, or an X1 category. Next slide.

So in these scenarios, we're going to show how the patient relationship categories might overlap for co-management or the team-based care situations that were mentioned in public comment. So in this scenario, Patient Traore has hypertension, diabetes, and arterial fibrillation. She sees a

cardiologist regularly for her atrial fibrillation, a podiatrist for foot checks, and an ophthalmologist for eye exams, given her diabetes. Her nurse practitioner coordinates with the cardiologist, podiatrist, and ophthalmologist as part of her routine health maintenance. Let's review the patient relationships that we see here in the next slide.

So we have highlighted first the cardiologist in green. And the cardiologist is managing the arterial fibrillation over a long period of time. As we know, it's a condition that doesn't go away, so we have a Continuous/Focused relationship, which is X2 for that cardiologist. The podiatrist, as well, is doing foot checks over a long period of time given the patient's diabetes. This is also a continuous, but focused type of relationship, and also illustrated by X2. The ophthalmologist, as well, in light blue has a Continuous/Focused relationship focusing on the eye exams over this patient's life span. And then finally, the last practitioner, her nurse practitioner coordinates with all of these specialists and also coordinates the routine health maintenance for this patient. So, the nurse practitioner may take on a broad-based strategy for care and do this continuously over the patient's lifespan, as well. That defines a nurse practitioner as Continuous/Broad with X1 as a relationship code. Next slide, please.

So those are the simple scenarios that we created to address the key concerns from public comments. And now we move on to two more complex patient stories. Feel free to submit written questions on these scenarios as we're going through them, and we'll try to pause during some of the discussion to read and answer as many of the scenario-specific questions directly after each time, if time allows. Next slide, please.

So, here's a more complex scenario. We have Patient Rodriguez sees a resident working under a primary care physician at an academic medical center for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same academic medical center. The colonoscopy revealed a large mass. And after examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the lass was too large to resect, Patient Rodriguez was referred to a surgical oncologist for resection, and afterward, to a medical oncologist for adjuvant chemotherapy. While receiving chemotherapy, he developed neutropenic fever and was admitted to the hospital. There, he was cared for by a hospitalist, an infectious disease consultant, and his medical oncologist. He also saw a dietician because of his poor appetite. Due to the progression of his illness, he was transferred to the ICU where an intensivist cared for him. After meeting with a palliative care clinician, Patient Rodriguez decided to go home with hospice care. At home, he has visits with a hospice nurse practitioner. As you can see, there are a number of clinicians involved in this patient's care. And we will review the specific patient relationships based on their clinical focus and the nature of their interaction. Next slide, please.

Let's first highlight the clinicians that are categorized as X1, or the Continuous/Broad services. In this, you can see that the patient is seeing a resident working under a primary care physician. So again, this physician is providing Continuous/Broad services. Whether it's occurring at an academic medical center or not, the relationship is really the key. At the bottom of this paragraph, the patient is seeing a hospice nurse practitioner, who is also coordinating broad services and doing so in a continuous manner. Next slide, please.

We've also got the medical oncologist who is treating the patient with adjuvant chemotherapy. This could be an indefinite period of time, but it is focused on the patient's cancer, so this would be a Continuous/Focused service that's provided by the medical oncologist or categorized by X2. Next slide, please.

We've got an X3 clinician who provides the Episodic/Broad services. So when Patient Rodriguez was admitted to the hospital, he was cared for by a hospitalist who was handling the acute nature in an episodic type of fashion, but also handling many things broadly for the patient care. This would also occur with the intensivist who's taking care of the patient when he was transferred to the ICU. Next slide, please.

So, several of the clinicians also fall under the X4 Episodic/Focused services. The patient receiving the routine screening colonoscopy by the gastroenterologist receives a focused service on the colon. It's episodic in nature, given that it's a procedure. The surgical oncologist also does a procedure--doing a resection--focused on the mass. And the infectious disease consultant, his medical oncologist and dietician, they specialize in specific areas of the patient's care. It might be the infectious disease. It could be the cancer, or it could be the patient's diet, overall diet. These again are occurring in the hospital, so they're episodic in nature, and they're focused on his specific condition. Finally at the bottom, when he's meeting with his palliative care clinician, this is also occurring within the hospitalization, and it's episodic in that regard. Focused on the patient's quality of care coordination. That could be Episodic/Focused or X4, as well. Next slide, please.

And then finally, we've got the clinicians that are examining the biopsy or interpreting the PET scan, so that would include the pathologist and radiologist respectively. These are the X5 clinicians who are performing services only as ordered by another clinician. And mainly doing diagnostic interpretations and contributing to the patient care in that manner. Next slide, please.

We wanted to provide a summary here with the many types of clinicians in the middle column. We've given the clinical context on the left-hand column to demonstrate that the type of management that is occurring for that patient's scenario. And then on the far-right hand column, we've got the patient relationship we've described. Whether it'd be X1 through X5. So at this point, we'll also pause to read a few questions that we've received from the question and answer box. I'll turn it over to the rest of the team to read out any questions.

Thanks, Rose. The first question, is the intent for a physician to document the code on every patient encounter, including if they have a continuous relationship, or just the first encounter?

Thank you for that question. So the intent is with each interaction to be able to define or give the flexibility to the clinician to define that type of interaction. It could change with time, and that can be updated with every claim. Or it could remain the same. And so, given that our relationships with our patients do change over time and with the services rendered, that gives good flexibility for the clinician to be able to describe their relationship at each encounter.

Great, thanks. The next question: In simple example two, you said that the two pulmonologists could be the same provider. If it was known at the time of providing the care in the hospital that the pulmonologist would be the follow-up provider, should we put continuous instead of episodic?

That's a great question. So I think in that scenario, if I were to be the pulmonologist seeing the patient during the acute exacerbation, I might define that type of interaction as episodic. Even if I know that later on, I'll be seeing that patient continuously as an outpatient. When I do start seeing them as an outpatient, I may change my relationship code to reflect that it's a Continuous/Focused type of relationship.

Great, thanks. The last question for this slide, can multiple patient relationship codes be applied? For example, if a physician is focused on one aspect of care but coordinating with other specialists on broader healthcare issues, could they assign X2 and X1 to the same patient?

That's also a great question. So I think whatever relationship is most well-characterized by that specific encounter, I would opt to use that type of coding. So, if the majority of that visit is spent on focusing on broad care of that patient, I would probably elect to use the Broad/Continuous type of category. But if I am focused mainly during that visit, the patient's -- Let's say if they're doing cataract surgery, or they're talking about cataract, I might focus -- I might categorize that as a focused type of interaction.

Great, thanks. I think we can continue with this presentation.

Thank you very much.

So, we welcome any more comments, and we will have another pause during the rest of the clinical scenarios to go over a few more questions. And then at the end, of course, we're going to open up the phone lines to allow for any further questions or comments. Thank you for those that we've received already. So next slide, please.

And so here is the second of our complex clinical scenario. We have Patient Adams who developed a sudden onset of weakness on her right side. Her son called an ambulance, and they transported her to a hospital. An emergency physician evaluated her, but since the hospital did not have a stroke center, she was transported by ambulance to a second hospital where a neurologist evaluated her. The neurologist ordered a CT scan without contrast and gave her tPA. Initially, she was stable, but then she lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral wound. A neurosurgeon evaluated her, and then transferred her to a neurological ICU for care under an intensivist. She was placed on a respirator. Over the course of the next three days, her condition stabilized, and she was transferred out of the ICU into an acute care bed where she was managed by a hospitalist and seen by the neurologist and neurosurgeon. The hospitalist called a physiatrist to examine her need for post-stroke rehabilitation. And the physiatrist recommended she be transferred to a rehabilitation hospital, where she was cared for by another physiatrist for a 20-day stay. Since she had not improved sufficiently to return home, she was transferred to a SNF, or a skilled nursing facility, where she spent another 25 days. A geriatrician cared for her there, and she also had visits with a consulting physiatrist. Let's review. As we can see,

there's a number of physicians that are involved in this patient's care. Let's review a few of the relationships in the next slide.

The first few types of patient relationship categories that we see are the X3 Episodic/Broad services, and we've highlighted it here. So the intensivist that's taking care of the patient in the neurological ICU is involved in Episodic/Broad services with the patient. Managing her care on the respirator, as well as any other conditions that may occur over her course of stay. The hospitalist who's also managing wants the patients transported out of the ICU is managing broadly the patient's overall care, again, in an episodic nature since this is an admission. The physiatrist that's also managing the patient's overall care over a 20-day stay could also be categorized as Episodic/Broad. And finally, the geriatrician that's taking care of her at the skilled nursing facility for that 25-day stay is managing Episodic/Broad services. Next slide, please.

Now let's focus on the X4 Episodic/Focused services. So again, these might occur during the patient's hospitalization, making them episodic in nature. They may address the specific disease condition or organ system, and so Episodic/Focused could involve the emergency physician who first sees the patient as managing the patient's acute issues and getting her stabilized. The neurologist who's also managing her stroke symptoms and getting her ready for tPA and the CT scan is also doing focused services during that episodic care. And then the neurosurgeon who's evaluating her for the intracerebral bleed is also categorized under this. The physiatrist who's evaluating her for rehabilitation potential is also conducting Episodic/Focused services. And finally, the consulting physiatrist on the outpatient setting -- sorry, in the skilled nursing facility, setting is also focusing on her rehabilitation, but doing so in the episodic nature. All these clinicians would fall under the X4 Episodic/Focused services category. Next slide, please.

So now we have X5, and this category, these again are clinicians providing services that are only as ordered by another clinician. And of course, we have the radiologist who is interpreting the CT scan that was ordered by other clinicians. Looking at her intracerebral bleed, giving a diagnostic information to assist in the patient's care, but not necessarily involved in guiding the rest of the treatment. This radiologist would be X5. Next slide, please.

And so we've got in this next slide a summary, again, of the clinical contacts and all of the patient's course of care. We've got the clinicians that are involved throughout the patient's course of care and the category that we can assign to each clinician. So at this point, let's pause again to read a few questions that we've received. So I'd like to send it over to the rest of the team to read a few of those out.

Thanks, Rose. The first question: Slide 40 indicated X2 would be used for an endo doing DM management. Why would a primary care use X1 for the same relationship?

Could you read that again? I'm sorry. I'm just going to take a look at the categories.

Yes. Slide 40 indicated that X2 would be used for an endo doing DM management. Why would a primary care use X1 for the same relationship?

Hmm. So that's a great question. I think the X1 versus X4 type of categorization would depend on -- I guess there's time-based type of considerations as well as the type of care that's being provided. So X1 is continuous, and that would be the long-term management of that patient. It's also broad. The primary care physician or clinician might fall under the X1 category mainly because it's a long-term type of care providing, again, services for the patient's overall medical history. So it could include basically all aspects of the patient's care. The X4 is more about an episodic type of service provided. So in many of the examples we've provided, it could be in the acute hospitalization. So if a patient's just getting diagnosed in the in-patient setting, that might be episodic. And then again, focused is another characteristic of X4, and that's addressing the patient's specific disease or organ system. So that might be the specialist that's taking of the patient on the end patient setting. That could be one example. I hope that clarifies.

Thanks, Rose. The next question: can you speak to how an emergency department visit here would be classified?

That's a great question, and we were hoping that the scenario we just went over would demonstrate where an emergency physician comes into play. So, given that they're seeing the patient usually in an acute setting, so when they first enter the emergency department, it's going to be episodic in nature. It's going to be a time-limited type of interaction that's happening at the emergency room doors. And then they are going to be focused on the patient's acute management and maybe their chief complaint for entering the emergency room. That kind of puts them in -- at least in this top line, and you can see in this slide. It puts them kind of in the X4 category where they're episodic. They're taking care of the patient as soon as they hit the emergency room, and it's focused on the patient's clinical scenario. so, this chief complaint was the patient's stroke symptoms. And the emergency physician was managing the ischemic stroke.

Great, thanks. The next question. Would pre-op medical clearance on an established primary care patient be considered episodic rather than broad since the nature of the visit is different than overall primary care?

Hmm. That's also a very good question. So, I think given that it's going to be preoperative clearance, the clinician is probably reviewing the patient's health in a broad manner. So it is also focused on -- I shouldn't use these words. It is going to be concentrated mainly on the patient's overall care. That would probably make them continuous. The relationship that that clinician has with that patient, it may -- it sounds to me as if it's still a long-term relationship. So even if you are making a recommendation for something that's a procedure that's coming up, the relationship doesn't necessarily change in my mind. It's a primary care clinician taking care of the patient probably, which might mean planning for their upcoming surgery. And then also reviewing the patient's comorbidities as a whole and doing so over a long period of time. So I still feel like that situation is going to be a primary care clinician doing things in a Continuous/Broad manner, so an X1.

Great, thanks. I think at this time, we can move into our full Q&A session. Stephanie, if you can please move to slide 47 and provide the attendees here with information on how to dial in.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via the phone, please dial in at 1-877-388-2064. Again, that's 1-877-388-2064. If prompted, please enter the ID 1097565. If you should have a question at this time, please press *, then the number 1 on your telephone keypad. Again, that's *, then the number 1 on your telephone keypad to ask your question.

Thanks, Stephanie. While we're waiting for everyone to dial in to ask their question over the phone, we do have a couple questions that we've been seeing in the chat box that I'd like to ask out loud to our panelists right now. The first question: since these will be used as part of the cost component of MIPS, which has a weight of 10% right now, will these not be voluntary anymore?

Thanks, Allison. This is Reena. I'll answer that question. So the patient relationship categories are in a voluntary period for education and outreach right now. A decision has not been made at a policy level when they will become mandatory. I will say, it's important from our perspective here at CMS to really allow adequate time for clinicians to gain familiarity with these codes before we do make them mandatory. In addition, during this voluntary period, it will allow us time to really click data on the validity and reliability on the use of these codes before we actually use them in the attribution for our cost measures.

Thanks, Reena. The next question, while we're waiting for everyone to dial in, it was said that patient relationship codes were voluntary to report for 2018. Does that mean they will be required in 2019?

So this is Reena again. That question is similar to the first one you asked, so at this point, there's been no decision been made when these codes or categories will become mandatory.

Thanks, Reena. Stephanie, do we have anyone on the phone line?

No audio questions at this time.

Okay. The next question, how will these relationship codes either affect or be incorporated into overall CPS scores? Will they be directly involved in the attribution models for resource use?

So this is Reena again. the intent of these patient relationship categories are to be able to allow the clinician to self-identify their patient relationships. And as clinicians are able to self-identify, the more we're hoping to use that data to help facilitate the attribution of patients in episodes through the use of our episode-based cost measures.

Thanks, Reena. If a patient begins their care with a specialist during a calendar year, but then over the years becomes a regular, would it be appropriate to move him from an Episodic/Focused modifier to a Continuous/Focused modified in later years?

This is Rose. I can answer that question. So yes, I think that would be appropriate. The great thing about these PRCs is that you can change the relationship over time. There are things that we can't anticipate as clinicians on how long our relationships are going to last. We can sometimes plan for them, but they do change. So at each stage that we are interacting with the patient and the claims committed, we can update the codes as such.

Thanks, Rose. How are these category codes reported? Claims based and/or registries?

So this is Rose again. the intent is to report these relationship categories on the claims themselves. The claims will have information on the types of services that were rendered by the clinician, but also, there will be that modifier section where the clinician can help identify the relationship to the patient.

Great. Thank you. Do we have anyone on the phone yet?

We have a question from Kelly Dennis.

Good afternoon. I also sent it on the question Q&A, but I'm not sure how long that was, so I want to just call in. You didn't mention these Level II HCPCS, but they sound like they're informational and statistical, meaning they are reported in a position after payment modifiers. I just want to confirm that and find out how many modifier spaces you can report to CMS.

So, thank you for your question. That's a very good question. I will have to get back to you on the answer on that in terms of number of spaces that you can put into the claim. If I may look at your information, I'd be happy to e-mail you with those details.

Sure. Thank you very much.

Do we have anyone else on the line?

We're holding for the next question. You may go ahead with a check question.

Great, thanks. Can you please go over again how the patient relationship categories and codes have any impact on the QPP/MIPS and/or APM reporting?

Sure. So this is Reena again. So these patient relationship categories have been generated from the quality payment program. And just to go over, the payment quality program has several performance areas, and one of them includes resource use or cost performance category. So when you think about this particular category, we are developing episode-based cost measures that will have to have some type of attribution affiliated with them where clinicians have to identify whether they're responsible for particular items and services that they provide for the patient. The goal of these patient relationship categories is to allow for clinicians to actually facilitate what the attribution because they'll be self-identifying their relationships when it relates to the episode-based cost measure.

Great, thanks. Are the codes reported in a modifier field for every CPT code submitted on the claim?

I'm sorry. Could you repeat that question again? This is Rose.

Sure. Are the codes reported in a modifier field for every CPT code submitted on the claim?

So this is Rose. I believe that we can get back to you on more information on how many of the lines that we can report it. My understanding is that it's a modifier -- Level II modifier that can be reported at the claim line

level. So, I think for a given clinician, that they have a PRC, they can just report the one where it summarizes the overall relationship with the patient. And that should be enough.

Great, thanks. Do we have any questions at this time?

We have a question from Michelle Druitz.

Hi. I've actually submitted this, but I don't think that's going through. We are a radiology pro-fee group only. So two questions. Obviously, we can have multiple CPTs, so we will watch for a response on, does this need to be on every single CPT code because we don't always know if we have more coming in on a patient. But the other thing is, we don't do anything that's not by referral or by order of another physician. Will there be any application process or category status that would give us an exception? Or do we just need to do the X5 on every single patient, every single charge until they decide if that's an issue or not?

This is Rose. That's a great question. So the current guidance says that your group might report an X5, which is the only ordered by another clinician. While your group might not be reporting nay other categories, they can be submitted on each claim for the purposes of gathering information for the use of the PRCs. So during the volunteer reporting period, whether and how these codes are reported will not affect Medicare payment. And so we do understand that every claim line for a given CPT could submit a PRC, essentially. But usually, if it's just going to be an X5, I think that should be sufficient for your group.

Thank you.

Do we have any additional questions on the line?

We have another question from Jessie Bulb.

Hi. My question is, if we report a PRC incorrectly, who determines if it's incorrect, and what happens if it's deemed incorrect?

This is Reena. I can take that question. It's a really good question. So part of these patient relationship categories is for clinicians to be able to self-identify their relationships, so there's not a method for us to be able to, at this time, validate whether those relationships are correct or not. Part of the intent is for clinicians to be able to self-identify what the relationship is with their patient.

Thank you.

Anyone else on the line?

If you still have a question, please press * and the number 1 on your telephone keypad. We'll pause for the next question. You may go ahead with the chat question.

Great. Thank you. As a follow-up to an earlier question, just to clarify, if we are billing more than one CPT on a given claim, can we just attach the PRC modifier to one of the CPTs, or does it have to be attached to each CPT?

This is Reena again. Another good question. I would have to go back and check with our colleagues here in how that technically would work. Again, happy to provide further guidance on that, so we'll note this question and provide feedback to you on that.

Great. Thanks, Reena. Are the code/modifiers X1 through X5 reported with every CPT or HCPCS code on a CMS 1500 claim? And are those codes submitted every single time for the same diagnosis?

So this is Rose. I could take that. I think it's related to some of the questions that have come through already where we do note that every claim line for a CPT, a clinician can submit a PRC, essentially, and that could be carried over for the whole visit if that is the case in that claim. So, I think for the most part, you should be able to submit as many PRCs as you think are necessary for that specific CPT or that claim line. Some clinicians might choose to just do one PRC for that claim itself. But we can get back to you on some of the more of the details about what might be required for that.

Great, thank you. Do we have anyone on the phone line yet?

We do have a question from Acula Days.

Yes, hello? Can you hear me? Okay. This is a cardiology practice, and our cardiologists attends the STEMI. So when the ER physicians call him for the call when the patient arrives with a heart attack. So, then they have to do the cardiac care for the STEMI call and all these things. So, the procedure will qualify us on X5 category because ER physician, if he's been referred by the ER physician?

This is --

Also for future, like, it is established patient, and then the other artery gets clogged up, then doctor has to perform another CAT or angioplasty. So it is established patient, but that's a new occurrence, so how are we going to treat that?

This is Rose. That's a great question. I think with the first part of your question, you brought up a good point about how to distinguish between an X5 and an X4, perhaps. The ER clinician or the general cardiologist evaluating the patient calls a STEMI, the interventionalist would come in to provide services, which could be diagnostic, but I would also say that they are more treatment guiding types of services. So the interventionalist would most likely fall under the X4 Episodic/Focused. They're coming in to manage the STEMI itself. It's not purely diagnostic given that the interventionalist is intervening on the culprit lesion and then providing medications and then a treatment plan for that patient. Given that they have taken on treatment, I would categorize them more as an X4, Episodic/Focused so they're focused on the STEMI itself and guiding treatment. X5 is mainly reserved for the clinicians that are performing diagnostic testing and not necessarily engaging in treatment from that period on. So hopefully, that's a clarification that helps you.

So CAT can be supported as X5, and the angioplasty can go back to 4 because it's a treatment.

That would be - yes - that actually would be a good example. So if it's truly diagnostic, then yes, it would probably be X5, and if there is a treatment plan and a continued -- a little bit of a limited relationship afterwards, that would be X4. So maybe diagnostic cap is X5, angioplasty, stenting, et cetera, would be X4.

Okay, so what I understand, the whole purpose of this process is that to identify the intensity of the diagnosis or care. One of the scenarios we were going into, the ER physician we are considering as an episodic but it can be broad-based too. The patient can have the flu or have pneumonia or have underlying problems, too. Don't you think the [inaudible]. Because it's focus on chief complaint, but also that could be when ER physician has to look into all of these things, underlying cause. He's going to process as a broad spectrum or not?

That's a great point. And that is also why we leave it up to the clinician to self-identify because it does change by the clinical context. I think [inaudible] would know emergency physicians do take care of chief complaint, but sometimes they do provide broad-based care for a patient that doesn't have a primary care clinician, for instance. That might be one example. Coming in with a number of complaints and an acute exacerbation, perhaps. And also in an episodic fashion. So the timeframe would be most likely episodic since it's an emergency room visit. It's kind of discreet and maybe not really ongoing, but given the reason for the patient's -- the patient's entry into the emergency room, if it's one chief complaint, it could be focused. However, if it is something related to a broad-based care such as flu, hypertension, diabetes, and all of those conditions, it might be more broad in nature. And we have seen emergency clinicians handle broad-based types of interactions with patients. So I think there's some flexibility on whether that emergency clinician would categorize themselves as X3, Episodic/Broad, or X4, Episodic/Focused. It would depend on that clinical situation.

Thanks, Rose. Stephanie, do we have anyone else on the line?

We have a question from Rene Pettijohn.

Hello?

Hi, we can hear you.

Okay. We are an ENT office, so we actually see a multitude of different patients for different reasons. So, just in this kind of a scenario, we're kind of wondering what PRC categories we would use. So let's say we have a patient referred to us, had a mole removed, and they need a wider excision. They're referred to us to do the wider excision. It ends up being a cancerous lesion that we have to then treat the patient long-term for. But during that treatment, the patient gets an ear infection that we then also treat them for. How would we code all those different situations?

This is Rose. I can take this question. It's a very good question, and I think there are -- it's a great example, actually. So for the wider resection, for the actual procedure, what I might do is choose an X4, Episodic/Focused type of a relationship. So with that, the ENT surgeon is doing something that's very discreet, such as doing that wide resection, and doing it in a focused fashion of the procedure itself. For the longer term management, the ENT specialist is still acting as a specialist, maybe more

focused on the long-term management post resection. So, it might be more continuous focused, which is X2, which is the longer term, specialty care. Then if there is something that happens like a flare or management of an ear infection, that -- I would say that's kind of maybe still specialty based if it's an ENT physician that's managing it or ENT clinician that's managing it. You might still choose something that's for the flare itself, Episodic/Focused. So it might be explore. Or if it's something that overlaps into broad-based patient care. You could turn it into something that's more Episodic/Broad. There's a lot of flexibility there, depending on what condition it's flaring, and what that clinician is managing. I think just the two variables there are really just going to be time-based. And then also the nature of the condition itself. If that helps.

Okay, thank you.

Stephanie, any other questions on the line?

Our next question is from Tamara Howell.

Hello. Can you hear me? Hello?

Yes.

Yeah, we hear you.

I just wanted to know how the attorney/client privilege or the doctor/patient privilege and HIPAA policy is applied to this categories and codes webinar.

Hi, this is Reena. Can you elaborate a little bit more with your question, please?

Are you there?

Tamara, your line is still open.

Yes. Oh, do I have to press a button? What do I need to do?

Go ahead and restate your question. They want you to elaborate.

My question is, how does the HIPAA policy apply to these categories and codes? Do I need to change the -- the settings on my phone to answer that question?

I'm not sure how you mean how it applies to the settings on your phone. Are you referencing when you actually self-identify on a claim and how it relates to HIPAA? I'm just trying to understand the question.

Yes, the privacy concerns. Are there privacy concerns involved with this process?

They're not. So these are claims based -- these modifiers are put on claims, and so these claims are submitted in a secure fashion. And so when the clinician is submitted the claim to CMS, and then through the modifier field, they will actually put their relationship with the patient through the Level II HCPCS code, so that would all be through a secure modality.

Thanks. Stephanie, do we have anyone else on the line?

Your next question is from Julie Kiles.

Hi, thanks for taking my question.

I'm wondering how and when CMS might release more information about whether or not these codes will be mandatory next year? Will they be in a separate rule making or announcement, or it might be in a supposed physician fee schedule?

Thanks for your question. So, I had mentioned earlier, there are no times at this point to make it mandatory for next year. We are in a voluntary reporting period right now, but like with everything that we do, we do propose these, if there are changes, to make the mandatory. We will have an extensive comment period, and that includes proposing it through a rule. For now, it is through the physician fee schedule.

Next question, Stephanie.

Our next question is from Jennifer Wenning. Jennifer, you may go ahead with your question.

I think we may have lost her. Jennifer, are you there? Are you there?

You may have your line muted, Jennifer.

Can you hear me now?

Go ahead.

Okay. I am with a hospital-based radiology group, and the majority of what we do is going to fall under the X5 category, but I do have an interventional radiologist, and I want to just clarify in different scenarios that he sees patients. If he is actually making the decision that the patient needs the procedure -- for example, he was -- the patient was referred to him, and a venous ultrasound was ordered, and it is determined that there's some sort of a blockage, and he needs to do some sort of venous closure device. At that point, he becomes the attending, making the recommendation. He's the one ordering the procedure, the intervention, so he would go then to an Episodic/Focused category. But if it's maybe an angio or something where another clinician is placing the order for the procedure, then he would still remain under the X5 category. Am I correct in that?

This is Rose. I think that's a great illustration. I would say the short answer is yes on how you described it. It really is going to be the treatment versus diagnostic as the distinguisher between the X4 and the X5. So in your example, his treatment plan where he's becoming the attending that does the procedure and continues with treatment, that would be X4 Episodic/Focused. So if you're doing a thrombectomy or doing a procedure, and then continuing on with treatment--that's how he would categorize himself. And then if he's really just doing the diagnostic, imaging, that might be a little bit more invasive, but also providing that information to the other clinician who will, once again, take over the care. He would be X5 in that situation.

Great, thanks. Stephanie, next caller.

We have a follow-up question from Acula Days.

Yeah, it's just a quick question. That for the office visit, the Level II, III, do you think it's directly related to X3 and X2? The level you put with the CPT code?

This is Rose. Just as clarification, are you referring to the ENM level?

No, no, no, just office visit. Usually like X2, X3. I know 4 and 5 is mainly concerned about the procedure and the treatment and all. But the office visit, we put that as an established patient. Is that X3, X2 directly related to 99205 or 203 or 99212 or 213?

Mm-hmm.

Is that a direct relation?

So this is Rose. In some ways, it's the Level II HCPC modifiers. They're not intended to be associated with the intensity of the service or change the meaning of the codes that you're using for your CPT. I think what you're asking, if my understanding is correct, are we applying the X1, X2 to outpatient services, such as a visit? I would say yes. For the clinicians that are seeing the patients in the outpatient setting and providing maybe continuous, long-term, indefinite care, it'd be probably X1 or X2, depending on whether they're doing broad-based services or specialty-based services. So you might see them quoted alongside the office visit, so some of those codes you mentioned before. But they aren't intended to change the meaning of the actual CPT or the level of intensity or anything like that. But I guess I would think of it kind of in broad-brush strokes that the continuous type of care would be kind of the outpatient setting, long-term management. The episodic type of care would be maybe the in-patient setting or in-patient rehab, and things like that. Does that clarify for you?

I think her line may have dropped off. Stephanie, do we have any other callers on the line?

Your next question is from Carrie Appleroth.

Hi, good afternoon. Thanks for taking our call. We have an orthopedic specialist, and we will treat for osteoarthritis of the knee, and then eventually, the patient will come back in, and then we'll treat osteoarthritis of the hip, same provider. We just want to clarify, at that encounter, would you bill with an X1 modifier? And to elaborate a little bit more, if that's the case, we do have orthopedic spine specialists and pain management doctors, so they'll treat for cervical spine, and then later on may treat for lumbar spine. It's, you know, pretty much the same area. Would that also be an X1 when they move to the lumbar spine? Thank you.

This is Rose. I can take that. That's a great question. I guess in my mind, the way I would think of it, for broad versus focused, when I'm thinking of broad, I think about all the patient’s comorbidities, not just related to the musculoskeletal system, but also the other systems involved. It could be GI, it could be health care maintenance, et cetera. Those are the ones that I see as more of the broad. F or the orthopedic specialist, I think that even if it's involving multiple levels of the musculoskeletal system, it sounds to me that it's more focused. The specialist is providing care for

the musculoskeletal system, and it could be osteoarthritis of different joints. I do think it's still focused on the musculoskeletal system. So the category I'd probably choose for your orthopedic surgeon would be the continuous/focused in those examples that you gave.

Great, thanks. Stephanie, next question, please?

Your next question is from Kim Stecans.

Yes, hello. Will the actual modifier codes be the X1 through X5?

I'm sorry, this is -- It messed up. Could you repeat that question really quick?

Yes. Will the modifiers that we're going to be using actually X1 through X5?

That is correct. So those are the Level II HCPC modifier codes, the X1 through X5, correct.

Okay. And the other question I have is, when do we need to start using these voluntarily?

Hi, this is Reena. I can answer that. The voluntary reporting period actually began on January 1st of this year, so you can go ahead and start using them on your claims.

Okay, thank you. That's all I had.

Great, thanks. Stephanie, next question, please.

Our next question is from Lori Simmons.

Hi. You mentioned earlier that at this current time, there's no method to validate the use of these codes. Should medical record documentation capture the relationship between the patient and the clinician in order to support the appropriate code at a future time?

So that's a great question. So as I mentioned, the intent of the patient relationship categories are for clinicians to self-identify their patient relationships. But as we are collecting this data, we will have a process where we will be actually doing some validity and reliability testing on these codes before we actually make them mandatory. So there will be a process, as you suggest, even with, like, cross-referencing with medical records to help us further refine the categories and help with the validity of the identification.

Great, thanks. Stephanie, next question, please.

One moment for the next question.

Okay, sounds like we're still waiting for a couple more questions. If you have a question, please dial in using the telephone number and pass code on your screen right now. In the interim, a couple questions have been coming in. Will we get penalized if we do not report these codes?

So, we're in a state of voluntary reporting, so there's no effect on anyone's payment at this time.

Great, thanks. Are there any other uses anticipated for these relationship attributions, aside from being used for the cost component of MIPS?

Another great question. At this point, these patient relationship categories to the MACRA Act were indicated to be developed for the use of the cost measures.

Great, thanks. Stephanie, anyone on the phone line?

We do have a question from Allison.

Hi. Can you hear me?

Go ahead.

You mentioned that these codes will be added to the claim, and the provider would be self-identifying their relationship. So where do you envision that the provider would actually be documenting that information within the EHR since they wouldn't necessarily be updating the claim themselves.

So this is Rose. That's a great logistical question. I think it would probably fall under I guess the documentation itself. Where maybe in the assessment end plan, the clinician is demonstrating their overall plan and when they're planning to see this patient again. That can indicate to the person coding. I think obviously we have a good sense of what clinicians, whether they're going to be broad-based or focused, depending on the current relationship they have with the patient. And then when they indicate maybe the time offering that they plan on seeing the patient, that can also demonstrate if it's going to be continuous or episodic. Grossly, it's been kind of the end-patient setting. It kind of takes on an episodic nature. And then the outpatient setting has kind of taken on a continuous. Just as a very rough rule that you can use.

Okay, thank you.

Stephanie, next question, please.

There are no additional questions at this time. If you would like to ask a question, *, then the number 1.

Great. While we're waiting, could you please explain how this will impact large-group practices? Is CMS considering replacing TPCC attributions?

I can answer this. So right now in the MIPS program, for the cost performance category, we have two measures, the TPCC and the MSPB. And so those measures are currently in the program. And I'm sorry, what was the last part of the question?

It was, can you please explain how this impacts large-group practices? Is CMS considering replacing TPCC attribution?

Okay. So, I mean, those are currently in the program, those two measures. As far as it affects large practices, I think just to bring it back to the episodes, just to keep in mind, the patient relationship categories apply to the cost measures in particular. We're thinking about them for our episode-based cost measure development. So that’s where I think that's where you'll

be able to see in terms of the impact to your specific practice and how that will work. And Rose, you have anything else to add to that?

No, thank you. Nothing to add.

Okay, thanks.

Great, thank you, Reena and Rose. Stephanie, do we have any other questions on the phone line?

One moment for your next question.

Okay, I know we're getting a little low with time, so I'm going to ask one more question and then pass it back to Rose to give a quick recap. So, can you please confirm that a physical or speech therapist would always use the X4 modifier? Is there an instance where another modifier may be more appropriate?

This is Rose. So thanks for that question. I think in terms of the speech pathologist, that's an interesting situation because it could be an X5, where they are performing services that are ordered by another clinician and doing something more diagnostic, and then sending the patient back to the main provider. But there are instances I could see where they might take on a focused type of relationship, whether it's continuous or episodic. So that might be the speech pathologist that's doing the diagnostic testing, but then starts initiating some therapies or treatment plan. At that point, that speech pathologist would probably have a continuous or an episodic relationship with the patient. It's still focused, since it's dealing with speech pathology, but they are no longer just providing diagnostic services. They are now initiating a treatment plan itself. So, whether it's going to be continuous or episodic, again, depends on the scenario. But I could see them going off into the X4 or X2 categories.

Great, thank you. At this time, if we could move to slide 48, and I'll pass it back to Rose and Reena and the Acumen team to close this webinar out today.

Thank you very much.

So, we will move on to the last slide, slide 48, and we just wanted to let everybody know that we will be having the recording, the transcript and slides for this presentation, along with an FAQ document, which is going to be posted on the MACRA feedback page as soon as these documents become available. So hopefully for your review, and then we really appreciate the thoughtful questions and comments that come through today and the time that you spent with us. So, we welcome any further questions and comments throughout this process. And as a reminder, the voluntary reporting period began January 1, 2018. You may now code your patient relationships on the claims themselves. Thank you so much for your questions and comments and your interaction during this webinar.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.