

# CMS Patient Relationship Categories and Codes

[The Quality Payment Program](#) aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations. These aims are centered on improving beneficiary outcomes and engaging patients through patient-centered policies, and enhancing clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (P.L. 114-10) was enacted on April 16, 2015. Section 101(f) amended section 1848 of the Social Security Act (the Act) to create a new subsection (r) entitled “Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement.” Section 1848(r) of the Act requires the establishment and use of classification code sets: care episode and patient condition groups and codes, and patient relationship categories and codes.

The purpose of patient relationship categories and codes is to facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care. Section 1848(r)(3) of the Act requires an interactive and collaborative process with the clinician community and other stakeholders where CMS posts a draft list of patient relationship categories and codes, solicits comments and then posts an operational list of patient relationship categories and codes on the CMS website. This posting presents the operational list of patient relationship categories and codes on the CMS website.

## Draft List and Supplemental Posting

As required by section 1848(r) of the Act, in April 2016 CMS posted the following draft list of patient relationship categories. We solicited public comment on the categories and the policy principles that were used in developing them, including examples that illustrate how clinicians may be categorized, as well as questions for consideration and feedback.

### Continuing Care Relationships:

- (i) Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care.
- (ii) Clinician who provides continuing specialized chronic care to the patient.

### Acute Care Relationships:

- (iii) Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode.
- (iv) Clinician who is a consultant during the acute episode.

### Acute Care or Continuing Care Relationship:

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

The public comment period closed in August 2016. In [December 2016](#), based on comments received in the April 2016 posting, we decided to solicit additional comment on potential modifications to these categories. The updated categories have been included below. Additionally, we sought comment on a path for finalizing the categories, as well as a method to operationalize the coding of these categories on the Medicare claim.

1. **Continuous/broad:** This category could include clinicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role.  
**Examples include, but are not limited to:** Primary care specialists providing comprehensive care to patients in addition to specialty care, etc.
2. **Continuous/focused:** This category could include a specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.  
**Examples include, but are not limited to:** A rheumatologist taking care of a patient's rheumatoid arthritis longitudinally but not providing general primary care services.
3. **Episodic/broad:** This category could include clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization.  
**Examples include, but are not limited to:** A hospitalist providing comprehensive and general care to a patient while admitted to the hospital.

4. **Episodic/focused:** This category could include a specialist focused on particular types of time-limited treatment. For example, when the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.

**Examples include, but are not limited to:** An orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.

5. **Only as ordered by another clinician:** This category could include a clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians.

**Examples include, but are not limited to:** A radiologist interpreting an imaging study ordered by another clinician.

## Operational List of Patient Relationship Categories

Based on the public comments received and consultation with experts, CMS is posting the following operational list of patient relationship categories:

1. **Continuous/broad services:** For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role. Reporting clinician service examples include primary care services and specialists providing comprehensive care to patients in addition to specialty care.
2. **Continuous/focused services:** For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. A reporting clinician service example would be a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services.
3. **Episodic/broad services:** For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization. A reporting clinician service example would include a hospitalist providing comprehensive and general care to a patient while the patient is admitted to the hospital.

4. **Episodic/focused services:** For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention. A reporting clinician service example would be an orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.
5. **Only as ordered by another clinician:** For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the four categories described above. A reporting clinician service example would be a radiologist interpretation of an imaging study ordered by another clinician.

## Reporting of Patient Relationship Codes using Modifiers

We have been planning for the use of procedure code modifiers for the reporting of patient relationship codes. In December 2016, we also sought comment on the use of Level II Healthcare Common Procedure Coding System (HCPCS) Modifiers for this work. We received public comments which indicated that Current Procedural Terminology (CPT) Modifiers would be the best way to operationalize the reporting of patient relationship codes.

We have been working with the American Medical Association's (AMA) CPT Editorial Panel, which is responsible for maintaining the CPT code set. We have submitted an application for the CPT modifiers for reporting of the patient relationship categories. We expect that the modifiers will be considered at the June 2017 meeting of the CPT Editorial Panel.

## Next Steps

We expect that the patient relationship categories and codes would be part of the CMS notice and comment rulemaking process. The codes and any revisions to the categories based on comments received as part of the CPT Editorial Panel process would be included in the rulemaking. Section 1848(r)(3)(F) of the Act requires the Secretary, through rulemaking, to annually, by November 1st, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. We seek input on potential revisions to this Operational list of patient relationship codes and will make revisions as appropriate.

In order to address questions from the clinician community on how to use the categories and CPT modifiers in their everyday practice, we plan on engaging with stakeholders through education and outreach before the modifiers would be required on Medicare claims. Some of our engagement efforts

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may include: webinars, listening sessions, focus groups, and targeted outreach to specialties and practice management organizations. For questions on how these patient relationship categories and modifiers will relate to the Quality Payment Program, please visit the QPP website: <http://www.qpp.cms.gov>.

