

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, such as patient relationship categories and codes. CMS will be considering the utility of patient relationship categories and codes to improve the attribution of resources to clinicians in developing measures of cost, as required by the Medicare Access and CHIP Reauthorization Act (MACRA) Pub. L. No. 114-10. These measures will be considered for use in the Quality Payment Program. Please submit comments to patientrelationshipcodes@cms.hhs.gov no later than January 6, 2017.

Background:

MACRA, was enacted on April 16, 2015. Among many provisions, section 101(f) amends 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.

As required by section 101(f) of MACRA, in April 2016 CMS posted a draft list of patient relationship categories and 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. The public comment period closed in August 2016.

Section 101(f) of MACRA requires that we post the operational list of patient relationship categories and codes by April 2017 and that the codes be included by clinicians on all Medicare claims, as determined appropriate by the Secretary, beginning January 1, 2018. This document is a supplementary posting, not required by MACRA, to gain additional stakeholder input on these categories and codes.

In [April 2016](#), we posted for public comment the following draft categories:

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.

New Categories:

CMS received over 75 public comments on the April 2016 posting. Based on those comments, we have decided to modify the categories that we posted for public comment in April 2016. The updated categories have been included below. Additionally, we have determined a path for finalizing the categories, as well as a method to operationalize the coding of these categories on the Medicare claim.

In order to engage stakeholders as often as possible during development of these categories and codes, this posting provides stakeholders another opportunity to comment on the categories and codes, as well as on our plans to operationalize this work. We would appreciate comments on the following categories:

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. 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.

Codes:

CMS is considering options for codes to identify patient relationship categories, which must be included on claims submitted for items and services furnished by physicians and applicable practitioners on or after January 1, 2018. Based on comments and our analysis, we believe the use of Healthcare Common Procedure Coding System (HCPCS) modifiers appears to be the most appropriate option for clinician-submitted codes on claim forms. The Level II HCPCS codes, which are established by the CMS Level II HCPCS Coding Workgroup, primarily represent items, supplies, and services not covered by the American Medical Association's Current Procedural Terminology-4 (CPT-4) codes. Medicare, Medicaid, and private health insurers use HCPCS codes and code modifiers for claims processing. We envision that clinicians would first report a CPT Code (Level I HCPCS) and then identify a Level II HCPCS modifier to identify their relationship to the patient. HCPCS Level II alphanumeric codes and code modifiers comprise the A to V range. The CMS Level II HCPCS Coding Workgroup meets regularly (generally monthly) to consider requests for new HCPCS codes and modifiers. Information on the code request and approval process can be found [here](#).

We believe that using Level II HCPCS modifiers is the most appropriate option for coding these relationship categories on claims because: establishing a new HCPCS modifier code for each patient relationship category would rely on an established process for the creation of new modifier codes; CMS data systems are already able to accept such codes; clinicians are already familiar with how Level I and Level II HCPCS codes operate; the modifiers would be applicable to the combination of clinician and service, thereby allowing more precise analysis of attribution; and it would allow us to establish these codes within the timeframe set out in section 101(f) of

MACRA. Public comments on the April 2016 posting supported the use of modifiers for this work.

Questions for Consideration:

CMS seeks comment on these draft patient relationship categories, as well as our proposed method to operationalize the coding of these categories on claim forms. We are specifically seeking comments on the questions below:

1. Are the draft categories clear enough to enable clinicians to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation?
2. 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?
3. Are HCPCS modifiers a viable mechanism for CMS to use to operationalize this work to include the patient relationship category on the Medicare claim? If not, what other options should CMS consider and why?

Please submit comments to patientrelationshipcodes@cms.hhs.gov no later than January 6, 2017.