

CMS Patient Relationship Categories and Codes

Summary

The Medicare Access and CHIP Reauthorization Act of 2015 (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 Collaboration with the Physician, Practitioner and Other Stakeholder Communities to Improve Resource Use Measurement. Subsection (r) requires the establishment and use of classification code sets: care episode and patient condition groups and codes¹, and patient relationship categories and codes. This posting addresses the patient relationship categories and codes required by section 1848(r)(3) of the Act and presents the policy principles that we used in developing the draft relationships with examples that illustrate how clinicians may be categorized and questions for consideration and feedback.

At this time, we are posting the patient relationship categories for public comment. As there are many types of codes that can be submitted on an administrative claim, CMS believes it will be best positioned to determine the specific codes to be submitted once the patient relationship categories are finalized based on public comment. Please submit comments to patientrelationshipcodes@cms.hhs.gov no later than August 15, 2016.

Background

Not later than one year after the enactment of the MACRA, paragraph (3) of section 1848(r) requires the Secretary to post on the CMS website a draft list of the patient relationship categories and codes for review and comment. The comment period must be open for 120 days after the posting, and an operational list of patient relationship categories and codes must be posted on the CMS website no later than 240 days after the close of the comment period. Updates to the operational list (as the Secretary determines appropriate) shall be made through rulemaking no later than November 1 of each year, beginning with 2018. Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 shall, as determined appropriate by the Secretary, include a patient relationship code. A timeline of events is included in Appendix A.

In order to evaluate the resources used to treat patients, under section 1848(r)(5) of the Act, the Secretary is required to conduct an analysis of resource use based on the care episode, the patient condition, and patient relationship codes that will be submitted on claims. CMS is required to post for public comment the draft patient relationship categories and codes as well as a draft list of care episode and patient condition groups (which will be posted in November 2016). CMS

¹ The CMS Episode Groups document was posted for public comment on October 15, 2015. The Public Comment period closed on March 1. More information is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html>

will analyze the public comments received and will use these as part of the analysis of resource use. The patient relationship codes reported on claims will be used to attribute patients and episodes (in whole or in part) to one or more physicians/practitioners.

Section 1848(r)(3)(B) defines patient relationship as follows:

“(3) Attribution of patients to physicians or practitioners.—

“(B) Development of patient relationship categories and codes.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who--

(i) considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

Policy Principles for Developing Patient Relationship Categories and Codes

The development of patient relationship categories and codes is new and exciting work for CMS. The ability to attribute patients to clinicians (in whole or in part), based on clinician reporting of the different relationships that they have with their patients is something that currently does not exist in current coding procedures.

Since this is new work for CMS, we used the following policy principles for determining the patient relationships to ensure that CMS is appropriately considering the role of the physicians and practitioners in patient care to ensure accurate resource use measurement.

1. Develop a clear, simple classification code set to identify patient relationship categories that define and distinguish the different relationships and responsibilities

- physicians and practitioners have with a patient at the time of furnishing an item or service.
2. Ensure that the majority of clinician relationships are captured with the patient relationship codes.
 3. Ensure flexibility in and ease of submission of codes as part of claims, reflecting that the relationship a clinician has with a given patient may change depending on the clinical situation.
 4. Ensure that CMS is open and transparent during the development of patient relationship categories and codes and educate clinicians on the intent and use of the categories and codes.
 5. Enable accurate and effective resource use measurement.

Using the patient relationships categories described in section 1848(r)(3)(B) of the Act a starting place, CMS believes that one way to approach distinguishing patient-clinician relationships is to determine whether items and services are furnished on an acute basis or non-acute (i.e., continuing) basis. To help guide our thinking on this distinction, we have included a draft description of an acute episode.

Draft description of an acute episode:

Acute episodes may encompass a disease exacerbation for a given clinical issue, a new time-limited disease (e.g. acute bronchitis), a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. It may occur or span inpatient and outpatient settings. Continuing care occurs when an episode is not acute, and requires the ongoing care of a clinician.

Draft Patient Relationship Categories

Using this framework of care furnished on an acute vs non-acute basis, we sought to distinguish the different categories of clinician- patient relationships that occur in each of these situations. Usually within each type of acute or non-acute situation, there is a clinician who has primary responsibility for the care of the patient and a clinician who furnishes care on a consultative or supportive basis. When reviewing the relationships described in section 1848(r)(3)(B), we believe that there may be some overlap between three of the illustrative categories listed below because many clinicians can assist in the care of a single patient. Determining when a clinician furnishes items and services only as ordered by another clinician versus furnishes services on a continuing basis or an occasional basis may be due to the clinical situation (e.g., a pathologist who reads a breast tissue biopsy vs. a kidney doctor/nephrologist taking care of a patient receiving dialysis). CMS believes that there are many ways to interpret these categories and as we develop the operational list of categories and codes we will want to make it as easy as possible for clinicians to accurately identify their relationship to the patient. To distinguish

between these categories, we are considering a category specific to non-patient facing clinicians. We seek comment on the best way to distinguish between these situations and the inclusion of this category.

- The clinician that furnishes items and services only as ordered by another clinician;
- The clinician that furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role; and
- The clinician that furnishes items and services to the patient on an occasional basis, usually at the request of another practitioner.

As required by subparagraphs (B) and (C) of section 1848(r)(3) of the Act, we have developed and are posting on the CMS website the following draft list of patient relationship 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.

Examples include but are not limited to: Primary care physician providing annual physical examination (outpatient); geriatrician caring for resident (Nursing Home); nurse practitioner - providing checkups to adult asthma patient (outpatient).

- (ii) Clinician who provides continuing specialized chronic care to the patient.

Examples include but are not limited to: Endocrinologist (inpatient or outpatient) treating a diabetes patient; cardiologist for arrhythmia; oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology.

Acute Care Relationships:

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

Examples include but are not limited to: Hospitalist caring for a stroke patient (inpatient); gastroenterologist performing a colonoscopy (outpatient ambulatory surgery); Orthopedist performing a hip replacement; urgent care practitioner caring for a patient with the flu (ambulatory); emergency room physician assistant treating a motor vehicle accident patient (outpatient), attending at a Long Term Care Hospital or Inpatient Rehabilitation Facility

- (iv) Clinician who is a consultant during the acute episode.

Examples include but are not limited to: Infectious disease specialist treating a patient for sepsis or shingles; gastroenterologist performing an upper endoscopy on a

hospitalized patient (inpatient); rheumatologist performing an evaluation of an acutely swollen joint upon referral by a primary care physician; dietician providing nutritional support to an Intensive Care Unit patient (inpatient).

Acute Care or Continuing Care Relationship

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

Examples: Non-patient facing Clinicians such as pathologists, radiologist, and other practitioners who care for patient in specific situations ordered by a clinician but have very little or no relationship with a patient.

Questions for Consideration:

CMS seeks comment on these draft patient relationship categories as well as suggestions for additional relationships or modifications to these relationships. We are also seeking comments on the questions below:

1. 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? 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?
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?
3. Is the description of an acute episode accurately described? If not, are there alternatives we should consider?
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?
5. Are we adequately capturing Post-Acute Care clinicians, such as practitioners in a Skilled Nursing Facility or Long Term Care Hospital?
6. What type of technical assistance and education would be helpful to clinicians in applying these codes to their claims?

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?
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?

APPENDIX A- Statutory Timeline

Section 101(f) Requirement	Statutory Deadline	Corresponding Date
<i>Care episode and patient condition groups and codes</i>		
Post on CMS website a list of episode groups developed pursuant to section 1848(n)(9)(A) and accompanying description	NLT 180 days after date of enactment	October 16, 2015
Public comment	Duration 120 days	February 15, 2016
Post on CMS website a draft list of codes for groups	NLT 270 days after end of public comment	November 9, 2016
Public comment, including additional mechanisms (e.g., ODF, town hall meetings)	Duration 120 days	March 9, 2017
Post on CMS website an operational list of groups and codes	NLT 270 after end of public comment	December 14, 2017
Annual updates	By November 1 of each year, beginning in 2018	November 1, 2018
<i>Patient relationship categories and codes</i>		
Post on CMS website a list of patient relationship categories and codes	NLT 1 year after date of enactment	April 15, 2016
Public comment, including additional mechanisms (e.g., ODF, town hall meetings)	Duration 120 days	August 13, 2016
Post on CMS website an operational list of categories and codes	NLT 240 days after end of public comment period	April 10, 2017
Annual updates	By November 1 of each year, beginning in 2018	November 1, 2018

KEY: NLT = not later than; ODF = Open Door Forum