mln webcast

A MEDICARE LEARNING NETWORK® (MLN) EVENT

PATIENT RELATIONSHIP CATEGORIES AND CODES

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Presenters:

Rose Do, M.D., Acumen LLC
Paul Rosen, M.D., MPH, MMM, CMS
Wilfred Agbenyikey, Sc. D, MPH, CMS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

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Purpose of Webcast

- To provide guidance for clinicians and other stakeholders in classifying patient relationships, through:
  - Explaining the purpose of the patient relationship categories and codes
  - Expounding upon the operational list definitions
  - Illustrating the proper coding of patient relationships through real world clinical scenarios
  - Answering questions and highlighting additional resources

Agenda

- Introduction
- Patient Relationship Categories and Codes
- Clinical Scenarios
- Q&A Session

Acronyms Included in this Presentation

Acronym	Term
AMC	Academic Medical Center
CMS	The Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography
CY	Calendar Year
EMG	Electromyography
HCPCS	Healthcare Common Procedure Coding System
ICU	Intensive Care Unit
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
PET	Positron Emission Tomography
PFS	Physician Fee Schedule
SNF	Skilled Nursing Facility
S/P	Status Post
tPA	Tissue Plasminogen Activator

Introduction

Statutory Context, Policy Principles, and the Development Process

Statutory Context

- MACRA repealed the Sustainable Growth Rate formula and introduced the Quality Payment Program, a new way to pay clinicians.
- The Quality Payment Program evaluates clinicians on a range of performance areas, including resource use (“cost”).
- MACRA requires the development of patient relationship categories and codes for potential use in the attribution methodology for 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
  - facilitate the attribution of patients and episodes to one or more clinicians
  - allow clinicians to self-identify their patient relationships

82 FR 53232 https://www.federalregister.gov/d/2017-23953/p-2190

Statutory Context

- The operational list of patient relationship categories and codes was finalized in the CY2018 PFS final rule.
- The codes are now in a **voluntary reporting period.**
- Whether and how the codes are reported will not affect Medicare payment.
- The goals of this period are to:
  - educate clinicians and stakeholders about proper coding of patient relationships
  - collect data for validity and reliability testing of the codes before their potential use in the attribution methodology for cost measures

82 FR 53232 https://www.federalregister.gov/d/2017-23953/p-2190

Statutory Context

- Current MIPS eligible clinicians include:
  - Physicians, which includes doctors of medicine, doctors of osteopathy (e.g., osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors; physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, a group that includes such professionals

- However, all eligible clinicians (MIPS and non-MIPS) can report their patient relationships on their Medicare claims.

82 FR 53232 https://www.federalregister.gov/d/2017-23953/p-2190

Policy Principles Used in Development

- Develop a clear and simple classification code set
- Capture the majority of patient relationships
- Ensure flexibility in and ease of submission of codes on claims
- Maintain openness and transparency
- Enable accurate and effective cost measurement

April 2016 Posting

A Participatory Development Process

Development Timeline for Patient Relationship Categories and Codes

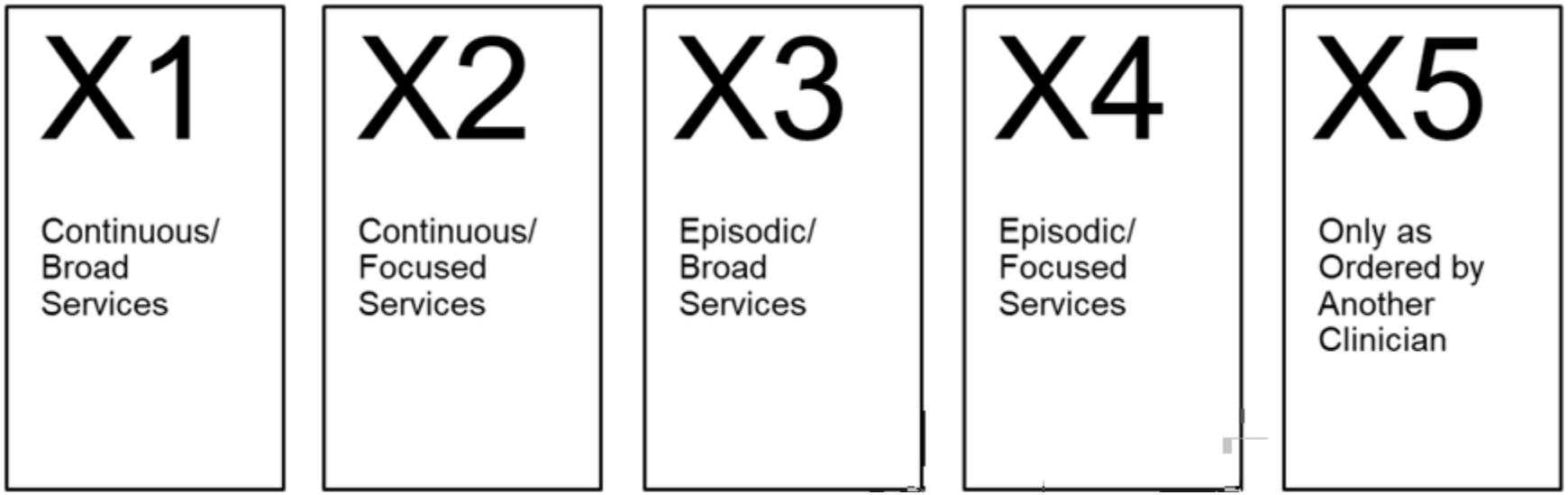
- CMS has solicited extensive input from clinicians and other stakeholders at every step of the process.
- In addition to these public postings, CMS held two listening sessions in July 2016 and solicited comment on the CY2018 PFS proposed rule.

Patient Relationship Categories

The Operational List, and Types of Clinicians and Services

Patient Relationship Categories and Codes

There are five patient relationship categories in the operational list, which are operationalized through Level II HCPCS modifier codes.



X1 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.

Examples include but are not limited to:

- Primary Care Clinicians
- Specialists also providing primary care services

Operational List Posting

X2 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.

Examples include but are not limited to:

- Endocrinologist managing diabetes
- Orthopedist managing osteoarthritis before knee replacement
- Ophthalmologist managing glaucoma or diabetic retinopathy
- Pulmonologist managing asthma
- Speech-language pathologist providing ongoing therapy for difficulty swallowing
- Infectious disease consultant managing care for a patient with HIV

Operational List Posting

X3 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.

Examples include but are not limited to:

- Hospitalist managing a patient in the hospital
- Intensivist managing a patient in the ICU
- Physiatrist managing a patient in an inpatient rehabilitation setting

Operational List Posting

X4 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.

Examples include but are not limited to:

- Surgeon performing a one-time procedure (e.g., ophthalmologist performing cataract surgery, orthopedist performing knee replacement)
- Physical therapist working with a patient on rehabilitation after a procedure (e.g., knee replacement)
- Emergency physician addressing condition that brought a patient to the ER
- Specialist providing no further services after an initial evaluation
- Anesthesiologist or CRNA providing anesthesia and post-operative monitoring of a patient

Operational List Posting

X5 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 previous four categories.

Examples include but are not limited to:

- Radiologist reading a CT scan
- Pathologist examining polyps
- Neurologist conducting an EMG
- Allergist conducting an allergy test
- Audiologist conducting hearing and balance test

Operational List Posting

Patient Relationship Categories and Codes

Summary

Code	Category	Description
X1	Continuous/Broad Services	Clinician providing comprehensive care for a patient with no planned endpoint of the relationship
X2	Continuous/Focused Services	Specialist providing ongoing management of a specific chronic disease or condition over an indefinite period
X3	Episodic/Broad Services	Clinician responsible for overall care and coordination for a patient during an acute hospitalization or inpatient rehabilitation
X4	Episodic/Focused Services	Clinician providing services for a specific condition or treatment for a definite period of time
X5	Only as Ordered by Another Clinician	Clinician furnishing services to provide information to another clinician without directly initiating a treatment plan

Clinical Scenarios

Clinical Scenarios

- Simple scenarios to address key concerns from public comments
- Complex scenarios to demonstrate how a range of clinicians involved in patient care should self-identify their patient relationships
- Note: The scenarios presented here are purely hypothetical and do not represent real patient cases.

Key Concerns from Public Comments

- “Continuous” and “episodic” are vague and open to interpretation.
- It is unclear if these categories capture changes in patient relationships over time.
- These categories may undermine co-management and team-based care.

Operational List Posting

Simple Clinical Scenario 1

Episode Length Variation by Clinical Situation

Scenario	Patient Relationships
Patient Khan develops actinic keratosis and sees a dermatologist for treatment with cryotherapy. Her interaction with the dermatologist spans two visits.	
A few months later, Patient Khan undergoes a joint replacement procedure by an orthopedic surgeon. She sees the orthopedist for post-operative check-ups	

Simple Clinical Scenario 1

Episode Length Variation by Clinical Situation

Scenario	Patient Relationships
Patient Khan develops actinic keratosis and sees a ***dermatologist*** for treatment with cryotherapy. Her interaction with the dermatologist spans two visits.	***Episodic/Focused – X4***
A few months later, Patient Khan undergoes a joint replacement procedure by an ***orthopedic surgeon***. She sees the orthopedist for post-operative check-ups	***Episodic/Focused – X4***

Simple Clinical Scenario 2

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Gogol is admitted for exacerbation of COPD and is managed by a hospitalist who coordinates her care.	
She has never been diagnosed with COPD, and a pulmonologist is consulted to help treat her COPD exacerbation.	
After being discharged, she begins following up with the pulmonologist regularly for her COPD.	

Simple Clinical Scenario 2

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Gogol is admitted for exacerbation of COPD and is managed by ***a hospitalist*** who coordinates her care.	***Episodic/Broad – X3***
She has never been diagnosed with COPD, and a ***pulmonologist*** is consulted to help treat her COPD exacerbation	***Episodic/Focused – X4***
After being discharged, she begins following up with the ***pulmonologist*** regularly for her COPD.	***Continuous/Focused – X2***

Simple Clinical Scenario 3

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Ramone undergoes 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	

Simple Clinical Scenario 3

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Ramone undergoes a colonoscopy by his ***gastroenterologist.***	***Episodic/Focused – X4***
The ***pathologist*** reads the biopsies and issues a report that the findings are consistent with Crohn's Disease.	***Only as Ordered by Another Clinician – X5***
The ***gastroenterologist*** initiates treatment for Crohn's Disease and continues to monitor him	***Continuous/Focused – X2***

Simple Clinical Scenario 4

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Ventura does not have a primary care clinician. He is admitted to a 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. 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 also treating his hypertension and doing regular health check-ups.	

Simple Clinical Scenario 4

Changes in a Patient Relationship over Time

Scenario	Patient Relationships
Patient Ventura does not have a primary care clinician. He is admitted to a hospital for a new diagnosis of diabetes where he is treated by an ***endocrinologist.***	***Episodic/Focused – X4***
He begins seeing an ***endocrinologist*** as an outpatient for his diabetes. After a few years of treatment, his endocrinologist notes that he should be on treatment for hypertension.	***Continuous/Focused – X2***
Since she has developed a long standing relationship with Patient Ventura, the ***endocrinologist*** begins also treating his hypertension and doing regular health check-ups.	***Continuous/Broad – X1***

Simple Clinical Scenario 5

Team-based Care

Scenario	Patient Relationships
Patient Traoré has hypertension, diabetes, and atrial fibrillation. She sees a cardiologist regularly for her atrial fibrillation.	
She sees a podiatrist for foot checks.	
She also sees 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.	

Simple Clinical Scenario 5

Team-based Care

Scenario	Patient Relationships
Patient Traoré has hypertension, diabetes, and atrial fibrillation. She sees a ***cardiologist*** regularly for her atrial fibrillation.	***Continuous/Focused – X2***
She sees a ***podiatrist*** for foot checks.	***Continuous/Focused – X2***
She also sees an ***ophthalmologist*** for eye exams, given her diabetes.	***Continuous/Focused – X2***
Her ***nurse practitioner*** coordinates with the cardiologist, podiatrist, and ophthalmologist as part of her routine health maintenance.	***Continuous/Broad – X1***

Complex Clinical Scenarios

- Complex scenarios to demonstrate how a range of clinicians involved in patient care should self-identify their patient relationships
- Note: The scenarios presented here are purely hypothetical and do not represent real patient cases

Complex Clinical Scenario 1: Colon Cancer

Patient Rodriguez sees a resident working under a primary care physician at an AMC for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the mass 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.

Complex Clinical Scenario 1: Colon Cancer

X1 Continuous/Broad Services

Patient Rodriguez sees a resident working under a ***primary care physician*** at an AMC for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the mass 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***.

Complex Clinical Scenario 1: Colon Cancer

X2 Continuous/Focused Services

Patient Rodriguez sees a resident working under a primary care physician at an AMC for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the mass was too large to resect, Patient Rodriguez was referred to a surgical oncologist for resection and, afterward, to a ***medical oncologist*** *f*or 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.

Complex Clinical Scenario 1: Colon Cancer

X3 Episodic/Broad Services

Patient Rodriguez sees a resident working under a primary care physician at an AMC for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the mass 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.

Complex Clinical Scenario 1: Colon Cancer

X4 Episodic/Focused Services

Patient Rodriguez sees a resident working under a primary care physician at an AMC for his diabetes. He had a routine screening colonoscopy by his ***gastroenterologist***, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A PET scan read by the radiologist showed no metastatic disease. Since the mass 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.

Complex Clinical Scenario 1: Colon Cancer

X5 Only as Ordered by Another Clinician

Patient Rodriguez sees a resident working under a primary care physician at an AMC for his diabetes. He had a routine screening colonoscopy by his gastroenterologist, an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the ***pathologist*** confirmed that it was cancerous. A PET scan read by the ***radiologist*** showed no metastatic disease. Since the mass 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.

Complex Clinical Scenario 1: Colon Cancer

Summary

Clinical Context	Clinician Type	Patient Relationship	Slide #
Diabetes Management	Primary Care Physician	Continuous/Broad – X1	35
Colon Cancer Screening	Gastroenterologist	Episodic/Focused – X4	38
Colonic Tissue Interpretation	Pathologist	Only as Ordered by Another Clinician – X5	39
PET Scan Interpretation	Radiologist	Only as Ordered by Another Clinician – X5	39
Colorectal Cancer Resection	Surgical Oncologist	Episodic/Focused – X4	38
Colorectal Cancer Treatment/Chemotherapy	Medical Oncologist	Continuous/Focused – X2	36
Neutropenic Fever/Diabetes Management	Hospitalist	Episodic/Broad – X3	37
Neutropenic Fever Evaluation	Infectious Disease Consultant	Episodic/Focused – X4	38
Neutropenic Fever Evaluation	Medical Oncologist	Episodic/Focused – X4	38
Nutrition Management	Dietician	Episodic/Focused – X4	38
Neutropenic Fever/Diabetes Management	Intensivist	Episodic/Broad – X3	37
Palliative Care	Palliative Care	Episodic/Focused – X4	38
Hospice Care	Nurse Practitioner	Continuous/Broad – X1	35

Complex Clinical Scenario 2: Stroke

Patient Adams 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 head scan without contrast and gave her a tPA. Initially, she was stable, but then she lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral bleed. 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.

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 evaluate her need for post-stroke rehabilitation. 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, where she spent another 25 days. A geriatrician cared for her, and she also had visits with a consulting physiatrist.

Complex Clinical Scenario 2: Stroke

X3 Episodic/Broad Services

Patient Adams 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 head scan without contrast and gave her a tPA. Initially, she was stable, but then she lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral bleed. 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.

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 evaluate her need for post-stroke rehabilitation. 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, where she spent another 25 days. A ***geriatrician*** cared for her, and she also had visits with a consulting physiatrist.

Complex Clinical Scenario 2: Stroke

X4 Episodic/Focused Services

Patient Adams 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 head scan without contrast and gave her a tPA. Initially, she was stable, but then she lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral bleed. 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.

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 evaluate her need for post-stroke rehabilitation. 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, where she spent another 25 days. A geriatrician cared for her, and she also had visits with a ***consulting physiatrist*.**

Complex Clinical Scenario 2: Stroke

X5 Only as Ordered by Another Clinician

Patient Adams 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 head scan without contrast and gave her a tPA. Initially, she was stable, but then she lost consciousness. The ***radiologist*** conducted a repeat CT, which showed an intracerebral bleed. 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.

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Complex Clinical Scenario 2: Stroke

Summary

Clinical Context	Clinician Type	Category	Slide #
Ischemic Stroke Treatment	Emergency physician	Episodic/Focused – X4	43
Ischemic Stroke Treatment	Neurologist	Episodic/Focused – X4	43
Head CT Interpretation	Radiologist	Only as Ordered by Another Clinician – X5	44
Intracerebral Hemorrhage Treatment	Neurosurgeon	Episodic/Focused – X4	43
Intracerebral Hemorrhage Treatment	Intensivist	Episodic/Broad – X3	42
Intracerebral Hemorrhage Treatment	Hospitalist	Episodic/Broad – X3	42
S/P Intracerebral Hemorrhage Management	Physiatrist – Hospital	Episodic/Focused – X4	43
S/P Intracerebral Hemorrhage Management	Physiatrist – Rehab	Episodic/Broad – X3	42
S/P intracerebral Hemorrhage Management	Geriatrician	Episodic/Broad – X3	42
S/P intracerebral Hemorrhage Management	Physiatrist – SNF	Episodic/Focused – X4	43

Question & Answer Session

For More Information

The recording for the February 2018 PRC webinar, the transcript for the February 2018 PRC webinar, and the slides for the February 2018 PRC webinar are posted on the MACRA Feedback page.

A PRC FAQ Document with more examples of clinical scenarios is also available on the MACRA Feedback page.

For all other inquiries about the Patient Relationship Categories and Codes, please contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 1-866-288-8292, TTY: 1-877-715-6222.

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