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TRANSCRIPT

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Patient Relationship Categories and Codes Webcast

Moderated by: Aryeh Langer
October 17, 2018 1:30pm

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Operator: Hello and welcome to today's Medicare Learning Network® event. My name is Jen and I'll be your web event specialist today.

All lines have been placed on mute to prevent any background noise. Please note that today's event is being recorded. During the presentation, we'll have a question-and-answer session. You can ask text questions at any time. Click the green Q&A icon on the lower left-hand corner of your screen, type your question in the open area and click submit.

We will also be taking questions via the phone line and instructions on how to do so will be given at the appropriate time. If you would like to view the presentation in a full screen view, click the full screen button in the lower right-hand corner of your screen. Press the escape key on your keyboard to return to your original view. For optimal viewing and participation, please disable your pop-up blockers. And finally, should you need technical assistance as a best practice, we suggest you first refresh your browser. If that does not resolve the issue, please click on the support option in the upper right-hand corner of your screen for online troubleshooting.

It is now my pleasure to turn to today's program over to Aryeh Langer. Aryeh, the floor is yours.

Announcements & Introduction

Aryeh Langer: Thank you so much. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS and I'm your moderator for today's webcast. I'd like to welcome you to this Medicare Learning Network Webcast on the Patient Relationship Categories and Codes.

Before we get started, there are few items that I would like to quickly cover. Today's event uses webcast technology. We recommend streaming the audio live through your computer speakers. Those of you participating via webcast may download a copy of today's slide presentation by clicking the blue files button at the bottom left side of your screen. And please note that this event is being recorded and transcribed.

Today's event is not intended for the press and the remarks are not considered on-the-record. If you are a member of the press, you may listen in, but please refrain from asking any questions during the question-and-answer session. If you have any inquiries, please contact press@cms.hhs.gov.

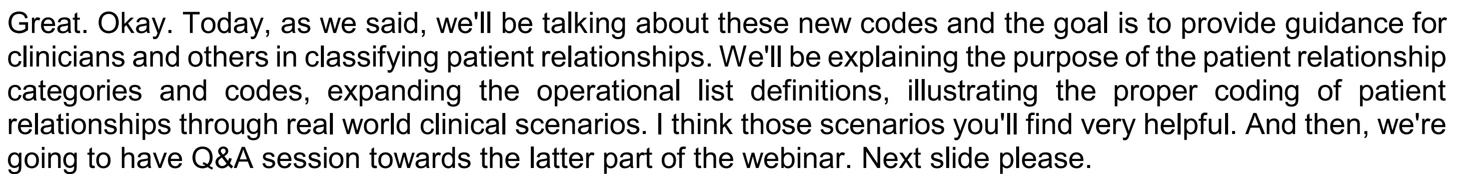
At this time, I would like to turn the call over to Dr. Paul Rosen from CMS.

Presentation

Dr. Paul Rosen: Thanks so much, Aryeh. My name is Paul Rosen; I'm a pediatrician and a medical officer here at CMS. Thanks so much -- thanks so much for joining us on this webinar where we'll be getting in to the Patient Relationship Categories and Codes.

I'll spend the next few minutes just giving a brief introduction. Next slide please.

This is our CMS disclaimer which basically explains that this program is a general summary and it is not sort of a legal document. We'll go on to the next slide.



Great. Okay. Today, as we said, we'll be talking about these new codes and the goal is to provide guidance for clinicians and others in classifying patient relationships. We'll be explaining the purpose of the patient relationship categories and codes, expanding the operational list definitions, illustrating the proper coding of patient relationships through real world clinical scenarios. I think those scenarios you'll find very helpful. And then, we're going to have Q&A session towards the latter part of the webinar. Next slide please.

Great. Here's our agenda and I'll be giving the introduction and then we'll go on from there. Next slide please.

Okay. Here's some of the acronyms we'll be using. I think most of you have seen most of these acronyms. HCPCS is Healthcare Common Procedure Coding System. And I think some of the other ones you're familiar with. Next slide please.

All right, we'll go to the next slide.

Okay. Great. Well, so as you all know, since MACRA went into place, we've been working with the quality payment program and- you know- redesigning how we pay clinicians to promote value, improve quality, decrease cost. And the quality payment program evaluates clinicians in the number of areas including resource use or costs. And MACRA actually requires the development of these Patient Relationship Categories and Codes to help us with attributions for these cost measures.

The Patient Relationship Categories are intended to define the relationship and responsibility of clinicians with patients at the time of furnishing a service, then facilitate the attribution of patients and episodes to one or more clinicians and also allow clinicians to self-identify their patient relationships. Next slide please.

All right, so the -- we have -- the patient relationship categories and codes were finalized in Calendar Year 2018 Patient Physician Schedule -- excuse me, Physician Fee Schedule Final Rule and these codes if you recall are voluntary. We're currently in a voluntary reporting period and the codes do not affect how Medicare payment is currently being made. And the goals of this period are to educate clinicians and stakeholders about using the codes and also, we want to collect data and test the validity and reliability of these codes before further use for cost measures. Next slide please.

Okay. As you know, this is our list of current MIPS eligible clinicians. As you know, for the physicians, DOs, doctors of dental medicine, podiatrists, and there's the list of eligible MIPS clinicians. And anyone can use these codes in terms of whether they're MIPS and non-MIPS eligible. We'd like to see these codes used across the spectrum from MIPS and non-MIPS eligible clinicians. Next slide.

Great. So, some of the principles that were used to develop these codes were -- the goals were being clear and having a simple classification code and to be able to capture the majority of the patient relationships, ensure flexibility and ease in submitting the codes -- on claims, staying open and transparent, and then enabling accurate and effective cost measurement. Next slide.

Great. And as usual, we have asked for input from clinicians and others as we've developed these codes -- as these codes have been developed and in addition to public postings, CMS has held listening sessions as well and comments and solicited feedback on the -- on the proposed rule. Next slide.

Okay. Great. Well, I'll turn it over to my colleague, Dr. Rose Do now to take us to the next part of the -- of the presentation. Thank you.

Patient Relationship Categories

Dr. Rose Do: Thank you, Dr. Rosen. My name is Rose Do; I'm a Cardiologist at Acumen. And I'm pleased to be here to discuss the patient relationship categories and answer any questions you may have after the presentation.

So, at this stage, we're going to provide an overview of the Patient Relationship Categories and Codes and the operational list. This is slide 13. We will describe the five patient relationship categories, all of which can be coded using the Level II HCPCS Modifier Codes and briefly the relationship categories are Continuous/Broad, Continuous/Focused, Episodic/Broad, Episodic/Focused, and Only as Ordered by Another Clinician.

In the next few slides, we'll describe the types of clinicians and services for each of these categories and in general though, it may be helpful to think of the categories in this way. Continuous and Episodic referred to the length of the clinician-patient interaction, while Broad and Focused referred to the focus of the clinical care that's provided in that interaction. Next slide please.

For the first example, we can discuss the Continuous/Broad services and this relationship is categorized by clinicians that provide comprehensive care for a patient with no planned endpoint of the relationship. And you can see here that some examples might be a primary care clinician or a specialist that also provides primary care to a patient. Next slide please.

For Continuous/Focused services, there might still be a need for ongoing and long-term care, but it might be for a specific organ system or a condition. So some examples we have listed below, they might include specialist such as an endocrinologist that manages diabetes or perhaps a speech language pathologist that provides ongoing care for dysphagia. Next slide please.

In this example here, we have the Episodic/Broad services. And these are basically interactions where clinicians may be responsible for the overall care and coordination of a patient but it's during an acute hospitalization or an inpatient rehabilitation. So, we also have examples here where it might be the hospitalist or the intensivist or even in the rehab setting it might be a physiatrist.

Next slide please. Thank you.

For X4, we have the Episodic/Focused services, and these are for clinicians that are providing services for a specific condition or treatment, but it's for a definite period of time. So, it's time-limited care and it's also fairly specialized or focused. So, we also have the examples of a surgeon that's maybe doing just the one-time procedure, a physical therapist that is working on a patient's rehab after a knee replacement. So, as you can see, it's a defined period of time, not necessarily with a specific timeframe that we will define -- we'll state, but it is just the defined treatment for that condition. Next slide please.

And finally, we have only as ordered by another clinician. These are clinicians that furnished services to provide information to another clinician without directly initiating a treatment plan. So the relationship might be with the

clinician that ordered this service and it's not as if they are, “I'm going off and creating an entire treatment plan for the patient themselves."

So, you can think of clinicians such as the radiologist that’s interpreting a CT scan, perhaps the allergist is conducting an allergy test and audiologist is doing hearing and balance testing as well.

Next slide please.

Aryeh Langer: It's slide 19, if anyone joined us late.

Dr. Rose Do: Thank you. Yes, so slide 19, we have the patient relationship categories and codes. This is a summary table of the various categories and codes that we've just discussed in the previous slides, so I'll leave it up here for a bit so you can take a look at the five categories. And again, we had things based off of the timeframe as well as the focus of care.

Next slide please.

Clinical Scenarios

So, this is slide 20, it's clinical scenarios and we'd like to bring up a few clinical scenarios to help illustrate those definitions a bit more. Next slide please.

So, we'll begin this section with a few simple clinical scenarios before we move on to a couple of complex clinical scenarios. The simple clinical scenarios are made to address concerns that were raised in the public comments and we hope they do address them. The complex clinical scenarios will then demonstrate how a wide range of clinicians involved in patient care can identify themselves relative to a given patient. And please note that these scenarios are completely hypothetical. Next slide please.

So, we wanted to start with a few concerns that we saw in public comments. The main concerns were that there was a feeling that these terms were vague or open to interpretation. It was unclear how all this was going to be captured over time and we wanted to make sure that there was some team-based care and co-management that was addressed with these categories.

So, what we'll try to illustrate from these simple clinical scenarios is that these categories are designed to show how the relationships can be specific, but they can also be dynamic and flexible. We also want to show how these relationship categories can exist within a setting of team-based care. Next slide please.

This is slide 23 and we are in clinical scenario number 1. This is a simple scenario that’s going to show the definition of Episodic. It depends on the clinical context itself. So Patient Khan develops actinic keratosis and sees a dermatologist for treatment with cryotherapy.

Her interaction with the dermatologist spans two visits. In a few months later, Patient Khan undergoes a joint replacement procedure by an orthopedic surgeon. She sees the orthopedist for postoperative check-up.

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So, in the next slide, we have highlighted the clinician as well as the patient relationship. So, you'll see that the dermatologist has an Episodic/Focused relationship with the patient and the orthopedic surgeon also has an Episodic/Focused relationship.

And depending on the condition being treated, these Focused relationships may have a discreet time window, but they can also vary in length. The dermatologist may take two visits. The orthopedic surgeon may take a few more postop checkups.

And because the clinical context defines Episodic, the categories for Continuous and Episodic patient relationships are not defined by a specific number of days. Next slide please.

So, this is slide 25, we are -- we have clinical scenario number 2. 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.

And we will go to the next slide and that again we have highlighted the clinicians as well as the relationships, so the hospitalist is Episodic/Broad. Again, this is during the inpatient stay during a COPD exacerbation, so it's Episodic care. But, the hospitalist coordinates overall care and therefore has a Broad relationship with the patient.

The pulmonologist that have been brought in as consultation is also helping in the acute phase, so Episodic. But, then is focused on the patient’s pulmonary status; therefore, making this relationship Focused. And finally, upon discharge, the pulmonologist who continues to see the patient for her lifelong COPD engages in a Continuous relationship but is still Focused on her pulmonary status. Next slide please.

Slide 27, this is clinical scenario 3. We've got Patient Ramone undergoing a colonoscopy by a gastroenterologist. There is the pathologist that reads the biopsies and issues a report and notes that the patient has findings consistent with Crohn’s Disease. The gastroenterologist then initiates treatment for Crohn’s Disease and continues to monitor Patient Ramone.

So next slide. You can see here, we've got the patient relationships carved out again. So, we've got gastroenterologist who does the colonoscopy has a Focused care for the patient’s GI system and does a colonoscopy making it Episodic. The gastroenterologist orders a biopsy and read. The pathologist takes on the relationship category as Only as Ordered by Another Clinician.

The pathologist interprets the findings and sends those findings back to the gastroenterologist who is again seeing Patient Ramone for a longer period of time for this lifelong Crohn’s Disease Focused on the GI tract, but a Continuous relationship with the patient. Next slide please.

Now, we have clinical scenario number 4 on slide 29. 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 longstanding relationship with Patient Ventura, the endocrinologist begins also treating his hypertension and doing regular health check-ups.

From the next slide, we have the relationship categories again. The endocrinologist, in the beginning, has an Episodic/Focused relationship treating the diabetes. After seeing this endocrinologist for a few years, it becomes Continuous but still focused on the diabetes.

But since the patient does not have a primary care of clinician, the endocrinologist starts taking on primary care responsibilities and starts initiating regular check-ups over the patient's broad condition. This becomes a Continuous/Broad relationship over time. Next slide please.

And this is slide 31 with clinical scenario number 5. We've got Patient Traoré has hypertension, diabetes, and atrial fibrillation. And she sees a cardiologist regularly for her atrial fibrillation. She also sees a podiatrist for foot check.

And 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. And this shows how the patient relationship categories may overlap in co-management.

You can see here on slide number 32, even with this team-based interaction, you've got a cardiologist who takes on the Continuous Focused relationship. Podiatrist and ophthalmologist are also Continuous/Focused. And the nurse practitioner who is coordinating the care amongst all these specialists has a Continuous/Broad relationship with the patient. Next slide please.

This is slide number 33 and we will move on to two more complex patient stories. And I just wanted to note, feel free to submit any written questions on any of these scenarios as we're going through them. We are trying to answer the questions during this webinar, but we can answer as many as we can as time allows after the presentation. So next slide please.

This is slide 34 with complex clinical scenario number 1 regarding a treatment for colon cancer. We've got Patient Rodriguez who 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, who is an attending physician at the same Academic Medical Center. 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.

And due to the progression of his illness, he was transferred to the ICU where an intensivist cared for him. After meeting with the palliative care clinician, Patient Rodriguez decided to go home with hospice care. At home, he has visits with the hospice nurse practitioner.

You can see this is a very -- there are a number of clinicians involved in caring for Patient Rodriguez. Each of these clinicians have a specific relationship to the patient based on the clinical focused and the nature of their interaction.

So, let's move on to the next slide please.

Here we have highlighted a few of the clinicians in this scenario and we'll discuss their relationships to Patient Rodriguez. The first relationships to highlight are those of the primary care physician and the hospice nurse practitioner. These clinicians provide Continuous/Broad services managing the patient's overall care over an indefinite period of time.

Next slide please.

Aryeh Langer: And, we're moving on to slide 36.

Dr. Rose Do: Thank you. So, on slide number 36, we have a few more of the -- we have a specialist, the medical oncologist highlighted here. This medical oncologist assists Patient Rodriguez with adjuvant chemotherapy. And again, the focus is on the patient's colon cancer. The treatment is Continuous. This relationship fits into the Continuous/Focused role. Next slide please.

Slide number 37 we are highlighting the hospitalist and the intensivist here. They care for the patient during an acute care situation such as the admission to the hospital and a stay in the ICU, respectively. These clinicians also provide Broad overall care, but it is Episodic in nature since this is an acute care situation. Next slide please.

And in this slide, 38, we are highlighting the gastroenterologist, surgical oncologist, infectious disease consultant, medical oncologist, dietitian and palliative care clinician. These clinicians focus on a specific condition or organ system and they provide services when they're needed, so therefore, providing Episodic/Focused services. Next slide please.

Slide 39, we're highlighting the pathologist and the radiologist. These clinicians fall under the X5 Category which are Only as Ordered by Another Clinician. Their services have been ordered by others. Their care generally remains limited to fulfilling that request and interpretation. They do not necessarily start their own care plan for the patient, but theirs -- their expertise is much needed. Next slide please.

This table summarizes all of the clinical context, the clinician types, and the patient relationships in the clinical scenario we just discussed. So, I'll just stay here for a little bit, so you can kind of see all the clinicians that were involved. And then, we can move on to the complex clinical scenario number 2. Next slide.

So, now we're on slide 41 and this is our second complex clinical scenario involving the care of a patient with stroke. So 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 -- gave her tPA.

Initially, she was stable, but then she lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral bleed. A neurosurgeon then evaluated her and 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 hospitalist and seen by the neurologist and neurosurgeon. The hospitalist called the physiatrist to evaluate her need for post-stroke rehab.

The physiatrist recommended she be transferred to rehabilitation hospital, where she was cared for by another physiatrist for a 20-day stay. Since she has not improved sufficiently to return home, she was transferred to a SNF -- Skilled Nursing Facility, where she spent another 25 days. A geriatrician cared for her, and she also had visits with the consulting physiatrist. So next slide please.

We are highlighting a few clinicians here to illustrate the Episodic/Broad Services or X3. We have the intensivist, the hospitalist, physiatrist and geriatrician. And in this case, they're providing care during acute care inpatient stays or rehab stays, so it's Episodic in nature but again they may coordinate overall care for the patient's services are Broad. Next slide please.

This is slide number 43. We have highlighted the emergency physician, neurologist, neurosurgeon, physiatrist and consulting physiatrist. So, -you can see these might be specialists who are providing Focused care and again in an episodic fashion during the acute phase. Next slide please.

This is slide number 44 and we are highlighting the radiologist. The radiologist interpreted the CT scan and conducted a repeat CT and provided an interpretation to the other clinicians so that the other team members could use that information to further treat the patient. Next slide please.

So, this slide is the summary of all the clinician types and the relationship categories we just discussed in scenario number 2 and I just want to stay here so you can take a look.

And now we can move on to the next slide.

So, I would like to turn it over to my colleague as we go through the question-and-answer session. Thanks for your time.

Question & Answer Session

Aryeh Langer: Thank you very much, Dr. Do.

Our subject matter experts will now take your questions about patient relationship categories and codes. Throughout the Q&A session, we will ask webcast participants to provide feedback about their experience with the technology used today. Remember to disable your pop-up blockers for best results. We will begin our session

by answering a few questions that we received from webcast participants and we'll then take questions from the phone.

Operator, please prompt the telephone users and begin to compile that Q&A roster.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick-up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you are asking your question, so anything you say, or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Aryeh Langer: And while you're compiling the roster, we'll just start with taking a few questions from the webcast.

The first question submitted is how long is the voluntary reporting period?

Dr. Rose Do: So this is Rose. I can take that question. So, CMS has not established the duration of the voluntary reporting period but anticipates it will include at least Calendar Year 2018. CMS may adjust the length of the voluntary period based on the factors including clinician adoption of the codes, data analysis findings, stakeholder feedback, and mandatory reporting will be established through the rule-making. Until then, reporting is voluntary.

Aryeh Langer: Thank you very much. Our second question is, if a clinician always has the same patient relationship, can they apply to be exempt from reporting?

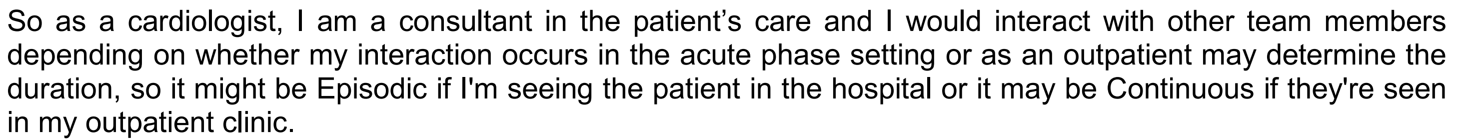
Dr. Rose Do: That’s a good question. This is Rose. Others can also correct me if they have other advice in this situation. I think that if they -- at least, we can speak to the possibility that if they remain having the same relationship category that they would just report that each time on the Form 1500, the CMS Form 1500.

But, I may defer to others on how to go about exempting themselves from further reporting. The intent again of reporting is to require as minimal burden as possible; so therefore, it is listed under the modifier which is also included on the claims form itself.

Aryeh Langer: Thank you. How will the patient relationship categories affect co-management and team-based care?

Dr. Rose Do: This is Rose again. Thank you for that question.

We hope that the clinical scenarios that we presented during this webinar were helpful. We did have the simple clinical scenarios, but the complex clinical scenarios were intended to show how team-based care which happens real-life -- we are still able to identify a relationship to the patient.



So as a cardiologist, I am a consultant in the patient's care and I would interact with other team members depending on whether my interaction occurs in the acute phase setting or as an outpatient may determine the duration, so it might be Episodic if I'm seeing the patient in the hospital or it may be Continuous if they're seen in my outpatient clinic.

I am fairly Focused, but I hope to work with the primary care clinicians and other clinicians that are caring for this patient to continue with team-based care. So, my relationship with the patient is not necessarily inhibited or affected by the others. In fact, I hope it is complementary.

Aryeh Langer: Thank you very much. Let's go ahead and take our first question from the phone lines, please.

Operator: Your question comes from the line of Cherie McNett.

Cherie McNett: Good afternoon. Can you hear me?

Aryeh Langer: Yes. Go ahead please.

Cherie McNett: Great, thanks. I appreciate this webinar. It's been very helpful.

I do realize that 2018 is a voluntary reporting period and I'm wondering is there going to be -- I know you're collecting data and doing reliability testing -- are you going to release the results of that so that the public can also understand and know more about how the reporting period went?

Aryeh Langer: Rose, do you want to handle that question?

Dr. Rose Do: Yes. Thank you, Aryeh. I will probably have to consult with our CMS colleagues to see what the plan is with the data that we do collect from the voluntary period. I don't want to speak for them, but just want to assure everybody that we would be collecting data and reviewing also the comments that we're receiving from the clinical community.

Cherie McNett: Great, thanks.

Dr. Paul Rosen: Yes. This is Dr. Rosen and I'm -- I think we're here to learn together how these codes are working and we want to be able to share that with clinicians so we're all kind of learning together how these codes are working. So, once we get these lessons, the hope would be we can -- we can share the learning with the community.

Cherie McNett: Great, thank you. Appreciate it.

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Aryeh Langer: Okay. I'll go ahead and go with our next question that's been submitted through the webcast. Our nephrologists are still acting as PCP for a small number of patients, would it be appropriate to do the different code based on what type of visit the physician has on that specific day?

For instance, if the patient's appointment on one day is related to PCP care, it would be X1. But, if on another day, the physician only addresses the patient's CKD and related issues it would be X2, is that right?

Dr. Rose Do: This is Rose. Thank you for that question and that is absolutely correct. So, we hope that these relationships can be dynamic. So, yes, we know that the clinician can sometimes be doing primary care type of care during a certain visit and that will allow the clinician to code for that on the 1500 Form.

For that date and the services rendered during that stay, they may have the X1 relationship. On another day, if they're doing other types of services and -- that will fall under X2, we would hope that you can code it as such under that claims. That is the correct interpretation.

Aryeh Langer: Thank you very much. Our next question is, are the modifiers X1, X2, et cetera, last listed on the CPT Line? If I'm billing the professional services for radiologists, would it look like 71045-26-X5?

Dr. Rose Do: This is Rose again. Thank you for that question. I'm actually looking at the CMS-1500 form. On the line items, there is date of service, the place of service, and then there will be the procedure itself which is the CPT and there is a space for that.

There is also a separate space for the modifier code, so you may not have the dash or hyphen. It seems like it's actually discreet at -- different space than what you'll see from the actual CPT or HCPCS Code. So you'll have the modifier probably at the end, but not necessarily attached if that make sense.

Aryeh Langer: Thank you very much. Our next question submitted is since adjuvant chemotherapy in this context is time-limited wouldn't the medical oncologist report an Episodic/Focused patient relationship rather than Continuous/Focused?

Dr. Rose Do: That's a good question. This is Rose. I think in this situation, we could leave it to the discretion of the specialist. If they do feel that there is a time-limit that's very discreet and it will not continue for an indefinite period of time, then we do agree with you that it would most likely be Episodic.

Some examples that we have given for Episodic care were not necessarily in acute setting, so I apologize if I confuse anybody with those examples. But you can have somebody have Episodic care receiving a few visits for therapy, it gets wrapped up and the patient leaves from your relationship for the rest of their life. So, you can have that and in this, we would like to give some flexibility to the clinician, since they know their relationship the best.

Aryeh Langer: Thank you. Our next question is, do we just attach X as a modifier to the CPT code on billing?

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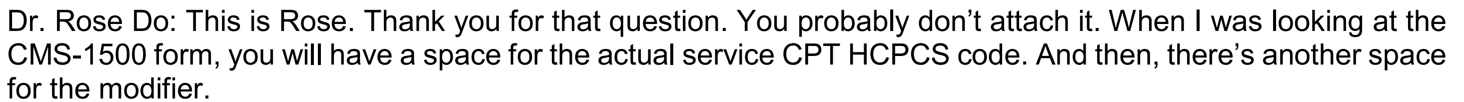

Dr. Rose Do: This is Rose. Thank you for that question. You probably don't attach it. When I was looking at the CMS-1500 form, you will have a space for the actual service CPT HCPCS code. And then, there's another space for the modifier.

Aryeh Langer: Thank you very much. Our next question is where are these codes reported on the HCFA 1500 forms?

Dr. Rose Do: This is Rose. I am actually reviewing the CMS-1500 form and believe it is item 24, so you will have a section with the dates of the service, the place of service, the procedures to be listed, as well as the modifier. So, if you were to pull up a picture of that CMS-1500, is what it's called, you'll be able to see in item 24 what I'm talking about and hopefully that will help.

Aryeh Langer: Thank you, Rose. Our next question, these went into effect on a voluntary basis, January 1st, 2018. When do they become mandatory?

Wilfred Agbenyikey: Hello. This is Will Agbenyikey from CMS. CMS may adjust the length of the voluntary periods based on such as have included in the clinician's adoption of these codes, the analysis that we'll find based on the attribution analysis that they will find and also stakeholder feedback. But mandated reporting would be established through rule-making and we would make everybody aware of that before we make that mandatory -- we make it mandatory.

For now, it's voluntary until we establish it through rule-making.

Aryeh Langer: Thank you very much, Will. Our next question is, we understand the reporting on the patient relationship codes are voluntary. When will they mandatorily need to be reported?

Appears that's the same question we just answered, so let's move on to the next one, apologize for that.

Do we get paid extra for this extra reporting? Again, the question is, do we get paid extra for this extra reporting?

Dr. Paul Rosen: Yes. I mean -- this is Paul Rosen from CMS. Right now, this is voluntary reporting and there's no linkage to payment and then this will be reevaluated going forward.

Aryeh Langer: Thank you very much. Next question. How will this reporting affect MIPS scoring under cost category?

Wilfred Agbenyikey: I think we are collecting data presently. This is Will Agbenyikey. We are collecting data presently for this attribution methodology -- cost attribution methodology calculations. And we would be able to let that be known in -- sooner than later, when we are done with the collection of data.

Aryeh Langer: Thank you. Our next question is where do the modifiers fall in sequencing?

Unidentified Female: Thanks.

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Yvette Cousar: This is Yvette Cousar, Provider Billing Group. It doesn’t matter, I think. I don’t know if that -- if that answers it...

Aryeh Langer: Okay. Let’s go ahead

Yvette Cousar: As long as they’re reported -- I don’t know if that’s what they’re looking for. It's...

Aryeh Langer: Okay. Thank you.

Yvette Cousar: Yes

Aryeh Langer: Are the HCPCS codes currently available? Again, are the HCPCS codes currently available?

Dr. Rose Do: This is Rose. I could take a stab at this question. So, we’re actually introducing modifier codes, so HCPCS Level 2 modifier codes are currently available. And those are again, in the section that will follow the HCPCS CPT codes that you’ll list for your service itself. You can read more about them in the FAQ documents that have been published, but yes, they are available.

Aryeh Langer: Our next question is, does the modifier need to be on every line item on a claim form or just one?

Yvette Cousar: This is Yvette. It has to be on every line item.

Aryeh Langer: The next question is, if two or more clinicians co-manage care for a patient, and elect the same patient relationship, can the report -- can they report the patient relationship code on the claim only once?

Yvette Cousar: If two -- say the beginning -- if two or more physicians manage the patient?

Aryeh Langer: If two or more clinicians co-manage care for a patient, and elect the same patient relationship, can they report the patient relationship code on the claim only once? I believe that’s a question for Rose.

Yvette Cousar: Yes, I think so.

Dr. Rose Do: Okay. Yes. Thank you, Yvette though. So they -- we would say you probably should just report the relationship that you have and if that means that both of you are reporting the same relationship, that’s okay, because you are co-managing -- sorry. Did I -- was anybody else going to say anything? Just want to make sure I didn’t cut anyone off. Okay.

Aryeh Langer: No, that’s good.

Dr. Rose Do: Yes.

Aryeh Langer: Thank you, Rose.

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Dr. Rose Do: I -- Okay. Yes, thank you Aryeh.

Aryeh Langer: Our next question is how should clinicians capture changes in their patient relationships over time?

Dr. Rose Do: This is Rose. I can answer that. So when you are writing down the service that you've rendered to the patient when you're putting that into your claim form, you'll have the date of service. And for that interaction, you will probably code the service that you've provided, as well as the relationship that you had with that patient.

For any claims to follow that occur over whatever period of time that you're seeing that patient, we do know that it's dynamic. Things can change, so you will, again, just have a different date of service. You'll have a different service, potentially, and then, you may have a different modifier depending on whether your relationship has changed with that patient.

Aryeh Langer: Okay. Thank you, Rose. Our next question, how exactly will these codes be used in attributing responsibility for a care episode and ultimately measuring cost performance under MIPS?

Dr. Rose Do: This is Rose. I'm -- defer to our CMS colleagues on how ultimately, we would be using it for calculation. I think having the relationship categories will be definitely helpful in identifying attribution of episodes of care. But for further information, I'd like to defer the -- our CMS colleagues.

Dr. Paul Rosen: Yes. This is Paul Rosen. We don't have a final determination on how there'll be an impact -- I mean, were you getting the data here now. We're verifying these codes and then they'll be used to inform how we develop cost measures. I don't – have any final answer on that yet, but we'll collecting some information.

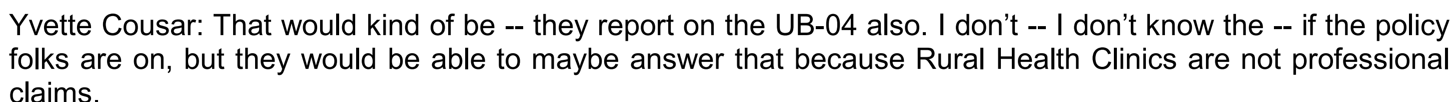
Aryeh Langer: Okay, thank you very much. Our next question is, is the reporting -- is the reporting required on CMS-1500 only? Will there be any scenarios where the patient relationship modifiers will be required on the UB-04?

Yvette Cousar: I guess they're asking does it require -- does it apply to hospitals that we're going to provide our billing side.

Aryeh Langer: The question is, is the reporting required on CMS-1500 only? Will there be any scenarios where the patient relationship modifiers will be required on the UB-04?

Yvette Cousar: Like, is it -- is it going to be billed -- are there entities other than professional claims involve any other SNFs, home health, hospitals, they bill on UB-04?

Aryeh Langer: That's only part of the question that was submitted, so let's move on to the next one. Do these codes need to be reported for an office that is under Rural Health Clinic status?



Yvette Cousar: That would kind of be -- they report on the UB-04 also. I don't -- I don't know the -- if the policy folks are on, but they would be able to maybe answer that because Rural Health Clinics are not professional claims.

Aryeh Langer: Okay, thank you.

Yvette Cousar: Yes.

Aryeh Langer: Our next question, is there a CMS transmittal with all these guidelines and codes?

Yvette Cousar: Is there a CR related to this program -- change request?

Aryeh Langer: Yes, please.

Yvette Cousar: That's what they -- that's what they're asking. Is it -- is it public or is it confidential?

Aryeh Langer: Is there something public? CMS transmittal with the guidelines and codes.

Dr. Rose Do: So, this is Rose. I could probably point us to some publicly published FAQs and there is a Macro Patient Relationship Category FAQ on the Web Site that you can access, which have a lot of guidelines and answers to very common questions. I think that would be helpful to the clinicians if that's what they're asking for.

Yvette Cousar: Will there be something published that's making this mandated? I think that's what they -- will there be a change request with all of these provisions in it that I guess since it's voluntary, even if it's voluntary, there probably should be a change request I think providers on what they need to do.

Wilfred Agbenyikey: This is Wilfred Agbenyikey again. Yes. So far, all information about -- that we have for the public is on the MACRA Feedback page on the CMS Web Site. Yes, and in the future, when it becomes mandatory …

Yvette Cousar: Okay.

Wilfred Agbenyikey: … to the public.

Yvette Cousar: I'm just curious. If it's voluntary, usually, we would still put out a change request for something that's voluntary just to let the providers know what they need to do and how they need to go about enacting the change in preparation for something to be mandatory …

Aryeh Langer: Hello, let's -- let's …

Yvette Cousar: … so I don't know if you guys …

Aryeh Langer: … we'll …

Yvette Cousar: … look into that or not …

Aryeh Langer: … cover that offline. Is that Okay?

Yvette Cousar: Okay.

Aryeh Langer: Thank you so much. Our, next question is, this person is at a recovery center for substance abuse and wants to know the codes for recovery coach. Again, this person is at a recovery center for substance abuse and wants to know what the codes are for a recovery coach.

Dr. Rose Do: So, this is Rose. My thinking is this person would be perhaps Episodic because they're at the center and it might be Focused. It might be X4 because they're helping with the recovery itself, so it's -- it is fairly Focused type of care.

Aryeh Langer: Okay. Our next question is, we have an onsite lab that we will build services for. Would we use these modifiers for lab services or they only appropriate to use for professional services?

Dr. Rose Do: This is Rose. So, these relationship categories are mainly to demonstrate the relationship for professional services, so it is involving the clinicians themselves.
Aryeh Langer: Thank you. Our next question, who determines which level a relationship is?

Dr. Rose Do: This is Rose. It would be the discretion of the clinician. That's why we do want to leave that -- leave that, so the clinician knows best what the relationship is to the patient and would probably be able to code it the most accurately, so hope that answers that question.

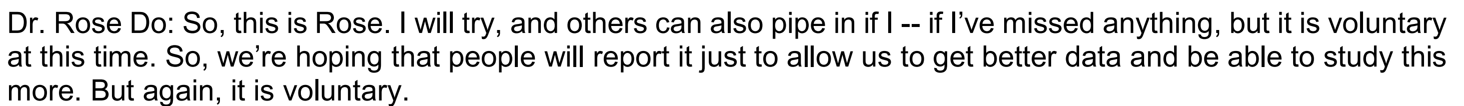
Aryeh Langer: Thank you. The next question submitted, is there an attribution algorithm available that will help the field understand how patients are finally attributed to providers -- attributed to the providers against all the codes submitted for patient in a given year or episode of events?

Wilfred Agbenyikey: Hello, this is Will Agbenyikey, again. We are in the process of collecting data for the attribution algorithm calculation, that is why it's important that this stage of voluntary submission, we would get more clinicians into reporting these codes so -- to help us create this algorithm.

Aryeh Langer: Okay, thank you Will. Our next question actually directed to Rose. What if they have chronic Parkinson's and acute stroke and they both need management, Continuous, Episodic with Focus, or Broad care?

Dr. Rose Do: So, thank you for that question. I think this would be -- probably the best advice to give is to pick the relationship code that best summarizes that visit, mainly because you have one-line item for that service. Let's say you've given two services for that visit. Then you probably have two areas to build two modifier codes. But if you are only billing one service and you only have one modifier to choose, I would choose the one that reflects that care for that day.

Aryeh Langer: Thank you. Our next question, can you report sometimes and at other times, not report?



Dr. Rose Do: So, this is Rose. I will try, and others can also pipe in if I -- if I've missed anything, but it is voluntary at this time. So, we're hoping that people will report it just to allow us to get better data and be able to study this more. But again, it is voluntary.

Aryeh Langer: Thank you very much. Our next question, we submit all of our claims electronically directly to Medicare. Are we able to report this information in the electronic data file?

Yvette Cousar: This is Yvette. I would think if they submit their claims electronically, they can report -- do this reporting, just along with their regular claim submission.

Aryeh Langer: Thank you.

Yvette Cousar: Yes.

Aryeh Langer: Our next question, so CMS is developing new MIPS cost measures and these patient relationship codes are not yet mandatory. Will CMS then reevaluate the new cost measures? That is, measures will be released and then potentially changed shortly thereafter.

Dr. Paul Rosen: This is Paul Rosen. If I understand the question, I think the caller just wants to make sure we're not adding some burden and we were working together. And as we're developing these things, it's all – the work is coordinated, so yes. That's the goal, we develop the cost measures and that these data from these relationship codes will form those cost measures.

So, we do want to make this as seamless for the clinicians as possible and make sure we're not adding burden and make sure we're collecting useful data as easily as possible. The goal is not to add additional burden or have the clinicians do extra work.

Aryeh Langer: Thank you very much. Our next question, as a specialist, if on the same date of service, can one service related to Continuous/Focused and another service is Episodic or Focused -- can the two different relationships be on the same form?

Dr. Rose Do: This is Rose Do. I think we had a similar question earlier, so my best advice was if you can fit it on to the form, it is fine to do it. We do have to have one modifier per service, so if you only have one service that you've rendered that day, you might put the modifier that best summarizes your relationship for that day.

Aryeh Langer: Thank you, Rose. Our next question, will there be a transcript of questions and answers? The answer to that is yes. There will be a transcript of questions and answers. That information will be posted on our CMS Web Site, approximately, two weeks after today's webcast.

Our next question, if you have a relationship with a patient as an outpatient that is Continuous/Focused, does the relationship change if you see them in the hospital for an exacerbation of the problem?

Dr. Rose Do: This is Rose Do. That's a great question. So, it probably will. You may be seeing them in the outpatient setting, making it Continuous but still Focused if you're a specialist. But let's say you're taking care

of that patient's exacerbation. It's acute. It's during a hospitalized setting. You're trying to get that patient out of the exacerbation phase. It's most likely going to be Episodic/Focused at that time. It can change, depending on where you're seeing the patient.

Aryeh Langer: Thank you very much. Our next question, you mentioned hospice providers. Hospices themselves bill for physician services using a UB-04 form. Would the reporting be done on a line item basis correlating with the CPT codes for physician services?

Dr. Rose Do: This is Rose Do. And Yvette can also correct me, but that is correct. We are talking about the CMS-1500 form, which is more regarding the clinician level of care professional services. It will be under item 24, which is where we have the CPT HCPCS rendered by the clinician and then a modifier code along that same line.

Aryeh Langer: Thank you very much. Our next question, should the code be included on all claim lines for one date of service? For example, patient has an intravitreal injection, will the code be included as a modifier on injection CPT code and also the J CPT drug code? I hope I got that right.

Yvette Cousar: This is Yvette. It would be -- if it's one service, then -- if it's one code, it goes one line. If it's another code, it goes on another line. I'm a little bit -- little -- the question's a little bit confusing, but that's how billing works. And then you would just put whatever other modifiers or whatever other types of codes that go with that procedure code, you put that all on the same line. So, if there's two different procedures, it's a different line. I don't know if that answers it or not but …

Aryeh Langer: Yes, thank you. Our next question, if a patient comes in for right knee pain and it's treated for -- I believe this is says, OA conservatively, how would you code this, same patient is then going to do a TKA, do we use at Code X4 at this point? Same patient is being treated for the right shoulder pain at a later date. How do you code this?

Dr. Rose Do: Aryeh, this is Rose. Would you mind repeating the first part of that question? I want to make sure I got all the relationships they were mentioning.

Dr. Paul Rosen: Okay, Rose, this is Paul. I think -- I think the question relates to a patient's coming in with osteoarthritis, they're being seen by their doc and then it's probably an orthopedist who then goes on to do a total knee replacement in another time. And then how does the relationship change from a conservative management -- non-operative conservative management of osteoarthritis to surgical management of knee replacement and going forward. I think -- I think that's the question, if I have it right.

Dr. Rose Do: Oh, yes. Thank you -- thank you so much, Paul. I think if we're talking about the same clinician, let's say it's the orthopedist who was doing conservative management and it was going to be Continuous/Focused, so it's -- if it's the orthopedists most likely it's Focused Service just because it's a specialist.

Continuous if there was like no -- and no pre-determined end date. If it's chronic management of osteoarthritis, that would probably fit into Continuous. If it's something where the orthopedist did a surgery, it's probably going to be Focused again, most likely Episodic for that knee arthroscopy.

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And then let's say, the orthopedist is doing a postop visit and thinks that they may be able to discharge the patient from their clinic eventually. That could also be Episodic/Focused if the orthopedist feels like they're going to be seeing that patient for a long period of time again, indefinite that might be more Continuous/Focus.

If there were two clinicians in this scenario and one was a primary provider, I would probably say that a Broad relationship. I hope that answers all the questions -- answers the questions for that.

Aryeh Langer: Thank you very much, Rose. Our next question is what would happen if CMS deemed a self-reported code inappropriate, could a code ever be wrong? Yvette can you address that question?

Yvette Cousar: I'm trying to understand what the question is. Could a code be wrong if they report it? Are you saying what if they come back and say they didn't mean to report it. I'm not understanding what the -- what they mean by “Could the code be wrong?”

Dr. Paul Rosen: This is Paul Rosen from CMS. Yes, I mean I think as a pediatrician and as a physician, I think we're all kind of learning how these codes work together now and going forward. If there's a scenario and we would call it and let's say X4 and the clinician billed it -- or code it as X2, is that the wrong -- but I think -- I think we are -- that's what we're doing now, we're looking at the validity and the reliability of how we're coding this and opportunities to make this better.

Well, do that -- do that capture the answer there? Yes, so I think the question is what if -- what if your clinician and you coded a way that doesn't follow the script here, what's the implication of that? But I think right now, again, as we're collecting this data voluntarily and we're trying to go through reliability, we're trying to determine how the system works for now.

Aryeh Langer: Okay. Thank you. Our next question, actually, before we take our next question from the webcast. Dorothy, do you mind reminding folks on the phone lines if they want to ask a question, how they need to go about that?

Operator: As a reminder, if you would like to ask a question, please press star then the number 1 on your touch-tone phone. To remove yourself from the queue, press the pound key and remember to pick up your handset before asking your question to ensure clarity.

Aryeh Langer: Thank you very much. Dorothy, you can let us know after the next question I read here and is answered, if we have any questions from the phone lines. Our next question based on the information so far provided it sounds like this would not apply to independent labs.

Again, based on the information so far provided it sounds like this would not apply to independent labs. Is that correct?

Yvette Cousar: This is Yvette. It’s a provider billing, right? Which …

Aryeh Langer: It would appear that way.

Yvette Cousar: I mean -- I don’t know what provider she’s identified, but it wouldn't -- it wouldn't be labs on -- independent labs wouldn't be included in that.

Wilfred Agbenyikey: For now, I think those who can report or those are not exempted from these, our physicians, assistant nurse practitioners, clinical nurse specialists and certified registered nurse and aesthetics. For now, I may think at a ppoint it would be expanded more to take other clinicians buat as for independent labs. I cannot compare.

Dr. Paul Rosen: Yes, that's right. I mean the focus is clinicians, so we're talking about pathologists but not sort of a phlebotomist in the lab, billing a code. It wouldn't be for phlebotomists, but it would be for a pathologist on this investment.

Aryeh Langer: Thank you. Dorothy, can we take a question from the phone line?

Operator: Again, if you would like to ask a question, please press star then the number 1 on your touchtone phone. There are no questions at this time.

Aryeh Langer: Okay. I will continue to take questions from the webcast. Our next question, if a primary care physician sees the patient for a visit that would be considered X1 and then also gives the patient a vaccine, would the vaccine service be concerned X1 also or X4?

Dr. Rose Do: This is Rose. That's a good question. I feel as if -- if the vaccine is more for Broad health care maintenance, it probably still does fit into the Continuous/Broad. I guess if you -- if we are talking about professional billing for the clinician actually administering it, we would leave to the clinician's discretion.

You know- if it is -- if it is that you're doing this one service, it's tight -- kind of procedural maybe it's just Episodic in that --in that time then you could -- you could code it as such. And again, regarding Dr. Rosen's comment, we would like to just kind of review all the coding, the validity and reliability of them of during this time. I think both would be valid.

Aryeh Langer: Okay, thank you. If you have a Lab X-ray and visit on the claim, it would be the E/M Code that needs a modifier, would the Lab or X-ray need modifier? It’s not entirely clear, let me read that again. If you have Lab X-ray and visit on the claim, it would be the E/M Code that needs the modifier, would the Lab or X-ray need modifier?

Yvette Cousar: This is Yvette. They will also use whatever modifiers would be applicable to the normal services they use. So, it would just be an additional modifier on the claim. So, yes, they would still need to use the other required modifiers.

Aryeh Langer: Okay, thank you. Dorothy, I believe we have a question on the phone line.

Operator: Your question comes from the line of Sheila Madhani.

Sheila Madhani: Hi, thank you and I apologize for any background noise. I just -- could back to a previous question and just a clarification, a professional claim has a -- procedures or services an item. The question

about the injection, there's a procedure code for the injection and I understand you would have a modifier used under this voluntary sort of period.

But for the J Code for the actual substance -- the item, the substance that you're injecting that also has a line item. Would you have to put a modifier for the items, the substance, you inject -- what you're injecting?

Wilfred Agbenyikey: No.

Yvette Cousar: No. This is Yvette, I would think no. It would just be for the procedure code, the way the program works.

Sheila Madhani: Okay. Thank you. You would think or is that the informal answer? Is that something you guys need to look into, just to make sure I understand that response?

Yvette Cousar: I would defer to – to the policy folks. But the way, I'm- I see the program, I believe it's only on the procedures that are being reported and not the actual -- not the actual vaccine but I'm not totally sure. So...

Sheila Madhani: Okay. Is there an -- is there someone on the line who can help or is there an email that we can send the question to clarify this issue?

Aryeh Langer: You can go ahead and submit the question to the address on slide 47 of the presentation.

Sheila Madhani: Okay, great. Thank you so much.

Aryeh Langer: Thank you. Our next question from the webcast, do diagnostic tests performed during the exam require Patient Relationship Codes? Again, do diagnostic tests performed during exam require Patient Relationship Codes?

Yvette Cousar: This is Yvette. Haven't the codes already been identified that would require the Patient Relationship so that -- but there was -- there was an -- you know.

Aryeh Langer: Oh, that's all the information that was …

Yvette Cousar: Right.

Aryeh Langer: … submitted. Let's go ahead and move to the next question. Are these codes to be included as modifiers on all CPT Codes on a claim including J-Codes, which are drugs, that we administer.

Again, are these codes to be included as modifiers on all CPT Codes on a claim including J-Codes, which are drugs, that we administer.

Yvette Cousar: This is Yvette. This is very similar to the one who she's asking about the vaccine.

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Dr. Rose Do: And this is Rose. Yvette, you can also -- I have been interpreting it very similarly to, to some of your advice to our previous questions. I think callers should keep in mind that it is voluntary. This is a voluntary reporting period and to think about this in the terms of the Clinician-Patient Relationship.

If you are providing services to your patient and you're billing for that and then I would say that that requires the modifier or that would -- that would open up a reason to put your modifier and your relationship. So, if it's an evaluation management for that date and it's Episodic/Focused, I would bill it as such.

If there are other things that aren't really indicative of the Patient-Clinician relationship, if their other codes there that don't really indicate what you are doing for that patient, for that organ system or for their overall care then those -- given that this is voluntary, you probably won't have to put a modifier.

Others can please correct me, but again, we're still just collecting information and seeing how these codes work with the types of services that clinicians will render to their patients.

Aryeh Langer: Okay. Thank you very much, Rose. Dorothy, can we take another question from the phone lines?

Operator: Your next question comes from a line of Jessica Fowler.

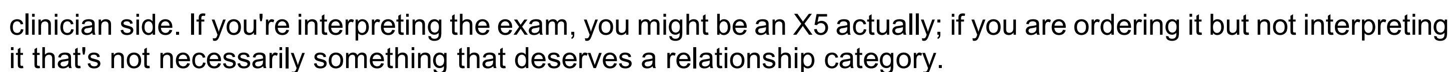
Jessica Fowler: Hello. Thanks for taking our call. I do have one question to follow up on the total knee for the patients that come in after care. Now, let's say for instance, we treat some of our total knees for years after they come in once a year for follow-up visits. But then, they'll also come in and say, “Oh, well my shoulder hurts too at the same time.” So, at this point, now we're talking about -- and then maybe at that moment were deciding, “Okay, well you also need shoulder surgery.”

The first question is, at that moment, are you -- we putting two different modifiers on an E&M visit that we're talking about follow up out of a global period for a total knee as well as the decision for surgery for the shoulder? And also, if we're talking about putting a modifier on every line item and say, we take X-ray on the knee and an X-ray on the shoulder are we talking about doing two separate -- on each X-ray, do we have to put two separate modifiers on there?

Dr. Rose Do: This is Rose Do. That's a great question. I think there's a couple things that play in that scenario that you presented. If it's out of the global period and then we're talking about another joint that the patient is having troubles with, then to me it’s still Focused. We're talking about musculoskeletal system, orthopedic system, so it's a Focused relationship for the orthopedist.

My sense with that is it could be Continuous given that this is outside the global period, you're done with your postop exams and wrapping things up but the patient's still having issues with let's say its osteoarthritis overall. That is most likely going to be a Continuous/Focused type of relationship because you're managing the overall osteoarthritis of the patient.

Regarding the exams, the way I'm thinking about it is from the professional side of billing. If we're talking about the examined interpretation for instance, and the professional or the clinician has been serving that patient by interpreting the X-ray, then that would deserve a modifier. If it's really ordering something, we also had stated that it's not necessarily the radiation, the X-ray tech, it's going to be mainly the professional services from the



clinician side. If you're interpreting the exam, you might be an X5 actually; if you are ordering it but not interpreting it that's not necessarily something that deserves a relationship category.

But I also want to defer to the -- to the others. I think the point of clarity that I want to make is that the relationship categories are really for the Clinician-Patient Relationship; they're not for the institution. They're not necessarily for every service that doesn't -- isn't well summarized by a relationship. I hope that helps.

Aryeh Langer: Thank you, Rose. And we have time for one final question please, Dorothy.

Operator: Your final question comes from the line of Jean Akins.

Female from the line of Jean Akins: cumbersome and so if they have to put it on …

Aryeh Langer: Hello your line is open.

Jean Akins: … claim. Okay.

Operator: Ms. Akins, your line is open.

Jean Akins: That's you. Go Ahead.

Jean Akins: Yes, we just wanted -- yes, we just wanted to clarify what -- why is -- why are we doing this? What is the reasoning for these relationship categories and codes?

Dr. Paul Rosen: Oh, yes, this is Paul Rosen. Well, the sort of the statutory reason in terms of you know -- we're responding to -- you have the law of MACRA. But really, I think the bigger picture is as we are advancing quality payment program and moving our work towards value and away from trying to deemphasize volume and improve quality and decrease cost.

We're going to need cost measures and attributions to cost measures. And, so I think all the data we can capture around how patients and clinicians are working together and we can codify those relationships -- that's going to inform us on how we develop these cost measures, which will help us -- help inform us on how the quality payment program moves forward to deliver value. That's kind of the overall picture and the reason behind it.

Aryeh Langer: Thank you.

Jean Akins: Thank you.

Additional Information

Aryeh Langer: And unfortunately, that's all the time we have for questions today. If we did not get to your question, please refer to slide 47 for more information and on how to contact the Quality Payment Program Service Center. On slide 48, you'll find information on how to evaluate your experience with today's event.

We'll also push out the link to the evaluations for our webcast participants right now. Evaluations are anonymous, confidential and voluntary, but we hope you'll take a few moments to evaluate your experience with today's event. As a reminder, disable your pop-up blockers for best results.

An audio recording and transcript will be available in about two weeks at go.cms.gov/npc, again, go.cms.gov/npc. I'd like to thank our subject matter experts and all participants who joined us for today's Medicare Learning Network event on the Patient Relationship Categories and Codes. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect.