



August 12, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the patient relationship categories and codes [document](#) posted on the Centers for Medicare & Medicaid Services (CMS) website on April 15, 2016.

The AAFP continues to support implementation of the *Medicare Access and CHIP Reauthorization Act* (MACRA), which includes section 101(f) that requires the establishment and use of patient relationship categories and codes. Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by CMS, include a patient relationship code.

We appreciate that CMS is proactively working with stakeholders to develop patient relationship categories and codes. We strongly urge CMS to provide additional information on how these patient relationship categories and codes will be used to attribute cost and patient outcomes to physicians and also how this information will be used related to episode groups. It will be essential for CMS to pilot test thoroughly these patient relationship categories before their use impacts payments. The AAFP calls on CMS to minimize the reporting burden for physicians and for the agency, through pilot testing, to address logistical issues and possible unintended consequences, especially for small practices.

The AAFP has grave concerns that the direction CMS is going with the categories it describes is inconsistent with these principles and will simply lead to more "administrivia" for physicians, will not achieve the intended aim of facilitating resource use allocation among physicians and will not lead to better outcomes of care. The AAFP understands that MACRA mandates the development and implementation of patient relationship categories and codes. However, we

www.aafp.org

President Wanda Flier, MD York, PA	President-elect John Meigs, Jr., MD Brent, AL	Board Chair Robert L. Wergin, MD Milford, NE	Directors Yushu "Jack" Chou, MD, Baldwin Park, CA Robert A. Lee, MD, Johnston, IA Michael Munger, MD, Overland Park, KS Mott Blair, IV, MD, Wallace, NC John Cullen, MD, Valdez, AK Lynne Lillie, MD, Woodbury, MN	John Bender, MD, Fort Collins, CO Gary LeRoy, MD, Dayton, OH Carl Olden, MD, Yakima, WA Marie-Elizabeth Ramas, MD, (New Physician Member), Mount Shasta, CA Richard Bruno, MD, (Resident Member), Baltimore, MD Tiffany Ho (Student Member), Baltimore, MD
Speaker Javette C. Orgain, MD Chicago, IL	Vice Speaker Alan Schwartzstein, MD Oregon, WI	Executive Vice President Douglas E. Henley, MD Leawood, KS		

think there are better ways to do so and hope that CMS will explore all options which could make this process as simple and automated as possible. The following comments are intended to constructively move CMS in a more positive direction in this regard.

In the CMS document, the agency first outlines policy principles used in the development of patient relationship categories and codes before then asking several questions for consideration. To improve the suggested patient relationship categories, the AAFP offers the following comments.

AAFP comments on policy principles

In the draft description of an acute episode, CMS states:

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

The AAFP points out an apparent disconnect in this description, since the agency describes the episode as being potentially limited by site of service yet also says that it potentially may span inpatient and outpatient settings. We urge CMS to clarify this description and the role of multiple sites of service. Please see our response to question 3, below, for a suggested revision.

The CMS policy principles then discuss the agency's belief that there may be some overlap between three of the illustrative categories outlined in the law, which are:

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

The AAFP fully agrees with CMS's assessment of these examples in the law and supports the critical need to develop categories that are better distinguished from each other and easier for physicians to use. Patient relationship categories must be mutually exclusive in a given situation, so a physician does not have to choose among two or more equally applicable categories for a patient in a particular circumstance. .

Next, the document discusses CMS's development of five patient relationship categories in the following three areas:

- Continuing Care Relationships
- Acute Care Relationships
- Acute Care or Continuing Care Relationships

Within the Continuing Care Relationship area, CMS proposes to define two patient relationship categories:

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

We urge CMS to add the following language to the end of category (i.): "not limited by problem origin, organ system, or diagnosis." Such an addition will help distinguish category (i) from category (ii), which otherwise attempt to differentiate between primary care providers and sub-specialty providers involved in the ongoing care of a patient. The AAFP bases this suggestion of the AAFP's definition of a [primary care physician](#).

In addition to the suggested addition to (i.), the AAFP also suggests that CMS add the following corresponding language to the end of (ii.): "that is typically limited by problem origin, organ system, or diagnosis."

Within the Acute Care Relationship area, under category "(iv.) Clinician who is a consultant during the acute episode," the AAFP finds the word "consultant" to be problematic. CMS does not recognize consultation codes for payment under the Medicare physician fee schedule, so it is confusing for CMS to ask clinicians to think of themselves as consultants. Based on the AAFP policy on [Consultations, Referrals, and Transfers of Care](#), we suggest that this category be reworded as "Patient-facing clinician who provides advice, a service, or written recommendations regarding diagnosis and treatment at the request of another physician during the acute episode."

Finally, in the Acute Care or Continuing Care Relationship area, under category "(v.) Clinician who furnishes care to the patient only as ordered by another clinician," we find this principle unclear as drafted by CMS and difficult to distinguish from category (iv). Almost all consultations in an inpatient setting are "as ordered by another clinician." The AAFP believes CMS is trying to describe in category (v) clinicians who furnish a diagnostic or therapeutic intervention that is limited to a single encounter with the patient (or patient's specimen or test result). Otherwise, as written, this definition prevents the need for a non-patient facing category.

AAFP Responses to CMS Questions for Consideration

1. Are the draft categories clear enough to enable physicians and practitioners to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation? As clinicians furnishing care to Medicare beneficiaries practice in a wide variety of care settings, do the draft categories capture the majority of patient relationships for clinicians? If not, what is missing?

No, the categories are most definitely not clear enough. Family physicians will find themselves in a precarious situation when trying to assign a patient relationship code based on these categories. For any given patient, they could be the primary care giver in a continuity relationship as well as the specialist managing conditions like diabetes and heart disease during an acute episode. Also, a family physician might be called in to consult on a patient that has been hospitalized during an acute episode, and likely, they are always coordinating that care.

As noted, the Acute Care or Continuing Care Relationship area, category "(v.) Clinician who furnishes care to the patient only as ordered by another clinician," can be confused with the Acute Care Relationships area category "(iv.) Clinician who is a consultant during the acute episode." This is due to the fact that most consultations are ordered by a clinician. We believe a better category for (v.) would be, "Clinician who furnishes a diagnostic or therapeutic intervention that is limited to an encounter with the patient or the patient's specimen or test result."

Furthermore, when applying patient relationship codes to encounters, there could be confusion if the clinician has different relationships based on the patient's different diagnoses. For example, a patient presents to his/her family physician for treatment of an upper respiratory infection, which is an acute, time-limited illness. While the patient is present, the family physician also manages the patient's diabetes and hypertension, which represent chronic conditions that the family physician is managing on a continuing basis. Thus, the family physician in this situation has both a continuing care relationship and an acute care relationship with the patient, which will make the family physician's choice of a patient relationship category for this encounter potentially confusing. Thus, the AAFP notes that choosing a patient relationship category based on CMS's proposed categories would also increase the administrative burden borne by the clinician. Without more knowledge of how patient relationship codes will be used and applied, it is difficult to comment on which level of association would be most appropriate for the given use case.

2. As described above, we believe that there may be some overlap between several of the categories. To distinguish the categories, we are considering the inclusion of a patient relationship category that is specific to non-patient facing clinicians. Is this a useful and helpful distinction, or is this category sufficiently covered by the other existing categories?

The AAFP does not believe this would be useful. Rather, we recommend (v.) needs to be modified to the new definition provided in our answer to the first question.

3. Is the description of an acute episode accurately described? If not, are there alternatives we should consider?

No, the AAFP does not believe it is accurately described. We recommend rewording the Acute Episode Definition to be, "Acute episodes may encompass an exacerbation for a given disease, a new time-limited disease (e.g. acute bronchitis) or clinical issue, a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. Continuing care occurs when an episode is not acute, and requires the ongoing care of a clinician."

For the purposes of differentiating acute from continuing care, skilled nursing care is considered acute if preceded by a related inpatient stay or if ordered by a clinician for a time-limited period related to an acute event or condition. Otherwise, skilled nursing care that is not related to an acute event or condition, as well as long-term care (traditionally referred to as long-term acute care), are considered continuing care for the purpose of differentiating an acute episode from continuing care.

4. Is distinguishing relationships by acute care and continuing care the appropriate way to classify relationships? Are these the only two categories of care or would it be appropriate to have a category between acute and continuing care?

Conceptually, classifying relationships by acute and continuing care makes sense. However, there are challenges in implementation as the borders between these two can be fuzzy and discontinuous. Other classification levels for consideration could include:

1. Whole person (not limited by problem origin, organ system, or diagnosis);
2. Disease; and
3. Procedure.

5. Are we adequately capturing Post-Acute Care clinicians, such as practitioners in a Skilled Nursing Facility or Long Term Care Hospital?

The proposed patient relationship categories have the potential to capture care relationships in a variety of post-acute care settings. However, as our comments elsewhere in this document make plain, we are not convinced that the proposed categories are sufficiently clear and distinct to ensure that they will be validly and reliably used by physicians. For the purposes of post-acute care, CMS may need to add place of service to the other classification levels for consideration noted in our answer to question 4, above.

6. What type of technical assistance and education would be helpful to clinicians in applying these codes to their claims?

Physicians will need to know why and when they need to apply these codes to their claims. Since this relates back to the Resource Use category in MIPS, CMS must notify and educate physicians as to whether there will be a new and designated place to put this code on an EHR or claim form. For instance, as noted in our answer to question 8, below, we think use of modifiers may be the best approach. In addition, CMS will need to inform physicians whether these codes are reported per visit, quarterly, or annually. Ideally, primary care physicians would report their relationship with a patient annually, reflecting the ongoing, comprehensive, continuous relationship that most primary care physicians have with their patients. However, depending on how CMS intends to use these categories and codes to allocate resource utilization (e.g. to an episode of care), some physicians may need to report their relationship with a patient more frequently than annually.

7. The clinicians are responsible for identifying their relationship to the patient. In the case where the clinician does not select the procedure and diagnosis code, who will select the patient relationship code? Are there particular clinician workflow issues involved?

As stated in our response to the sixth question, CMS must notify and educate physicians well in advance of when these new codes are required. If the relationship can be submitted with the claim and taken out of the hands of the clinician themselves, this would simplify the process and decrease disruption to clinical workflow. However, physicians will need to have personnel very well trained to carry out this assignment.

From a coding and billing perspective, it is not always apparent who is who in the medical record. Medical record headers cannot be trusted, as these are not always filled in, use old stay information, and are provided inaccurately, etc. No matter how well-trained coders are, they cannot be responsible for determining who has assumed liability for a patient, which is often subject to litigation in medical liability cases. The determination must be made by the clinician providing the services. The AAFP is concerned that CMS could cause serious disruptions in claims generation when physicians have to be queried to make this determination. If these determinations are eventually tied to quality and resource use, physicians might be hesitant to attach their name to high-cost patients. Finally, making these determinations will likely further slow claims generation and the resulting revenue cycle.

8. CMS understands that there are often situations when multiple clinicians bill for services on a single claim. What should CMS consider to help clinicians accurately report patient relationships for each individual clinician on that claim?

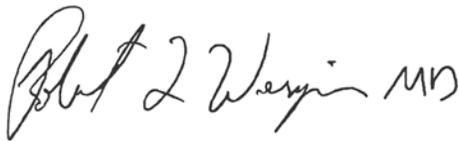
Acting Administrator Slavitt
Page 6 of 6
August 12, 2016

The AAFP agrees there are situations where multiple clinicians would have the same relationship to a patient. For example, during an inpatient stay, there could be a (iii.) clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode, multiple providers functioning as (iv.) clinicians who are consultants during the acute episode, as well as multiple providers functioning as (v.) clinicians who furnish care to the patient only as ordered by another clinician. CMS must identify straightforward and administratively simple reporting mechanisms that allow for this to occur, so that it is clinically accurate.

One potential method would be to continue using the A1 modifier, which CMS recommended in 2010 when consultation codes were discontinued from the Medicare Physician Fee Schedule. This modifier is used on inpatient claims to “identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care.”

We appreciate the opportunity to comment on patient relationship categories and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Robert L. Wergin MD". The signature is written in a cursive, flowing style.

Robert L. Wergin, MD, FAAFP
Board Chair