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."