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?