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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Comments to the CMS Request for Information, Patient Relationship Categories and Codes

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) amended section 1848 of the Social Security Act to require the establishment of certain classification code sets. One such required code set is the “patient relationship categories and codes.” The purpose of patient relationship codes, together with information on care episodes and patient condition, is to assist the Centers for Medicare and Medicaid Services (CMS) in collecting and analyzing data on the resources utilized in the course of delivering care to patients for a given care episode. CMS also seeks to obtain information on whether particular services are provided on an acute or non-acute basis.

AAPA strongly supports the goal of increased transparency in identifying which health professionals are providing what types of care to patients and we are pleased to see the provider-neutral language used in the category descriptions. We also appreciate CMS providing health professionals and organizations with an opportunity to review and provide comments on the draft code sets. However, AAPA cautions that the structure of patient relationship categories and codes must be developed in a way that does not 1) obfuscate an accurate depiction of a health professional’s contribution to care, 2) confuse health professionals and coders with a new set of codes that are dissimilar to existing codes used by PAs and physicians to report their services, or 3) unduly penalize practitioners by creating a system that is overly burdensome from an administrative and implementation point of view.

CMS must consider and explain how cost data collected via patient relationship categories and codes fit into the framework of episode groups under MACRA. Having multiple informational sources and/or multiple reporting mechanisms runs the risk of creating confusion and additional administrative burdens for practices and health systems.

After January 1, 2018, claims submitted for items and services provided by health professionals will include patient relationship codes. These codes will be used to attribute patients and care episodes (in whole or in part) to one or more health professionals. In its recent Request for Information (RFI), CMS has proposed an initial conceptualization of five patient relationship categories:

Continuing Care Relationships

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

Acute Care Relationships

- 3) Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode
- 4) Clinician who is a consultant during the acute episode

Either

- 5) Clinician who furnishes care to the patient only as ordered by another clinician

While we find this breakdown to be a good first effort by CMS to capture a clinician/patient relationship, AAPA has concerns regarding its vagueness and potential gaps in accurately capturing the relationship. These concerns are expressed below.

Defining Categories 1 and 3

AAPA is concerned with the language used in categories 1 and 3. These two categories are written as if to imply that the categories are usable by only one health professional per patient encounter. This could be problematic for two reasons. First, care of a patient, even when only one service is provided, may be performed by more than one health professional working in concert with one another. Clinicians, including PAs, often work in teams. As a result, treatment in continuing care relationships may be difficult to assign to just one health professional. In addition, as a patient may choose to have preventive visits such as an annual visit from whichever practitioner is available at a convenient time for them, as opposed to always seeing the same health professional. The provider of ongoing care may shift due to the medical concern, availability or circumstances.

A second reason the suggestion that only one health professional can use categories 1 and 3 is problematic is that at times practitioners provide care to the same patient distinctly from each other and thus may be unable to make accurate determinations as to whether they are the health professional who assumes responsibility for patient's coordination. The role of a coordinator and primary provider of care may change as more is learned about a patient's condition or as treatment progresses. For example, it is common that a specialist assumes the role of providing primary care services for a patient they are treating for a specified illness. Consequently, health professionals may be split in their interpretations of who is entitled to category 1 or 3 statuses.

AAPA is also apprehensive about the fact that patient relationship categories may provide flawed assessments of the actual relationship status. This is possible due to payment mechanisms such as "incident to" billing in which a health professional, such as a PA, who may be providing a significant amount of care is not recognized or included on the claim. When services delivered by PAs are billed under the name of the PA's collaborating physician as an "incident to" service, the PA's name and NPI typically do not appear on the claim form. This means that the actual provider of care, in this case the PA, is not identified in the CMS claims system and data sources are populated with information that does not represent or identify the actual provider of care. Consequently, a PA who provides care to a patient under "incident to" not only is unable to use categories 1 and 3, but would not even be able to indicate a supporting role when appropriate under category 5. In order to remedy this, AAPA recommends, as it did in its recent comment letter regarding the Quality Payment Program, that CMS eliminate the problem created by "incident to" billing by requiring the name and NPI number of the rendering provider, in this case a PA, to be included on all "incident to" claims.

Responsibility of Designating Relationship Categories

Often, the actual process of submitting a claim is not performed by the clinician, but rather by a coder or biller employed by the practice or a billing company. Consequently, it will be incumbent on each health professional to clearly communicate their understanding of their relationship with the patient, to a biller or coder for interpretation. Again, this may result in confusion if multiple health professionals see themselves occupying the same role for a patient. This stresses the importance of more precise definitions and clarity by CMS in the patient relationship categories and codes. It is unclear whether there will be multiple codes under the five categories that will provide increased specificity, or whether each of these categories will receive one corresponding code. AAPA supports greater specificity if it will lead to a more accurate data collection process.

Additional Questions

AAPA has additional questions regarding patient relationship codes that need clarification from CMS:

It appears that multiple clinicians may claim categories 2, 4 and 5, but is there ever a situation in which more than one health professional would claim either code 1 or 3 for the care provided in a single patient encounter?

There may indeed be instances in which multiple health professionals assume responsibility for care and coordinate the care of a patient. If CMS accepts this premise, it may then need to determine a way to operationalize the division of this shared responsibility from a reporting perspective. What would happen if two clinicians declared themselves to be the primary health care provider for a given patient encounter/episode of care?

How will various codes affect resource use determinations?

When CMS uses this information to evaluate the resources use to treat patients, is it the same “resource use” information that will be referenced under the Merit-based Incentive Payment System (MIPS)? If so, CMS should provide enhanced information on the impact on a MIPS score. Furthermore, CMS should indicate if resource determinations are to be used for other comparative purposes, and, if so, how various practitioners will be compared. Depending on the patient and the nature of a practitioner’s care, costs may seem high, especially if a specialist who is performing the services of an individual’s primary care provider is compared against other primary care practitioners. It will be important to reassure the provider community that comparisons on resource use will occur among like clinicians.

Claims Submission

Whether the current categories proposed by CMS remain or, as we suggest, more granular categories and codes are created, CMS should discuss and explore just how these categories/codes will be placed on the actual claim form and how the placement of those codes will interact with existing coding conventions and software applications. We can all agree that it would be counterproductive to develop codes sets that create confusion and/or disruption at either the practice level, in choosing the appropriate code, or at the claims processing level.

Education of Health Professionals

AAPA underscores the importance for CMS to provide robust and ongoing education to health professionals on all changes in claims submission processes. This must be done sufficiently in advance of the January 1, 2018 implementation date. In its efforts, CMS should continue to work with relevant medical societies and partners, such as AAPA, in order to educate stakeholders, including billers and coders, and ensure minimal disruption in the claims process. In addition, the nature of this requirement to define a practitioner/patient relationship suggests that all webinars and print educational materials should include a multitude of situational practice examples so that health professionals in various clinical scenarios and practice settings will find examples closely related to the ones in which they find themselves. Finally, after January 1, 2018, CMS should show similar flexibility and leniency as it did after the implementation of ICD-10 by not penalizing health professionals immediately for what is sure to be a challenging process of determining and defining a patient relationship.

AAPA appreciates this opportunity to provide feedback on the patient relationship codes RFI and welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. For any questions you may have in regard to our comments and recommendations, please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,



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