MACRA Patient Relationship Categories and Codes: Frequently Asked Questions (FAQ)

May 2018

This document contains questions and answers that may be useful for clinicians and stakeholders interested in learning about the MACRA Patient Relationship Categories and Codes. The appendix lists the verbatim questions received during the educational webinar on February 21, 2018. This document is intended for informational purposes only and provides information for reporting patient relationships as of April 2018.

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1 POLICY CONTEXT

1.1 What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula and authorized the Quality Payment Program, which provides new financial incentives for clinicians enrolled in Medicare. Section 101(f) of the MACRA amended section 1848 of the Social Security Act (the Act) to create a new subsection (r). Section 1848(r)(3) of the Act requires the development of patient relationship categories and codes to facilitate the attribution of patients and episodes to one or more physicians or applicable practitioners (collectively referred to in this document as "clinicians") for purposes of cost measurement. Section 1848(r)(4) of the Act requires clinicians, as determined appropriate by the Secretary, to include the applicable patient relationship codes on claims submitted for items and services furnished on or after January 1, 2018. For more information, we refer readers to the discussion in the CY 2018 Physician Fee Schedule final rule (82 FR 53232 through 53234).

1.2 What are the MACRA patient relationship categories and codes?

The MACRA patient relationship categories aim to distinguish the relationship and responsibility of a clinician with a patient at the time of furnishing an item or service, thereby facilitating the attribution of patients and episodes to one or more clinicians for purposes of cost measurement. The Centers for Medicare & Medicaid Services (CMS) has finalized five patient relationship categories, as summarized in Table 1 below, for use in a voluntary reporting period beginning January 1, 2018. For more context regarding the development of these categories, please see the operational list.[1]

The MACRA patient relationship codes are Healthcare Common Procedure Coding System (HCPCS) Level II modifier codes that clinicians report on claims to identify their patient relationship categories. These codes are also included in Table 1 below.

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf

Table 1. Operational List of Patient Relationship Categories and Codes[2]

HCPCS Modifier	Patient Relationship Category	Operational List Definitions
X1	Continuous/ Broad Services	For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role. Reporting clinician service examples include primary care services and specialists providing comprehensive care to patients in addition to specialty care.
X2	Continuous/ Focused Services	For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. A reporting clinician service example would be a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services.
X3	Episodic/ Broad Services	For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization. A reporting clinician service example would include a hospitalist providing comprehensive and general care to a patient while the patient is admitted to the hospital.
X4	Episodic/ Focused Services	For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention. A reporting clinician service example would be an orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.
X5	Only as Ordered by Another Clinician	For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the four categories described above. A reporting clinician service example would be a radiologist interpretation of an imaging study ordered by another clinician.

1.3 What is the value of reporting patient relationships for clinicians?

The patient relationship categories and codes provide an opportunity for clinicians to self-identify their relationship with and responsibility for a patient at the time of furnishing an item or service. Reporting patient relationships is intended to improve the accuracy of attributing episodes to clinicians, if the patient relationship codes are incorporated into the attribution methodology for episode-based cost measures in the future.

[2] 82 FR 53233 https://www.federalregister.gov/d/2017-23953/p-2203

1.4 Where can I learn more about the patient relationship categories and codes?

If you have any questions, please email the Quality Payment Program (QPP) Service Center at QPP@cms.hhs.gov or call 1-866-288-8292 (TTY: 1-877-715-6222).

To read more about the patient relationship categories and codes, please visit the MACRA Feedback Page.

2 REPORTING

2.1 How long is the voluntary reporting period?

CMS has not established the duration of the voluntary reporting period, but anticipates it will include at least calendar year 2018. The goals of this period are to educate clinicians on proper coding of patient relationships and to collect initial data for further study. The data collected will be used to conduct validity and reliability tests on the patient relationship categories and codes before consideration of their potential future use in the attribution methodology for cost measures. CMS may adjust the length of the voluntary reporting period based on factors including clinicians' adoption of the codes, data analysis findings, and stakeholder feedback. Mandatory reporting would be established through rulemaking, and until then reporting will be voluntary.

During the voluntary reporting period, claims will be paid regardless of whether and how the patient relationship codes are included, and CMS will work with clinicians to educate them about the proper use of these codes.[3]

2.2 Who can report their patient relationships?

The patient relationship categories and codes are currently in a voluntary reporting period, which began January 1, 2018. As of this date, the following clinicians may report patient relationships: physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. CMS may expand this list to include additional clinicians through rulemaking for future years.

2.3 How do clinicians report their patient relationships?

Clinicians may report their patient relationships on claims by adding one of the patient relationship codes, as listed in question 1.2, to each claim line, in the same way that modifier codes are submitted on each claim line for each service rendered. This method of reporting patient relationships allows clinicians to report different patient relationships for separate items and services billed on the same claim. CMS is investigating alternative methods of reporting (e.g., where one patient relationship code applies globally to all services or claim lines). This alternative method of reporting patient relationships would allow clinicians to report one code on a claim if the patient relationship is the same for all the items and services listed on the claim lines. Any updates regarding the availability of this alternative method would be communicated to the public through rulemaking.

[3] 82 FR 53233 https://www.federalregister.gov/d/2017-23953/p-2204

There are no requirements regarding the positioning of the patient relationship code relative to other modifier codes. In other words, the patient relationship code may be added at any position in the modifier fields on the claim.

2.4 Are clinicians who are excluded from the Merit-based Incentive Payment System (MIPS) also exempt from reporting patient relationships?

Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, including those who are excluded from MIPS, may report a patient relationship code on Medicare claims during the voluntary reporting period.

2.5 If a clinician always has the same patient relationship, can they apply to be exempt from reporting?

During the voluntary reporting period, clinicians may forgo reporting patient relationships on their claims. Currently, CMS has not established a method to exempt clinicians from reporting patient relationships. Developing a method for such exemptions or a default patient relationship category may potentially be considered in the future.

2.6 What steps has CMS taken to ensure that reporting patient relationships does not create undue clinician and administrative burden, especially for small practices and solo practitioners?

To alleviate administrative burden, CMS has integrated the patient relationship codes into the HCPCS coding system. CMS believes using Level II HCPCS modifiers is an appropriate option for coding patient relationships on claims because: (i) CMS data systems are already able to accept such codes and (ii) clinicians are already familiar with Level I and Level II HCPCS codes given their current broad usage. Coding patient relationships will be similar to adding "left" or "right" HCPCS modifiers for surgeries. For additional reasons supporting the decision to use Level II HCPCS modifiers to operationalize the patient relationship categories, please see page 3 of the December 2016 Patient Relationship Categories posting.[4]

Additionally, CMS established an initial voluntary reporting period to allow time for clinicians to gain familiarity with the patient relationship categories before mandatory reporting begins. The information gathered during the voluntary reporting period will help CMS learn how to minimize burden for clinicians and administrative staff in reporting patient relationships.[5]

[4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes-Posting-FINAL.pdf
[5] 82 FR 53234 https://www.federalregister.gov/d/2017-23953/p-2219

3 DEVELOPMENT AND IMPLEMENTATION

3.1 How did CMS develop the patient relationship categories?

The patient relationship categories were developed with extensive clinician and stakeholder input. CMS posted a draft list of patient relationship categories in April 2016,[6] seeking public comment on the categories, the policy principles used to develop them, and the clinical examples used to illustrate their intended use. Based on those comments and consultation with stakeholders and experts, CMS posted a modified list of patient relationship categories in December 2016.[7] CMS sought public comment on the modified categories, a path for finalizing them, and a method for operationalizing them for coding on claims. The public comments received on the December posting informed the operational list of patient relationship categories, which was publicly posted on May 17, 2017.

3.2 What steps has CMS taken to improve the clarity of the patient relationship categories such that they enable consistent and reliable self-identification by clinicians?

CMS has taken steps to improve the clarity of the patient relationship categories. As detailed in question 3.1, CMS developed the operational list of patient relationship categories by incorporating extensive stakeholder input through previous public comment periods on draft postings. In addition, CMS held two listening sessions in July 2016 to gather input from stakeholders. One listening session was targeted toward specialty and clinician societies, and the other toward practice management organizations. In addition, CMS hosted a webinar on February 21, 2018, to provide further education on the patient relationship categories using real world clinical scenarios. The webinar recording and transcript may be found on the MACRA Feedback Page.

The operational list may be further revised based on experience, new information, and input from stakeholders each year through rulemaking.[8] CMS hopes that this evolution will enable clinicians' more consistent and reliable self-identification of patient relationships over time, as these categories and codes become more integrated into the Medicare program.

3.3 How will the patient relationship categories affect co-management and team-based care?

The patient relationship categories allow multiple clinicians to identify their role in a single patient's care.[9] Clinicians working in teams can identify the same or different patient relationship

[6] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes.pdf
[7] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes-Posting-FINAL.pdf
[8] 82 FR 53232 https://www.federalregister.gov/d/2017-23953/p-2199
[9] 82 FR 53234 https://www.federalregister.gov/d/2017-23953/p-2217

codes for the same patient. Therefore, the patient relationship categories should complement co-management and team-based care. For an example of how the patient relationship categories work in co-management and team-based care scenarios, please see Section 4.

3.4 How will the patient relationship categories affect beneficiaries' access to and quality of care?

In the short term, CMS does not anticipate that the patient relationship categories will have an impact on beneficiaries' quality of care since declaration of a relationship should not affect care provided. CMS will monitor patient relationship reporting as data become available to assess any potential impacts on cost, access, and quality in the Medicare program in the long term.

3.5 When and how can patient relationship categories be used in the attribution methodology for episode-based cost measures?

CMS believes experience and analysis is needed before incorporating the patient relationship categories and codes into episode-based cost measures.[10] The patient relationship categories may be considered for use in the episode-based cost measurement methodology after reliability and validity tests are conducted. CMS anticipates collecting several years of claims data to allow sufficient time for clinicians to gain familiarity with correctly coding their patient relationships and for CMS to understand the attribution potential of these codes. Over this time, CMS plans to engage in extensive education and outreach to help clinicians understand the categories and codes and their proper use. Once the necessary reliability and validity analyses have been conducted and clinicians have become acclimated to the use of these codes, CMS may consider their use in attribution for cost measures.

MACRA provides for the patient relationship categories and codes to be used to facilitate the attribution of patients and episodes to clinicians. Although CMS may work with clinicians to explore incorporating the patient relationship categories into the MIPS cost performance category and the Quality Payment Program in future years, the cost measures that have been finalized to date and those currently under development do not require patient relationship reporting to properly measure clinicians' quality and resource use.[11]

[10] 82 FR 53234 https://www.federalregister.gov/d/2017-23953/p-2221
[11] 82 FR 53233 https://www.federalregister.gov/d/2017-23953/p-2205

3.6 How can a practice or specialty society propose new patient relationship categories or changes to the existing categories for rulemaking?

Any practice, specialty society, or other stakeholder may propose patient relationship categories via public comment during rulemaking. CMS will consider these comments when making revisions. Any revisions to the operational list of patient relationship categories and codes would be made no later than November 1 of each year, beginning with 2018, as required under section 1848(r)(3)(F) of the Act.[12]

[12] 82 FR 53232 https://www.federalregister.gov/d/2017-23953/p-2199

4 CLINICAL SCENARIOS

4.1 How should clinicians capture changes in their patient relationships over time?

The patient relationship categories and codes are designed to be flexible to accommodate changes in clinician-patient relationships over time. This flexibility is achieved through clinicians reporting different relationships as needed on individual claims for the same patient over time.

Because the patient relationship categories are operationalized as HCPCS Level II modifier codes to be reported on claims, clinicians should think of the patient relationship categories as describing a discrete clinical encounter. CMS recognizes that acute conditions can become chronic and that chronic conditions can have acute exacerbations. Nonetheless, determining whether a clinician-patient relationship is episodic or continuous depends on a given point in time when the claim is being submitted for the item or service furnished by the clinician. For example, in the case where a chronic condition has an acute exacerbation, the managing clinician would report:

- Continuous/focused (X2) on claim lines with items and services provided for the long-term management of the chronic condition
- Episodic/focused (X4) on claim lines with items and services provided for treatment of the acute flare

For specific clinical examples illustrating the dynamic nature of the patient relationship categories, please see the clinical scenarios under "Changes in a Patient Relationship over Time" in section 4.4.1 below.

4.2 Can clinicians report multiple patient relationships on a single claim?

The method for reporting patient relationships is designed to allow clinicians to report multiple patient relationships on a single claim. A clinician may report distinct patient relationship categories for various services listed on a claim for the same patient.

4.3 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?

The patient relationship categories are intended to classify one-to-one clinician-patient relationships. Therefore, even in team-based or co-managed care scenarios where two or more clinicians have the same patient relationship, each clinician should report their patient relationship on their respective claim or claim line.

4.4 How do the patient relationship categories and codes work in real-world clinical scenarios?

The following clinical scenarios are purely hypothetical. They are intended to illustrate the assignment of patient relationship categories in clinical practice, which clinicians may refer to for guidance during the voluntary reporting period. Any binding rules about how to report the patient relationship categories after the voluntary reporting period would be established through rulemaking. These scenarios are not examples of notes that clinicians must submit along with the patient relationship code(s) reported on claims.

4.4.1. Simple Clinical Scenarios

These simple clinical scenarios are intended to demonstrate (1) how clinical context defines the term "episodic", (2) how the patient relationship categories and codes can capture changes in patient relationships over time, and (3) how the categories and codes may be applied in team-based care settings.

Episode Length Variation by Clinical Situation

Patient Khan develops actinic keratosis and sees a dermatologist for treatment with cryotherapy. Her interaction with the dermatologist spans two visits. A few months later, Patient Khan undergoes a joint replacement procedure by an orthopedic surgeon. She sees the orthopedist for post-operative checkups.

Table 2: Patient Relationship Categories for Clinical Situations Varying in Length

Service	Clinician Type	Category	Rationale
Cryotherapy for Actinic Keratosis	Dermatologist	X4	Time-limited, specialized interventions
Joint Replacement	Orthopedist	X4	Time-limited, specialized interventions

This example shows clinical context defines the term "episodic". For example, a dermatologic episode of care may span a few days, while an orthopedic episode of care may span months.

Changes in a Patient Relationship over Time

Example #1

Patient Gogol is admitted for exacerbation of chronic obstructive pulmonary disease (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.

Table 3: Patient Relationship Categories for Changing Patient Relationships – Example #1

Service	Clinician Type	Category	Rationale
Treatment of COPD Exacerbation	Hospitalist	X3	Management of hospitalization
Treatment of COPD Exacerbation	Pulmonologist	X4	Specialized care during hospitalization
Management of COPD	Pulmonologist	X2	Ongoing, specialized care

Example #2

Patient Ramone undergoes a colonoscopy by his gastroenterologist. The pathologist reads the biopsies and issues a report that the findings are consistent with Crohn's Disease. The gastroenterologist initiates treatment for Crohn's Disease and continues to monitor him.

Table 4: Patient Relationship Categories for Changing Patient Relationships – Example #2

Service	Clinician Type	Category	Rationale
Colonoscopy	Gastroenterologist	X4	Specialized procedure
Pathological Assessment of Biopsy	Pathologist	X5	Ordered by gastroenterologist
Management of Crohn's Disease	Gastroenterologist	X2	Ongoing, specialized care

Example #3

Patient Ventura does not have a primary care clinician. He is admitted to a hospital for a new diagnosis of diabetes, where an endocrinologist treats him. He begins seeing an endocrinologist as an outpatient for his diabetes. After a few years of treatment, his endocrinologist notes that he should be on treatment for hypertension. Since she has developed a long-term relationship with Patient Ventura, the endocrinologist begins also treating his hypertension and doing regular health check-ups.

Table 5: Patient Relationship Categories for Changing Patient Relationships – Example #3

Service	Clinician Type	Category	Rationale
Management of Hospitalization for Diabetes	Endocrinologist	X4	Specialized care during hospitalization
Management of Diabetes	Endocrinologist	X2	Ongoing, specialized care
Management of Diabetes and Hypertension; Routine Health Maintenance	Endocrinologist	X1	Ongoing, broad care

Team-based/Co-managed Care Delivery

Patient Traoré has hypertension, diabetes, and atrial fibrillation. She sees a cardiologist regularly for her atrial fibrillation, a podiatrist for foot checks, and an ophthalmologist for eye exams, given her diabetes. Her nurse practitioner coordinates with the cardiologist, podiatrist, and ophthalmologist as part of Patient Traoré's routine health maintenance.

Table 6: Patient Relationship Categories for Team-based Clinicians

Service	Clinician Type	Category	Rationale
Management of Hypertension, Diabetes, and Atrial Fibrillation; Routine Health Maintenance	Nurse Practitioner	X1	Ongoing, broad care
Management of Atrial Fibrillation	Cardiologist	X2	Ongoing, specialized care
Diabetic Foot Screening	Podiatrist	X2	Ongoing, specialized care
Diabetic Retinopathy Screening	Ophthalmologist	X2	Ongoing, specialized care

4.4.2 Complex Clinical Scenarios

Complex Scenario 1: Colon Cancer

Patient Rodriguez sees a resident working under a primary care physician for his diabetes at an academic medical center (AMC). He had a routine screening colonoscopy by his gastroenterologist, who is an attending physician at the same AMC. The colonoscopy revealed a large mass. After examining the biopsy, the pathologist confirmed that it was cancerous. A radiologist read a PET scan showing no metastatic disease. Since the mass could be resected, 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, a hospitalist, an infectious disease consultant, and his medical oncologist cared for him. He also saw a dietician because of his poor appetite. Due to the progression of his illness, he was transferred to the intensive care unit (ICU) where an intensivist cared for him. After meeting with a palliative care clinician, Patient Rodriguez decided to go home with hospice care. At home, he has visits with a hospice nurse practitioner.

Table 7: Patient Relationship Categories for Clinicians in Colon Cancer Scenario

Service	Clinician Type	Category	Rationale
Management of Diabetes; Routine Health Maintenance	Primary Care Doctor	X1	Ongoing, broad care
Colonoscopy for Colon Cancer Screening	Gastroenterologist	X4	Specialized procedure
Pathological Assessment of Biopsy	Pathology	X5	Ordered by gastroenterologist
PET Scan	Radiologist	X5	Ordered by gastroenterologist
Colectomy for Colorectal Cancer	Surgical Oncologist	X4	Specialized procedure
Chemotherapy for Colorectal Cancer	Medical Oncologist	X2	Ongoing, specialized care
Treatment of Neutropenic Fever and Diabetes	Hospitalist	X3	Management of hospitalization
Treatment of Neutropenic Fever	Infectious Disease Consultant	X4	Time-limited, specialized care
Treatment of Neutropenic Fever	Medical Oncologist	X4	Time-limited, specialized care
Dietician Consult	Dietician	X4	Time-limited, specialized care
Treatment of Neutropenic Fever and Diabetes	Intensivist	X3	Management of ICU stay
Palliative Care Consult	Palliative Care Clinician	X4	Time-limited, specialized care
Hospice Care	Nurse Practitioner	X1	Ongoing, broad care

Complex Scenario 2: Stroke

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 a tissue plasminogen activator (tPA). Initially, she was stable, but then she

lost consciousness. The radiologist conducted a repeat CT, which showed an intracerebral bleed. A neurosurgeon evaluated her and then 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 a hospitalist and seen by the neurologist and neurosurgeon. The hospitalist called a physiatrist to evaluate her need for post-stroke rehabilitation. The physiatrist recommended she be transferred to a rehabilitation hospital, where she was cared for by another physiatrist for a 20-day stay. Since she had not improved sufficiently to return home, she was transferred to a skilled nursig facility (SNF), where she spent another 25 days. A geriatrician cared for her, and she also had visits with a consulting physiatrist.

Table 8: Patient Relationship Categories for Clinicians in Stroke Scenario

Service	Clinician Type	Category	Rationale
Treatment of Ischemic Stroke	Emergency physician	X4	Time-limited, specialized care
Treatment of Ischemic Stroke	Neurologist	X4	Time-limited, specialized care
Head CT Scan	Radiologist	X5	Ordered by neurologist
Treatment for Intracerebral Hemorrhage Evaluation	Neurosurgeon	X4	Time-limited, specialized care
Treatment of Intracerebral Hemorrhage	Intensivist	X3	Management of ICU stay
Treatment of Intracerebral Hemorrhage	Hospitalist	X3	Management of hospitalization
Rehabilitation Assessment	Physiatrist	X4	Time-limited, specialized care
Rehabilitation Hospital Stay	Physiatrist	X3	Management of rehab hospitalization
SNF Stay	Consulting Physiatrist	X4	Time-limited, specialized care
SNF Stay	Geriatrician	X3	Management of SNF stay

Complex Scenario 3: Joint Replacement

Patient Ling had pain in his knee, which he mentioned to his primary care physician during his visit to renew his medicine for high blood pressure and elevated lipids. He told his physician that the knee pain has kept him from walking as much as he had in past years. The physician ordered a standing x-ray of his knees, which per the radiologist, showed a very narrow joint space in the right knee. The primary care physician advised him to see a rheumatologist, who told him they could try knee injections, and a physical therapist. The rheumatologist gave Patient Ling a series of three injections and wrote a prescription for physical therapy. Four months later, he returned to the rheumatologist with increased knee pain. At this time, the rheumatologist referred him to an orthopedic surgeon, who recommended a knee replacement. A date for the elective surgery was set two months ahead. Patient Ling was required to obtain medical clearance, which involved clearance by a cardiologist. The cardiologist ordered and performed a nuclear stress test. After the surgery, an anesthesiologist followed up with use of anesthetic blocks for pain control in the post-operative period and a physical therapist saw Patient Ling in the hospital. After his hospital discharge, a home health agency cared for him for

his initial two weeks at home after the surgery. Then he transitioned to outpatient physical therapy under orders written by his orthopedic surgeon.

Table 9: Patient Relationship Categories for Clinicians in Joint Replacement Scenario

Service	Clinician Type	Category	Rationale
Management of Hypertension and Hyperlipidemia; Routine Health Maintenance	Primary Care Physician	X1	Ongoing, broad care
Right Knee X-ray	Radiologist	X5	Ordered by primary care physician
Treatment of Right Knee Osteoarthritis	Rheumatologist	X2	Ongoing, specialized care
Physical Therapy for Right Knee Osteoarthritis	Physical therapist	X2	Ongoing, specialized care
Right Total Knee Replacement	Orthopedic Surgeon	X4	Specialized procedure
Medical Clearance for Surgery	Cardiologist	X4	Time-limited, specialized care
Anesthesia and Pain Management	Anesthesiologist	X4	Time-limited, specialized care
Rehabilitation Post Joint Replacement	Physical Therapist	X4	Time-limited, specialized care

Complex Scenario 4: Pneumonia and Lung Mass

Patient Achebe sees his nurse practitioner for hypertension, diabetes, and routine health maintenance. He also sees a pulmonologist for COPD, and, given his diabetes, a podiatrist for foot checks and an ophthalmologist for eye exams. At one point, Patient Achebe was admitted to the hospital for pneumonia and exacerbation of COPD, where a hospitalist and pulmonologist managed his care. A radiologist interpreted a chest x-ray revealing a mass. There was a CT scan follow-up, and a surgeon or interventional radiologist performed a biopsy. A pathologist reviewed the specimen and determined it was benign. Patient Achebe had a prolonged stay and was deconditioned. He was discharged to a SNF, where he was managed by a family practice clinician and underwent treatments with physical therapists. After successful rehabilitation, he was discharged home and continues follow-up with his nurse practitioner and outpatient pulmonologist.

Table 10: Patient Relationship Categories for Clinicians in Pneumonia and Lung Mass Scenario

Service	Clinician Type	Category	Rationale
Management of Hypertension and Diabetes; Routine Health Maintenance	Nurse Practitioner	X1	Ongoing, broad care
Management of COPD	Pulmonologist	X2	Ongoing, specialized care
Diabetic Foot Screening	Podiatrist	X2	Ongoing, specialized care
Diabetic Retinopathy Screening	Ophthalmologist	X2	Ongoing, specialized care
Treatment for hospitalization for Pneumonia and COPD Exacerbation	Hospitalist and Pulmonologist	X3	Management of hospitalization
Chest X-Ray	Radiologist	X5	Ordered by hospitalist and/or pulmonologist

Service	Clinician Type	Category	Rationale
Biopsy of Lung Mass	Interventional Radiologist or Surgeon	X4	Specialized service
Pathological Assessment of Lung Mass	Pathologist	X5	Ordered by hospitalist and/or pulmonologist
SNF Stay	Family Practice Clinician	X3	Management of SNF stay
Physical Therapy during SNF Stay	Physical Therapist	X4	Time-limited, specialized care
Management of Hypertension and Diabetes; Routine Health Maintenance	Nurse Practitioner	X1	Ongoing, broad care
Management of COPD	Pulmonologist	X2	Ongoing, specialized care

5 WEBINAR FOLLOW-UP

5.1 Where can I find the February 21 webinar slides, recording, and transcript?

The slides, recording, and transcript for the MACRA Patient Relationship Categories and Codes webinar held on February 21, 2018 are available on the MACRA Feedback Page.

6 APPENDIX: VERBATIM QUESTIONS FROM WEBINAR CHAT

This appendix contains the verbatim questions submitted via the chat box during the MACRA Patient Relationship Categories and Codes webinar on February 21, 2018. The questions are organized according to the same five sections as the FAQ: Policy Context (6.1), Reporting (6.2), Development and Implementation (6.3), Clinical Scenarios (6.4), and Webinar Follow-Up (6.5). You may find general information for each category of the verbatim questions in its corresponding section in the FAQ.

6.1 Policy Context

You may find general information for the following questions in Section 1: Policy Context above.

1. I have a question related to these codes. It's long so bear with me: In the 2018 MPFS final rule for 2018, in response to commenter's questions and concerns related to the voluntary submission of patient relationship codes, CMS explains that, "while we are still developing episode-based measures, the patient relationship categories and codes can help as we define cost measures in the future. The current cost measures in MIPS and those in immediate development do not use these patient relationship codes. We believe additional experience and analysis will be needed before we incorporate the codes into cost measures. We plan to engage clinicians in the use of these codes as we gain experience with their use and submission." The Agency's response to comments which includes this sentence "the current cost measures in MIPS and those in immediate development do not use patient relationship codes" confounds us. If the patient relationship codes are not used with episode cost measures, then what is the usefulness of the codes and how will the codes be used?
2. What will they be used for?
3. How will this data be used?
4. Can you please define the purpose of reporting patient relationship codes?
5. Why is CMS requesting this information and what is the end purpose for collecting it?
6. What is the ultimate goal in reporting relationship codes? Is it payment?
7. Regarding administrative burden of reporting these codes, what is the benefit to a physician for using these codes? I know its voluntary now, but what about in the future when it is not voluntary. We struggle with the purpose of the codes and what benefit, clinical or otherwise these codes have on the care of patients.
8. How will these relationship codes either affect or be incorporated into overall CPS scores? Will they be directly involved in the attribution models for resource use?

9. I understand the concept but what is the ultimate purpose of these codes? will it affect reimbursement...eventually?
10. Please explain how these relationship codes equate to cost and the measurement of cost?
11. What is the data CMS is hoping to capture from these codes and how will it be used to influence provider payment?
12. What data is CMS hoping to capture from these modifiers and how will it impact provider payment?
13. Does this effect the billing?
14. I thought that in the Cost Category of MIPS, there was no reporting for clinicians to do.... the entire category is going to be evaluated by CMS based on claims data. So, what Cost Measures are you referring to?
15. Is the recommendation for these modifiers to be used with HCPCS codes this year? Aren't these modifiers meant to be used with episode-based cost measures?
16. Time wise what is considered "continuous" is there any limit. Will that affect the payment?
17. What is the difference between X1 & X2?
18. What is the description for X1 and X2?
19. Example from proposed rule had Podiatrist noted as example of X5 - only as ordered by another clinician. Has this criteria changed due to Podiatrists eligible in MIPS?
20. Because PRCs are used to attribute cost to various clinicians, how does this affect a pathologist or other clinician that falls into the X5 category?
21. Please describe how cost will be attributed to pathologists or other clinicians categorized as X5?
22. Where is the X series of modifiers list and explanation? I don't see it on the webinar pdf
23. Will the Patient Relationship Categories and Codes have any impact on the Quality Payment Program MIPS and/or APM reporting?
24. Please explain how this relates to MACRA / MIPS?
25. How do these codes interact with APMs? MIPS APMs and Advanced APMs
26. If a physician participates in the pilot, do they receive any sort of credit under MIPS?
27. Is this going to replace the attribution methodology? to help understand how to attribute a patient into a TIN?

28. Is the intent to replace the current attribution model for the cost measure under MIPS or APMs for attributing patients to primary care physicians?
29. Are the voluntary category codes going to be used in making attribution decisions this year?
30. Are there other uses anticipated for these relationship attributions aside from being used for the Cost component of MIPS?
31. Could you explain the CMS perspective of the value to large group practices? Is CMS considering replacing TPCC attribution? thank you,
32. Physicians already have to worry about CPT's and ICD's. Are you worried about another layer to the claims/billing process that has no/little value to the physician in its acceptance?
33. If providers report the codes voluntarily in 2018, will it impact their attribution?
34. Would self-reporting these relationships improve the way patients are currently attributed to the provider for the purpose of Per Capita Costs and MSPB?
35. So it would only apply to Episodic Cost measure in terms of patient attribution, not the total cost per capita measure?
36. When can we expect a ruling on the codes?
37. Is there a timeline for when this could be implemented within QPP?
38. As more information is gathered on specialists through the use of PRC's, if it becomes mandatory, is it conceivable that more episodic cost measures will develop and be put in play in the future? IBD, RA management, etc.?
39. 1. At the beginning of the presentation you listed the provider types to which this reporting applies. For behavioral health providers the only applicable providers are psychiatrists and physical assistants. Do you see this expanding to Masters level clinical providers over time (ie Social Workers, Licensed Professional Counselors, etc..)? 2. At this time MACRA is only for Medicare funded clients, correct? Do you know of any plans to expand this to Medicaid?
40. Are these codes only to be applied to Medicare patients, or all patients?
41. Is this only for Medicare part B FFS?
42. Education and outreach of what?
43. Physicians know what their relationship is with their patients and do not need a code placed on every claim to define it.

6.2 Reporting

You may find general information for the following questions in Section 2: Reporting above.

44. Will qualified APMs and AAPMs be required to submit these codes since the cost category is 0% weigh?
45. I think you covered this in the beginning but I missed it, How will CMS use the data collected with this additional coding and is there a long term plan to make this mandatory?
46. It was said that Patient Relationship codes were voluntary to report for 2018, does that mean they will be required for 2019?
47. Will these modifier be mandatory in 2019?
48. Since these will be used as part of the Cost component of MIPS which has a weight of 10% now, will these not be voluntary anymore?
49. Certain clinicians do not have statutory authority to participate in QPP so they do not need to report these for 2018. Will they have to report these codes if Secretary determines they have to participate in QPP in 2019?
50. When will CMS issue its decision on whether these codes will be mandatory next year? Will it be in a proposed rule such as the physician fee schedule or a separate rule-making?
51. Are the codes/modifiers X1-X5 reported with every CPT or HCPCS code on a CMS 1500 claim and are those codes submitted every single time for the same diagnosis?
52. Will the HCPCS modifiers be required on every line of CPT Code?
53. Do the X modifiers go on the CPT codes? Sorry if I missed this info; I was a bit late joining.
54. I don't believe that answered my question. Are the modifiers to be entered on every single CPT code line on a claim form?
55. Is the intent for a physician to document the code on every patient encounter, including if they have a continuous relationship. Or just the first encounter?
56. Is the modifier attached to EVERY cpt code billed by one provider, or just the E& M code?
57. Do these codes need to be on the claim and in the note for each patient visit
58. Was the answer to modifier added to all claims yes?
59. Question remains, are these codes used for every CPT/HCPCS code submitted on a claim for professional services?
60. Are the codes reported in a modifier field for every CPT code submitted on the claim?
61. So we would have one code per claim? One code per service? How should we handle multiple providers on a single service/claim?
62. Is this meant to primarily be billed with E&M codes or with every code billed?

63. This is a big deal in that if it has to be reported on every single cpt code it will take a lot amount of work.
64. This is confusing. Previously you stated to select a PRC that best describes the encounter if multiple encounter types are being provided. (i.e. different problems are being addressed). Later you stated you could submit as many PRCs as the clinician feels necessary. This contradicts the previous statement. Which is it?
65. If I see patient A for a 99213 and a 20610, do I report the modifier on each of these. If I see patient A again in a week for follow-up, do I AGAIN need to report the same codes? MUST THEY BE REPORTED EACH TIME WE SEE A PATIENT?
66. So just to clarify, if we are billing more than one CPT on a given claim, can we just attach the PRC modifier to one of the CPT's or does it have to be attached to each CPT?
67. As a radiology group providing the professional component only, all of our services would fall under X5 order/refer by another physician. ? Is there a classification to identify us so we do not have to do these, or do we need to submit these on every single patient as we do everything based on order by another provider?
68. My apologies if this is duplicate but I'm not seeing it from hitting submit: We are professional component radiology interp only -- every single study we do will be a 5X ordered/referred by another physician. Is there any application or status that would apply as an exception OR do we need to send every single charge/patient with the 5X designation?
69. Hi all, I've tried dialing in, get asked a # of questions and it's not giving me a way to get in... I've also submitted by Q&A but have not heard this yet...I've asked if there will be any designation for practices like us, pro fee only for radiology, where EVERY charge/patient will be an X5 -- will we need to submit that on every charge line (does that include PQRS as well?) OR will there be a way to apply for a designation to indicate we don't have anything except X5 and not have to add?
70. Typically billers would be the ones updating the claims. How do you envision the provider's documenting their relationship?
71. Is the expectation for the clinician to select their relationship at the time of the encounter? Clinicians do not submit their claims, medical staff does so is this supposed to work?
72. Does CMS expect the physician to determine the relationship and add the modifier when submitting claims?
73. What if the PRC is reported incorrectly, who determines that and what happens if so?
74. Will claims be denied if CMS believes the relationship was coded incorrectly? Who makes this decision?

75. If you enter a PRC code incorrectly, who determines it is incorrect and what does happen?
76. What will the penalty be (if any) for inaccurate categorization and how will accuracy be evaluated?
77. Will we be penalized if we do not report these codes?
78. What happens if the relationship codes are not submitted with claims in 2019 if required? Is there a penalty? Follow up - is there a percentage of eligible encounters that require submission, e.g. 50%?
79. So if the patient stays with the pulmonologists in this particular example then the relationship changes between the emergent care and the continued follow up. The physician makes that notation in the claim?
80. how does the coding work in a group. If I am standing in for my colleague would I use the same code within the same specialty?
81. Who is responsible for assigning the codes? clinicians, or do billers/coders need to discern and extract from reports?
82. Have heard some concerns regarding secondary payers rejecting claims that contain the new PRC modifiers, with rejections explaining that the codes are not valid HCPCS codes and/or that the payer does not understand the modifiers. Have you heard of this, and is there any recommendation for these providers?
83. All of our providers began reporting 1/1/18. 100% of the crossover claims from Noridian Part B, Jurisdiction J have failed. The notices from Noridian state due to the X modifier but the secondary payers are all stating they are not denying the claims and can process the X modifiers. It appears this is a Noridian issue, but we have been unsuccessful resolving it. Who can address this?
84. Presuming these are statistical/informational modifiers, please confirm they are reported after payment modifiers (such as QK, QS X4 for example). Also is there a limit on how many modifiers are reported to CMS?
85. If a surgery claim has 5 CPT codes. Should the X4 modifier be used on each CPT code or just on 1 of the 5 codes?
86. Are the X1-5 the modifiers to be used when billing claims or are there specific Category II HCPCS codes to bill?
87. For radiology claims that require multiple modifiers, TC, RT for example, where is the X5 modifier positioned? First? Last?
88. Is there a recommended modifier position to include the pt relationship modifier? should it be first, second, etc is other modifiers are also applicable to the interaction (ie, 50, 25)

89. In which position should the modifier be reported if we are billing other modifiers as well? Will this always go as the last modifier? What if we more than the 4 modifiers allowed on the claim?
90. Could you also email me on the modifier placement for claims? Would this modifier be placed after an AT modifier on a chiropractic claim, for example?
91. Are claims clearinghouses recognizing these modifiers?
92. Where can we find more guidance on entering these codes on the CMS website?
93. Where on the claim form do you put the patient relationship code?
94. This is probably really silly, but how does the physician submit the relationship codes?
95. How are these category codes reported? Claims based and/or registry?
96. How are these codes submitted?
97. Can these codes be reported through a certified registry?
98. What are the hcpcs codes that are needing to be reported via a claim? is there just one code or is there a list to choose from?
99. Where do you actually place the codes. Do you use them as a modifier?
100. How are we communicating these codes to CMS? on the claim?
101. Do these modifiers go only on evaluation & management CPT codes?
102. Where will these codes be reported, HCFA or EHR?
103. Please send the response on spaces/modifiers to EVERYONE after you find out. Thanks!
104. Please let everyone know about the number of modifiers on a claim and the position of these x modifiers on the claim.
105. Can you email that detail to everyone? Its a very important component of this; where to actually put the codes on a claim.
106. Can you include the information regarding the number of available lines for modifiers on the claim for all participants? We are also interested in this information.
107. Can you please email me the information on how many modifiers you can put on a claim (if these modifiers are following payment modifiers)? We use two payment modifiers frequently and I want to know how these patient relationship modifiers will affect this. My email is [email_address] Thank you

108. I would like to be follow-up information re: the number of modifiers that can be reported for each CPT code & their sequencing; example [78815, 26, ps, (x5)]. my email is [email_address] thank you.
109. What is the implementation date?
110. Are these PRC's to be used beginning January 1, 2018?
111. When can clinicians start checking off these codes on claims to CMS?
112. When do we start adding this Patient Relationship codes in billing
113. So when do we start using these codes?
114. When does the voluntary submission period end?
115. Is there an advantage to voluntarily report this information?
116. If providers utilize the codes voluntarily in 2018, will that impact their attribution?
117. If these are reported on the claim are the Medicare intermediaries prepared to accept these codes and not deny the claim?
118. I think I found the answer if you would just like to confirm.A/B MACs (B) and DME MACs are required to accept at least 2-position numeric or alpha modifiers and process both modifiers completely through the claims processing system (including any manual portion) as far as payment history. A/B MACs (A) or (HHH) must be able to accept at least five modifiers and process them completely through the system.Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf [email_address]
119. As you can see there are a lot of operational questions that need to be answered before folks even begin to voluntarily report these codes. Perhaps a MedLearn Matters article or some other type guidance is needed from CMS.
120. On questions that you state need further research, can you send the answers out to all attendees?

6.3 Development and Implementation

You may find general information for the following questions in Section 3: Development and Implementation above.

121. What is the relationship between patient relationship categories and codes and the Episode-Based Cost Measures work CMS is doing?
122. Would you expect to see medical record documentation to capture the reason or basis for the PR code selection?

123. Is the future intent of these patient related codes to use them for attribution in the cost category of MIPS?
124. What was the cost of developing this PRC reporting system?
125. I missed most of the presentation, what are the PRC modifiers
126. When will additional guidance be out?
127. Is there CEU available?

6.4 Clinical Scenarios

You may find general information for the following questions in Section 4: Clinical Scenarios above.

128. In Simple Example 2, you said that the two pulmonologists could be the same provider. If it was known at the time of providing the care in the hospital that that pulmonologist would be the follow-up provider, should we put "Continuous" instead of "Episodic"?
129. In scenario 4. If the endocrinologist is still treating the patient's diabetes then would they have a X2 modifier for that diagnosis/treatment, and another X1 modifier on the same claim for the general health checks E&M codes?
130. In simple example 4, would the relationship code vary based on the charge/visit? For example, if the endocrinologist has a visit for diabetes and then a separate visit for HTN, would the code still be Continuous/Broad following the change in relationship?
131. Could you explain why the medical oncologist shifted from X2 to X4? Thanks.
132. What if, instead of a single cardiologist providing continuous focused care for atrial fibrillation, a patient sees both a cardiologist and a physician assistant (PA) for ongoing arrhythmia management. Would both the cardiologist and PA have an X2 relationship? What if the patient usually sees his/her cardiologist but sees a PA for one office visit related to his/her chronic condition? Would the cardiologist have an X2 relationship and the PA an X4 even though the patient is receiving continuous care between the two providers?
133. A previous slide indicated X2 would be used for an endo doing DM management. Why would a primary care use X1 for the same relationship? (Slide 40)
134. Slide 43-could the emergency phys also be categorized as episodic/broad?
135. On slide 43 why wasn't the geriatrician included
136. Sorry, apparently I missed you mentioning the Geriatrician
137. Can you speak to how an Emergency Department visit isn here would be classified

138. In a teaching hospital where residents see patients but staff physicians review and actually charge for patient care how can continuous care be defined? Can continuity team staff members be considered or does a specific staff have to continually see the patient?

139. Any physician, regardless of specialty can report these codes, is that correct? For example, what code would an infectious diseases physician use for treating an inpatient with pneumonia that developed only after the patient was admitted for another condition?

140. We have a group practice that treats residents at nursing facilities - dentists, podiatrist, optometrists, audiologists and NP (ear wax removal only) any thoughts on code to use. Care could range from 1 visit to 20 visits or more. Generally care is ordered by their PCP but could be ongoing depending on their Dx and how long they stay in the nursing home.

141. Can multiple patient relationship codes be applied? For example, if a physician is focused on one aspect of care but coordinating with other specialists on broader health care issues. Could they assign X2 and X1 to the same patient?

142. Q for presenters: If a patient begins their care with a specialist during a calendar year, but then over the years becomes a "regular" would it be appropriate to move from an episodic focused modifier to a continuous focused modifier in later years?

143. For Interventional radiologist, the procedure may be ordered by primary doc, how would that qualify for IR doc if they perform the procedure?

144. Would a radiation oncologist who does radiation treatments for an 8-week period then post-tx followups, would the rad/onc doctor be x2 or x4

145. We are an ENT clinic. Can you walk us through this scenario: A patient has had a biopsy at another physician's office and is then referred to us for a wider excision/treatment. This turns out to be cancerous so we will then be providing care for the patient for an undetermined amount of time. During the time the patient then has an ear infection that we treat them for. How would these relationships be defined.

146. If orthopedic physician is treating for oa of knee and then also starts treating patient for oa of hip-would you use X1?

147. So to clarify, would an encounter in a hospital or other facility always be considered episodic?

148. A family practice physician is following a patient in the hospital. The physician is the primary care provider for the patient. What would be the modifier for the hospital stay.

149. When a physician sees a patient for an office visit and a procedure, would a modifier go on both codes? And would one be X1, and the other X4?

150. Are these examples just scenarios or supposed to be an example of an actual note that a medical coder would use to assign these PRCs?
151. Pre-operative medical clearance on an established primary care patient would be considered episodic rather than broad, since the nature of the visit is different than overall primary care?
152. As a radiology group, it appears that most of our relationship codes will fall under X5 for diagnostic services and X4, perhaps, for interventional radiology services. Is this correct?
153. What about ongoing services that have a time limit, of say, 6 months? Are they episodic or continuous?
154. If surgeon admits the patient for observation in the hospital for abdominal pain thinking initially it is gastroenteritis. Later, it is determined the patient has appendicitis and needs to surgery. He follows up with the patient once sent home to remove staples. Would he start out as an X3, then X4 and when seen as outpatient X4?
155. If a physiatrist sees a patient for an EMG ordered by another Dr, would the E&M prior to the EMG use X5 or X4?
156. How does this effect Chiro?
157. As a chiropractor, if I am treating a person for a degenerative condition that flares up periodically, would this be an episodic focused or episodic continuous?
158. In the case of Chiropractic care, if the patient has an ongoing chronic condition that they are being treated for, would that fall under continuous broad services or continuous focused? And in the case that the same patient comes in with a new exacerbation, would that then become episodic focused?
159. A vascular surgeon sees pt in office, has his sonographer run a test, schedules sx, has post op care then yearly follow up appointments would be same relationship throughout
160. A nephrologist sees a patient regularly to manage their Chronic Kidney Disease. However, since the patient also has Hypertension and Diabetes, which complicate the treatment of Chronic Kidney Disease, the nephrologist also addresses, but does not manage, the Hypertension and Diabetes. Would this relationship be considered focused or broad?
161. Are these modifiers also going to be associated with diagnosis
162. How does this tie to the physicians listing all co-morbid conditions, regardless of whether they are directly related to the care (e.g. wrist fx seeing an orthopedist who also has diabetes and is overweight)?

163. If an ophthalmologist is managing a patient's glaucoma but also the patient's overall eye health as his/her sole eyecare provider, how should visits be coded? X2 for glaucoma-focused visits and X1 for comprehensive ones that include other findings?

164. How would you enter modifiers for a specialist treating a stroke that's also providing general health maintenance tasks (flu shots for example)? Could you have one modifier for the stroke care (focused) and another for the flu administration (broad)?

165. Should a provider choose the relationship code based on the specific episode of care only? For example, a Dermatologist follows a patient for history of Melanoma, however they are being seen today for an acute condition such as a rash.

166. Dermatology patient comes in for acne, no referral from a pcp. Do we use modifier X1?

167. If physiatrist main job is assessing acute rehab snf candidate, it is X4?

168. We are urgent care a patient comes in for ear pain, then we find out they are having TIA how would we code this?

169. So a physical or speech therapist would basically always use the X4 modifier? Can you think of an instance where another modifier would be appropriate?

170. We are a primary care provider with an inhouse lab. The modifier would be X1 for the providers for e & m services and X5 for any labs reported from 80000 to 89999. Is this correct?

6.5 Webinar Follow-Up

You may find general information for the following questions in Section 5: Webinar Follow-Up above.

171. When will the slides be posted to the cms website? I don’t see them at this time

172. Will the session be available for us to print a copy for reference purposes

173. Was the deck for this presentation uploaded to the link provided above?

174. Will there be a call in number to provide feedback?