CMS Patient Relationship Categories and Codes
Pamela Ballou-Nelson, RN, MSPH, PhD
Principal Consultant MGMA
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Objectives

- Why patient relationship codes?
- Define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service
- Identify codes
- Placement on claim form
- What next?
The purpose of patient relationship categories and modifiers is to facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.

- *Patient relationship categories and modifiers define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.*
• Weighting the MIPS cost performance category to 10% of your total MIPS final score.

• Including the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures to calculate cost performance category score for the 2018 MIPS performance period.

• See your QRUR report for these costs
Costs

Cost Reporting: The Good News

• These two measures are carried over from the Value Modifier Program and are currently being used to provide feedback for the MIPS transition year.

• CMS will calculate cost measure performance; no action is required from clinicians.
**Cost Measures**

**Weight to final score:**
- Finalized at 10% in 2020 payment year
- 10-30% in 2021 MIPS payment year and beyond

**Measures:**
- Includes (MSPB) and (TPCC) cost performance category for the 2018 MIPS performance period

- For the 2018 MIPS performance period, CMS won’t use the 10 episode-based measures adopted for the 2017 MIPS performance period.
- CMS is developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures in Fall 2018.
- CMS expect to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.
Cost Measures

Reporting/Scoring:
• CMS will calculate individual MIPS eligible clinician’s and group’s cost performance using administrative claims data if they meet the case minimum of attributed patients for a measure and if a benchmark has been calculated for a measure.
• CMS compares your performance with the performance of other MIPS eligible clinicians and groups during the performance period so measure benchmarks aren’t based on a previous year.
• Performance category score is the average of the 2 measures.
• If only 1 measure can be scored, that score will be the performance category score.
SCORING

- Assign 1 to 10 points to each measure.
- Compare your performance to other MIPS-eligible clinicians’ and groups’ during the performance period, not on a past year.

\[
\text{COST PERFORMANCE} = \frac{\text{Total Points Scored on Each Measure}}{\text{Total Possible Points Available}}
\]
Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain

Domain Score

* A domain score was not calculated because your TIN did not have at least one cost measure with the minimum number of eligible cases or episodes to be included in the domain score.

<table>
<thead>
<tr>
<th>Cost Measure</th>
<th>Your TIN</th>
<th>All TINs in Peer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Eligible Cases or Episodes</td>
<td>Per Capita or Per Episode Costs</td>
</tr>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>13</td>
<td>$3,945</td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary</td>
<td>7</td>
<td>$26,704</td>
</tr>
</tbody>
</table>

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure’s peer group during calendar year 2015. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.
### Exhibit 7-AAB. Costs for All Attributed Beneficiaries Domain

**Domain Score**

- **You**: -0.60

#### Standard deviations from the mean domain score (negative scores are better)

<table>
<thead>
<tr>
<th>Cost Measure</th>
<th>Number of Eligible Cases or Episodes</th>
<th>Per Capita or Per Episode Costs</th>
<th>Standardized Cost Score</th>
<th>Included in Domain Score?</th>
<th>All TINs in Peer Group</th>
<th>Benchmark (National Mean)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>2,519</td>
<td>$10,529</td>
<td>-0.51</td>
<td>Yes</td>
<td>$12,380</td>
<td>$3,631</td>
<td></td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary</td>
<td>1,646</td>
<td>$19,580</td>
<td>-0.68</td>
<td>Yes</td>
<td>$20,411</td>
<td>$1,220</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure’s peer group during calendar year 2016. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.
Attribution Using
CMS Relationship Codes
Patient Relationship Categories and Codes

There are five patient relationship categories in the operational list, which are operationalized through Level II HCPCS modifier codes.

<table>
<thead>
<tr>
<th>X1</th>
<th>X2</th>
<th>X3</th>
<th>X4</th>
<th>X5</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1</td>
<td>X2</td>
<td>X3</td>
<td>X4</td>
<td>X5</td>
</tr>
<tr>
<td>Continuous/ Broad Services</td>
<td>Continuous/ Focused Services</td>
<td>Episodic/ Broad Services</td>
<td>Episodic/ Focused Services</td>
<td>Only as Ordered by Another Clinician</td>
</tr>
</tbody>
</table>
1. **Continuous/broad**: This category could include clinicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role.

   • **Examples include, but are not limited to**: Primary care specialists providing comprehensive care to patients in addition to specialty care, etc.
2. **Continuous/focused**: This category could include a specialist 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.

- **Examples include, but are not limited to**: A rheumatologist taking care of a patient’s rheumatoid arthritis longitudinally but not providing general primary care services.
3. **Episodic/broad:** This category could include clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization.

- **Examples include, but are not limited to:** A hospitalist providing comprehensive and general care to a patient while admitted to the hospital.
Relationship Codes

4. Episodic/focused: This category could include a specialist focused on particular types of time-limited treatment. For example, when the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.

• Examples include, but are not limited to: An orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.
5. Only as ordered by another clinician: This category could include a clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians.

- **Examples include, but are not limited to:** A radiologist interpreting an imaging study ordered by another clinician.
## Patient Relationship Categories and Codes

### Summary

<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1</td>
<td>Continuous/Broad Services</td>
<td>Clinician providing comprehensive care for a patient with no planned endpoint of the relationship</td>
</tr>
<tr>
<td>X2</td>
<td>Continuous/Focused Services</td>
<td>Specialist providing ongoing management of a specific chronic disease or condition over an indefinite period</td>
</tr>
<tr>
<td>X3</td>
<td>Episodic/Broad Services</td>
<td>Clinician responsible for overall care and coordination for a patient during an acute hospitalization or inpatient rehabilitation</td>
</tr>
<tr>
<td>X4</td>
<td>Episodic/Focused Services</td>
<td>Clinician providing services for a specific condition or treatment for a definite period of time</td>
</tr>
<tr>
<td>X5</td>
<td>Only as Ordered by Another Clinician</td>
<td>Clinician furnishing services to provide information to another clinician without directly initiating a treatment plan</td>
</tr>
</tbody>
</table>
Simple Clinical Scenario 1
Episode Length Variation by Clinical Situation

Scenario
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 check-ups.

Patient Relationships
Episodic/Focused – X4
Episodic/Focused – X4
Simple Clinical Scenario 2
Changes in a Patient Relationship over Time

Scenario
Patient Gogol is admitted for exacerbation of 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.

Patient Relationships
Episodic/Broad – X3
Episodic/Focused – X4
Continuous/Focused – X2
Simple Clinical Scenario 3
Changes in a Patient Relationship over Time

Scenario
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.

Patient Relationships
Episodic/Focused – X4
Only as Ordered by Another Clinician – X5
Continuous/Focused – X2
**Simple Clinical Scenario 4**

Changes in a Patient Relationship over Time

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Patient Relationships</th>
</tr>
</thead>
</table>
| Patient Ventura does not have a primary care clinician. He is admitted to a hospital for a new diagnosis of diabetes where he is treated by an **endocrinologist**. 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 standing relationship with Patient Ventura, the **endocrinologist** begins also treating his hypertension and doing regular health check-ups. | **Episodic/Focused – X4**  
**Continuous/Focused – X2**  
**Continuous/Broad – X1** |
### Simple Clinical Scenario 5

**Team-based Care**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Patient Relationships</th>
</tr>
</thead>
</table>
| Patient Traoré has hypertension, diabetes, and atrial fibrillation. She regularly sees a **cardiologist** for her atrial fibrillation, and, given her diabetes, a **podiatrist** for foot checks and an **ophthalmologist** for eye exams. Her **nurse practitioner** coordinates with the cardiologist, podiatrist, and ophthalmologist as part of her routine health maintenance. | **Continuous/Focused** – X2  
**Continuous/Focused** – X2  
**Continuous/Focused** – X2  
**Continuous/Broad** – X1 |
FAQ

Q: Is the intent for the physician to document the code on every patient encounter even if they have a continuous relationship or just the first encounter?

• A: The intent is, with each interaction, to be able to define or give the physician the flexibility to define that type of interaction. It could change with time, and that could be updated with every claim, or it could remain the same. Given that the relationships with our clients do change over time and with the services rendered that gives the physician the flexibility to describe the relationship at each encounter.

Q: Can multiple patient relationship codes be applied?

• A: Whatever relationship is best characterized by that specific encounter should be used.
Q: How would an emergency department visit be classified?

• A: Given that the patient is usually being seen in an acute setting, it’s going to be episodic in nature; it’s going to be a time-limited interaction and focused on the patient’s clinical scenario. That puts this type of provider/patient relationship in the X4 category.

Q: Would pre-op medical clearance on an established Medicare patient be considered episodic rather than broad since the nature of the visit is different than overall primary care?

• A: Given that it’s going to be pre-operative clearance, the clinician is probably reviewing the patient’s health in a broad manner, so it is concentrated mainly on the patient’s overall care, which makes it continuous and X1.
FAQ

Q: Can people be used as part of the cost component of MIPS, which has a weight of 10 percent right now, will these not be voluntary anymore.

• A: The patient relationship categories are on a voluntary period for education and outreach right now. A decision has not been made on a policy level when they will become mandatory. During this voluntary period, it will allow [CMS] to collect data on the validity and reliability of the use of these codes before we use them as an attribution toward our cost measures.

Q: How will these relationship codes effect or be incorporated into overall MIPS composite performance scores?

• A: The intent of these patient relationship categories are to be able to allow the clinician to self identify their patient relationships, and [CMS] are hoping to use that data for the attribution of patients and episodes through the use of our episode-based cost measures.
FAQ

Q: How are these category codes reported?

• A: The intent is to report these relationship categories on the claims themselves … in the modifier section.
Bay Psychiatric
Create Scenarios for Psychiatry
Thank You.

Consulting@mgma.org