NUBC Meeting
August 16-17, 2016
Royal Sonesta Harbor Court Baltimore
550 Light Street
Baltimore, MD 21202
TENTATIVE AGENDA
(as of 8/2/16)

August 16, 2016 - Open NUBC Meeting - Hamptons
(Dress: Business Casual)

1:00 - 1:15 pm Welcome and Introductions

1:15 - 1:30 Review and Approve Minutes
- July 20, 2016 Conference Call

1:30 - 3:00 New Business
CMS Change Requests:
- End Stage Renal Disease (ESRD)
  - New Condition Code for Retraining Claims *(Attachment 1)*
  - Three new Value Codes to capture Valuable Data Contained in the Dialysis Prescription *(Attachment 2)*:
    - Dialysate Flow Rate
    - Blood Flow Rate
    - Time on Machine
- New Condition Code for Non-therapy Outpatient Department Services *(Attachment 3)*

3:00 - 3:15 Break

3:15 - 4:30 Other Issues/Changes

(OVER)

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TENTATIVE AGENDA
(as of 8/2/16)

August 17, 2016 - Open NUBC Meeting - Hamptons
(Dress: Business Casual)

8:00 - 8:30 a.m. **Breakfast**

8:30 - 10:00 Other Issues:
- Q&A with Medicare and Medicaid Reps
- State Issues

NUBC/NUCC Joint Meeting

10:15 a.m.
I. 2017 Meeting Planning
II. Version 7030 Public Comment Reviews
III. CMS SSN Removal Initiative (SSNRI)
IV. Patient Relationship Categories *(Attachment A)*

12:00 p.m. **Lunch**

NUCC Open Meeting (Agenda available from NUCC)
1:00 - 5:00 p.m.

ESRD – CONDITION CODE FOR RETRAINING

Self-dialysis and home dialysis training are programs provided by Medicare-certified ESRD facilities that educate ESRD patients and their caregivers to perform self-dialysis in the ESRD facility or home dialysis with little or no professional assistance. Home dialysis training can occur in the patient's home or in the facility when it is provided by the qualified staff of the ESRD facility. The Centers for Medicare and Medicaid Services (CMS) expects that the patients who elect for home dialysis are good candidates for home dialysis training, and therefore, will successfully complete their method of training before reaching the maximum number of sessions allotted.

An ESRD facility may bill for a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD using condition code 73.

Payment is made for retraining self-dialysis and home dialysis education after a patient or caregiver has completed the initial program if the patient continues to be an appropriate candidate for the modality. Most patients receive additional training on the use of new equipment, a change in their caregiver, or a change in modality. The ESRD facility may not bill for retraining services when they install home dialysis equipment or furnish monitoring services. For example, an ESRD facility nurse may not bill for retraining sessions to update treatment records, order new supplies, or add additional medicine for the treatment of infection.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting a new condition code for retraining claims. This will allow for a distinct differentiation between training and retraining and will allow CMS to monitor waste and abuse of these services.

2. **Include a brief, non-technical description of the service or issue.**

   CMS would like to request the addition of a new condition code for retraining that will allow for distinct differentiation and monitoring of training claims versus retraining and to implement systems edits that align with payment policy.

3. **Provide information regarding the "cause" of the proposed change.**
   Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

ESRD – CONDITION CODE FOR RETRAINING

This change is attributable to administrative improvements since it allows ESRD facilities to report training claims and retraining claims appropriately so that utilization edits can be implemented.

4. **Explain what the change is intended to accomplish.**
That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

The purpose of the administrative improvement is to implement system changes that will enforce policy related to utilization of training for home dialysis.

5. **Demonstrate that you are raising a national issue.**
Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")
(Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

Since this coding change impacts all Medicare beneficiaries with ESRD, it is a national issue that impacts all MACs.

6. **Indicate whether the proposal was presented to the SUBC.**
Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

This proposal was not presented to the SUBC.

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

ESRD – CONDITION CODE FOR RETRAINING

Existing UB-04 codes are tied to specific claims processing logic that does not differentiate training from retraining and, as a result, will not allow retraining claims to process correctly. No other existing codes could be used; therefore a new condition code is required.

8. **Indicate the impact on providers.**
   Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

   This change will affect all ESRD facilities that provide home dialysis, either hemodialysis or peritoneal dialysis, to their beneficiaries. As noted above, an ESRD facility may bill for a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for peritoneal dialysis using condition code 73. Training treatments furnished that exceed these limits are denied. ESRD facilities would submit either condition code 73 for training claims or the new condition code for retraining claims. Using 2015 claims data, we identified 32,000 training claims submitted by 3,025 ESRD facilities.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

   See the attached business requirements.

ESRD - NEW VALUE CODES

Typically, end stage renal disease (ESRD) patients receive dialysis three treatments per week and these treatments last three to five hours. The Centers for Medicare and Medicaid Services (CMS) is aware that some ESRD patients require a different plan of care and that ESRD facilities are able to provide treatments that are outside the typical treatment schedule.

The dialysis plan of care and prescription contains a number of valuable pieces of information that individualizes the patient's dialysis treatment. Currently, some of these items are already captured in the claim, such as medications, frequency of dialysis, location, and level of assistance. Including reporting of dialysate flow rate, blood flow rate, and duration of treatment will provide CMS a better understanding of the dialysis actually being administered. This additional information will inform future payment policy to ensure that ESRD facilities receive appropriate payment.

In an effort to collect meaningful data on how patients receive their dialysis, CMS is requesting new value codes to indicate the dialysate flow rate, the blood flow rate, and the time spent receiving dialysis (hereinafter referred to as time on machine) as indicated in the patient's dialysis prescription and/or plan of care. This information will be used to inform decision making for future payment rates and potential rate-setting methodologies as well as providing useful data for the monitoring and oversight of patient condition.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting 3 new value codes to capture valuable data contained in the dialysis prescription; dialysate flow rate, blood flow rate, and time on machine. Dialysate flow rate and blood flow rate are reported as milliliters per minute (ml/min). Time on machine is reported in 15-minute increments.

   We request that these value codes be effective by July 1, 2017.

   Our proposed descriptions are as follows:
   XX – dialysate flow rate (ml/min)
   XX – blood flow rate (ml/min)
   XX – Time on Machine (15-minute increments)

2. **Include a brief, non-technical description of the service or issue.**

   Dialysis prescriptions include valuable data regarding the specific dialysis treatment a patient receives. CMS needs that information in the claims data to inform methodological

ESRD - NEW VALUE CODES

refinements for rate-setting, current and future payment policy and for the monitoring and oversight of dialysis patients.

3. **Provide information regarding the "cause" of the proposed change.**
   Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

   This change is attributable to administrative improvements and problem solutions. CMS would like to capture the information included in the dialysis prescription in order to inform current and future payment policy and to more effectively monitor dialysis patients.

4. **Explain what the change is intended to accomplish.**
   That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

   This administrative improvement will be used to pay ESRD facilities consistently and appropriately for all dialysis treatments as well as to effectively monitor dialysis patients.

5. **Demonstrate that you are raising a national issue.**
   Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")
   (Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

   Since this impacts all Medicare beneficiaries with ESRD, it is a national issue.

6. **Indicate whether the proposal was presented to the SUBC.**
   Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

   This proposal was not presented to the SUBC.

ESRD - NEW VALUE CODES

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
   When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

   The information provided by the requested value codes is not currently available in the data submitted by dialysis facilities, but is readily available in each patient's dialysis prescription and plan of care.

8. **Indicate the impact on providers.**
   Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

   This change will affect all ESRD facilities as all ESRD claims would be required to report this information on the monthly claim. As this information is part of each patient's dialysis prescription, we believe it is readily available. In addition, where a patient's dialysis prescription does not change, the facility would repeat information from previous claims. This change will inform payment changes which will allow CMS to pay ESRD facilities consistently and appropriately for dialysis treatments.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

   See the following business requirements:

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

Typically, non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) are provided without a certified therapy plan of care. These are not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Currently, there is no way to identify that services provider were non-therapy outpatient department services or were actual physical therapy, occupational therapy, and speech-language pathology services.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting a new condition codes to identify that the services are distinctly non-therapy outpatient department services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) are provided without a certified therapy plan of care and functional reporting codes.

   We request that this condition code be effective by April 1, 2017.

   Our proposed descriptions are as follows:
   XX – Outpatient service packaged into Comprehensive APC (C-APC) procedure

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

2. **Include a brief, non-technical description of the service or issue.**

   Provides have indicated that their charge masters are set up to bill these "non-therapy" services in the "therapy revenue codes" and in order to accurately capture them as such, wish to continue to use these revenue codes. However, they have not performed many of the required operations necessary to report the services in the therapy revenue codes, such as, provide a certified care plan and reporting of functional coding. CMS does not wish to burden the providers with such reporting as these services are packaged into the C-APC and are not separately reimbursable. However, the cost of these services are still reportable on the claim.

3. **Provide information regarding the "cause" of the proposed change.**
   Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

   This change is attributable to administrative improvements and problem solutions. CMS would like to capture the information for the non-therapy outpatient department services without increasing provider reporting burden.

4. **Explain what the change is intended to accomplish.**
   That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

   This administrative improvement will be used to pay outpatient hospital facilities consistently and appropriately for all services provided during a Comprehensive APC (C-APC) procedure encounter.

5. **Demonstrate that you are raising a national issue.**
   Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")
   (Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

Since this impacts all Medicare beneficiaries with a Comprehensive APC (C-APC) procedure encounter that requires the non-therapy outpatient department services, it is a national issue.

6. **Indicate whether the proposal was presented to the SUBC.**
   Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

   This proposal was not presented to the SUBC.

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
   When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

   The information provided by the requested condition codes is not currently available in the data submitted by outpatient hospital facilities, but is readily available in each patient's medical record.

8. **Indicate the impact on providers.**
   Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

   This change will affect all outpatient hospital facilities paid under OPPS. As this information is part of each patient's medical record, we believe it is readily available. We do not know exactly the volume of impact as providers may have implemented work-around processes or may not be billing the services at all. This change will inform payer systems that the services were part of the non-therapy outpatient department services that are packaged and do not require detailed coding needed for separate reimbursement.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

   See the following business requirements:

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

Attachment - Business Requirements

(Business Requirements Template for use with Standard Change Requests)

Pub. 100-	Transmittal:	Date: 7/18/2016	Change Request:

SUBJECT (Change Request Title): Reporting of non-therapy outpatient department services on OPPS claims with a Comprehensive APC (C-APC) procedure

Effective Date: April 1, 2017

Implementation Date: April 3, 2017

I. GENERAL INFORMATION

A. Background:

Typically, non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) are provided without a certified therapy plan of care. These are not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Currently, there is no way to identify that services provided were non-therapy outpatient department services (which do not require a therapy plan of care and functional reporting) or were actual physical therapy, occupational therapy, and speech-language pathology services (which do require a plan of care and functional reporting).

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

B. Policy:

Outpatient Hospitals paid under OPPS will be required to submit the following condition code on claims with a Comprehensive APC (C-APC) procedure along with non-therapy outpatient department services when reported on the same claim, beginning April 1, 2017:

XX – Outpatient service packaged into Comprehensive APC (C-APC) procedure

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
XXXX.1	Medicare Contractors shall adjust system edits in relation to the new condition code descriptions identified in the policy section of this CR.	X			X			X	IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
XXXX.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/	X							

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Lela Strong at lela.strong@cms.hhs.gov (for policy questions) and Fred Rooke @ fred.rooke@cms.hhs.gov (for institutional claims processing questions).

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

NEW CONDITION CODE FOR NON-THERAPY OUTPATIENT DEPARTMENT SERVICES

VI. FUNDING

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

"(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

Deadline.
Web posting.

"(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

Comment period.

"(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

"(i) care episode groups; and

"(ii) patient condition groups.

"(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

"(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

"(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

"(II) assign codes to such groups.

"(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

"(II) other factors determined appropriate by the Secretary.

"(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

"(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code). Deadline. Web posting.

"(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms. Comment period.

"(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code). Deadline. Web posting.

"(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part. Deadline. Effective date. Regulations.

"(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

"(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

"(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that 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. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes

may reflect combinations of such categories), such as a physician or applicable practitioner who—

"(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

"(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

"(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

"(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

"(v) furnishes items and services only as ordered by another physician or practitioner.

Deadline.
Web posting.

"(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

Comment period.

"(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

Deadline.
Web posting.

"(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

Deadline.
Effective date.
Regulations.

"(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

"(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include— Claims. Effective date.

"(A) applicable codes established under paragraphs (2) and (3); and

"(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

"(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

"(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

"(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

"(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

"(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

"(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

"(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and Time period.

"(ii) use the claims data experience of such patients by care episode codes—

"(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

"(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

"(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

"(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

"(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

CMS Patient Relationship Categories and Codes

Summary

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted on April 16, 2015. Among many provisions, section 101(f) amends section 1848 of the Social Security Act (the Act) to create a new subsection (r) entitled Collaboration with the Physician, Practitioner and Other Stakeholder Communities to Improve Resource Use Measurement. Subsection (r) requires the establishment and use of classification code sets: care episode and patient condition groups and codes[1], and patient relationship categories and codes. This posting addresses the patient relationship categories and codes required by section 1848(r)(3) of the Act and presents the policy principles that we used in developing the draft relationships with examples that illustrate how clinicians may be categorized and questions for consideration and feedback.

At this time, we are posting the patient relationship categories for public comment. As there are many types of codes that can be submitted on an administrative claim, CMS believes it will be best positioned to determine the specific codes to be submitted once the patient relationship categories are finalized based on public comment. Please submit comments to patientrelationshipcodes@cms.hhs.gov no later than August 15, 2016.

Background

Not later than one year after the enactment of the MACRA, paragraph (3) of section 1848(r) requires the Secretary to post on the CMS website a draft list of the patient relationship categories and codes for review and comment. The comment period must be open for 120 days after the posting, and an operational list of patient relationship categories and codes must be posted on the CMS website no later than 240 days after the close of the comment period. Updates to the operational list (as the Secretary determines appropriate) shall be made through rulemaking no later than November 1 of each year, beginning with 2018. Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 shall, as determined appropriate by the Secretary, include a patient relationship code. A timeline of events is included in Appendix A.

In order to evaluate the resources used to treat patients, under section 1848(r)(5) of the Act, the Secretary is required to conduct an analysis of resource use based on the care episode, the patient condition, and patient relationship codes that will be submitted on claims. CMS is required to post for public comment the draft patient relationship categories and codes as well as a draft list of care episode and patient condition groups (which will be posted in November 2016). CMS

[1] The CMS Episode Groups document was posted for public comment on October 15, 2015. The Public Comment period closed on March 1. More information is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html

will analyze the public comments received and will use these as part of the analysis of resource use. The patient relationship codes reported on claims will be used to attribute patients and episodes (in whole or in part) to one or more physicians/practitioners.

Section 1848(r)(3)(B) defines patient relationship as follows:

"(3) Attribution of patients to physicians or practitioners.—

> "(B) Development of patient relationship categories and codes.—The Secretary shall develop patient relationship categories and codes that 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. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who--
>
> > (i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
> >
> > (ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
> >
> > (iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
> >
> > (iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
> >
> > (v) furnishes items and services only as ordered by another physician or practitioner.

Policy Principles for Developing Patient Relationship Categories and Codes

The development of patient relationship categories and codes is new and exciting work for CMS. The ability to attribute patients to clinicians (in whole or in part), based on clinician reporting of the different relationships that they have with their patients is something that currently does not exist in current coding procedures.

Since this is new work for CMS, we used the following policy principles for determining the patient relationships to ensure that CMS is appropriately considering the role of the physicians and practitioners in patient care to ensure accurate resource use measurement.

1. Develop a clear, simple classification code set to identify patient relationship categories that define and distinguish the different relationships and responsibilities

physicians and practitioners have with a patient at the time of furnishing an item or service.

2. Ensure that the majority of clinician relationships are captured with the patient relationship codes.
3. Ensure flexibility in and ease of submission of codes as part of claims, reflecting that the relationship a clinician has with a given patient may change depending on the clinical situation.
4. Ensure that CMS is open and transparent during the development of patient relationship categories and codes and educate clinicians on the intent and use of the categories and codes.
5. Enable accurate and effective resource use measurement.

Using the patient relationships categories described in section 1848(r)(3)(B) of the Act a starting place, CMS believes that one way to approach distinguishing patient-clinician relationships is to determine whether items and services are furnished on an acute basis or non-acute (i.e., continuing) basis. To help guide our thinking on this distinction, we have included a draft description of an acute episode.

Draft description of an acute episode:

Acute episodes may encompass a disease exacerbation for a given clinical issue, a new time-limited disease (e.g. acute bronchitis), a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. It may occur or span inpatient and outpatient settings. Continuing care occurs when an episode is not acute, and requires the ongoing care of a clinician.

Draft Patient Relationship Categories

Using this framework of care furnished on an acute vs non-acute basis, we sought to distinguish the different categories of clinician- patient relationships that occur in each of these situations. Usually within each type of acute or non-acute situation, there is a clinician who has primary responsibility for the care of the patient and a clinician who furnishes care on a consultative or supportive basis. When reviewing the relationships described in section 1848(r)(3)(B), we believe that there may be some overlap between three of the illustrative categories listed below because many clinicians can assist in the care of a single patient. Determining when a clinician furnishes items and services only as ordered by another clinician versus furnishes services on a continuing basis or an occasional basis may be due to the clinical situation (e.g., a pathologist who reads a breast tissue biopsy vs. a kidney doctor/nephrologist taking care of a patient receiving dialysis). CMS believes that there are many ways to interpret these categories and as we develop the operational list of categories and codes we will want to make it as easy as possible for clinicians to accurately identify their relationship to the patient. To distinguish

between these categories, we are considering a category specific to non-patient facing clinicians. We seek comment on the best way to distinguish between these situations and the inclusion of this category.

- The clinician that furnishes items and services only as ordered by another clinician;
- The clinician that furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role; and
- The clinician that furnishes items and services to the patient on an occasional basis, usually at the request of another practitioner.

As required by subparagraphs (B) and (C) of section 1848(r)(3) of the Act, we have developed and are posting on the CMS website the following draft list of patient relationship categories:

Continuing Care Relationships:

(i) Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care.

Examples include but are not limited to: Primary care physician providing annual physical examination (outpatient); geriatrician caring for resident (Nursing Home); nurse practitioner - providing checkups to adult asthma patient (outpatient).

(ii) Clinician who provides continuing specialized chronic care to the patient.

Examples include but are not limited to: Endocrinologist (inpatient or outpatient) treating a diabetes patient; cardiologist for arrhythmia; oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology.

Acute Care Relationships:

(iii) Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode.

Examples include but are not limited to: Hospitalist caring for a stroke patient (inpatient); gastroenterologist performing a colonoscopy (outpatient ambulatory surgery); Orthopedist performing a hip replacement; urgent care practitioner caring for a patient with the flu (ambulatory); emergency room physician assistant treating a motor vehicle accident patient (outpatient), attending at a Long Term Care Hospital or Inpatient Rehabilitation Facility

(iv) Clinician who is a consultant during the acute episode.

Examples include but are not limited to: Infectious disease specialist treating a patient for sepsis or shingles; gastroenterologist performing an upper endoscopy on a

hospitalized patient (inpatient); rheumatologist performing an evaluation of an acutely swollen joint upon referral by a primary care physician; dietician providing nutritional support to an Intensive Care Unit patient (inpatient).

Acute Care or Continuing Care Relationship

(v) Clinician who furnishes care to the patient only as ordered by another clinician.

Examples: Non-patient facing Clinicians such as pathologists, radiologist, and other practitioners who care for patient in specific situations ordered by a clinician but have very little or no relationship with a patient.

Questions for Consideration:

CMS seeks comment on these draft patient relationship categories as well as suggestions for additional relationships or modifications to these relationships. We are also seeking comments on the questions below:

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?

2. As described above, we believe that there may be some overlap between several of the categories. To distinguish the categories, we are considering the inclusion of a patient relationship category that is specific to non-patient facing clinicians. Is this a useful and helpful distinction, or is this category sufficiently covered by the other existing categories?

3. Is the description of an acute episode accurately described? If not, are there alternatives we should consider?

4. Is distinguishing relationships by acute care and continuing care the appropriate way to classify relationships? Are these the only two categories of care or would it be appropriate to have a category between acute and continuing care?

5. Are we adequately capturing Post-Acute Care clinicians, such as practitioners in a Skilled Nursing Facility or Long Term Care Hospital?

6. What type of technical assistance and education would be helpful to clinicians in applying these codes to their claims?

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?

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?

APPENDIX A- Statutory Timeline

Section 101(f) Requirement	Statutory Deadline	Corresponding Date
Care episode and patient condition groups and codes		
Post on CMS website a list of episode groups developed pursuant to section 1848(n)(9)(A) and accompanying description	NLT 180 days after date of enactment	October 16, 2015
Public comment	Duration 120 days	February 15, 2016
Post on CMS website a draft list of codes for groups	NLT 270 days after end of public comment	November 9, 2016
Public comment, including additional mechanisms (e.g., ODF, town hall meetings)	Duration 120 days	March 9, 2017
Post on CMS website an operational list of groups and codes	NLT 270 after end of public comment	December 14, 2017
Annual updates	By November 1 of each year, beginning in 2018	November 1, 2018
Patient relationship categories and codes		
Post on CMS website a list of patient relationship categories and codes	NLT 1 year after date of enactment	April 15, 2016
Public comment, including additional mechanisms (e.g., ODF, town hall meetings)	Duration 120 days	August 13, 2016
Post on CMS website an operational list of categories and codes	NLT 240 days after end of public comment period	April 10, 2017
Annual updates	By November 1 of each year, beginning in 2018	November 1, 2018

KEY: NLT = not later than; ODF = Open Door Forum