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August 15, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Relationship Categories and Codes

VIA EMAIL

Dear Acting Administrator Slavitt:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) request for comments on the proposed patient relationship categories and codes.

AHIMA is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to effective health information management, information governance, and applied informatics. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

General Comments

While AHIMA appreciates the goal to improve resource use measurement, this goal can only be achieved if the information collected is accurate and consistent. We do not believe the proposed patient relationship categories are sufficiently well-defined to produce accurate or meaningful data.

AHIMA is also concerned that an approach for resource use attribution that involves identification of the relationship between a patient and an individual clinician is not aligned with team-based care. In a team-based environment, determining the relationship between a patient and a given clinician can be very difficult. The complexity of team-based care needs to be captured in any methodology designed to measure resource use.

As described in greater detail below, determination of patient relationships will be especially challenging in the hospital inpatient environment, where patients are often being treated for multiple medical conditions, by multiple clinicians.

We also believe the value of the information generated by reporting of patient relationship codes should be balanced against the administrative burden of collecting the information. Given the limited information that has been provided, it is not possible to fully understand how the proposed patient relationship categories will work in the real world, how these categories will be used, how they will interact with episode groups, how and where they will be reported on claims, and what the logistical reporting and workflow challenges might be. However, it is apparent that the extent of additional work that will be involved will be significant. It is not as clear whether this patient relationship reporting will provide useful information concerning the attribution of resource use.

Operational issues surrounding the reporting of the relationship categories must be addressed well in advance of finalizing patient relationship categories. For example, where on the claim will the relationship codes be reported? Is it expected that one code per claim will be reported, or will relationship codes be reported per line item? Will revisions to the claim form be necessary, and if so, have necessary revisions been requested? Ideally, patient relationship categories and reporting logistics should be addressed in tandem, as the creation of usable categories that produce accurate information depends on an understanding of how and where the patient relationship codes will be reported.

Responses to Questions:

- 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?*

AHIMA believes the draft categories need to be better-defined. The categories are rather ambiguous and overlapping, and terms lack clear definitions. The distinction between “acute” and “chronic” is not well-defined. At what point does acute care become chronic care? If an acute condition evolves into a chronic condition during a lengthy hospitalization, would the patient relationship be considered acute or continuing care?

We recommend using a different term than “primary care provider” when describing patient relationship categories, to avoid confusion with the conventional, well-established meaning of a patient’s primary care provider.

There may be multiple clinicians providing “primary” health care during an episode, especially in team-based care. In that scenario, will more than one clinician be allowed to report the “primary” relationship category for the same episode of care? If only one clinician can report category (i) for a given episode, extensive communication among clinicians involved in the patient’s care may need to take place in order to determine who will report this category.

AHIMA recommends that category (v) be redefined as “Clinician who interprets tests ordered by another clinician” in order to have an unambiguous definition and be clear and distinct from other relationship categories. Category (v) could potentially be confused with (iv). While “non-patient-facing clinician” is used in the examples for (v), this description is not included in the definition. The specialties listed in the examples and described as non-patient-facing clinicians may have direct interaction with the patient in some instances. Also, while telemedicine providers are not face-to-face with the patient, they have direct patient interaction.

The relationship categories do not fully capture all types of patient relationships. For example, “acute on chronic” scenarios are not addressed. There is also no category for a clinician providing preventive services. Post-acute care, such as rehabilitation following treatment of an acute injury, is also not covered.

A clinician may fall into multiple categories for the same patient during a single episode (e.g., a physician may interpret a diagnostic test and later perform a procedure on the same patient). How would the relationship category be reported in this situation?

How will hospitalists/intensivists determine the appropriate relationship category, since patients are shared during a single hospitalization? Will multiple hospitalists/intensivists be allowed to select the same category?

How do telemedicine providers fit within the draft relationship categories?

- 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?***

AHIMA does not believe a relationship category for “non-patient-facing clinicians” would be a useful distinction. As noted above, a non-patient-facing clinician such as a radiologist interpreting a test may also have direct interaction with a patient during the same episode. Also, a patient-facing clinician may have a similar level of accountability for resource costs to a physician interpreting a test (such as a clinician performing a minor procedure at the bedside).

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

No, we do not believe the description of an acute episode is described accurately enough for clear and consistent reporting of the relationship categories. When does acute care become chronic? The line between “acute” and “chronic” can be blurred. And during a lengthy hospitalization, an acute condition may become chronic.

Many patients, especially Medicare beneficiaries, have multiple medical conditions which may include a mix of acute and chronic conditions. How will the relationship category be

determined if both acute and chronic care is provided by the same clinician during a single episode?

- 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?***

We are concerned the definitions are ambiguous and distinctions between acute and chronic care are sometimes blurred. Patients might be reasonably categorized in more than one way.

Some patient encounters do not clearly fall into “acute” and “chronic” categories, such as acute on chronic, post-acute care, and preventive services. Additional categories are needed for these types of care. Also, some medical conditions may not be easily or consistently classified as acute vs. chronic. For example, how would follow-up cancer care be categorized?

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

As noted above, post-acute care, such as rehabilitation, is not adequately captured by the draft relationship categories.

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

Extensive education of both clinicians and coding staff will need to be provided.

Numerous clinical examples would be useful in demonstrating the appropriate use of each patient relationship category.

- 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?***

AHIMA believes that office staff, such as coding personnel, will primarily be responsible for selecting the patient relationship code. However, the clinician will still be responsible for understanding the distinctions between the relationship categories and providing sufficient documentation that a trained staff member can accurately select the most appropriate code. Both clinicians and the staff charged with selecting the code will require extensive education.

To minimize administrative burden and increase accuracy, AHIMA recommends that the patient relationship categorization process be as simple and straightforward as possible, with as few categories as is reasonable to capture significant differences in relationships. Creation of too many categories increases administrative burden as well as the potential for overlap and ambiguity, resulting in inaccurate and useless information. The methodology

needs to be simple enough for a non-clinician to be able to review the clinical documentation and assign the appropriate relationship category.

Category definitions need to be very clear and distinct to ensure accurate code selection regardless of whether the clinician or an office staff member is selecting the code.

Types of necessary workflow adjustments will vary by practice and setting of care. Modifications of electronic health record and practice management software will need to be undertaken, and since such modifications take time, comprehensive information regarding the definitions of the patient relationship categories and reporting logistics is needed as soon as possible. Guidance on the clinical documentation necessary to support the selected relationship category will also be needed.

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?*

AHIMA recommends that CMS consider the use of modifiers to identify the patient relationship category, which we believe may be the simplest method of addressing the reporting of patient relationship categories when multiple clinicians bill for services on a single claim.

The use of modifiers may also mitigate some of the challenges noted in our comments above, such as a single clinician with multiple relationships with the same patient during a single episode or multiple clinicians with the same patient relationship during a single episode.

Conclusion

AHIMA appreciates the opportunity to comment on the CMS patient relationships categories and codes. If we can provide any further information, or if there are any questions regarding this letter and its recommendations, please contact Sue Bowman, Senior Director of Coding Policy and Compliance at (312) 233-1115 or sue.bowman@ahima.org. In Sue's absence, please feel free to contact AHIMA's Vice President of Policy and Government Relations, Pamela Lane, at (202) 659-9440 or pamela.lane@ahima.org.

Sincerely,



Lynne Thomas Gordon, MBA, RHIA
Chief Executive Officer

cc: Sue Bowman, MJ, RHIA, CCS, FAHIMA
Pamela Lane, MS, RHIA, CPHIMS