CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2300	**Date: May 10, 2019**
	Change Request 11259

SUBJECT: Reporting the Patient Relationship Categories and Codes

I. SUMMARY OF CHANGES: This Change Request (CR) advises and provides educational information regarding reporting claims of the HCPCS Level II code modifiers for the Patient Relationship Categories and Codes (PRC). This is a non-system CR, and useful for the voluntary reporting period of the PRC. A subsequent system/implementing CR will be released at a later date when the PRC becomes mandatory and is incorporated into cost measures. Until that time, this CR contains advice and educational information for clinicians reporting the PRC.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 12, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
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.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Section 1848(r)(3) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the development of PRC to facilitate the attribution of patients and episodes to one or more physicians or applicable practitioners (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.

Currently, during this initial period of implementation, reporting of the PRC on claims is voluntary now; however, in the future it will be made mandatory and tied to cost measures preceded by rulemaking.

This CR provides further educational information to the Medicare Adminstrative Contractors (MACs) and clinicians on how different PRC shall be reported by clinicians.

B. Policy: As of January 1, 2018, Medicare Part B Merit-based Incentive Payment Sytem (MIPS) eligible clinicians may now report their patient relationships on Medicare claims using the Patient Relationship Categories and Codes.

Below is the description of the PRC Code Modifiers X1, X2, X3, X4 and X5:

- X1 - Continuous/Broad services = For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship
- 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.
- 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.
- 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.
- 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.

These categories encompass different scenarios. Information materials on requirements, scenarios and reporting of these code modifiers can be found on https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-feedback.html.

The Centers for Medicare and Medicaid Services (CMS) has multiple goals for the voluntary reporting period:

- For clinicians to gain familiarity with the categories and experience submitting the codes

- To collect data on the use and submission of the codes for analyses to inform the potential future use of these codes in cost measure attribution methodology in the Quality Payment Program

The codes are currently in a **voluntary reporting period**. Whether and how the codes are reported on claims will not affect Medicare reimbursement. For now, the modifiers have no impact on beneficiaries.

Reporting of these modifiers will be mandatory in the near future and CMS advises clinicians to participate for easier transition.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11259.1	Effective for dates of service on or after January 1, 2018, contractors shall accept and process claims for the Patient Relationship Category (PRC) program "as outlined in Section above" that contain Healthcare Common Procedure Coding System (HCPCS) Modifiers X1-X5. **NOTE**: The use of these modifiers is voluntary until CMS requires their mandatory use.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11259.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Yvette Cousar, 410-786-4399, Wilfred Agbenyikey, Wilfred.agbenyikey@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0