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Partnership for Quality Measurement Pre-Rulemaking Measure Review Committee
Submitted Electronically via https://p4qm.org/media/3166

**Re: MUC2024-100 Non-Pressure Ulcers Episode-Based Cost Measure Pre-Rulemaking Measure**

Dear Partnerships for Quality Measurement (PQM; Powered by Battelle) and Centers for Medicare
and Medicaid Services (CMS) Pre-Rulemaking Measure Review Committee:

I served as a member of the Clinician Expert Workgroup and as the representative of the American Association of Nurse Practitioners (AANP). In my role as AANP representative, I will focus on the concerns raised by my own Field Test. I fully support the development of a measure which would reflect the cost of the care for non-pressure ulcers for costs that are clearly under the control of the practitioner. As a wound care practitioner, **I am providing examples from my own Field Test to demonstrate why the non-pressure ulcer cost measure currently under consideration should not be implemented.**

I served as a member of the Clinician Expert Workgroup, but **I write this letter in the capacity of a practicing wound care practitioner**. I whole-heartedly support the development of a measure which would reflect the cost of the care for which I am responsible but in reviewing the rest of my field test report (although admittedly, I only have a rudimentary understanding of the results), *this measure is not working.*

Please allow me to give background information on my clinical practice setting. Wound care is a melting pot of subspecialties and disciplines as there is not a designated wound care specialty (i.e. Woundologist). As such, it is extremely common to have multiple providers staffing an outpatient wound care practice and that these providers are from different specialties and even different practice group settings. There are at least 700 Hospital-based Outpatient Provider Departments (HOPD) in the United States and typically there are several practitioners at each location.

In my practice, we are staffed by Nurse Practitioners who are employed by the hospital and podiatrists who are employed by the Faculty Practice Group. **This means we are NOT in the same TIN.** This creates challenges with billing and insurances when both the Nurse Practitioner and the Podiatrist are involved in the care of the same patient but on different anatomical locations. This conundrum was evident in the results of my field test.

### *How can I be a non-attributing NPI to my own report?*

**In column W, note that I am a “non-attributing NPI” in my own report. How is that possible?**

Also, why is Laboratory Corporation of America Holdings even in this list?

| | M | N | O | P | Q | R | S | T | U | V | W |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | PISODE_ | EPISODE_ | ATTR_CLI | SPEC_ATT | NUM_W_R | NUM_O_R | HOSP_1 | HOSP_2 | SNF_HHA | SNF_HHA | NON_ATTR_NPI |
| 2 | /26/2021 | 1/25/2022 | Kara Cou | Nurse Pra | 1 | 6 | District Hc | - | - | - | Joanna King; Cinderella Samandi; Lindsay Sher |
| 3 | 1/1/2022 | ######## | - | - | 3 | 0 | District Hc | - | - | - | Paul Gobourne; Kara Couch; Michele Yingling |
| 4 | 2/5/2021 | 2/4/2022 | Kara Cou | Nurse Pra | 1 | 2 | District Hc | - | Premium | - | Julie Rosner; Farah Siddiqui |
| 5 | 1/1/2022 | ######## | Michele Yi | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 6 | 1/1/2021 | ######## | Michele Yi | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 7 | ####### | ######## | Danyelle [ | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 8 | /11/2021 | 6/2/2022 | Michele Yi | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 9 | /17/2021 | 6/20/2022 | Michele Yi | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 10 | 2/9/2021 | 12/8/2022 | Hannah K | Physician | 1 | 0 | District Hc | - | Professio | - | - |
| 11 | 1/8/2021 | ######## | Danyelle [ | Nurse Pra | 4 | 11 | District Hc | District Hc | CCN 2170 | - | Robyn Macsata; Michael Stempel; Bao-Ngoc Nguyen |
| 12 | 1/1/2022 | ######## | Hannah K | Physician | 2 | 0 | District Hc | Whitman- | - | - | Paul Gobourne |
| 13 | 9/9/2021 | ######## | Hannah K | Physician | 2 | 3 | District Hc | Howard U | - | - | Paul Gobourne; Edwin Chapman; Donnie Spencer |
| 14 | 4/1/2021 | 3/31/2022 | Danyelle [ | Nurse Pra | 1 | 1 | District Hc | - | - | - | Patricia Schultz |
| 15 | 3/8/2021 | 3/7/2022 | Michele Yi | Nurse Pra | 1 | 1 | District Hc | - | - | - | Laboratory Corporation Of America Holdings |
| 16 | /22/2021 | 5/18/2022 | Michele Yi | Nurse Pra | 1 | 11 | District Hc | - | Eh Home | - | Farah Siddiqui; Muralidharan Jagadeesan; Rohan Paul |
| 17 | ####### | ######## | Hannah K | Physician | 1 | 1 | District Hc | - | - | - | Pamela Lewis |
| 18 | 0/7/2021 | ######## | Michele Yi | Nurse Pra | 1 | 3 | District Hc | - | - | - | Louisa Whitesides; Julie Rosner; Laboratory Corporation Of Ameri |
| 19 | /16/2021 | 5/23/2022 | Danyelle [ | Nurse Pra | 1 | 0 | District Hc | - | - | - | - |
| 20 | /24/2021 | 5/23/2022 | Michele Yi | Nurse Pra | 1 | 0 | District Hc | - | Medstar H | - | - |
| 21 | 1/1/2022 | ######## | Hannah K | Physician | 2 | 1 | District Hc | - | - | - | Paul Gobourne; Neal Sikka |
| 22 | 2/4/2021 | 2/3/2022 | Michele Yi | Nurse Pra | 1 | 2 | District Hc | Washingt | Medstar H | - | David King; Steven Abramowitz |

## *The method of Attribution may be a problem for NPs*

With regards to the most expensive pt #16, the entire episode is attributed to the hospital employed NP who performed her initial consultation for hyperbaric oxygen therapy for a diabetic foot ulcer. In our practice, Hyperbaric Oxygen Therapy Services are performed by the Nurse Practitioners. Although the patient’s initial visit was for her HBO consult, she did NOT start her treatment that day. She began a few days after the initial visit. She has since been cared for exclusively by podiatry. She continues to see them weekly and has not seen the NP in follow up for her wound. The podiatrist did her wound care updates to maintain her ability to do HBO and the NP was the supervising provider for the HBO. The patient underwent years of care in our center (she is still an active patient today), had months of intravenous antibiotics, surgical intervention, amputation and other chronic ulcer care. As detailed above, the podiatrists at our institution work for the physician practice group. When NPs employed by our institution perform “initial evaluations” it appears that the subsequent care which is determined by the DPMs and MDs employed by the practice group are attributed to the NPs. These clinical decisions are clearly outside the control of the NP. I would think this will be a serious problem for the attribution of costs to NPs.

In my practice group (i.e. my direct clinical partners who are employed by the same entity as I am and who treat each other’s patients during vacations and absences), all 3 of us (Paul Gobourne, Michele Yingling and myself) are all listed as non-attributing NPI. **How can this be?** In addition, I do not have any knowledge of who Joanna King, Cinderella Samandi, Edwin Chapman, or Donnie Spencer are. I have been in this practice setting for 10 years and have close

contact with the primary care providers and specialist providers for my patients. I know who is actively involved in the care of my patients.

**Table 3: Service Use and Cost by Medicare Setting and Service Category**

| Medicare Setting and Service Category | Share of Episodes with ≥1 Service | | | Average Observed Cost of Services among Episodes with ≥ 1 Service | | |
|---|---|---|---|---|---|---|
| | Your TIN | National Average | Your Risk Bracket | Your TIN | National Average | Your Risk Bracket |
| **All Services** | 100.0% | 100.0% | 100.0% | $7,511 | $8,202 | $10,345 |
| **Hospital Inpatient Services** | 9.5% | 34.7% | 28.0% | $10,387 | $7,709 | $8,028 |
| Inpatient Hospital | 9.5% | 25.0% | 18.5% | $8,735 | $12,777 | $12,886 |
| Amputations for Circulatory System Disorders | 0.0% | 11.4% | 6.6% | $0 | $20,094 | $19,792 |
| Skin grafts and Wound Debridement | 0.0% | 12.0% | 6.4% | $0 | $12,603 | $12,665 |
| Cellulitis | 0.0% | 14.3% | 8.9% | $0 | $6,201 | $6,283 |
| Osteomyelitis | 0.0% | 8.4% | 3.7% | $0 | $8,080 | $8,345 |
| Physician Services During Hospitalization | 9.5% | 34.6% | 27.8% | $1,652 | $1,061 | $1,074 |
| **Outpatient Services** | 100.0% | 100.0% | 99.9% | $3,012 | $2,952 | $3,836 |
| Evaluation and Management (E/M) Services | 95.2% | 99.1% | 99.2% | $1,091 | $841 | $986 |
| Major Procedures | 4.8% | 14.4% | 10.0% | $618 | $1,901 | $1,938 |
| Ambulatory/Minor Procedures | 66.7% | 74.0% | 72.0% | $2,915 | $3,080 | $3,994 |
| Skin Procedures | 52.4% | 71.2% | 68.4% | $2,230 | $2,624 | $3,375 |
| Joint Injections | 0.0% | 0.9% | 1.1% | $0 | $198 | $256 |
| Vascular Procedures | 0.0% | 17.2% | 7.4% | $0 | $677 | $742 |
| Hyperbaric Oxygen | 4.8% | 15.7% | 10.1% | $14,822 | $12,985 | $12,905 |
| Physical, Occupational, or Speech and Language Pathology Therapy | 0.0% | 18.3% | 11.7% | $0 | $842 | $950 |
| **Ancillary Services** | 61.9% | 61.9% | 60.9% | $1,423 | $855 | $911 |
| Laboratory, Pathology, and Other Tests | 23.8% | 47.0% | 39.7% | $140 | $89 | $88 |
| Imaging Services | 4.8% | 35.7% | 32.5% | $218 | $468 | $468 |
| Ultrasound | 4.8% | 33.8% | 29.9% | $89 | $378 | $374 |
| Standard X-Ray | 4.8% | 19.8% | 15.2% | $128 | $343 | $340 |
| Computed Tomography (CT) Scan | 0.0% | 11.6% | 8.5% | $0 | $179 | $180 |
| Durable Medical Equipment and Supplies | 42.9% | 41.2% | 37.3% | $1,953 | $1,159 | $1,211 |
| Orthotic Devices | 0.0% | 17.6% | 12.1% | $0 | $511 | $589 |
| Wheelchairs | 4.8% | 13.9% | 7.3% | $3,656 | $1,267 | $1,383 |
| Oxygen and Supplies | 0.0% | 5.5% | 2.0% | $0 | $644 | $647 |
| Other DME | 4.8% | 17.1% | 10.7% | $33 | $1,289 | $1,376 |
| **Emergency Department Services** | 9.5% | 22.2% | 15.1% | $323 | $756 | $758 |
| Evaluation and Management (E/M) Services | 9.5% | 22.1% | 15.0% | $323 | $735 | $740 |

Table 3 does not make sense based on our practice pattern. **Our TIN had 9.5% of inpatient costs attributed to us but we rarely perform any inpatient care. We also rarely see patients in the emergency department, so I am flummoxed how 9.5% of that care is attributed to us. It is also not possible that 52.4% of our costs could be due to "skin procedures" (unless those include 97597 services**).

| Medicare Setting and Service Category | Share of Episodes with ≥1 Service | | | Average Observed Cost of Services among Episodes with ≥ 1 Service | | |
|---|---|---|---|---|---|---|
| | Your TIN | National Average | Your Risk Bracket | Your TIN | National Average | Your Risk Bracket |
| Procedures | 0.0% | 8.7% | 5.0% | $0 | $222 | $250 |
| Laboratory, Pathology, and Other Tests | 0.0% | 11.7% | 5.6% | $0 | $9 | $9 |
| Imaging Services | 0.0% | 16.2% | 9.7% | $0 | $36 | $35 |
| **Post-Acute Care Services** | 28.6% | 45.6% | 41.8% | $9,012 | $10,080 | $10,277 |
| Home Health | 28.6% | 43.9% | 39.7% | $7,742 | $8,708 | $8,909 |
| Skilled Nursing Facility | 0.0% | 18.2% | 11.3% | $0 | $11,660 | $11,740 |
| Inpatient Rehabilitation or Long-Term Care Hospital | 4.8% | 11.5% | 6.1% | $7,615 | $23,809 | $24,498 |
| **Part D Services** | 57.1% | 74.6% | 70.2% | $42 | $311 | $366 |
| Antibiotics | 57.1% | 74.6% | 70.1% | $42 | $306 | $360 |
| Wound Care Products | 0.0% | 10.2% | 5.0% | $0 | $1,457 | $1,639 |
| Medical Devices and Supplies | 0.0% | 2.4% | 0.0% | $0 | $2 | $0 |
| **All Other Services** | 57.1% | 76.6% | 72.9% | $42 | $2,106 | $2,313 |
| Ambulance Services | 0.0% | 0.0% | 0.0% | $0 | $0 | $0 |
| Anesthesia Services | 0.0% | 18.5% | 0.0% | $0 | $48 | $0 |
| Other Part B-Covered Drugs | 0.0% | 29.0% | 20.9% | $0 | $15,176 | $15,434 |
| Injections and Infusions | 0.0% | 23.9% | 15.6% | $0 | $719 | $830 |
| All Other Services Not Otherwise Classified | 0.0% | 13.4% | 10.7% | $0 | $596 | $780 |

Refer to the Glossary, Table A3 for definitions of metrics.

We do not order intravenous antibiotics. We do not order home health services. In fact, we have not been able to get skilled home health services since COVID. We do not admit to inpatient rehabilitation or long-term care facilities. We do not order DME to account for 42.9% of the episode. **These numbers cannot be correct; and this confirms that there are serious problems with attribution.**

## *Ulcer type might not be properly captured*

| | A | B | C |
|---|---|---|---|
| 1 | EBCM | EP_ID | SUB_GROUP |
| 2 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| 3 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 4 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| 5 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 5 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 7 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 3 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 9 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 0 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 1 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 2 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 3 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 4 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| 5 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 6 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| 7 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| 8 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Non-Specific Ulcer Type |
| 9 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| :0 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Diabetic Ulcer Type |
| :1 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Venous Ulcer Type |
| :2 | Non-Pressure Ulcers | ######## | Non-Pressure Ulcers with Multiple Ulcer Types |
| :3 | | | |

One of the patients with an arterial ulcer was listed under multiple ulcer types (the last line). She had ICD10 codes of I73.9, I89.0, L97.219 (she had a mid-calf wound and an above knee amputation).

One of the non-specific ulcer types was coded L97.919, R60, I50.31 and E11.40. I find this surprising because the patient had a diabetic foot ulcer that eventually became a left below knee amputation. We had treated him for many months but had not seen him in clinic for 4 months before this trigger episode (he was followed by podiatry), and he came in with bullae.

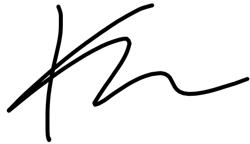
I had previously submitted many of these specific issues during the comment period after the initial field testing. I did not receive any feedback on these comments and neither did my colleagues on the work group. This is both extremely concerning and quite frankly disrespectful of the time we took from our clinical practices and direct patient care to undertake our volunteer role seriously and to provide feedback to create a measure that is meaningful, equitable and just. **With the apparent disregard of those who are clinical experts and actively practicing, why should any clinician take these measures seriously?** The cost measure, as it currently stands, is entirely flawed in its methodology, attribution, implementation plan.

The feedback/comment process appeared to be only a perfunctory process that needed a check box, not an actual consideration of the very real issues with this measure.

Thank you for the opportunity to provide feedback on the Non-Pressure Ulcers episode-based cost measure. **The current cost measure should not be utilized.**

I greatly appreciate the opportunity to allow me to comment on the **Non-Pressure Ulcer Episode-Based Cost Measure. After reviewing the field-testing report and response to the field tests, I firmly believe that this measure should not be used in its current form because there are serious problems with the episode, the attribution and the diagnosis coding of ulcers. This will result in serious unintended negative consequences that are not the goal of this entire process. I urge you to withdraw this measure currently to undergo additional refinement and field testing to ensure parity and accuracy in reflecting real-world data.**

Yours sincerely,



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