

# Questions on “CMS Support of Wound Care in Private Outpatient Therapy Clinics: Measuring the Effectiveness of Physical or Occupational Therapy Intervention as the Primary Means of Managing Wounds in Medicare Recipients” PFPM Proposal Submitted by Upstream Rehabilitation

December 17, 2018

## Payment

1. Page 16 states that, “utilizing the tiered evaluation system introduced in 2017 for physical and occupational therapy, we proposed a further system for categorizing those patients with comorbidities and complicating factors that [would] extend the level of care needed to adequately address their wound care issues.” Please provide additional details regarding the proposed system that would be used for defining the levels of complexity, and explain how patients would be assigned to the three risk categories. For example, would this determination be solely based on the participating PT/OT’s clinical judgment, or are there objective or existing criteria for assigning patients to the proposed low, moderate, or high risk categories which would be used for this purpose?

This simply means that we would utilize the system already developed and implemented in January of 2017 to determine low, moderate, or high categories to determine the level of payment received for that wound. Low complexity wound evaluations would receive the lowest tier of payment (\$3500), moderate complexity wound evaluations would receive the middle tier of payment (\$4500), and the high complexity evaluations would receive the highest tier of payment (\$5500). An example of the education to clinicians would be as follows:

## Step One:

Review Client’s Medical and Therapy History.

Treatment approaches to address the **wound** in the past if applicable and other factors that may impact patient’s ability to progress and reach goals

Includes social history, living environment, work status, cultural preferences, other clinical tests (**including BWAT or another wound outcome measurement**).

Comorbidities that impact function and the ability to progress through a plan (**may include diabetes, renal issues, autoimmune disorders that may affect wound healing**).

Previous functional level; context of current functional abilities.

*What does the medical and therapy history reveal?*

No personal factors and/or comorbidities that impact the plan of care	<i>Low</i>
1-2 personal factors and/or comorbidities that impact the plan of care	<i>Moderate</i>
3-4 personal factors and/or comorbidities that impact the plan of care	<i>High</i>

**Step Two:**

Evaluate and document the following, including:

Body Structures and functions examined (limbs, organs, systems—**this would include detailed documentation of all body areas affected by the wound site**).

Activity Limitations: Includes the ability to make needs known, consciousness, orientation, emotional/behavioral responses, & learning barriers.

Participation Restrictions: Includes restrictions that the **wound** has imposed on mobility, self-care, domestic life, interpersonal relationships/interactions, & community/social/civic life.

*How many elements from the list are examined?*

Examine <b>1-2 elements</b> from body structures, functions, activity limitations, and/or participation restrictions	<i>Low</i>
Examine <b>3 or more elements</b>	<i>Moderate</i>
Examine <b>4 or more elements</b>	<i>High</i>

**Step Three:**

Document the clinical presentation of the patient. Then determine:

Stable and/or uncomplicated characteristics	<i>Low</i>
Evolving clinical presentation with changing characteristics	<i>Mod</i>
Unstable and unpredictable characteristics	<i>High</i>

**Step Four:**

Document a standardized assessment and/or a measurable assessment of functional outcome.

Then determine the clinical decision making required:

Low complexity, using standardized patient assessment instrument and/or measurable assessment of functional outcome	<i>Low</i>
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Moderate complexity, using standardized patient assessment instrument and/or measurable assessment of functional outcome	<i>Mod</i>
High complexity, using standardized patient assessment instrument and/or measurable assessment of functional outcome	<i>High</i>

The eval code should be the lowest of the four levels determined. If any of the levels are low, the code to use is **low (97165)**. If the lowest level is moderate, code as **moderate (97166)**. If all four levels are high, code as **high (97167)**.

- On page 7, the proposal states that “any participating clinician whose average total Medicare reimbursed cost per episode across all patients treated is greater than \$3500 for all low-complexity, \$4500 for all moderate-complexity, and \$5500 for all high-complexity” patients will be subject to probation/dismissal; and that participating clinicians demonstrating an “average reimbursement cost per visit [sic] across all patients treated of less than \$3500 per episode for all . . . low complexity patients, \$4500 for all moderate complexity, and \$5500 [for all] high complexity will be eligible for a 3% savings bonus at the end of the two-year program.” Please explain the analytic process that was used to develop the proposed \$3,500, \$4,500, and \$5,500 thresholds for average total Medicare reimbursed cost per episode based on level of complexity.

These payment levels were based on comparing the 2017 data of the 200+ patients treated in our facilities and the average length of stay compared to their evaluation complexity. Patients who were evaluated for wounds and the evaluation complexity was low were seen an average of 35 visits; wound care patients with moderate complexity evaluations were seen for an average additional 10-12 visits, and those with high complexity evaluations were seen for an additional 10-13 visits beyond the moderate complexity evaluations. The \$3500, \$4500, and \$5500 calculations were based on a net average of \$100 per visit. We used our average lengths of stay as the gold standard due to the advanced training and experience of the therapists leading our wound care program.

- What proportion of the proposed total Medicare reimbursed cost per episode would you estimate to be fees paid to the physical therapist / occupational therapist (PT/OT) vs. wound care products, medical devices, etc.? If you expect that the proportion of fees vs. other items would differ significantly for the three risk categories, what proportions would you estimate in each category?

The proposed \$3500/\$4500/\$5500 fees paid to the physical therapist do not include the cost of the wound care supplies proposed stipend (\$250) or any specialty high-cost dressings (as those are paid as separate DME). The proportion of fees paid for the physical or occupational therapy intervention as compared to the total cost of the episode are going to vary based on the severity of the wound. My estimation is that the proportion of fees paid for the physical/occupational therapy intervention to overall intervention are going to be lower as the complexity of the wound increases (as these patients will have more need for complex dressings).

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4. Please explain the basis for selecting 3% as the proposed savings bonus (which is discussed on page 7 of the proposal).

Three percent was chosen as it was modeled after the top incentive for MIPS (estimated to be 3.58% for top performers, <https://www.saignite.com/industry-expertise/quality-payment-program/mips-education/10-faqs-about-mips/>). This proposal is intended to be a short-term study that will examine the true cost (and savings) of wound care being performed in rural, private, outpatient clinics versus in outpatient or inpatient hospital savings. After the proposed two-year run of the study, intended to gather data to answer just such questions, we will be prepared to more accurately determine not only a bonus that will be budget neutral (and in this author's estimation, more likely significant savings), but lengths of stay and outcomes that will determine the most appropriate lengths of stay (episodes of care), products, and procedures that will procure optimal outcomes for wound-care patients, especially those in underserved areas and of marginalized populations.