Measure Specifications Quick Reference

This page provides a quick, at-a-glance reference for the Non-Pressure Ulcers episode-based cost measure specifications. More details and logic for each component will be available in the full Draft Cost Measure Methodology document and the Draft Measure Codes List file, which will be posted on the CMS.gov QPP Cost Measure Information pages at the beginning of the field testing period.

Episode Window: During what time period are costs measured?

An episode is a segment of time during which clinicians or clinician groups are assessed for the care that they provide to a patient with non-pressure ulcers.

- The episode window length for the Non-Pressure Ulcers measure is between 1 year (365 days) and 2 years minus 1 day (729 days), and can vary in length across patients.

Triggers: How does the measure identify the patient cohort and start of care?

- Patients receiving medical care for treatment of their non-pressure ulcers are included in the measure.
- The start or continuation of a clinician group’s management of a patient’s non-pressure ulcers is identified by the appearance of a pair of services within 180 days of one another: a trigger code followed by a confirming code. For the Non-Pressure Ulcers measure:
  - A trigger code is any code from a set of CPT/HCPCS codes for clinically relevant outpatient services (outpatient evaluation and management codes [E/Ms], measure-specific outpatient E/Ms) when accompanied by an ICD-10 diagnosis code indicating relevant ulcers.
  - A confirming code is either any code from the same trigger set of CPT/HCPCS codes for clinically relevant outpatient services when accompanied by an ICD-10 diagnosis code indicating relevant ulcers, or a code from an additional set of CPT/HCPCS codes (for rehabilitation services, wound debridement, skin grafts, wound modalities, or wound dressing products) when accompanied by an ICD-10 diagnosis code indicating relevant ulcers.

Sub-Groups: Is the measure stratified into smaller patient cohorts?

1. Diabetic ulcers
2. Arterial ulcers
3. Venous ulcers
4. Multiple ulcer types
5. Non-specific ulcers

Service Assignment: Which clinically related costs are included in the measure?

Assigned services generally fall within the following clinical themes:

- Outpatient E/M services; rehabilitation services; diagnostic services (e.g., imaging, labs/pathology)
- Related inpatient hospitalization services (e.g., amputations, cellulitis, osteomyelitis, skin grafts and wound debridement, and other physician services during hospitalization)
- Post-acute care
- Major/minor procedures (e.g., vascular procedures, hyperbaric oxygen, skin grafts, debridement, and other skin procedures)
- Part B and D medications (e.g., antibiotics, nononcologic injections and infusions, wound care products, medical devices and supplies)
- Emergency department care
- Durable medical equipment (DME) and supplies (e.g., orthotic devices, wheelchairs and accessories, and supplies)
**Risk Adjustors:** Which risk factors are accounted for in the risk adjustment model?

- Risk adjustors for factors specific to the condition, including smoking and frailty. For the full list of standard and measure-specific risk adjustment variables, please reference the “RA” and “RA_Details” tabs of the Draft Measure Codes List file.
- Standard risk adjustors, including comorbidities captured by 86 Hierarchical Condition Category (HCC) codes that map with thousands of ICD-10-CM diagnosis codes, count of HCCs, interaction variables accounting for a range of comorbidities, patient age category, patient disability status, patient end-stage renal disease (ESRD) status, number and types of clinician specialties from which the patient has received care, and recent use of institutional long-term care.
- A separate log-linear regression is run for each sub-group and Part D enrollment status combination to ensure fair comparison. The episode group’s scaled (i.e., annualized) observed costs are winsorized at the 98th percentile prior to the regression for each model to handle extreme observations.

**Exclusions:** Which populations are excluded from the measure?

- Measure-specific exclusions including calciphylaxis, pyoderma gangrenosum, scleroderma, sickle cell anemia, and vasculitis. For the full list of measure-specific exclusions, please reference the “Exclusions” and “Exclusions_Details” tabs of the Draft Measure Codes List file.
- Standard exclusions to ensure data completeness:
  - The patient has a primary payer other than Medicare for any time overlapping the episode window or 120-day lookback period prior to the episode window.
  - The patient was not enrolled in Medicare Parts A and B for the entirety of the lookback period plus episode window, or was enrolled in Part C for any part of the lookback plus episode window.
  - The patient was not found in the Medicare Enrollment Database (EDB).
  - The patient’s death date occurred before the episode end date.
  - The patient has an episode window shorter than one year.
  - The patient has extremely low treatment costs.
  - The patient resided outside the United States or its territories during the episode window.
Measure Flowchart: Non-Pressure Ulcers

**Triggering**
- Identify patient-clinician relationship via a pair of Part B Physician/Supplier (Carrier) claims biled by a clinician group within 130 days.
  1. Trigger claim outpatient evaluation and management (E/M) or a measure-specific E/M with relevant non-pressure ulcers diagnosis, plus
  2. Confirming claim: either another trigger claim, or additional code (for rehabilitation services, wound dressing products, wound modalities) with relevant non-pressure ulcers diagnosis.

**Exclude**
- Claims do not meet criteria

**Open 365-day attribution window**

**Define episode of care**
- Extend the attribution window by 1 year for each additional confirming claim referred to as a reaffirming claim.
- Divide total attribution window into episodes of minimum 1 year and attribute each episode to the clinician in the measurement period in which the episode ends.

**Stratify episodes into 1 of 5 sub-groups**
- Are there any ICD-10 DGNs indicating diabetic, arterial, or venous ulcers?
  - Yes
  - No

**Are 80% or more of DGNs diabetic, arterial, or venous ulcers?**
- Yes
- No

**At least 2 ulcer types present**
- 1. Diabetic Ulcer
- 2. Arterial Ulcer
- 3. Venous Ulcer
- 4. Multiple Ulcer Types
- 5. Non-Specific Ulcers Sub-Group

**Apply data cleaning to ensure data completeness**

**Exclusions**
- Episodes with missing data
- Does the patient have a history of pyoderma gangrenosum, sickle cell anemia, calciphylaxis, scleroderma, or vasculitis?

**Attribute episodes to**
- TIN that billed trigger and confirming claims
- TIN-NPI within the attributed TIN that billed at least 30% of triggering or confirming codes with a relevant non-pressure ulcer diagnosis on Part B claim lines during the episode

**Exclude**
- No attributed clinician

**Calculate episode scaled observed cost (O) from clinically related services**
- Outpatient E/M services; rehabilitation services; diagnostic services (e.g., imaging, labs/pathology)
- Related inpatient hospitalization services (e.g., amputations, cellulitis, osteomyelitis, skin grafts and wound debridement, and other physician services during hospitalization)
- Post-acute care
- Major/minor procedures (e.g., vascular procedures, hyperbaric oxygen, skin grafts, debridement, and other skin procedures)
- Part B and D medications (e.g., antibiotics, nononcologic injections and infusions, wound care products, medical devices and supplies)
- Emergency department care
- Durable medical equipment (DME) and supplies (e.g., orthotic devices, wheelchairs and accessories, and supplies)

**Assign Costs**

**Risk Adjustment**
- Estimate expected episode cost (E) through risk adjustment, separately for each sub-group and Part D enrollment status combination.
  - Standard risk adjustors: Hierarchical Condition Categories (HCC) based on CMS-HCC V24, HCC count, patient demographics, clinician specialties, reason for enrollment, recent use of institutional long-term care,
  - Measure-specific risk adjustors: smoking and frailty

**Score Calculation**
- Calculate ratio of O/E for each episode
- Calculate weighted average O/E ratios across all attributed episodes, weighted by number of assigned days for each episode
- Multiply weighted average O/E ratio by national average winsonized scaled observed episode cost to generate dollar figure for the measure score

*To ensure that TIN-NPIs are appropriately attributed, the methodology also imposes an additional check TIN-NPIs meeting the 30% threshold must also have billed at least 1 trigger or confirming code within 1 year prior to or on the episode start date.*