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)

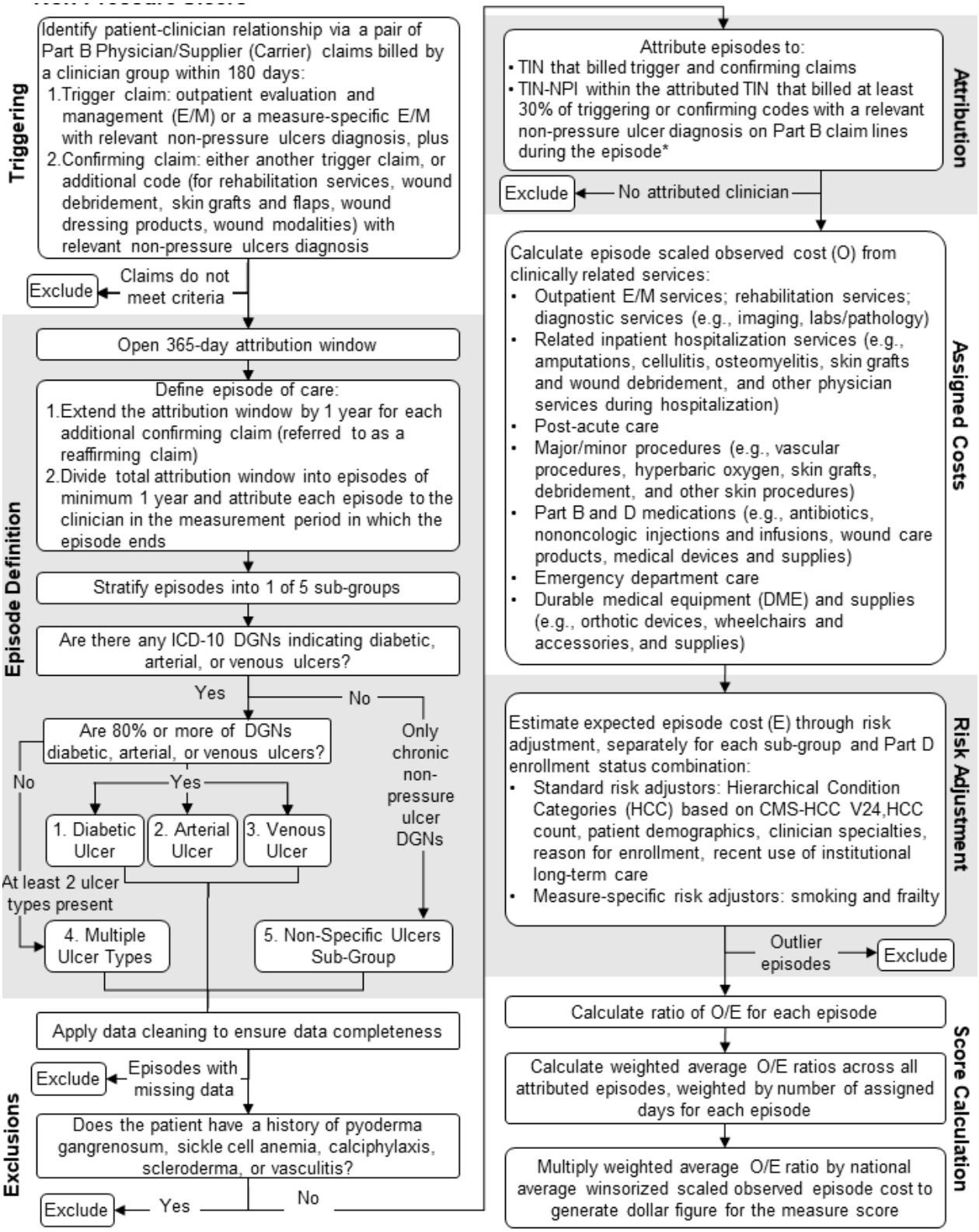
Risk Adjustors: Which risk factors are accounted for in the risk adjustment model?

- 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



* 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