AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

November 30, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
C/O Angela Tejeda, ASPE
Room 415F
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Via Electronic Submission: PTAC@hhs.gov

Re: 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

Dear Members of the PTAC

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on a recently proposed Physician-Focused Payment Model (PFPM) to measure the effectiveness of physical or occupational therapy interventions as the primary means of managing wounds in Medicare recipients.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer reconstruction. ASPS promotes the highest quality patient care and professional and ethical standards and supports education, research, and public service activities of plastic surgeons.

Below we highlight several areas of concern with this proposal as written.

Appropriateness of Skin Substitutes

As written, this model appears to limit beneficiary access to skin substitutes within the range of codes C5271-C5278 and Q4100-Q4172, and assumes low-cost skin substitutes are the most appropriate option for all wounds. However, ASPS believes that depending on clinical characteristics and circumstances, a high-cost skin substitute may provide greater overall value to the beneficiary and the Medicare program. Specifically, high-cost skin substitutes may increase dressing wear time, require less changing and associated medical supplies and visits, improve patient compliance, and ultimately reduce healing time and increase patient satisfaction. Further, many of these products have increased shelf-life, making purchasing and planning less stressful.

By both arbitrarily limiting the available options for skin substitutes while relying upon medical professionals who lack the appropriate training and expertise to ascertain which skin substitute would be most appropriate for beneficiaries, the model is fundamentally flawed and will likely result in poor patient outcomes.

PT/OT as "Primary Coordinator" of Chronic Wound Care

As an indispensable professional in the overall treatment of chronic wound care, we disagree with the fundamental premise of the proposed payment model that physical therapists and occupational therapists (PT/OTs) are the appropriate "primary coordinator" of chronic wound care.

First, the submitters acknowledge key skills required to provide appropriate wound care, highlighting *sharp debridement* as chief among their skill set. Sharp debridement, even *conservative*, is an invasive procedure that does not fall within the scope of practice for PT/OT in all states. We do not believe the agency should establish a model that would unintentionally expand scope of practice for PT/OTs in the Medicare program.

Second, while PT/OTs have acquired the necessary training to perform certain services integral to wound care management, they do not possess the requisite expertise in diagnosis, management, and surgical technique required to treat wounds, especially chronic wounds. For example, the training of a PT/OT does not include the pathology of disease, which is fundamental given the impact diabetes, renal failure, peripheral vascular disease, and other risk factors (such as smoking) can have on wound healing. The submitters appropriately cite wound research, pointing to studies that demonstrate the challenge in wound healing for those patients with chronic, comorbid conditions. However, they failed to acknowledge other mitigating factors that play a role in clinical wound care, such as medications, offloading, nutrition, and tissue perfusion/oxygenation. Clinical decision making is key to getting chronic wounds to heal. Without understanding the pathophysiology of wounds and not addressing underlying contributing factors such as assessing whether there is adequate vascular flow/perfusion, off-loading, nutrition, adequate debridement/dressings, etc, the effectiveness of care decreases, increasing cost and patient morbidity.

Finally, PT/OTs are not equipped to address problems that may arise from the application of skin substitutes, such as the initiation of an immune response leading to rejection. For these reasons, PT/OTs are ill-suited as the "primary coordinator" of wound care.

While PT/OTs are *invaluable* members of the wound care team, ***we oppose a model that positions these professionals at the forefront of clinical decision-making for wound care***.

Measuring Quality of Care

Notwithstanding our aforementioned concern, we note that the model does not include measures of *clinical* quality improvement, which are key to evaluating the impact on quality in relation to cost in any alternative payment model. The US Wound Registry, a Centers for Medicare and Medicaid Services (CMS) Qualified Clinical Data Registry (QCDR), includes several clinical quality measures relevant to

wound care, including measures of patient experience. Several of these measures have been developed in collaboration with the Alliance for Wound Care Stakeholders, which includes the American Physical Therapy Association (APTA). Despite being statutorily excluded from the Merit-Based Incentive Payment System (MIPS) until at least the 2019 performance year, the US Wound Registry will allow participation and reporting of clinical quality data by PT/OT. Bearing that in mind, we question how clinical quality will be measured if not through the registry. Given our obvious concerns with the model drastically affecting patient outcomes, it is critical that clinically relevant quality improvement be appropriately measured.

The submitter also states that the model would capture patient satisfaction. Unfortunately, the instrument planned for use is not described. While extremely important in measuring quality, patient satisfaction is highly subjective and requires the use of a valid, reliable tool. Surveys available under the Consumer Assessment of Healthcare Providers and Systems (CAHPS), generally regarded as the industry standard for assessing patient experience, do not include instruments appropriate for evaluating PT/OT care.

Conclusion

We appreciate the effort made by Benchmark Rehabilitation Partners in fostering the development of a Physician-Focused Payment Model (PFPM) proposal. Nonetheless, we have significant concerns with the model as proposed, which would: 1) limit access to currently available advanced high-cost skin substitutes as well as potentially new, innovative skin substitutes that may be classified as high-cost; 2) inappropriately expand scope of practice for PT/OT; and 3) prioritize cost of care to the detriment of clinical quality.

We urge PTAC not to recommend the model for adoption and testing.

Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Director, at cfrench@plasticsurgery.org or at (847)981.5401.

Sincerely,

Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS Board Vice President of Health Policy & Advocacy
Gayle Gordillo, MD – ASPS Board Vice President of Research
Steve Bonawitz, MD – Chair, ASPS Healthcare Delivery Subcommittee
Aamir Siddiqui, MD – Chair, ASPS Quality and Performance Measurement Committee
Paul Weiss, MD – Chair, ASPS Coding and Payment Policy Subcommittee