ALLIANCE OF
WOUND CARE
STAKEHOLDERS
POWER THROUGH COLLECTIVE ADVOCACY

June 25, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1588–P
P.O. Box 8011
Baltimore, MD 21244–1850.

RE: **CMS-1588-P P**roposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and FY 2013 Rates and to the Long Term Care Hospital PPS and FY 2013 Rates

Dear Acting Administrator Tavenner:

The Alliance of Wound Care Stakeholders ("Alliance") is submitting the following comments in response to the ""Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and FY 2013 Rates and to the Long Term Care Hospital PPS and FY 2013 Rates. The Alliance is a 501 (c)(6) multidisciplinary trade association representing 19 physician and clinical organizations whose mission is to promote quality care and patient access to wound care products and services. These comments were written with the advice of Alliance organizations that not only possess expert knowledge in complex acute and chronic wounds, but also in wound care research. A list of our members can be found on www.woundcarestakeholders.org.

There were provisions within this proposed rule which address Pressure Ulcers. Based on our vast expertise in wound care, we offer our comments solely on one of those provisions.

***Unstageable Pressure Ulcers Should Continue To Be Classified As A Non-CC For** FY 2013*

The Alliance disagrees with your clinical advisors recommendation that "unstageable pressure ulcers should continue to be classified as a non-CC because the stage is not clearly designated as a stage III or IV. Unstageable codes do not delineate what the stage of the ulcer might be. As a result, we believe that unstageable pressure ulcers should continue to be classified as a non-CC for FY 2013."

So, called "unstagable pressure ulcers" represent a significant co-morbid condition for the following reasons:

5225 Pooks Hill Rd | Suite 627S | Bethesda, MD 20814
T 301.530.7846 | **C** 301.802.1410 | **F** 301.530.7946
marcia@woundcarestakeholders.org

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1. According to the National Pressure Advisory Panel (NPUAP) and the CMS LTCH Quality Reporting Program Manual Chapter 3: Section- M, the definition for a Stage II Pressure Ulcer is ***"****Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed,* ***without slough****. May also present as an intact or open/ruptured serum-filled blister."* As such, an ulcer that is unstageable because of the presence of slough or eschar cannot be a Stage I or II ulcer but must be at least a full-thickness Stage III ulcer. A suspected deep tissue injury is also not a Stage I or II superficial ulcer but a deep tissue injury, again full-thickness in nature. In other words, any ulcer which has slough or eschar covering the wound bed must be full thickness in nature and thus according to the NPUAP, cannot be "stage II." It will be staged either as a stage III or stage IV when the wound bed is clean. Since both stage III and stage IV ulcers are significant co-morbid conditions, unstageable pressure ulcers should also be considered in this category.

2. It is unclear from the proposed rule whether CMS allows "not examined" ulcers/wounds to be classified as "unstageable". An ulcer should not be classified as "unstagable" simply because it was not examined. Patients being admitted to an LTACH would be expected to have their wounds assessed within the 48 hour window. It is highly unlikely that a dressing applied before admission would be left in place for more than 48 hours on any wound after admission to a hospital. Also, it would border on negligent if a dressing was not removed from a known wound on an admission to an LTCH within the 3 days assessment.

3. A device applied over a known pressure ulcer, such as a NPWT pump or cast would never be utilized for a superficial, partial-thickness stage II pressure ulcer. An orthopedic device applied near /over a known pressure ulcer may not be removable to allow observation of a pressure ulcer on admission to an LTCH. However, the patient hospital discharge information would have identified the presence of an ulcer and typically its stage. If a dressing, wound device or cast was not removed, it would highly likely be due to the complexity of the wound, indicating the ulcer is at least full-thickness.

The NPUAP allowed the category of "unstageable" to exist when eschar or other material prevented the assessment of whether an ulcer was Stage III or Stage IV. Since**, by their own classification system, these ulcers cannot be "stage II" ulcers, these lesions must represent a major co-morbidity and therefore warrant at least the "CC" level of severity.**

The **Alliance does not agree that the diagnosis code 707.25 should remain as a non-CC code**. CMS has stated that diagnosis code 707.25 has a C1 value finding of 1.87. The C1 and C2 findings are more supportive of a CC classification rather than an MCC and consequently suggest that this code is more similar to a CC than an MCC severity level.

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The **Alliance recommends that diagnosis code 707.25 be assigned a CC designation**. This is appropriate and justified due to costs incurred to offload the pressure ulcer, debride the necrotic tissue and then manage the underlying full-thickness ulcer.

We appreciate the opportunity to comment on this proposed rule. If you need more information or have any questions, please do not hesitate to contact me.

Sincerely,

Karen S. Ravitz
Senior Policy Advisor
Karen.ravitz@comcast.net
301 807 5296