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PPS 2008:

How to manage supplies, ensure accurate payment

By Lynda Laff

Now is the time to implement best practices for tracking and billing your supplies – PPS 2008 has tied payment to non-routine supplies.

The home health industry is now feeling the effects of past lack of attention to medical supply management. In the new PPS, CMS used the limited data they had and unbundled medical supplies in a way that will force home health agencies to pay close attention to what supplies they purchase, how they use and manage those supplies and how they bill for them.

To secure accurate non-routine supply (NRS) payments in 2008, your clinicians will have to not only complete an accurate clinical assessment but learn how to efficiently track and capture the amount and cost of supplies ordered.

Since the implementation of the original PPS in 2000, many home health agencies didn't even bill for supplies deciding that it was an unnecessary burden since they only would be paid the $52.53 included in each episode for supplies, whether they provided them or not.

Now, as most providers are learning, PPS 2008 includes multiple therapy thresholds, case mix variables, episodic timing algorhythyms and an increased number of diagnoses that will result in additional revenue. More importantly, payment for non-routine medical supplies is now totally dependent on these factors.

How to determine NRS payment in new PPS

Clinical assessment, care planning and diagnosis coding directly determine the payment over and above the HHRG for non-routine medical supplies.

For example, a "Skin 1" primary diagnosis and specific associated clinical case-mix variables are assigned supply points. These supply points then translate into supply severity levels that equate to six levels of NRS payment.

More specifically, a non healing surgical wound is categorized as a skin 1 post-operative complication in the NRS case-mix table (CMS table 10b) and assigned 23 NRS points. Also, this primary diagnosis plus a score of three in OASIS M0488 (surgical wound status), garners 14 additional NRS points.

Adding up the NRS points (skin 1 primary diagnosis + M0488 score 3) will determine the supply severity level and ultimately the payment for supplies. In this example, a primary skin 1 diagnosis and a score of three at M0488 will result in a total 37 supply points, an NRS severity level of four, which means an NRS payment of $207.76.

OASIS & coding critical in determining NRS

The following patient example illustrates the revenue value of HHRG and NRS points related to the clinician's assessment:

Scenario: A patient was admitted to home care after exploratory surgery for care of his surgical incision and assessment of his pulmonary condition. The patient also has a diagnosis of COPD. On admission the nurse documented a non-healing surgical wound as a secondary diagnosis and COPD (Chronic bronchitis) as a primary diagnosis. This patient is in his first episode and no therapy was projected.

Incorrect:

Diagnosis	Case-mix points
M0230 (Primary): Chronic Bronchitis (COPD)	1
M0240: Non-healing surgical wound	6
Total clinical points	7

Important note: Seven case-mix points translates to a C2 with HHRG revenue of $342.35 (CMS table 3 & 4). The $342.35 is the difference between C1F1S1 and C2F1S1.

In this situation, the primary diagnosis should have been the non-healing surgical wound. Look what happens to the revenue when the diagnosis coding is changed so that the non-healing wound (which was the reason for the home health referral) is primary:

Correct:

Diagnosis	Case mix points
M0230 (Primary): Non-healing surgical wound	10
M0240: Chronic Bronchitis (COPD)	1
Total clinical points	11

With 11 points, the C score would be C3 and the total clinical domain HHRG revenue would be $722.64. The HHRG value of a C3 is $380.41 more than a C2.

And don't forget to add the non-routine supply revenue:

Diagnosis & case-mix variables	NRS points
M0488: Non-healing surgical wound score 3	14
M0230: 998.83 Post-op complications (Primary diagnosis: Non-healing surgical wound)	23
Total clinical points	**37**

***Note*:** A total of 37 points is a NRS severity level 4, which translates to a $207.76 payment for your HHA, according to CMS' table 9 of the final rule. For more information on the severity levels and revenue associated with the NRS point distribution see table below.

NRS point distribution and revenue		
Severity level	**Points**	**Payment**
1	0	$14.12
2	1 – 14	$51.00
3	15 – 27	$139.84
4	28 – 48	$207.76
5	49 – 98	$320.37
6	99+	$551.00
Source: CMS Table 9 in final PPS rule		

4 steps to help you manage medical supplies

It's important to remember that in addition to the NRS revenue, HHAs will also generally receive additional HHRG revenue for direct care through diagnosis coding and OASIS case-mix scoring. When those two dollar amounts are combined, there are in most instances, adequate payments to cover the cost of non-routine supplies and nursing resources, but only if the agency takes at least five specific steps to manage medical supplies:

1. **Review current medical supply practices to manage cost and utilization**. Now is the time to implement medical supply oversight processes, especially if you're among the many agencies that still maintain a supply closet. Start by conducting a cost-benefit analysis of patient-specific supply management. Work with a single vendor to get the best contract prices and service possible, including an interoperable ordering system to prevent duplication of supply entry. Also, review your internal billing processes to insure that you are indeed billing supply charges correctly now that the rules have changed.

2. **Develop a process to audit the HIPPS code and claim prior to billing to insure that the 5th position matches the bill**. If the codes are incorrect, you will begin to have claims returned for correction once the grace period expires. Supply bills should also be matched with supply orders to validate accuracy of charges.

3. **Streamline product formularies**. It's not necessary or practical to order several different types and brands of similar products just because four different nurses prefer four different products. Convene a diverse expert committee to achieve unity. This best practice alone can result in improved patient outcomes and control costs.

4. **Teach coders and OASIS reviewers how to look for OASIS inconsistencies and omissions**. A major resource to consider is the use of automated expert OASIS edits. These OASIS edits should be real time and accessed prior to OASIS submission to CMS in order to identify errors including coding omissions and inconsistencies. Many information systems have built-in OASIS edits, however many are

inadequate, difficult to use and have not been updated for 2008 – these will be of no value to you without real time 2008 updates. If that's the case for any provider, look outside your own information system for these edits.

Heed the new NRS billing requirements, or miss payment

CMS has created a 2-step process for managing supply claims, and if you haven't mastered the new system, your claims will be returned to you without payment, according to CMS.

Initially, all claims will be paid as they are regardless of whether the supplies are billed or not because CMS is allowing a grace period, which began in April.

During the grace period, CMS will create an editing process to match the HIPPS code and the claim to verify that supplies were actually provided and billed.

Once that grace period is over, claims with supplies billed that have a ***number*** as the 5th digit of the HIPPS code, will be returned to the provider (RTP) without payment for correction. The claim will also be returned if the claim ***does not*** show supplies billed and the 5th digit of the HIPPS code is a ***letter.***

How to complete billing claims for NRS

The 5th position of the HIPPS code will reflect the use of supplies. When supplies are ***not*** provided, the fifth digit of the HIPPS code will be a number (1-6), and when supplies ***are*** provided, the fifth digit of the HIPPS code will be a letter based on the supply case-mix severity index (S=1, T=2, U=3, etc.), according to Table 1 HIPPS Coding – position 5.

To receive your supply payment, claims will eventually be required to have both a letter and supplies billed.

Supplies should be listed on a single line on the claim with Revenue Code 0270 (dressing supplies can be separated out with Revenue Code 0623). Charges included would be the total charges for all ***non-routine supplies***. It will be important for clinicians to examine supply formularies and make certain they're billing ***only*** for non-routine supplies.

Interestingly, the definition for non-routine supplies hasn't been republished or clearly redefined by CMS since the inception of PPS. Prior to PPS, CMS defined non-routine supplies as "those supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care." Routine supplies are defined in a CMS transmittal 277, April 1996, as "supplies customarily used during the course of most home care visits. Routine supplies are usually included in the clinicians' supplies and not designated for a specific patient including but not limited to; thermometers, alcohol preps, cotton swabs, Band-Aids, non-sterile gloves, non-sterile applicators, infection control supplies and lab draw items. The cost of routine supplies is expected to be included in the total cost of providing the home care visit."

Tip: Do not include routine supplies on your bills. Until a new definition of non-routine supplies is issued, we must adhere to this definition.

Table 1 HIPPS Coding – Position 5	
S – level 1, supplies provided	1 – level 1, supplies ***not*** provided
T – level 2, supplies provided	2 – level 2, supplies ***not*** provided
U – level 3, supplies provided	3 – level 3, supplies ***not*** provided
V – level 4, supplies provided	4 – level 4, supplies ***not*** provided
W – level 5, supplies provided	5 – level 5, supplies ***not*** provided
X – level 6, supplies provided	6 – level 6, supplies ***not*** provided

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