Unbundling Medical Supplies - A Disease Management Initiative?

CMS refined and redistributed Medicare payments to health care providers across the continuum. Changes in the redistribution of Medicare dollars throughout the entire health care delivery system have a recurrent theme. CMS is clearly focusing on patient care improvement and prevention of adverse medical conditions. Incentives provided in the Prospective Payment System (PPS) Final Rule for hospitals and home care are the first of many steps leading health care into the Pay for Performance and Disease Management future. Unbundling medical supplies from the episode payment is part of this vision.

The final Hospital PPS 2008 Rule was also published in August 2007. This rule included several prevention incentives to hospitals. One of the incentives is to prevent pressure ulcers from occurring during a hospital stay. This new directive states that CMS will no longer pay for additional care for an inpatient related to pressure ulcers acquired during the hospital stay. Much like home care, there will be outcomes to measure the patient's status at discharge. This directive is a major incentive for hospitals to focus on **prevention** of pressure ulcers. Changes in the Home Health PPS 2008 Final Rule also follow this concept. Although selected skin diagnoses are included in the clinical domain, pressure ulcers are not one of the diagnoses included for payment. Diagnosis points are included for nearly every other type of wound. Clinical case mix points will be given only for actual pressure ulcers staged at M0450 an identified as most problematic at M0460. Interestingly, gait abnormality, currently a common home care diagnosis to support therapy services, will only garner points if combined with a score at M0460 for most problematic pressure ulcer in the first episode with 0 to 13 therapy visits. **Clearly, the incentive is to get the patient up and moving as soon as possible when fewer therapy visits may be required to prevent pressure ulcers and with debilitation!** There will be those situations where the burden of care for patients who developed pressure ulcers in the hospital will be discharged to home care. It would be a good guess that there will be some type of disincentive included for hospitals to have patients discharged with unhealed or deteriorating wounds and most especially wounds that were not present prior to hospitalization. The incentive for both the care of inpatients and for care of patients at home is prevention, better wound care management and aggressive attention to heal pressure ulcers. Not co-incidentally, there will be no incentive in PPS 2008 for home care agencies to provide twice daily nursing visits using non-evidence based wound care procedures such as wet to dry dressings. CMS is looking very critically at episodes of care that produce home care payment "outliers".

So what does this have to do with the unbundling of non routine medical supplies? During their analysis of actual home care expenses, CMS realized that the bundling of medical supplies was not equitable for home care providers and that this inequity had an effect on the admission of specific higher cost patients to home care. It was not insignificant that the statistics from home health care cost reports used by CMS to refine the PPS identified that chronic wound care patients were not as prevalent in

home care as they were prior to the PPS. There were also statistics to indicate that more patients were being re-admitted to the hospital with deteriorating wound conditions-possibly as a result. CMS also discovered that over 60% of home health care providers did not bill for medical supplies once PPS was implemented. As a result, the data that CMS used to calculate the PPS 2008 payment refinement did not include the actual volume or costs of medical supplies used by home care providers. Patients with pressure ulcers often become "outliers" in home care often due to high nursing costs as a result of high visit utilization. Home care providers also know that supply costs for these patients can be significant. CMS determined that the high cost of chronic care patients was the result of a payment model with no real incentive to prevent adverse conditions. The movement to a model of care that rewards improvement in patient outcomes and penalizes controllable adverse events is on the horizon.

CMS is changing incentives in home care to promote prevention of pressure ulcers and effective, efficient wound healing. The Proposed PPS Rule for Home Care published in April described a new model for supply payment with 5 non-routine supply (NRS) severity codes with the highest payment level equaling $367.34. CMS revised the NRS severity table and included a 6th payment level equaling $551.00 as a result of the rebasing the 2008 PPS model on 2005 data and also as a result of analysis of many excellent industry comments and suggestions for making NRS payment more equitable. It will definitely be in home care's best interest to use the most effective products and procedures to manage wound care healing efficiently**.** A pressure ulcer diagnosis is no longer included in clinical domain points. The payment effect will rely completely on the accuracy of wound **staging**. This provides real incentive to home care to ensure that the OASIS questions are answered correctly by the clinicians. Without correct answers to wound questions, there will be no additional payment for pressure ulcers in the clinical domain **or** for the NRS add on.

Based on considerable analysis of case studies of patients with pressure ulcers, it appears that the NRS add on payment alone will be adequate for the majority of episodes. There of course will be those extenuating circumstances where costs may be higher. But it is important when thinking about non-routine medical supplies that you consider not only the direct payment add-on relative to the supplies used and billed but also consider the additional revenue incurred by having a diagnosis in the clinical case mix points (other than pressure ulcer) that will garner additional clinical points as well as having OASIS case mix items such as M0460 that will score additional clinical points. These clinical points will generally take the Home Health Resource Group (HHRG) to the next payment level. The additional points that will be received in the NRS tables 10a and 10b will then result in an additional payment add on to the HHRG. In 2008 medical supplies must be billed on the End of Episode (EOE) UB-92 to support the claim for NRS add on. Specific instructions will be published prior to implementation.

The following table illustrates the HHRG, revenue and NRS add on payment effects of clinical accuracy. The HHRG for the patient episode was originally calculated as a (2008) C1F2S2.

Revenue Effects of Wound Staging

Wound Staging	HHRG & Case Weight	Revenue	Additional Case Mix Dollars	NRS Points Severity Level & Revenue	Total Revenue
Un-staged Wound	C1F2S2 .9393	$2,132.53	**0**	0 points Level 1 **$14.12**	**$2,146.65**
1 Stage 2 PU	C2F2S2 1.0901	$2,474.87	**$342.34**	14 points Level 2 **$51.00**	**$2,525,87**
1 Stage 3 PU	C3F2S2 1.2577	$2,855.29	**$722.76**	29 points Level 4 **$207.76**	**$3,063.05**
2 Stage 4 PU	C3F2S2 1.2577	$2,855.29	**$722.26**	67 points Level 5 **$320.37**	**$3,175.66**

The first row indicates the result of a patient with a stage 2 pressure ulcer with no score on the OASIS for a pressure ulcer because the nurse failed to stage the wound. The HHRG for this patient is C**1**F2 S2 for a case weight of .9393 and revenue of $2,132.53. There were no NRS supply points since there was no score at M0460. The NRS severity level is 1 and $14.12 is added to the revenue for a total of $2,146.65.

Let's look at what happens when that wound is staged. The HHRG becomes C**2**F2S2, case weight 1.0901 and revenue of $2,474.87. Fourteen NRS points are added due to the staging of the pressure ulcer (M0460 most problematic pressure ulcer stage 2). With 14 NRS points, the NRS severity level is 2. This adds $51.00 to the revenue for a total of $2,525.87. By staging the wound, you receive **$342.34 additional dollars attributed to clinical case mix.** The additional $342.34 plus the $51.00 add on is a substantial total increase of $393.34 – definitely enough to treat and heal a stage 2 pressure ulcer!

What if the nurse incorrectly staged the pressure ulcer and the pressure ulcer was actually a stage 3? If the pressure ulcer was a stage 3, the HHRG would be C**3**F2S2 with a case weight of 1.2577 and revenue of $2,855.76. The case would score 29 points for a stage 3 pressure ulcer, have a severity level rating of 4 and an NRS add on of $207.76 for total revenue of $3.063.05. This represents additional clinical case mix revenue of $380.42 and a total payment increase of $537.18.

The last example (row 4) describes a patient with 2 stage 4 pressure ulcers. Based on the same clinical characteristics used in the first two case studies, the HHRG and revenue would be the same as with a stage 3 pressure ulcer however, in this situation, the NRS points equal 67 and the severity level is a 5. The NRS add on for a severity level 5 is $320.37. The total revenue for this patient is $3,175.66.

CMS is moving the focus of patient care for all components of the health care delivery system. There will be much to gain for patients and for providers of care with a payment model that focuses on prevention and outcome improvement. The future holds no financial gain for less than the best patient care.