Medical Supply Management in the New PPS Era: Improve Revenue through Enhanced Utilization Review and Proactive Oversight

How does home care maximize the patient outcome while minimizing nursing time and supply costs? Are we realizing that medical supplies are a revenue source, not a cost? To secure accurate non-routine supply (NRS) payments in 2008, clinicians must complete an accurate clinical assessment and learn how to efficiently track and capture the amount and cost of supplies ordered. But do clinicians really have the time, tools or information to accurately track supplies, know costs, and understand the overall supply utilization standards that CMS and other third party insurance providers follow? Can they match products to proper diagnoses? Can we benchmark the clinical protocols to supply usage? Is the supply vendor helping with both the clinical and supply aspects of this? In this article, a 14-month case study with a large hospital-based home care agency will be reviewed in which the agency implemented a complete supply management process that included proactive formulary and utilization management. The rules-based approach from their supply vendor provided more cost savings than any procurement specialist could dream of. The results prove that medical supply management is more than having a list of "approved" products to use and then having them shipped from an old distributor model. The process instead should incorporate complex "behind the scenes" proactive rule sets that can impact supply utilization at the point of order.

The Buzz and Background…

The PPS changes in 2008 finally provide revenue from clinical assessment, care planning and diagnosis coding directly over and above the HHRG for non-routine medical supplies. We know how critical correct coding is and realize that prior to 2008 medical supplies were viewed as only an expense to a home care agency. That perspective for all intent and purpose was likely a fair assessment since a home care agency typically would "watch" what the nurses were taking out of the supply closet, or do the annual investigation of the dreaded stockpiles of supplies in the car. The instance where an indwelling catheter leaked in the summer was likely a manufacturer defect, not the fact that the catheter sat in 120 degree temperatures for a week. We know that instead of the one rate of $52.53 for all episodes of care provided for medical supplies, the additional revenue source is calculated based on the case mix severity level as noted in Table 1. Today we must track supply costs per patient and understand how to analyze trends and look at benchmarks based on diagnosis. Beginning in October, 2008 claims must include the HIPPS code and

Table 1
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

the fifth digit should be a letter if supplies are utilized. The letter should correspond to the case-mix severity level as noted in Table 2 below. With the severity scores dependent on the diagnosis and specific MO items on OASIS, an audit of the HIPPS process is important to ensure correct reimbursement for non-routine supplies.

Table 2: HIPPS Coding – Position 5

Letter Code, Severity Level	Number Code, Severity Level
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**

Enhanced Supply Management…a Key Factor in 2008 and Beyond

A critical aspect of supply management encompasses not only a strong formulary, (and a complete system to monitor the formulary), but also a complex methodology to proactively perform supply utilization based on *product category*. At Resurrection Home Health Services located just outside Chicago, Illinois, a progressive step of implementing a complete supply management program saved the agency over 30% in supply costs while their average patient census increased nearly 12%!

Resurrection is a hospital-based home care agency that in October, 2007 in anticipation of the PPS changes on the horizon, wanted to make an impact in supply management. Our supply vendor has a robust set of oversights and rules that can be applied to virtually any aspect of patient care, as illustrated in Table 3. Our clinical team and WOCN reviewed with the vendor's assistance the types of customized rules that would be best for our agency. We used the period of 7 months from March, 2007 through September, 2007 to create a baseline for data collection. In October, 2007 a full implementation using our supply vendor's rule sets began. We decided on using rules 1-4 as indicated in Table 3 below. It was a cultural shift in how the clinicians looked at supply usage and most importantly how they case-managed the patient from a clinical perspective.

Focal Points – Silver Product Usage/Advanced Wound Care

At the onset of the study, Resurrection knew that its silver product usage was high and there was potential waste, as silver products accounted for 21.83% of all supply costs. Knowing silver products are expensive but necessary to achieve positive outcomes, the agency wanted to focus particularly on silver usage. Typically physicians would order a silver antimicrobial and it would be used till near patient discharge, when really the wound may not have been infected after 2-3 weeks. The Silver Utilization rule provided over a 61% savings in silver supply expenditures alone. 12% of overall costs were now silver products, a statistically significant result.

The overall outcome from the other important rule sets listed above, particularly advanced wound care utilization management, resulted in just over a 30% cost reduction as a percentage of our total spend. The average case weight for the period March, 2007 through September, 2007 was 1.26 versus 1.22 for October, 2007 through April, 2008.This process was implemented after review of protocols and how products *should* be used by clinicians. This result simply equates to better case management of patients, improved outcomes, reduced waste of supplies and enhanced revenue from overall episode of care. It is further attributed to clinical education and protocol adherence.

Table 3

Rules-based Oversights	Example	Goal
1. Formulary Management	Ensuring one hydrocolloid is the preferred option	Maintain best pricing, best clinical product for positive outcomes and teaching; streamline protocols
2. Cost per patient per time period	$150 per patient per 2 week period	Monitor high cost patients
3. Silver Antimicrobial Utilization	Flag patient orders that use more than 2 weeks of silver products	Reduce waste of Silver products; communicate with physician
4. Advanced Wound Care Utilization	Follow CMS guidelines for product categories like Foams, 3 eaches, per wound, per week	Reduce waste of supplies; monitor change in plan of care/protocol
5. Per Patient Per day Rate	For use with Hospice especially, i.e.$2.00 per patient per day	Easily track patient costs for DME/Supplies
6. Number of Orders per Patient per Time Period	One order per patient per week	Reduce small orders; engage nurses in "smart ordering"

Conclusion

It is clearly illustrated that home care can save bottom line dollars through medical supply management. A summary of our findings are located in Table 4 below. Too often, the cost of supplies from something as simple as gauze or gloves is over-evaluated. More importantly with the PPS changes in 2008 and the potential for future changes, it is so critical for home care to insist on comprehensive medical supply management that includes the entire rule sets described above in Table 3. Additionally, clinical education is pertinent to overall revenue and survival in a market where wound care, done exceptionally well, can be a driving force for agencies nationwide. An example is the revenue difference between a stage II and stage III pressure ulcer. This value is approximately $500, of which non-routine supplies account for nearly $150 of the total $500.

Table 4

	Period March, 2007 through September, 2007	**Period October, 2007 through April, 2008**
Medical Supply Costs	$163,242	$113,641 *30.38% reduction in costs*
Silver Product Spend	$35,643	*$13,876* *61.07% reduction in costs*
Silver % of total Spend	21.83%	12.21%
Case Mix	1.26	1.22
Average Census	Baseline	11.83% increase

This should be enough reason to urge your provider of medical supplies to create, assist in implementing, and monitor the protocols and supplies for diagnoses such as pressure ulcers, venous ulcers, and post-surgical wounds. The above case study is proof that change can create positive energy on many levels and that cost control goes well beyond the price of an item.