OASIS Alert

Reimbursement: Report Non-Routine Supplies Or Risk Cash Flow Delays

CMS gives with one hand and takes away with the other.

Answers you report on your OASIS assessment will determine reimbursement for non-routine medical supplies for episodes after Jan. 1, 2008.

Under the final Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 ("final rule"), released Aug. 22, the **Centers for Medicare & Medicaid Ser-vices** addressed industry concerns that non-routine medical supplies (NRS) reimbursement did not adequately compensate for NRS costs to home health agencies.

The result: After the final rule takes effect Jan. 1, the agency will "expect that HHAs will report NRS costs on their claims." And to provide a stronger incentive for agencies to report supplies costs, "claims that do not report NRS costs, unless explicitly noted [on the claim] by the HHA that NRS was not provided, will be returned to the provider (RTP)," CMS says in the final rule. The HHA must then resubmit the claim with either the NRS costs reported or the fact that NRS were not provided noted on the claim, CMS explains.

Grace period: CMS will determine and communicate a grace period for this change, the final rule reports. CMS plans to monitor the accuracy of the new method of reimbursing NRS and explore alternative methods, the agency says.

Past Problems Cost Agencies In The Future

Historically, home health agencies have encountered problems with clinicians keeping track of supply cost, says senior consultant **Debbie Dawson** with **HealthCare Strategies Inc.** in Chat-tanooga, TN. HHAs also neglect reporting NRS costs on claims because of an attitude of "we don't get paid for them, so why bother," she tells **Eli**.

More than 40 percent of the cost reports CMS reviewed before proposing the new NRS reimbursement rates did not contain any costs for NRS, reports senior consultant **Judy Adams** with Charlotte, NC-based **LarsonAllen**. This causes inadequate NRS reimbursement at least until CMS revisits this issue, she says.

In the proposed PPS refinement, CMS eliminated the NRS reimbursement contained in the home health PPS base rate and instead suggested paying NRS separately based on a system of five severity ratings. The final rule expands that to six severity ratings (see related story, page 87).

Most episodes (63.7 percent) will fall into the lowest severity rating, CMS expects. That level will pay $14.12 for NRS for an episode. Only 0.3 percent of episodes will score at the highest severity level, CMS predicts. That level will pay $551.00 for the episode's NRS (see chart, page 87).

Upside: The PPS refinements are budget neutral; however, the new NRS reimbursement plan gives you more options to receive part of the available case mix funds, Adams says.

Downside: To maintain budget neutrality, CMS plans to offset the increased NRS reimbursement by reducing the national standardized 60-day episode payment rate, the final rule explains. That rate for episodes beginning and ending in calendar year 2008 will be $2,270.32, according to the final rule.

OASIS Accuracy Counts Heavily For NRS

Even though it is not ideal, CMS' plan to reimburse NRS using severity levels and diagnoses plus other OASIS items as indicators is a good approach and a move in the right direction, Adams says. Under the final rule, reimbursement for NRS flows from the OASIS assessment, she explains. And for agencies to receive appropriate NRS reimbursement, accurate assessment is very important, she warns.

Example: An ostomy related to an inpatient stay or regimen change is worth 35 points toward the NRS severity rating, Adams explains. But an ostomy not related to an inpatient stay or regimen change adds only 21 points. Determining exactly which category the patient fits into at start of care can gain or lose reimbursement dollars.

NRS Points Are Additive

NRS reimbursement under the final rule combines a number of OASIS items. A selection of case-mix diagnoses provides some points toward reimbursement. For example, a patient with a primary diagnosis (M0230) of anal fissure, fistula and abscess -- ICD-9-CM codes 565.x and 566 -- will score 16 points. Anal fissure, fistula and abscess as a diagnosis other than primary will score 9 points.

Responses other than "0" to M0450 (Current number of pressure ulcers at each stage) can add from 12 to 143 points. M0 items concerning stasis ulcers, surgical wounds, ostomies, infusions and catheters also add NRS points. Point values also may differ depending on whether the episode is an "early" or "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes.

Tip: Points for NRS are additive, the final rule explains, "but points may not be given for the same line item in the table more than once. Points are not assigned for a secondary diagnosis if points are already assigned for a primary diagnosis from the same diag-nosis/condition group," CMS adds.

Caveat: These NRS calculations do not apply to low utilization payment adjusted (LUPA) episodes, the final rule clarifies. CMS plans to continue studying the issue of NRS associated with LUPAs, Adams says.

Note: NRS information begins on page 252 of the final rule at www.cms.hhs.gov/homehealthPPS/downloads/CMS-1541-FCdisplay.pdf. For a pdf copy, contact Marian Cannell at marianc@eliresearch.com, with "Final PPS Rule" in the subject line. For details on NRS calculations, go to the proposed rule at www.cms.hhs.gov/HomeHealthPPS/downloads/CMS-1541-P.pdf.