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HEALTHCARE CONSULTANTS

Medical Supplies

Routine vs. Non-Routine

Medical supplies are essential to providing home health care and carrying out physician orders for the treatment or diagnosis of the patient's illness or injury. But when it comes to cost reporting, bookkeeping, and billing, medical supplies tend to be one of the more neglected areas of business operations.

The reason medical supplies tend to be "forgotten" can be attributed to the fact that the payment for the cost of the supplies is bundled under home health PPS. Reimbursement is already incorporated into the per visit and episode payment rates. Providers tend not to track their supplies as diligently as they should, presumably because it does not have an impact on their reimbursement.

Although reimbursement may not be directly influenced by supply costs or charges, it is a requirement of CMS that all ***non-routine*** supplies furnished to a patient during an episode of care be reported on the final claim, as well as tracked separately with the cost of these supplies reported on the year-end Medicare Cost Report. CMS uses data collected from both cost reports filed and claims submitted to determine future reimbursement rates. For this reason, it is imperative that providers accurately track and report medical supply costs and charges, both in their general ledger and on their Medicare claims.

Medical Supplies Are Classified In Two Ways:

- **Routine** – supplies used in small quantities for patients during the usual course of most home visits
- **Non-routine** – supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care that are directly identifiable to an individual patient

CMS offers a consolidated billing list which can help providers accurately identify which supplies in their inventory are considered non-routine. These supplies should be monitored and tracked when used for the care of a patient, so they are easily identified for billing purposes. The provider can track supplies through the use of manual forms or within the billing software, as long as there is a clear process for using and reporting non-routine supplies.

Although non-routine supplies reported on the final claim may not directly affect reimbursement, the ***anticipation*** of the supplies to be furnished over the course of an episode can and will have a dramatic effect on the episode's reimbursement rate. As of 2008 and the coinciding case-mix refinement changes, the fifth position of the Health Insurance Prospective Payment System (HIPPS) code now indicates a supply severity level, which is based on clinician responses to the Outcome and Assessment Information Set (OASIS) assessment items.

A letter in the fifth position indicates that non-routine supplies were provided by the agency during the episode. A number indicates that non-routine supplies were not provided to the patient. Initially, the HIPPS code generated from the OASIS will default to a letter in the fifth position and is the HIPPS code that is submitted with the request for anticipated payment (RAP) claim.

The following table outlines the six levels for non-routine supplies, their corresponding letters and the 2015 base rate for the supplies (as an add-on to the wage adjusted HHRG rate):

Supply Severity Level/Value if Supplies Not Provided	Value if Supplies Provided	2015 Supply Rate
1	S	$14.36
2	T	$51.86
3	U	$142.19
4	V	$211.25
5	W	$325.76
6	X	$560.27

In the event that non-routine supplies are used over the course of an episode, they are to be reported on the home health final claim. Only non-routine supplies are reported on the home health final claim.

Supplies are billed using one of two revenue codes:

- **027X** for Medical Surgical Supplies
- **0623** for wound care supplies

All supplies used during the course of the episode can be listed as one line item for each revenue code (027X and 0623). Each line item must contain a total charge amount for the supplies used, as well as the date the supplies were furnished (earliest date of supplies used).

Providers should develop a process to ensure that all non-routine supplies are accurately captured on the final claim and that the HIPPS code appropriately reflects supplies used/not used. A claim that is submitted with a letter in the fifth position but with no supplies will be returned to provider (RTP) by the Medicare Administrative Contractor (MAC). It is the responsibility of the provider to change the fifth digit from a letter to a number if non-routine supplies were not used.

Providers should also develop a charge structure for non-routine supplies in order to report these charges on the final claim. The charge structure must remain consistent among all payers. Charges should be based on a markup of the supply item cost and can range anywhere between 100% and 400%. The markup policy should be kept as simple as possible to make billing procedures and expense tracking easy and fluid.

Resources:

Home Health Consolidated Billing Master Code List:

- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html

Medicare Benefit Policy Manual: Chapter 7 (Home Health Services):

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html