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Advancing the Healthcare Supply Chain

Technology Trial Case Study: Making Objective Decisions with Subjective Data

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Scottsdale Healthcare recently transformed a hodge-podge of minimally invasive equipment to standardized video towers in 50 operating room suites. The journey began with a vision and ended with a standardized process that set a precedent for product trials and raised the bar for decisions involving highly technical equipment.

Status

Scottsdale Healthcare, a large, metropolitan, multi-facility organization, identified a portion of its flat surgical volumes as directly related to its minimally invasive surgical equipment. Performance levels were negatively impacted by poor visibility, long turnover times related to equipment safaris, and a lack of accessories allowing for terminally sterile products to begin each case.

Audits of the organization's competitive areas indicated a less than stellar market position. The percentage of minimally invasive surgical (MIS) technology procedures to open procedures accounted for 27% of the organization's total surgical volumes, while the 2003 national average determined by the Healthcare Advisory Board was 33%.

As an organization, Scottsdale Healthcare had budgeted for 'replacement units' in the 2007 fiscal year. An inventory of existing equipment demonstrated a definite need for total revamping of its technology philosophy. There were up to 11 different brands of equipment even within the same facility, and most of the equipment was five or more years old. Repair costs were extremely high and the organization had several procedure-specific towers for orthopedic, gynecology, and urology equipment only, and therefore would not be appropriate in other types of cases. In addition, Scottsdale Healthcare averaged only 1.5 cameras per console, requiring rapid processing between cases, further extending turnover times, and increasing wear and maintenance on the camera heads.

Because the organization has five separate facilities acting independently, collecting the current status of equipment required many hours of data collection, walk through audits, and matching of multiple independent logs.

Vision

Scottsdale Healthcare's vision included standardized High Definition MIS towers in each OR suite, enough scopes and cameras for terminally sterile products for each case, state-of-the-art equipment for every patient, perpetual upgrades, and the ability to monitor and maintain equipment competency.

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Project Perfect World Foundation

Bob Simpson, President/Founder
Project Perfect World Foundation (PPW)

Project Perfect World Expands Services into Spinal Surgery and Neonatal Care

For the past 11 years Project Perfect World's (PPW) mission has been repairing cleft lips and palates and performing orthopedic surgery on children in third world countries. Through the monetary support and donations of medical supplies from healthcare supply chain professionals and organizations, we have been fortunate enough to help thousands of children all over the world. Now, we are embarking on providing two new services – spinal surgery and neonatal care.

First, the Midwest orthopedic team, coordinated by Dale Montgomery from the Hays Medical Center in Hays, Kansas, has requested permission to initiate spine cases in Ecuador. For several years, the team has been performing hip and knee surgeries as well as training local surgeons. With this, the need for PPW to continue these cases has become limited. So this summer, we are sending our first medical team to Ecuador for two weeks to perform spine operations as well as help the orthopedic cases. Spine cases are difficult and the team is very experienced and well trained. I know they will be successful and that they will help the children to walk upright and live normal, happy lives.

The second service is being initiated by the Boston-based Plastics Team. They have been doing facial surgeries for several years at the Benjamin Bloom Children's Hospital in El Salvador, the largest children's hospital in Central America. The hospital also has a very large and active neonatal unit that could benefit from PPW's involvement. After returning from a recent trip to El Salvador, I asked Lee Memorial Health System's neonatal unit if they would like to get involved with the Benjamin Bloom Children's Hospital. They were happy to assist and a trip was scheduled. The trip, funded with the help of Sandra Green from MedAssets, was the team's first visit to the neonatal unit in El Salvador, and it was an exciting one. They immediately saw how bringing basic teaching and educational programs to the facility brought positive change to the lives of the newborn babies. The babies' positions were examined and evaluated to help prevent deformities in their legs. These prevention techniques should help diminish the number of surgeries the PPW orthopedic team will need to perform in the future.

PPW is excited to open a new door for our medical teams to walk through, spinal surgery and neonatal care. With these additional services, more children will have a chance at a normal life. On behalf of the children who cannot speak to you directly, I thank you again for making this possible.

When You Need to Raise Some Dough

Linda Robinson, Director, DataPros for Healthcare, Tampa, Florida

Hard work is the yeast that raises the dough – understanding and achieving supply reimbursement can seem like hard work. Professionals in the supply chain are usually sandwiched between compliance, the CDM (charge master), and patient financial services. Materials managers are held hostage through endless discussions and waste time over a common statement "that supply isn't billable". It is not a secret that declining reimbursements are reason enough to become more sophisticated in the approach taken by supply managers toward financial management.

This is the first in a series of articles about supply reimbursement. Supply reimbursement is constantly changing, and third party reimbursement is complex. What was a successful approach 10 years ago might not be the best path to success today. It's time to start kneading the dough by looking at a "warehouse" of CDM, compliance, and patient financial services information.

Compliance

Even basic knowledge of the finance world says, "If the supply is not in the CDM, it will never be billed." Materials managers sometimes have an uphill battle when attempting to get a supply item into the CDM. In order to be compliant, but still bill for supplies, materials managers must have an understanding of the regulations to challenge the statement, "that supply is not billable". Determination of what is billable should not be based on anecdotal information.

Guess what? Surprise! There is no definitive list of billable supplies. What is billable becomes the judgment of the facility and the Medicare contractor. However, some Medicare contractors do publish a list of non-billable supplies. Ask the compliance department if a list exists for your hospital's regional Medicare contractor.

What supplies should be billed? Follow these Medicare guidelines to determine if an item is billable:

1. The item must be medically necessary, reasonable for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The item must be furnished at the direction of a physician.
2. Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.
3. Routine supply items are found in the "floor stock" and would generally be available to all patients receiving supplies in that location. The supply items are included in the general cost of the room in which the services are delivered and are not separately billable.
4. The item must have been delivered to or used on or for the patient for whom it was ordered.
5. Durable Medicare Equipment (DME) must be billed directly by the supplier to one of the durable medical equipment Medicare contractors. Some items that are DME are billable by a hospital. These items have been granted an exemption to the DME billing regulations. The general categories are implanted DME, surgical dressings and prosthetics and orthotics, prefabricated.

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These regulations can be like a foreign language when put to practical use. The federal government communicates its philosophy, intent, and interpretation through many published documents. One example is an audit performed by the General Accounting Office who identified these issues:

- Billing for supply items that are not reusable
- Billing for equipment as if it were a supply
- Equipment and routine supplies such as gowns and gloves used in the operating room are considered cost items for the facility and are not separately billable to Medicare

Charge Master

The CDM is a bridge containing a service item number, so the material item charged crosses the CDM bridge over to the claim for payment. The CDM bridge carries the Current Procedural Terminology (CPT), Healthcare Financing Administration (HCPCS), revenue codes, and charge. For the item to be reimbursed, it first has to exist in the CDM as a billable item.

One area that commands a closer look into separately billable supplies is the miscellaneous charge representing supplies. A miscellaneous charge is a crutch or artificial support used instead of adding supply items to the CDM. Miscellaneous charges are necessary in certain circumstances. There is a wide margin for error because miscellaneous charges involve several mathematical calculations to determine the charge amount. When the last time the staff's math proficiency was reviewed?

In the past, bundling supply charges was popular and easy for clinical staff. Today it is important to bill packaged services as separate line items. CMS directed hospitals to submit all charges even though most supplies are not separately payable by Medicare. Medicare uses its history of all billed items to adjust payment amounts. Medicare is so concerned with supply usage and charges that they mandated supply coding for certain devices.

Patient Financial Services

Understanding the billing process means having a clear overview of how supplies are billed. Managed care contracts many times have carve-outs – separating specific implants from the overall surgery payment. These arrangements have become common features of managed care plans but are seldom communicated to key players. Implant carve-outs are usually paid on a percentage of charges and can also have a charge threshold so only items over a certain charge are eligible for a carve-out payment.

Carve-outs are required to be identified by specific revenue codes – a three-digit code required for billing purposes. Revenue codes represent specific accommodations, ancillary services, or billing calculations and can affect reimbursement, particularly for outpatient claims. Some examples of revenue codes are 278 (implant), 275 (pacemaker), 276 (intraocular lens), and 279 (other implant). Without the correct revenue code assigned in the CDM to the implant supply item, the additional money for the expensive implant is lost.

Summary

Your budget doesn't necessarily have to reflect expenses. There can be revenue generated by identifying the separately billable items and adding them to the CDM. Revenue can be generated by ensuring implants are assigned the correct revenue code.

It is important to ensure supply costs are reported accurately. Even though most supplies are not separately payable by Medicare, missing supply costs affect cost outlier payments, cost accounting systems, strategic planning, and managed care contract negotiations.

Starting with implants is an easy first step. The success of this step can be measured in net dollars. Even though there are many more facets to this project from data cleansing of the item master file, coding supplies, charging methodology, and charge capture, understanding these key points is a great starting pointing. ■