

PDPM Reports and Tools

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PPS Scheduling Aid

MDS v3.0 – Analytics/Reports – PPS Scheduling Aid

The Schedule

This report will give you the same information as before – the resident’s name, room number, observation period, assessment type, billing period, ARD if an assessment has been started/completed, and the score.

For Medicare and Medicare Advantage plans following the PDPM schedule, you will see the transitional IPA defaulted on the schedule for October 1-7. No other IPA will show unless you have opened the assessment. You will continue to see the 5-day and NPE as appropriate. The PDPM score will show for the billing period of 100 days unless there is a discharge or intervening IPA.

For Medicare Advantage plans that continue to follow the RUG-IV schedule, you will see the 5, 14, 30, 60, 90-day, COT, and NPE assessments as required.

Revenue Review

Since you may now have a combination of RUG and PDPM scores, we have also expanded the estimated revenue report. When you close the Scheduling Aid, say YES to export to excel:



There will be three tabs of information on the spreadsheet. You can move from one to the other by clicking on the tab title at the bottom of the window.

23	RMA - Re	\$272.88	0	\$0.00	0	\$0.00	0	\$0.00
24	RLB - Re	\$343.50	0	\$0.00	0	\$0.00	0	\$0.00
		RUG-IV by Category			PDPM by Category		by Day	

- RUG-IV by category lists all of the RUG categories. Next to each you will see the current rate you have set in the system. Then for each month covered by the date range you selected for the report, you will see the number of days for each RUG and the value for those days. Each month will be tallied and then the worksheet will be totaled for the entire period.
- PDPM by Category. There are too many options to list them all so you will see only those that you have generated for the time period you selected for the report. The PDPM and the traditional Medicare base rate exclusive of the per diem adjustment. You will then see the number of days at that score and the revenue generated. Revenue is based on the per diem rate for the resident and the insurance (if the insurance uses a different rate system than traditional Medicare, that system will be used for those insurance days). Each month will be tallied and then the worksheet will be totaled for the entire period.
- By Day. It shows the days in the period, the number of residents on that date and the total revenue.

PDPM Rates

Set Up the Tables

Accounts Receivable – Utilities – Maintain PPS PDPM Rates

Much goes into calculating the rate for your facility:

- Start with the Base Rate for each of the scores for each of the categories. Adjust for the category index.
- Take 70.1% of each individual rate and apply the wage index for your county. To this add the remaining 29.1% of the rate.
- Then apply your facility's VBP multiplier to each of the rates.

To help you with this process we have applied the formulas using the following information:

- The base rates were taken from the Federal Register for both urban and rural. The category case mix index was applied. We use the CBSA (Core Base Statistical Area) code for the county and look it up in the Federal Register tables to determine whether you are urban or suburban.
- CMS publishes tables for wage index factors for each county. We use this table and your county location to determine the adjustment made to 70.1% of your base rate.
- We use the facility ID to identify the VBP adjustment as publicized by CMS.

You can see the table of results if you push the **FY 2020 Rates** button on the right side of the rates window (under the dates). The report will show the rates for each of the categories and the index/adjusters that were used.

When you close out the report, it will ask if you want to move these rates to the current insurance. If you have reviewed all of the information in the report and you agree, you may answer YES. If you are not certain that we have the correct index/multiplier for your facility, answer NO and manually enter what you know to be true. You may have more updated information than that published by CMS. You may always contact us so that we may review the information with you.

Review the Financial Impact

Accounts Receivable – Utilities – Review PDPM Score Financial Impact or MDS v3.0 – Analytics/Reports – Review PDPM Score Financial Impact

This is only available if you have the Financial Modules and have created the PDPM tables for each insurance.

In the upper left corner, use the drop down to select the correct insurance. Then enter the PDPM Score that you have calculated and press the UPDATE button.

Facility Rate will be the category rate adjusted for the case mix, wage index, and facility VBP and should match what you have set in your tables through Accounts Receivable. The lower portion of the screen will show you the per diem adjustment. You should be able to see that PT and OT begin to decline at day 21 and that the NTA rate is tripled for the first three days. Each time period is totaled across and shown at the right of each row.

Below is an illustration of the window prior to data entry:

Visualize Payment Impact of PDPM Score

Insurance: **MEDICARE (Traditional)** Score:

Facility Rates:

PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:

Variable Per Diem Payment Adjustment

Day	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
Day 1-3	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
4-20	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
21-27	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
28-34	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
35-41	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
42-48	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
49-55	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
56-62	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
63-69	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
70-76	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
77-83	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
84-90	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
91-97	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:
98-100	PT:	OT:	SLP:	Nsg.:	NTA:	Non-CMI:	Total:

Update Finish

How can you use this? Suppose you are at day 32 and you are wondering if you should submit an IPA. Enter the code for your last assessment and look at the rates for Day 32. Then enter your calculated score for the IPA. Look at the rate for Day 32. How do they compare? If reimbursement is going to be higher, then it may be beneficial to complete and submit the new IPA. If the rate is lower, then it may not be advantageous to submit. Remember, the rules for a Significant Change are not impacted by the PDPM. You may need to complete and submit a Sig Change even if you elect not to do an IPA>

Impact on Billing

What has changed for Traditional Medicare

CMS Transmittal 4409 was released October 4, 2019. It describes the changes that will be **effective November 5, 2019**. This link explains how to reflect the interrupted stay on your claims and gives examples. The document also explains how the AIDS adjustment will work under PDPM. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4409CP.pdf>

We do not know what will happen if you attempt to process PDPM claims prior to November 5th.

Before doing your first billing for October 2019, make sure that you have completed the setup:

- ADT – Utilities – Maintain Databases – Insurance. Review each of your Medicare Advantage plans and set the flag to reflect whether they are following RUG-IV or PDPM schedules/rates.
- Accounts Receivable – Utilities – Maintain PPS PDPM Rates. For traditional Medicare and each of the Advantage plans following the new PDPM, establish a schedule of rates.

Accounts Receivable – nothing about this process has changed. Rates will still be pulled from what is established on the room/unit/facility (the tables you maintain through Billing).

Claims – For traditional Medicare, 5-day assessments will look much the same except for the change from reporting the RUG-IV to the PDPM. Other requirements look the same.

The Interim Payment Assessment, IPA, does have some different requirements. You will need an Occurrence Span Code with dates of the interruption. For example, resident leaves 10/1 and returns 10/3. The two days of skip will be reflected as:

	Code	From	Through		Code	From	Through
1.	74	10/01/2019	10/02/2019	3.		//	//
2.		//	//	4.		//	//

You will also code these non-billable days with a code 81 and the number of days:

	Code	Amount		Code	Amount		Code	Amount
1.	80	17.00	5.		0.00	9.		0.00
2.	81	2.00	6.		0.00	10.		0.00
3.		0.00	7.		0.00	11.		0.00
4.		0.00	8.		0.00	12.		0.00

On the Claim Detail Tab, you will have an extra line with code 0180 for the Leave of Absence and the number of days as the units.

Demographics	Various Codes	Claim Detail	Insurance	Diag/Proc/Phys	Remarks/FL 81	
RvCd	Description	HCPCS	Date	Units	Total	Non-Cover
0022	Room 10/03/19-10/19/19	CDGE0		17	0.00	
0120	ROOM-BOARD/2BED	000340.00		17	5780.00	
0180	LEAVE OF ABSENCE OR LOA			2		
0001	TOTAL CHARGE				5780.00	

The claim will not include the individual category amounts or the per diem adjustments – it currently does not do that with your RUGs as well.

PPS Adjuster – This is where the adjustment to the A/R is made for the PDPM score and the per diem adjustment – same process as before. Once all charges have been accumulated and the assessments are complete, run the PPS Adjuster. Be sure you have all of the current rates entered through Accounts Receivable (Maintain PPS PDPM Rates). As in the past, you may run this once per period.

For those insurances who continue to use the RUG methodology, the adjuster will use the RUG rates you have established. You will need to evaluate what changes you may need to make to the RUG rates prior to running the PPS Adjuster.

Medicare Advantage Plans – We will use the flags that you have set in the insurance database to know if an insurance is RUG or PDPM.

For those following the old traditional Medicare RUGs, billing will remain the same as it has been. You will need to evaluate what changes you may need to make to the RUG rates prior to running the PPS Adjuster.

For those following the new traditional Medicare PDPM, we will follow the rules outlined above. Make sure that you have set this up for your Advantage Plans. If your insurances vary from these “norms”, you will have to manually adjust. Please let us know what variations you are running into. We may be able to come up with a way to assist you.

Quality Measures

Last March we began including information on the Quality Measures with each MDS. When you run the error report, under the section of the report that shows you who completed each of the sections and whether they have a valid signature, you will see the Quality Measures that will be impacted by this assessment. Has this been a useful tool for you?