COLORADO RURAL HEALTH CENTER

The State Office of Rural Health

Critical Access Hospital Swing Bed Manual

13th Edition

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Introduction

How to use the Swing Bed Manual

This Swing Bed Manual is a quick reference guide for Critical Access Hospitals (CAHs) to better understand the Medicare regulations associated with Swing Bed patients. It is not intended to be an all-inclusive, comprehensive manual. However, it does offer resources where more detailed information may be found. This is the 13th edition of the Swing Bed Manual. All websites and telephone numbers have been tested and were found to be working as of January 2016. Please notify the Colorado Rural Health Center (info@coruralhealth.org) if there is any inaccurate information.

General Information:

- The Swing Bed concept allows a CAH to use their beds interchangeably for either acute care or post-acute care. A Swing Bed is a change in reimbursement status. The patient swings from receiving acute care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.
- Swing Bed patients are not SNF patients. Swing Bed patients in CAHs are considered patients of the CAHs. Many of the regulations that govern these patients are found in the Medicare long-term care regulations (See Appendix A for references).
- In some circumstances, CAH Swing Bed regulations may be different than the Medicare long-term care regulations. For example, the CAH Swing Beds do not need to complete a MDS form to document the comprehensive assessment process. For CAH Swing Bed exceptions, use **Medicare State Operations Manual, Appendix W** – "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds in Critical Access Hospitals." See Appendix A of this manual for the access link and full references.
- Billing for CAH Swing Bed hospital-based services is cost-based and not a prospective payment system (PPS), like a skilled nursing facility or a nursing home. This manual does not address billing questions in detail although you can find a Swing Bed Billing FAQ in Appendix D. The best resource for billing questions is the Fiscal Intermediary (FI). The FI contact information is located under the General Eligibility Criteria section.
- As a general resource, Appendix C has frequently asked questions and answers.

Critical Access Hospital Program Description

The Medicare Rural Hospital Flexibility Program was created by Congress in 1997 to support any state that meets the Centers for Medicare & Medicaid Services (CMS) requirements for establishing a CAH Program. Critical Access was a new hospital licensure category created by the Balanced Budget Act of 1997.

The goal of the CAH designation is to improve the financial viability and stability of the hospital and assure continued access to quality medical care in rural areas. Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoP for CAHs is listed in the "Code of Federal Regulations" (CFR) at 42 CFR 485.601-647.

Designation as a CAH creates alternatives for small, rural hospitals that include:

- The potential for enhanced reimbursement from Medicare;
- An opportunity to better match the local community's needs to the hospital's capabilities; and
- Establishment of the foundation for a rural health network.

The following providers may be eligible to become CAHs:

- Currently participating Medicare hospitals;
- Hospitals that ceased operation during the 10 year period from November 29, 1989 through November 29, 1999; or
- Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

In order to be designated a Critical Access Hospital; a facility must meet the following criteria:

- Be located in a state that has established a State Flex Program (as of September 2011, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Demonstrate compliance with the CoP found at 42 CFR Part 485 subpart F at the time of application for CAH certification;
- Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff with specific on-site response timeframes for on-call staff;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, a CAH may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less (excluding swing beds services and beds that are within distinct part units). This requirement cannot be assessed on initial certification, but applies subsequent to CAH certification. (Note: payment rules require a physician to certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH); and

- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR prior to January 1, 2006 were State certified as a "necessary provider" of health care services to residents in the area.

Effective October 1, 2014, under new Office of Management and Budget (OMB) delineations, some CAHs previously located in rural areas may now be located in urban areas. A two-year transition period is provided, effective 10/1/2014, through 9/30/2016, for affected CAHs to seek rural classification under 42 CFR 412.103 to retain their CAH status after the two-year transition period ends. This policy to provide a two-year transition period also applies to future changes in OMB delineations.

Reference: CMS Critical Access Hospital Fact Sheet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf

Critical Access Hospital Swing Beds

Critical Access Hospitals (CAHs) wanting to provide Swing Bed services must have Swing Bed certification from CMS. This manual provides information about the Medicare Swing Bed Program and will assist CAHs in optimizing their use of Swing Beds to meet patient needs.

Swing Beds Defined

Swing Beds are defined as beds that may be used for either skilled nursing care or acute care on an as-needed basis in a CAH. CAHs may not use their beds designated for rehabilitation or psychiatric distinct part unit, intensive care-type unit or newborns. Skilled Nursing Care provides the necessary level of medical and 24-hour nursing care for the patient who does not require the specialized services of an acute care hospital stay. Skilled care is given when the patient needs nursing or rehabilitation staff to manage, observe, or evaluate care.

Who is eligible to use Swing Beds?

A rural hospital (located in a rural area with fewer than 100 beds) or Critical Access Hospital (CAH) with a Medicare agreement to furnish swing bed services may use its beds as needed to furnish either acute or Skilled Nursing Facility (SNF) level care.

Skilled Nursing Care may be provided in a hospital or in a nursing home. The CAH Swing Bed or Skilled Nursing Facility must receive certification from Medicare to provide post-hospital skilled nursing care.

The Medicare Swing Bed Benefit

The Medicare Swing Bed benefit includes 100 days of skilled nursing care per benefit period. Skilled Nursing Care may be provided in a Swing Bed hospital or a long-term care facility offering skilled nursing services. The first 20 days are covered in full. Coinsurance is required for days 21–100.

The Benefit Period

The Medicare Benefit Period is a period of consecutive dates during which covered services are furnished to the patient. For Medicare Skilled Nursing Care, the benefit period begins the day the Medicare beneficiary begins receiving covered skilled inpatient or extended care services by a qualified provider (Swing Bed hospital or SNF).

The benefit period ends:

- When the Medicare beneficiary has not received inpatient hospital or skilled nursing care for 60 consecutive days, beginning with the date the individual was discharged from care (hospital or SNF); OR
- If the Medicare beneficiary remained in the SNF, but did not receive skilled care for 60 consecutive days.

Medicare has no lifetime benefit limit meaning there is no limit to the number of benefit periods a Medicare beneficiary can have. The patient must pay the "Part A" deductible for each benefit period. Once a benefit period ends, the Medicare beneficiary must have another three-day qualifying hospital stay and meet other Medicare requirements listed under General Eligibility Criteria in this manual.

Breaks in Skilled Care

If a Medicare beneficiary stops getting skilled care in the SNF/Swing Bed, or leaves the SNF/Swing Bed facility altogether, future Swing Bed admissions will be dependent on how long the lapse in care occurred. The chart below describes what happens when patients go less than 30 days, 30-59 days, and 60 days or more without receiving skilled care in a SNF or Swing Bed.

Less than 30 days	• Medicare will cover additional SNF care, and no new 3-day hospital stay is required to qualify. • Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current period.
At least 30 days, but less than 60 days	• Medicare will NOT cover additional SNF care unless there is a new 3-day hospital stay. **Note: The new hospital stay does NOT need to be for the same condition that was treated during the previous stay.** • Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current benefit period.
At least 60 days	• Medicare will NOT cover additional SNF care unless there is a new 3-day hospital stay. The new hospital stay need not be for the same condition that was treated during the previous stay. • Since the break in skilled care lasted for at least 60 days in a row, this would end the current benefit period and renew the SNF benefits. This means that the maximum coverage available would be 100 days of SNF benefits.

Lifetime Reserve Days

For each benefit period, Medicare pays all covered costs except the Medicare "Part A" deductible for the first 60 days of inpatient care. Medicare limits the number of days you may stay in the hospital (as an inpatient) per benefit period to 90 days. Medicare has "Lifetime Reserve Days," which are an additional 60 hospital days that Medicare will pay for after the first 90 days without having to reset the benefit period time period.

Each 60 Lifetime Reserve Days can only be used once and the patient may access them one at a time.

Why Use Swing Beds?

There are multiple advantages to the effective use of Swing Beds for the facility, the physician, the patient and the community.

- Swing Beds can significantly improve the facility's financial viability since CAH Swing Bed services are reimbursed on a cost-related basis.
- Swing Beds can help a CAH comply with the annual average 96-hour length of stay restriction by swinging patients who no longer meet the acute care inpatient criteria, but who are not ready for discharge to home.
- In rural areas where access to services may be limited, patients ready for acute hospital discharge may need more care and support than can be achieved through a discharge to home with home health services.
- Improved quality of life may result when patients are able to return to their home community to receive skilled care in the local CAH Swing Bed rather than in an urban nursing home because they are closer to family and friends.
- It is easier for family and friends to visit as well as be more closely involved in the patient's recovery when receiving skilled care in the local CAH Swing Bed.
- CAH Swing Bed admissions may be less traumatic and threatening for the patient compared to an admission to a nursing home.
- Admission to a Swing Bed often feels like a continued hospital stay to the patient and offers a more positive hope for continued recovery and a return to independence.

Benefits of Swing Beds include:

- Cost-based reimbursement for the CAH, and full DRG payment for referral hospital
- Improved quality of life for patients who can remain in the community

Admission to Swing Beds

General Eligibility Criteria

In order to charge Medicare for a Swing Bed patient, the following criteria must be met:

1. The patient has to be a Medicare Part A enrollee and have benefit days available;
2. There must be a three-day qualifying stay;
3. Medicare age or disability/disease eligibility requirements must be met;
4. Patient's Swing Bed admission condition is the same as the qualifying stay condition;
5. Patient is being admitted to Swing Bed within thirty days of discharge; and
6. The patient's condition meets criteria to necessitate daily inpatient skilled nursing rehabilitation or combination of these services.

Medicare Part A Benefit Days

The beneficiary must be enrolled in Part A and have benefit days available to use within a Benefit Period. Medicare eligibility and benefit days may be verified by calling the Fiscal Intermediary's customer service number.

- Fiscal Intermediary: Novitas Solutions, www.novitas-solutions.com
  JH - (AR, CO, LA, MS, NM, OK, TX, Indian Health & Tribal facilities and Veterans Affairs)
  IVR: JH (855) 252-8782
  Provider Contact Center: JH (855) 252-8782
  TTY: JH (855) 498-2447

The Novitas Solutions Web site is intended for the use of medical professionals. If you need information for a Medicare beneficiary, visit http://www.medicare.gov.

Three-Day Qualifying Stay

The beneficiary must have had a three-day (three midnights) qualifying acute inpatient admission prior to the admission to Swing Bed. This requirement can be met even if the beneficiary has been in more than one hospital as long as the hospital stays totaled three or more consecutive days. The three-day qualifying stay may take place in a participating general hospital – this would include acute care hospitals, rehabilitation units /hospitals, and a hospital stay that is covered under the hospice benefit. In addition a three-day stay in a psychiatric hospital will also satisfy the prior hospital stay requirement. However, institutions that primarily provide psychiatric treatment cannot participate in the program as SNFs. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating Swing Bed/SNF is likely to receive only non-covered care. ***Section 20.1, Chapter 8 of the Medicare Benefit Policy Manual*** also specifies that the day of admission, but not the day of discharge, be counted as a hospital inpatient day.

- If there is no break in skilled care, another three-day qualifying stay is not necessary if a patient was readmitted to an acute care bed before "swinging" back to the Swing Bed as long as it is in the same benefit period.
- Observation stays are not included in the three-day qualifying inpatient stay. **Reference: Medicare Benefit Policy Manual, Chapter 8, Section 20.1 at** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
- There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to Swing Bed status regardless of whether the patient stays in the same facility or transfers to another facility.

Age or Disability/Disease Requirements
The discharge must have occurred on or after the first day of the month in which the individual reached age 65, or in a month for which he/she was entitled to health insurance benefits under the disability or chronic renal disease provisions of the Medicare law.

Condition Must Match Qualifying Stay Condition Treatment
The Swing Bed services must be provided for a condition which was treated during the beneficiary's qualifying inpatient stay, ***or*** arose while the patient was in the Swing Bed for treatment of a condition for which he/she was previously treated in a hospital. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

Admission to Swing Bed within 30 Days of Discharge
The Swing Bed services must be provided within thirty (30) days of discharge from:

- An acute inpatient bed in the Swing Bed hospital; or
- Discharge from another acute hospital; or
- Discharge from a Swing Bed or skilled nursing facility.

The thirty-day period begins on the day ***after*** actual discharge. For example, a patient discharged on July 1 and admitted to a Swing Bed on July 31 meets the 30-day requirement since the day of discharge is not counted in this 30-day transfer period.

- A new three-day qualifying stay may be required when a NEW condition arises within this 30-day period before being admitted to a Swing Bed. This would be extremely rare.

An exception may be made to permit a beneficiary to be admitted to a Swing Bed more than 30 days after hospitalization ***if*** the patient's condition at the time of discharge from the acute facility makes a Swing Bed admission medically inappropriate immediately

after discharge and ***if*** it is medically predictable at the time of discharge that he/she will require covered care within a pre-determined period of time.

Example

An individual is admitted to a SNF for daily skilled rehabilitative care. After three weeks, the therapy is discontinued because the patient's condition has stabilized and daily skilled services are no longer required. Six weeks later, however, as a result of an unexpected change in the patient's condition, daily skilled services are again required. Since the second period of treatment did not constitute care which was predictable at the time of hospital discharge and thus could not be considered as care which was deferred until medically appropriate, it would not represent an exception to the 30-day exception rule.

As a practical matter, the daily skilled services can only be provided on an inpatient basis in a skilled nursing facility or Swing Bed. In making a "practical matter" determination, consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services.

Example

A 75-year-old patient has a hip replacement at a large non-CAH facility following a fall and fracture. The patient lives 60 miles from the nearest hospital and requires physical therapy five days a week, but home health services are not available. The patient may be admitted to a Swing Bed in a CAH in his/her local community. As a practical matter, the patient can only receive these services from a skilled nursing facility or Swing Bed.

Information for the Patient

State and Federal laws require the Swing Bed Facility to provide certain information to the patient and/or representative at the time of admission. Often this information is given in the form of a packet that needs to be reviewed with the patient and/or representative. Once this packet of information is reviewed, the patient or representative should sign it. The signature indicates he/she was given the material, reviewed it, and understood the contents. **See Appendix F for an example of a Patient Admission Packet.**

It is important for patients and/or their representatives to understand that the patient must meet skilled care criteria and participate in his/her treatment program to stay in the Swing Bed. The patient must continue to meet Medicare criteria for Skilled Nursing Care admission. Since Skilled Nursing Care in a Swing Bed is a Medicare benefit, patients and/or their representatives may assume that admission to a Swing Bed is appropriate regardless of whether the patient meets on-going criteria for admission.

Medicare requires a CAH Swing Bed to meet certain requirements to be reimbursed for Swing Bed patients by CMS. Patients and/or their representative need to be given understandable information about their Medicare benefit coverage, and, if they are low-income, information about the Medicaid program. An explanation of the Medicare and Medicaid application process may be given to patients and/or representative on admission, although this is not a Federal requirement. The following information is required and detailed examples are included in the following pages:

1. Patient Rights and Notice of Rights and Services
2. Advance Directives
3. Free choice
4. Informed in Advance
5. Participating in Planning Care and Treatment
6. Privacy and Confidentiality
7. Admission, Transfer, and Discharge Rights
8. Patient Behavior and Facility Practices and Use of Restraints
9. Abuse
10. Staff Treatment of Patients
11. Activities
12. Dental Services
13. Grievances

1. **Patient Rights - A 1508, 483.10 Patient Rights and 483.10 (b) Notice of Rights and Services**

   A hallmark of the admission packet is the explanation of patient rights**.** Basic patient rights address civil liberties that are enjoyed by all. These rights can be reviewed, as needed, by the patient and/or representative. In addition, these rights must be communicated in an understandable manner.

   The State Operations Manual, Appendix W (485.645 pg. 154) provides detailed examples of patient rights. There are numerous additional resources available to assist CAH Swing Beds to identify rights. Some "basic" patient rights are self-explanatory and can be included in the patient information packet in a manner that addresses the uniqueness of the ***individual*** facility's general rules and regulations. Examples of basic patient rights include but are not limited to:

   - Privacy when communicating with any person of choice, including telephone privacy
   - Freedom when sending and receiving mail
   - Voting rights
   - Consensual sexual activity and rights of married couples
   - Visitation and patient freedom to approve or deny visitation rights to immediate family or other patients
   - Having and using personal possessions in the facility
   - Working in the facility whether voluntary or paid
   - The right of religious liberties

2. **Advance Directives - A 1510 483.10. (b) (8)**

   A detailed, understandable, explanation of Advance Directives should be included in the **Patient Information Packet** including facility responsibilities, the limits of advance directives and examples of how Advance Directives may be used. "Advance Directive" means a ***written*** instruction, such as a living will or durable power of attorney for health care recognized under State law, relating to the provision of health care when the individual is incapacitated. The facility must maintain written policies and procedures concerning Advance Directives and proof that staff has been trained on these policies and procedures. It must be documented, in the patient record, whether or not a client has advance directives.

3. **Free choice - A 1511 483.10 (d)**

   Although the patient and/or representative may choose a personal physician, this does not mean a physician ***must*** serve the patient. If the physician chosen by the client is unwilling or unable to treat, the facility must assist with finding another

physician. A list of attending physicians including name, address and phone number is an important part of the Patient Information Packet.

4. **Informed in Advance - A 1512 483.10 (d) (2)**

   The patient must receive information necessary to make health care decisions in a timely manner. The information should include his/her medical condition, changes in his/her medical conditions, the benefits and reasonable risks about treatments, and reasonable alternatives. Any financial costs to the patient in treatment options should be disclosed in advanced and in writing to the patient prior to his/her decision.

5. **Participating in Planning Care and Treatment - A 1513 483.10 (d) (3)**

   The patient must be given an opportunity to select from alternative treatment plans after the options are explained in understandable terms. In addition, the patient has a right to refuse treatment.

6. **Privacy and Confidentiality - A 1514 483.10 (e)**

   The facility is obliged to provide personal privacy, which includes visual and auditory privacy. The facility is not required to provide private rooms to maintain personal privacy. Cooperation between patients, families and staff results in creative use of space to maintain privacy.

   Confidentiality of ***personal and clinical records does not apply*** when the patient is transferred to another health care institution or records release is required by law.

7. **Admission, Transfer, and Discharge Rights - A1522 483.12 (a) through A1528 483.12 (a) (7) and A1541 483.20 (1)**

   Patients and/or their representatives need to be notified in writing when an admission is not covered. A sample of a Notice of Non-Coverage on Admission is included in Appendix F.

   The State Operations Manual, Appendix W – "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing- Beds in CAHs" defines transfer and discharge as that which includes ***movement*** of a patient to a bed ***outside of the certified facility*** whether the bed is in the same physical plant or not.

   When transfer or discharge are initiated by the facility, the transfer or discharge from a facility must be necessary and appropriate as related to:

   - The client's health and welfare,
   - Client safety issues within the facility,
   - Failed payment under Medicare and Medicaid after reasonable and appropriate notice, and

- Closure of the facility.

If a transfer is due to a significant change in condition, a physical assessment must be completed to determine if a new care plan will meet the patient's needs. An immediate transfer is initiated in an emergency situation.

Upon transfer or discharge, thorough documentation is required. This includes but is not limited to:

- Physician documentation
- Notification in writing to the patient, family member or legal representative, which includes specific contents of the notice as outlined in **The State Operations Manual Appendix W** – "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs", following applicable regulations regarding timing of transfer or discharge notification (at least 30 days before transfer or discharge in non-emergency situation)
- Sufficient preparation for the patient regarding the move, including safe transportation. All facets of the transfer or discharge require keeping the patient and/or representative informed. The patient and/or representative need to be engaged in selecting the new placement facility. When creating a patient information manual, a separate information sheet can be included to address the major issues related to transfer and discharge.
- When a CAH Swing Bed "anticipates discharge" it is implied that the patient was not discharged as an emergency or due to the patient's death. The discharge summary insures that appropriate discharge planning will be implemented that will assist the patient to adjust to his or her new living environment and provide for continuity of medical and personal care. Prior to drawing up the discharge summary, the patient and/or representative should be included in a post discharge plan of care.

8. Patient Behavior and Facility Practices and Use of Restraints - A1531 483.13 (a)

A patient has the right to be free from any physical or chemical restraints for purposes of discipline or convenience, and restraints not required to treat the patient's medical symptoms. Patient behavior also includes safety and security responsibilities. Each facility should determine its safety and security issues. Examples include, but are not limited to, a smoking policy, the procedure for lost or misplaced personal items, use of personal appliances, and leaving the facility on a day trip or overnight stay.

9. Abuse - (A1532 483.13 (b)

Patients, including patients in a comatose state, and their representatives have the right to be free of abuse. Abuse includes verbal, sexual, physical, mental, corporal punishment and involuntary seclusion. A facility is not only responsible

for preventing abuse but also for those practices and omissions, neglect and misappropriation of property, which, if left unchecked, may lead to abuse.

10. **Staff Treatment of Patients - A1533 483.13 (c)**

    The facility must have an effective system that prevents mistreatment, neglect, abuse and misappropriation of patient's property. Employers are called on to investigate the background of staff for unfitness due to violations such as court of law offenses and negative reports in the State Nurse Aide Registry or licensing authorities. Should untoward events take place, a system for conducting thorough investigations must be implemented. The result of ***all*** investigations must be reported to the Administrator and to other officials in accordance with State law, including the State Survey and Certification Agency, within 5 working days of the incident. A procedure for carrying out corrective action must also be in place.

11. **Activities - A 1537 483.15 (f)**

    The facility must provide ongoing, multifaceted activities that are directed by a qualified professional. The regulations list numerous positions and/or skill requirements to define "qualified professional." It is important to review these to determine organizational compliance. A comprehensive assessment of each patient should be completed to determine what activity will meet their interests and well-being. When activity needs have been identified, they should be included in the patient's individual care plan.

12. **Dental Services - A1548- 483.55 and A1550 – 483.55 (a)**

    The facility must assist patients in obtaining routine and 24-hour emergency dental care. Help with setting appointments and arranging transportation to the dentist's office is required. In addition, if a patient has lost or damaged dentures, a prompt dental referral is required.

13. **Grievances**

    Although providing information regarding grievances and complaints is not addressed in **The State Operations Manual, Appendix W**, it is strongly suggested that a policy regarding these issues be included in a **Swing Bed Patient Admission Packet**. An example of a Grievances and Complaints Information document is included in Appendix F.

Clinical Eligibility Criteria

There are several resources available for admission guidelines and/or criteria (see Appendix E). MCG Health or McKesson InterQual Level of Care guidelines for Subacute & SNF are two examples.

The following information is excerpted from the **Medicare Intermediary Manual** and the **Medicare Learning Network's Swing Bed Facility Prospective Payment System – Train the Trainer Manual**, Chapter 2 – "Clinical Criteria". It is not intended to represent the sum total of information available about Swing Bed coverage issues or to constitute hard fast criteria for admission. See Appendix B for examples of case studies.

Skilled Services Defined

Skilled nursing services or skilled rehabilitation services (or a combination of both of these services) must be needed and provided on a daily basis – essentially 7-days-a-week. A patient whose Swing Bed stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy is provided less than 5 days a week, the "daily" requirement would not be met). The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to "daily" skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a "daily basis." To meet this requirement, the patient must actually **need** skilled rehabilitation services to be furnished on each of the days that the facility makes such services available. It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is **furnished** each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the "daily basis" requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but **when** they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the "daily basis" requirement for SNF coverage would not be met.

At the time of admission each resident must have orders for immediate care. These orders at a minimum should include dietary, drugs and routine care to maintain or improve the resident's care and functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. Skilled nursing and/or skilled rehabilitation services are services that:

- Are ordered by a physician;
- Require the skills of qualified technical or professional health personnel; and
- Must be provided directly or under the general supervision of skilled personnel to ensure patient safety and achieve medically desired results.

Skilled personnel may include registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists.

Guidelines for Determining Whether a Service is Skilled

The following are scenarios for which skilled services would be required:

1. **Complex Services**
   If the ***inherent complexity of the service*** is such that it can only be performed safely and/or effectively under the general supervision of skilled nursing or skilled rehabilitation personnel, it may be considered skilled.

2. **Special Medical Complications**
   A non-skilled service could be considered skilled when, because of ***special medical complications***, skilled personnel are required to perform or supervise the service, or to observe the patient. Similarly, while having a whirlpool bath would not require skilled supervision, a qualified physical therapist may be required if the patient has a complicating condition such as circulatory deficiency, areas of desensitization or open wounds.

Example
A cast on an extremity does not automatically require skilled care. However, if there is an acute pre-existing skin condition, pre-existing peripheral vascular disease or a need for special traction, skilled nursing or rehabilitation personnel may be required to observe for complications or adjust traction.

3. **Management and Evaluation of Patient Care**

   Management and evaluation of patient care are considered skilled based on physician orders and if patient care meets the following criteria:

   - The patient's physical or mental condition requires skilled nursing personnel to safely plan, monitor and manage care; or
   - The plan involves a variety of personal care services and the aggregate of those services, in light of the patient's condition, requires the involvement of technical or professional personnel.

Example
Skilled nursing services may not be required for a patient with organic brain syndrome who requires oral medication and a protective environment. Skilled management becomes necessary when the total of unskilled services, considered in light of the patient's overall condition, requires skilled nursing personnel to promote recovery and ensure patient safety (See Appendix B for case examples).

4. **Observation and Assessment**

   Observation and Assessment are considered skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the need for modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is stabilized.

The need for these services must be documented by physician orders or nursing/therapy notes. (See Appendix B for case examples).

5. **Teaching and Training**

   Teaching and Training activities are those activities requiring the skills of technical or professional personnel for teaching self-maintenance programs. Examples are included below.

Examples of Skilled Nursing Services

- Intravenous or intramuscular injections or intravenous feeding;
- Insertion, sterile irrigation, replacement and care of suprapubic catheters;
- Nasogastric tube, gastrostomy, or jejunostomy feedings equal to 26% of daily calories and a minimum of 501 ml of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Application of dressings with prescription medications and aseptic technique;
- Treatment of decubitus ulcers (Grade 3 or worse) or widespread skin disorder;
- Heat treatments ordered by a physician requiring observation to evaluate patient's progress;
- Initial phases of a regimen involving administration of medical gases;
- Professional observation when the patient's condition requires 24 hour nursing supervision, including:
  - Medical conditions such as uncontrolled diabetes or acute congestive heart failure episodes; or
  - Vital sign monitoring for special purposes, such as when the patient is on specific medications; or
  - Psychiatric conditions such as depression, anxiety, suicidal behavior, etc.
- Institution and supervision of bowel and bladder training program;
- Colostomy or ileostomy care in the early postoperative period in the presence of associated complications; and
- Teaching or Training:
  - Self-administration of injectable medications;
  - A newly diagnosed diabetic to administer insulin, prepare and follow a diabetic diet, and observe foot-care precautions;
  - Care for a recent colostomy or ileostomy;
  - Self-administration of medical gases;
  - Gait training and prosthesis care to a recent leg amputee;

- Self-catheterization and self-administration of gastrostomy feedings, care and maintenance;
- Care and maintenance of central venous lines or Hickman catheter;
- Care of braces, splints, orthotics, and associated skin care; or
- Specialized dressings and skin care.

Skilled Rehabilitative Services Requirements

In general, therapy services must meet all of the following:

- Be directly and specifically related to an active treatment plan, designed by the physician after consultation with a qualified therapist; and
- Be of a level of complexity, or the patient's condition such that the judgment, knowledge and skills of a qualified therapist are required; and
- Be provided with an expectation that the condition of the patient will improve in a reasonable and predictable period of time, or the services must be required to establish a safe and effective maintenance program; and
- Be reasonable and necessary by accepted standards of clinical practice, for the amount, frequency and duration of the services.

Rehabilitation Services Eligibility
The deciding factor in determining whether rehabilitation services are skilled is not the patient's potential for recovery, but whether the services require the skills of a therapist or non-skilled personnel.

- Be provided with an expectation that the condition of the patient will improve in a reasonable and predictable period of time, or the services must be required to establish a safe and effective maintenance program; and
- Be reasonable and necessary by accepted standards of clinical practice, for the amount, frequency and duration of the services.

Note: Pursuant to the *Jimmo vs. Sebelius* Settlement, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Benefit Policy Manual Chapter 1, Section 110.3. This revision pertains to care in Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF), Home Health care (HH), and Outpatient Therapies (OPT). The CMS Transmittal for the Medicare Manual revisions, with a link to the revisions themselves, is posted on the CMS website at http://www.cms.gov/Regulations-and-guidance/Guidance/Transmittals/Downloads/R179BP.pdf

The CMS *MLN Matters* article is also available on the CMS site under "Downloads" at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

As CMS states in the Transmittal announcing the *Jimmo* Manual revisions: **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.** Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. See Appendix G for CMS Fact Sheet.

Short-term and long-term goals need to be established in each of the areas where deficits are identified. This process needs to be an interdisciplinary team approach with all stakeholders involved in the ongoing evaluation of goal attainment and response of the patient to the treatment plan.

Examples of Skilled Rehabilitation Services

- Assessment, of a patient's rehabilitation needs and potential (initial & ongoing)
- Physical therapy, occupational therapy, and speech therapy initial assessments are to include prior level of functioning and prior living situation. The medical condition that the patient is admitted for will dictate the evaluations that need to be completed. For example, someone admitted for stroke rehabilitation would most likely need to be evaluated by all therapies. Evaluations need only to be performed where there are identified deficits. Patient goals are set in each of these areas with patient and family involvement.
- Physical therapy initial assessment includes: ambulation, bed and wheelchair mobility, transfers, tolerance to activity, balance, posture and current neurological status
- Occupational therapy initial assessment addresses impairments only in the areas of strength, range of motion, and activities of daily living to include: eating, grooming, toileting, bathing, upper extremity and lower extremity dressing, and ability of the patient to utilize orthotic/prosthetic devices. Cognition is evaluated in terms of memory, problem solving ability and safety awareness.
- Speech/Language/Cognitive evaluation is done primarily when the patient has suffered a neurological event (Stroke, Brain Tumor, Closed Head Injury). This evaluation includes:
  - Functional limitations in the areas of expression and auditory sensitivity.

- Behavioral observations such as lability, ignoral, distractibility, impulsivity, denial, perseveration, deficit awareness, and motivation.
- Oral motor/speech functions such as dysarthria, apraxia, fluency, dysphagia and voice.
- Language/communication functions such as auditory and reading comprehension, and verbal and written language.
- Cognitive/Executive functions such as orientation and memory, and problem-solving skills in relation to math and money reasoning and ability.

Non-Skilled Situations/Services

The following situations/services ***do not*** meet the criteria for Swing Bed care:

- Administration of oral medications, eye drops, and ointments;
  - *Note: The fact that a patient cannot be relied upon to take medications or that state law may require medications to be dispensed by a nurse to institutional patients would not make this a skilled service;*
- General maintenance care of colostomy or ileostomy;
- Routine services to maintain functioning of indwelling catheters, including emptying containers, cleaning, clamping tubing, etc;
- Dressing changes for non-infected postoperative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application of creams or treatment for minor skin problems;
- General maintenance care in connection with a plaster cast;
  - *Note: Skilled supervision or observation may be required when the patient has pre-existing skin or circulatory condition or needs to have traction adjusted.*
- Routine care of an incontinent patient, including diapers and protective sheets;
- Routine care in connection with braces or similar devices;
- Use of heat as a palliative or comfort measure, such as whirlpool or steam pack;
- Periodic turning and positioning in bed;
- General supervision of exercises taught to the patient or performance of repetitious exercises that do not require skilled personnel for their performance;
- Routine administration of medical gases after a regimen has been established;
- Assistance in dressing, eating and going to the toilet; and
- Preparation of special diets.

Continued Stay/Discharge

Medicare benefits allow a patient to remain in a Swing Bed as long as he/she continues to meet all criteria and has benefit days available. Once the patient no longer meets criteria, Medicare will not reimburse for the services.

Transfers from Other Acute Care Hospitals

In accepting transfers from other acute care hospitals, it is critical to ensure that the patient is stable enough for a Swing Bed setting and that the receiving facility is able to meet the needs of the patient. The discharge coordinator in the transferring facility, who may or may not be a nurse, may not be aware of all of the patient's needs and requirements, and may inadvertently transfer a patient who still requires a higher level of care.

Recommendations for Accepting Transfers

1. Verify the pay source for the patient (Medicare, Medicaid, and if applicable, other insurance benefits) and ensure that the Swing Bed facility has the proper certification for the patient's pay source;
2. Ensure that an attending physician has been identified at the receiving facility and, whenever possible, that contact between the transferring and receiving physicians has occurred;
3. Dependent upon the type of skilled services to be provided, therapist to therapist, or nurse to nurse contact can ensure that the facility is able to provide the services required;
4. Review the services required by the patient to ensure that the patient meets criteria for Swing Bed admission;
5. Ensure that the facility can meet any special equipment needs (lifts, specialized beds, etc.) that the patient may require;
6. Ensure that the facility can meet staffing needs of the patient;
7. Identify the medications required by the patient and determine whether these medications are available through the receiving facility's pharmacy; and
8. Ensure that the patient understands what is expected of him/her in terms of participation and progress, and that the patient has the desire and is able to participate actively in a treatment program.

Swing Bed Documentation Requirements

In February 2002, CMS analyzed the significance of the full Minimum Data Set (MDS) reporting requirement for CAHs admitting patients to their Swing bed and concluded that completing a full MDS was a compliance burden which could be reduced without jeopardizing patient safety or health. CMS clarified that CAHs are required to complete a ***resident assessment and a comprehensive care plan*** for each Swing Bed patient.

Examples of "best practice" documentation forms are located in Appendix H.

Certification and Recertification

The CAH Swing Bed is responsible for obtaining the required certification and recertification statements and for retaining them in file for verification. The certification must clearly indicate that post-hospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a continuing basis for any of the conditions for which he/she was receiving inpatient hospital services. Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a nurse practitioner or a clinical nurse specialist or a physician assistant who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The first recertification must be made no later than the l4th day of inpatient extended care services. Subsequent recertifications must be made at intervals not exceeding 30 days.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required.

Comprehensive Assessment

A comprehensive assessment must be completed within 14 calendar days of admission. However, most facilities develop their own time frames, which require these assessments be completed within 24-48 hours of admission. These requirements reflect the short length of stay associated with many Swing Bed admissions. The intent of CMS is that residents be assessed in a timely manner.

Timely Assessments

A comprehensive assessment is required no later than 14 calendar days after admission, but most facilities assess the patient within 48 hours.

Reference: Medicare State Operations Manual, Interpretive Guidelines for Long-term Care Facilities, Appendix PP 483.2(b)(2) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

If the patient remains in the Swing Bed setting, a reassessment should be completed after 14 days, and following any significant changes in the patient's status, including deterioration or improvement that impacts more than one area of the patient's health status and requires interdisciplinary review or revision of the health care plan. At a minimum, a physician must reassess the patient ***every 30 days*** or as warranted based on the patient's medical condition.

The assessment process must include direct observation and communication with the patient, as well as communication with licensed and non-licensed direct care staff members on all shifts. While many components of the assessment can be completed by the nursing staff, other professionals on the CAH interdisciplinary team are also required.

The interdisciplinary assessment team must include:

1. A physician;
2. A registered nurse with responsibility for the patient's care; and
3. Other health care professionals as determined by the patient's needs including physical therapist, occupational therapist, speech therapist, dentist, social worker, pharmacist, etc.

Tapping into the multiple members of the CAH team in preparing the assessment, whether as full-time or part-time staff members, or as consultants, is important in creating a comprehensive assessment. This is the foundation upon which the care plan is built, and helps to ensure a successful outcome for the patient and his/her family.

The comprehensive assessment must include:

- Activity Pursuit
- Cognitive Patterns
  - Evaluation of the patient's ability to make decisions, including health care decisions, and his/her ability to participate in treatment activities.
  - Assessment of the patient's ability to problem solve, make decisions and respond to potential safety hazards.
- Communication
- Continence

- Customary Routine
  - The patient's ability to perform Activities of Daily Living (ADLs) including eating, drinking, bathing, dressing, grooming, transferring, ambulating, toilet use, and ability to speak or use communicative devices and language needs.
  - Assessment of the patient's ability to participate in activities aside from the ADLs. This should take into consideration the patient's normal everyday routines and activities that contribute to financial or emotional independence, pleasure, comfort, education, success, etc.
- Dental and Nutritional Status
  - Evaluation of eating habits or preferences, and dietary restrictions, if any.
  - An evaluation of the condition of the patient's teeth, gums and oral cavity, particularly as these affect the patient's ability to eat and maintain nutritional status; and communicate with others, including family and health care providers. Note if the patient has or needs dentures or other dental appliances.
- Discharge Potential
  - An assessment of the patient's discharge potential and projected length of stay.
- Disease Diagnoses and Health Conditions
  - A description of the patient's current medical diagnoses, including any history of mental retardation or current mental illness.
  - Objective information about the patient's current physical and mental status/abilities, including vital signs, clinical laboratory values or diagnostic tests.
  - Height, weight, and observation of the patient's nutritional status or needs.
- Documentation of Participation in Assessment
- Documentation of Summary Information regarding the additional assessment performed through the resident assessment protocols
- Identification and Demographic Information
- Medications
  - An evaluation of the over-the-counter and prescription drugs taken by the patient; including dosage, frequency of administration, potential drug interactions and allergies, and recognition of significant side effects most likely to occur.

- Mood and Behavior Patterns
- Physical Functioning and Structural Problems
  - Information about any sensory or physical impairments the patient may have, such as loss of hearing, poor vision, speech impairments, difficulty swallowing, loss of bladder or bowel control, etc.
  - An evaluation of the potential need for staff assistance or assistive devices, or equipment; including walking aids, dentures, hearing aids or glasses.
  - The patient's ability to improve his/her level of functional status and independence through rehabilitation programs.
- Psychosocial Well-Being
  - Description of the patient's ability to deal with life, interpersonal relationships, goals and ability to make health care decisions, as well as overall mood and behavior.
- Skin Condition
- Special Treatments and Procedures
  - Assessment of the need for specialized skilled services such as skin care for decubitus; nasogastric feedings; or respiratory care.
- Vision

Comprehensive Care Plan

The comprehensive care plan is developed by the CAH interdisciplinary team including the physician, a registered nurse with responsibility for the patient and other staff in Disciplines as determined by the patient's needs identified in the comprehensive assessment along with the patient and/or representative, and is based on needs identified in the comprehensive assessment.

The comprehensive care plan must:

- Include measurable objectives and timeframes to meet these needs;
- Be developed within 7 days after completion of the comprehensive assessment;
- Be reviewed periodically by the interdisciplinary team after each reassessment;
- Describe services that will be furnished to maintain or help the patient achieve their highest level of functioning; and
- Describe services that would be required but are not provided because the patient has exercised his/her right to refuse treatment.

CAH Swing Bed Conditions of Participation (CoP)

To meet the Medicare CoP in the Swing Bed program, the CAH must offer the following services which are described in detail below:

1. Organ, Tissue and Eye Procurement
2. Dental Services
3. Social Services
4. Program of Activities

1. Organ, Tissue and Eye Procurement
   - CAH must have and implement written protocols that incorporate an agreement with Organ Procurement Organization (OPO);
   - CAH must incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;
   - CAH must ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;
     - CAH must encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors; and
     - CAH must work cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.
2. Dental Services - The facility must assist residents in obtaining routine and 24-hour emergency dental care.

- Skilled Nursing Facilities
  - Must provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident;
  - May charge a Medicare resident an additional amount for routine and emergency dental services; and
  - Must if necessary, assist the resident
- In making appointments; and
- By arranging for transportation to and from the dentist's office; and
- Promptly refer residents with lost or damaged dentures to a dentist.

3. Social Services
   - The facility must provide medically related social services to attain or maintain the physical, mental, and psychosocial well-being of each resident.
   - The regulation, C-0386 483.15(g) Social Services list requirements to define "qualified professional".
4. Program of Activities
   - Swing beds must provide "for" a program of activities appropriate for the patient.

Discharge Summary

The physician must prepare a discharge summary whenever a CAH anticipates discharging a patient from the Swing Bed. The discharge summary should include:

- A summary of the patient's stay in the Swing Bed and the services received;
- A summary of the patient's health care status at the time of discharge;
- The patient's destination upon discharge (e.g., to home with family, home with home-health, a long term care facility, etc.); and
- A post discharge plan of care developed with the participation of the resident and his/her family that identifies the patient's continuing care needs after discharge; how those needs will be met; and any preparation and education given to the patient and his/her family prior to discharge.

Miscellaneous Considerations

Physician Billing

According to Medicare Claims Processing Manual, Chapter 12, Section 30.6.9.2 D at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf, contractors pay the hospital discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service. For physician billing and reimbursement purposes a Swing Bed is considered the same as a skilled nursing facility placement.

A physician (or physician extender) *must* assess the skilled nursing patient every 30 days and can bill for this service. However, the physician (or physician extender) may bill whenever he/she thinks it is warranted (usual for a change in condition). Documentation must support need for visit. Physicians can also bill for admission and discharge from Swing Bed.

Consolidated Billing

According to Section 10.2, Chapter 6 of the CMS Claims Processing Manual, consolidated billing **does not apply to CAHs**. Consolidated billing does apply to:

- Participating SNFs, and
- Short-term hospitals, Long-term hospitals, and Rehabilitation hospitals certified as Swing Bed hospitals, **except CAHs certified as Swing Bed hospitals**

Reference: CMS Claims Processing Manual, Chapter 6, Section 10.2 at
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf

Respite Care

Respite care is part of the hospice benefit, and is defined as "short-term inpatient care provided to an individual only when necessary to relieve the family members or other persons caring for the individual at home." Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating SNF that additionally meets the special hospice standards regarding patient and staffing areas. Therefore, respite care could be provided in a SNF or Swing Bed setting, ***if the Swing Bed meets the hospice standards***. Medicare does not reimburse the CAH for the hospice or respite services.
The CAH must negotiate such payments with the hospice through a contractual agreement.

Reference: Medicare Benefit Policy Manual, Chapter 9, Sections 40.2.2 and 40.1. at
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

Reference: State Operations Manual, Appendix W, Conditions of Participation C-0211, Hospice Services at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

Post-Acute Transfer Rule

The Inpatient Prospective Payment System (IPPS) differentiates between "discharged" and "transferred" patients for payment purposes:

- **Discharge Definition:** Patient is formally released from a hospital or patient dies in the hospital after receiving inpatient services
- **Transfer Definitions:**
  1. A patient is moved from one IPPS hospital to another IPPS hospital.
  2. A patient is moved from one IPPS hospital area or unit to another area or unit within the same hospital.
  3. A patient is moved from an IPPS hospital to another hospital that is excluded from PPS – such as a CAH (Effective October 1, 2010).

IPPS hospitals usually get paid the full DRG payment when patient is discharged, but these hospitals do not usually get full DRG payment for transfers. Transferring hospitals are paid based on a **per diem** amount for each day the patient received services, with the total payment not to exceed the applicable DRG payment. The receiving hospital is entitled to the full DRG payment (IPPS hospital) when patient is discharged, assuming patient is discharged. In addition to the situations listed in the Transfer Definitions above, patients are no longer considered "discharged" when they are admitted to the following facilities after leaving the acute care hospital:

- Inpatient Rehabilitation Facilities (IRFs)
- Long Term Care Hospitals
- Psychiatric Hospitals and Units
- Children's Hospitals
- Cancer Hospitals
- Skilled Nursing Facilities
- Home Health within 3 days after discharge from hospital
- Rehabilitation distinct part units located in an acute care hospital or a CAH
- Psychiatric distinct part units in an acute care hospital or CAH

Incentive for IPPS Hospital to transfer Swing Bed Patients to CAHs
An IPPS hospital receives a full discharge DRG payment when they transfer a Swing Bed patient to a CAH facility.

The IPPS post-Acute Transfer Policy applies to claims coded with patient discharge status codes 03, 05, 06, 62, 63, and 65. Patient discharge code 66 should be used to identify a transfer to a CAH. Discharges or transfers to a CAH swing bed (or other approved swing bed program) should use patient discharge code 61. CAH Swing Beds for skilled nursing care are not included in definition of Post-Acute Care Facility. Therefore, **an IPPS hospital will receive the full DRG payment** when the patient is discharged to CAH Swing Beds.

Reference: CMS Medicare Learning Network (MLM) Matters Number SE0801 Revised and Medicare's Post Acute Care Transfer Policy (42CFR412.4).

Note: A list of the FY 2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That is available on the CMS website. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS1247844.html

Appendix A – Regulations/Requirements

Federal

1. **Public Law 42 CFR Part 485 – Subpart F**: [Conditions of Participation: Critical Access Hospitals (CAHs)] Section §485.601 deals with the Conditions of Participation for Critical Access Hospitals. Section §485.645 identifies special requirements for CAH providers of long-term care services.
2. **Public Law 42 CFR Part 409, Subpart C, Section 409.27; and 42 CFR Part 409, Subpart D, §§ 409.30 – 409.36. Subpart D: (Includes requirements for coverage of post-hospital SNF Care).**

   Note: Both sets of regulations cited above may be found at the following website: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-part409.pdf
3. **Medicare State Operations Manual, Appendix W: "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs."** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
4. **Medicare State Operations Manual, Appendix T: "Regulations and Interpretive Guidelines for Swing Beds in Hospitals." (Applies only to hospitals reimbursed by SNF PPS regulations.)** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_t_swing_beds.pdf
5. **Publication 07: Medicare State Operations Manual, Chapter 2: "The Certification Process," and Chapter 7—"Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities."** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html
6. **CMS Swing Bed Website:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html?redirect=/SNFPPS/03_SwingBed.asp
7. **Comprehensive Assessment: Medicare State Operations Manual, "Interpretive Guidelines for Long-term Care Facilities" Appendix PP 483.2(b)(2)** http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
8. **Medicare Benefit Policy Manual: Section 20.1, Chapter 8** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
9. **Medicare Claims Processing Manual: Physicians/Non-physician Practitioners: Chapter 12, Section 30.6.9.2 B** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

10. **Medicare Claims Processing Manual: SNF Inpatient Part A Billing: Chapter 6, Section 10.2,** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
11. **Medicare Benefit Policy Manual: Chapter 9, Sections 40.2.2 and 40.1.5** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
12. **Medicare State Operations Manual: Appendix W, Conditions of Participation C-0211, Hospice Services.** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
13. **CMS Swing Bed Fact Sheet: Updated May 2014** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf
14. **Federal Register, Centers for Medicare & Medicaid: CMS 1500 – F, Table 5 (page 341) identifies the specific DRGs affected by the Post-Acute Transfer Rule.** http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms1500f.pdf

State

Each state has its own unique state requirements. Please refer to your state's website for the most current information. For Colorado CAHs:

1. **Chapter V – Long Term Care Facilities. Health Facilities Division, Colorado Department of Public Health & Environment:** http://www.colorado.gov/cs/Satellite/CDPHE-HF/CBON/1251590411457

Appendix B – Case Examples

Development, Management and Evaluation of a Patient Care Plan Examples

Example 1: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

Example 2: An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the non-skilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

Observation and Assessment of a Patient's Condition Examples

Example 1: A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized.

Example 2: A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required.

Example 3: A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

Example 4: A patient has been hospitalized following a heart attack and, following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized.

Example 5: A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration.

Skilled Rehabilitation Services Examples

Example 1: An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.

Example 2: A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

Appendix C – General Questions and Answers

Questions:

1. Why admit a patient to a Swing Bed facility when there is a nursing home with skilled nursing capabilities available?
2. Does a patient have to be moved from one bed to another if he/she is discharged from acute care and admitted to a Swing Bed status?
3. If both a Swing Bed in a Critical Access Hospital and a skilled nursing bed in a long-term care facility are available, does the patient have a "right" to be treated in the Swing Bed or choose which setting he/she prefers?
4. When there are changes in the regulations or the interpretive guidelines for CAHs, how soon do we have to update our procedures/manuals?
5. Does Appendix T of the Medicare State Operations Manual – "Interpretive Guidelines for Swing Beds" apply to Critical Access Hospitals?
6. What happens if a patient has been in the hospital for less than 3 days and requires admission to a Swing Bed?
7. What if the Medicare beneficiary stops getting skilled care in the SNF/Swing Bed or leaves the SNF/Swing Bed altogether? How does this affect Medicare SNF coverage if the Medicare beneficiary needs more skilled care in the SNF/Swing Bed later on?
8. Is there a minimum or maximum length of stay requirement for Swing Bed admissions?
9. Are observation beds included in the 25-bed limit if the observation beds are not separate from the swing beds and acute beds?
10. Is it correct that CAH swing beds follow the SNF regulations for everything EXCEPT the reimbursement regulations?
11. A patient has a 3-day stay in a psychiatric hospital and has a medical diagnosis in addition to the psychiatric diagnosis. Will this qualify for the 3-day qualifying acute inpatient stay?
12. What are Medical Social Services?
13. Can a patient have a temporary leave for an event, such as a funeral or special occasion, (not past midnight) and still be skilled?
14. How often must the provider see a swing bed patient during the swing bed stay?
15. What incentive does an urban hospital have to transfer patients to a CAH swing bed?
16. What are appropriate patient activities for short swing stays (average 14 days)?

17. Does a patient with a behavioral health three-day length of stay, who now requires PT and OT to return home, meet the prior hospital stay requirement? Example - diagnosis is paranoia and depression.
18. What do you do if a patient is admitted to the SNF bed on Friday, but the physical therapy assessment is not available until Monday?
19. If the acute stay ends on the 7th does the swing bed admission begin on the 8th?
20. We have been admitting patients with fractured hips to SB during non-weight bearing periods (4-6 weeks). PT works with them for balance and non-weight bearing gait; OT works with them to improve arm strength and ADLs. Is this wrong?
21. Regarding physician visits, is there a regulation that states the physician must see the patient every 30 days for recertification?

Answers:

1. **Why admit a patient to a Swing Bed facility when there is a nursing home with skilled nursing capabilities available?**

   Swing Bed services are a benefit recognized by Medicare and covered when skilled services, such as patient assessment, are required. While these services are frequently available in a long term care facility offering skilled services, the differences in staff/patient ratios offered by a Swing Bed facility may result in improved care, a speedier recovery and an improved outcome for frail, elderly patients.

2. **Does a patient have to be moved from one bed to another if he/she is discharged from acute care and admitted to a Swing Bed status?**

   No. The patient does not have to be physically moved, however, the patient must be discharged from the acute admission and the acute medical record closed as with any other discharge from the hospital. A new medical record must be opened for the Swing Bed admission.

3. **If both a Swing Bed in a Critical Access Hospital and a skilled nursing bed in a long-term care facility are available, does the patient have a "right" to be treated in the Swing Bed or choose which setting he/she prefers?**

   Post-hospital skilled nursing services are a benefit of the Medicare program and may be provided in a nursing facility approved by Medicare to provide such services, or in a CAH approved by Medicare to provide Swing Bed services. Regardless of which setting is used to provide these services, the patient must meet level of care and other criteria for skilled nursing services. However, the patient does have a right to choose providers and if more than one provider of skilled services is available, (nursing facilities and CAH Swing Beds), the patient should be allowed the right of choice.

4. **When there are changes in the regulations or the interpretive guidelines for CAHs, how soon do we have to update our procedures/manuals?**

   There is no set deadline as to when this must happen. If the changes are minor (i.e. a word here or there or a clarification that does not change the scope of the program) it may be possible to delay making revisions. If the changes are significant, the policies/procedures should be updated as soon as possible. In any event, the changes should be made before the CAH recertification survey. Note: At this time, CAH recertification surveys are not conducted on a regular basis in Colorado.

5. **Does Appendix T of the Medicare State Operations Manual – "Interpretive Guidelines for Swing Beds" apply to Critical Access Hospitals?**

   Appendix T applies only to hospitals that have Swing Bed reimbursement under SNF PPS regulations. The requirements for Swing Beds in CAHs are addressed in Appendix W – "Survey Tasks and Interpretive Guidelines for Critical Access Hospitals."

6. **What happens if a patient has been in the hospital for less than 3 days and requires admission to a Swing Bed?**

   Admission to a Swing Bed for a patient who has not met the qualifying requirement of a 3-day stay is not a covered benefit of the Medicare program.

7. **What if the Medicare beneficiary stops getting skilled care in the SNF/Swing Bed or leaves the SNF/Swing Bed altogether? How does this affect Medicare SNF coverage if the Medicare beneficiary needs more skilled care in the SNF/Swing Bed later on?**

   It depends on how long the break in skilled care lasts. See chart below:

Less than 30 days	• Medicare will cover additional SNF care, and no new 3-day hospital stay is required to qualify. • Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current period.
At least 30 days, but less than 60 days	• Medicare will NOT cover additional SNF care unless there is a new 3-day hospital stay. **Note: The new hospital stay does NOT need to be for the same condition that was treated during the previous stay.** • Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current benefit period.
At least 60 days	• Medicare will NOT cover additional SNF care unless there is a new 3-day hospital stay. The new hospital stay need not be for the same condition that was treated during the previous stay. • Since the break in skilled care lasted for at least 60 days in a row, this would end the current benefit period and renew the SNF benefits. This means that the maximum coverage available would be 100 days of SNF benefits.

8. **Is there a minimum or maximum length of stay requirement for Swing Bed admissions?**

   No, not as long as the beneficiary meets the level of care criteria for Swing Bed admission and has benefit days available. (See "benefit period" on page 5)

9. **Are observation beds included in the 25-bed limit if the observation beds are not separate from the swing beds and acute beds?**

   Observation beds are separate from the 25-bed count. The 25-bed count limit centers around inpatient status (Inpatient beds or Swing Beds). Observation beds are considered an outpatient service.

10. **Is it correct that CAH swing beds follow the SNF regulations for everything EXCEPT the reimbursement regulations?**

    Yes. CAH Swing Beds have the same patient requirements as SNF's. This is because the goal of the treatment (rehabilitation care) is the same. So, whatever the clinical and administrative requirements for SNF, (Example: nursing care, rehabilitation care, therapies, teaching and etc.), these requirements are also applicable to swing bed providers. Clinical requirements are the same across the board for SNF and for Swing bed care.

    Billing and reimbursement guidelines depend on the type of provider. (Example: Swing bed provider in PPS hospital, you go by the PPS billing methodology. Likewise, CAH swing bed providers get cost-based reimbursement and bill accordingly.)

11. **A patient has a 3-day stay in a psychiatric hospital and has a medical diagnosis in addition to the psychiatric diagnosis. Will this qualify for the 3-day qualifying acute inpatient stay?**

    Yes. The psychiatric diagnosis alone is not sufficient for admission into a swing bed, and if the patient only has a psych diagnosis, while the days in the psych hospital can meet the 3-day rule, the diagnosis doesn't.

    However, if the patient also has a medical diagnosis for which they the patient was treated while in the psychiatric hospital, and skilled services are required for this medical diagnosis, the 3-day stay in the psychiatric hospital would meet the requirements for 3-day stay.

12. **What are Medical Social Services?**

    Typically, Medical Social Services are a social worker assisting the case manager in:

    - Arranging services outside the swing bed facility (i.e. dialysis)
    - Assessing the social and emotional factors related to the patient's illness, the need for care, response to treatment, and adjustment in the facility.
    - Determining appropriate action to obtain case work services to assist in resolving problems in these areas.

- Assessing the relationship of the patient's medical and nursing requirements to his/her home situation, financial resources, and the community resources available to him or her in making the decision regarding their discharge.

13. Can a patient have a temporary leave for an event, such as a funeral or special occasion, (not past midnight) and still be skilled?

Yes, as long as the swing bed facility believes that the patient will return to the facility (i.e. that the patient has not gone to another swing bed facility.)

Leave of Absence (LOA) has nothing to do with "midnight". A patient can be gone past midnight, but staff must reasonably believe the patient is returning. The patient can go home, spend the holidays with family, etc., with the expectation that they are returning to the swing bed.

The documentation must indicate that while the patient is stable to leave the facility for a very short time, they still require skilled care. The documentation must describe how they will receive that care while away from the Swing Bed. A LOA longer than 48 hours should be discouraged as it makes it difficult to support the need for care in a Swing Bed.

If a patient leaves, and staff cannot say when or if they are coming back, this is not considered a temporary LOA. The patient must be discharged. Example: A patient, while in swing bed, develops a GI Bleed. He is transported to larger facility for surgery and etc. and staff has no knowledge when, or if he is returning to swing bed. The CAH must discharge the patient.

14. How often must the provider see a swing bed patient during the swing bed stay?

Information can be found in Chapter 4 of the Medicare General Information, Eligibility and Entitlement Manual. The CMS language is vague, but indicates that the physician should see the patient based on the diagnosis and whenever any new problems arise.

At a minimum, the physician needs to see the patient:

- upon admission
- at 14 days for recertification and every 30 days thereafter for recertification
- at discharge
- whenever medically necessary due to significant change in patient's status

15. What incentive does an urban hospital have to transfer patients to a CAH swing bed?

If a patient is in an urban facility, and the facility decides to transfer the patient to a swing bed in a CAH, the urban facility will keep the total DRG. If the urban facility were to transfer the patient to another PPS hospital or SNF facility, the urban center would have to split the DRG. Transferring an urban patient to a CAH swing bed is a win-win for everyone involved.

16. What are appropriate patient activities for short swing stays (average 14 days)?

Appropriate activities are anything that gets the patient physically or mentally stimulated (i.e. crossword puzzles, jigsaw puzzles, group social activities). It doesn't necessarily take a lot of money, but should include a lot of human contact and interaction. Some hospitals have done a good job of using volunteers to supplement these activities by getting patients out in open areas, engaging them in conversation, etc.

From the Medicare State Operations Manual Appendix W: *Interpretive Guidelines 483.15(f)(1)*: Because the activities program should occur within the context of each resident's comprehensive assessment and care plan, it should be multi-faceted and reflect each individual resident's needs. Therefore, the activities program should provide stimulation or solace, promote physical, cognitive and/or emotional health; enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice.

Activities can occur at any time and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers and visitors.

Survey Procedures and Probes 483.15(f)(1): Observe individual, group and bedside activities:

1. Are residents who are confined or choose to remain in their rooms provided with in-room activities in keeping with lifelong interest (e.g. music, reading, visits with individuals who share their interests or reasonable attempts to connect the resident with such individuals) and in-room projects they can work on independently?
2. If residents sit for long periods of time with no apparently meaningful activities, is the cause—
    - Resident choice;
    - Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities;
    - Lack of assistance with ambulation;
    - Lack of sufficient supplies and/or staff to facilitate attendance and participation in the activity programs;
    - Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex?

For residents selected for a comprehensive review, or focused review, as appropriate, determine to what extent the activities reflect the individual resident's assessment. (See especially MDS III.1 and Sections B, C, D, and< 1, MDS version 2.0 sections AC, B,C,D, and N.) Review the activity calendar for the month prior to the survey to determine if the formal activity program:

- Reflects the schedules, choices and rights of the residents;
- Offers activities at hours convenient to the residents (e.g. morning, afternoon, some evenings and weekends);
- Reflects the culture and religious interest of the residents' population;
- Would appeal to both men and women and all age groups living in the facility.

Review clinical records and activity attendance records of residents receiving a comprehensive review, or a focused review, as appropriate, to determine if --

- Activities reflect individual resident history indicated by the comprehensive assessment;
- Care plans address activities that are appropriate for each resident based on the comprehensive assessment,
- Activities occur as planned;
- Outcomes/responses to activities interventions are identified in the progress notes of each resident

Interpretive Guideline 483.15(f)(2): A "recognized accrediting body" refers to those organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professionals or registered occupational therapists.

17. **Does a patient with a behavioral health three-day length of stay, who now requires PT and OT to return home, meet the prior hospital stay requirement? Example - diagnosis is paranoia and depression.**

From Section 20.1 in Chapter 8 of the of the Medicare Benefit Policy Manual: While a 3-day stay in a psychiatric hospital satisfies the prior hospital stay requirement, institutions that primarily provide psychiatric treatment cannot participate in the program as SNFs. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating SNF is likely to receive only non-covered care. In the SNF, the term "non-covered care" refers to any level of care, which is less intensive than the SNF level of care, which is covered under the program.

18. **What do you do if a patient is admitted to the SNF bed on Friday, but the physical therapy assessment is not available until Monday?**

It would depend on why the patient is admitted to the swing bed – rehab or skilled nursing care. From Chapter 8 of the Medicare Benefit Policy Manual: 30.4.1 – Skilled Physical Therapy (Rev. 1, 10-01-03) A3-3132.3A, SNF-214 and 30.4.1.1 - General (Rev. 73, Issued: 06-29-07, Effective: 07-30-99, Implementation: 10-01-07)

Skilled physical therapy services must meet all the following conditions: The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist.

30.6 - Daily Skilled Services Defined (Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7 days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

19. **If the acute stay ends on the 7th does the swing bed admission begin on the 8th?**

    If there has been a 3-day acute care stay that is medically necessary that ends on the 7th then the swing bed admission would begin on the 8th.

20. **We have been admitting patients with fractured hips to SB during non-weight bearing periods (4-6 weeks). PT works with them for balance and non-weight bearing gait; OT works with them to improve arm strength and ADLs. We find that once the patient is allowed weight bearing, they are ready to progress rapidly and often discharge within the next week. Is this wrong?**

    No, this is not wrong as long as you can show this meets the skilled needs of the patient.

21. **Regarding physician visits, is there a regulation that states the physician must see the patient every 30 days for recertification?**

    From Chapter 4, Section 40.4 of the Medicare General Information, Eligibility and Entitlement Manual: The first recertification must be made no later than the l4th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

Appendix D – Swing Bed Billing Questions and Answers

Appendix D contains general information for swing bed billing, based on Medicare guidelines and frequently asked questions regarding swing bed billing. Please note: Each Fiscal Intermediary is tasked with interpreting and enforcing the CMS regulations, therefore hospitals should always refer to the CMS Manuals below for the latest Medicare regulations, and/or consult with your Fiscal Intermediary on interpretation and specific billing instructions.

Although other third party payers tend to follow Medicare guidelines, always make sure you check with the individual payer for specific requirements, which may differ from this information provided. All responses given assume medical necessity.

- Medicare Claims Processing Manual, Chapter 6 SNF Inpatient Part A Billing - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
- Medicare Benefit Policy Manual, Chapter 8 Coverage of Extended Care (SNF) Services Under Hospital Insurance - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
- Medicare General Information, Eligibility, and Entitlement Manual – Chapter 4 Physician Certification and Recertification of Services - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
- Medicare State Operations Manual, Appendix W - http://cms.hhs.gov/manuals/Downloads/som107ap_w_cah.pdf

Questions:

1. Should all labs and X-rays be billed under Part B?
2. As a CAH, should all ancillary services be billed separately with a bill type 221?
3. What services are excluded from the Swing Bed Part A benefit?
4. Does non-hospice end of life care qualify for swing bed coverage?
5. If a patient is at a swing bed facility for therapy, but also needs chemotherapy and goes to another facility to receive chemo and then back to the swing bed the same day, do the charges for the chemo get billed by the chemo rendering provider/facility or do they bill the swing bed facility and the swing bed facility bills the charges? If the latter, do these charges by the swing bed qualify for billing under Part B?
6. If a swing bed stay overlaps months, should the last day of the month go on the first bill and then the date of admission is the first day of the month?
7. We are a CAH that owns a Rural Health Clinic (RHC). If our swing bed patient is going from the swing bed to the RHC for casting, how should it be billed?

8. How should swing beds handle procedures or specialist visits such as colonoscopy, EGD or cardiologist?
9. Are wound-vacs & related supplies part of the Swing Bed Part A or are they billed under Part B?
10. If a swing bed patient is treated in the emergency department and returns to a swing bed, can this be part of the original swing bed admission as long as the emergency department visit is billed under Part B?
11. What type of paper work needs to be done for a temporary leave (for example swing bed to acute)?
12. Is a special code or a different bill type needed for a radiology, colonoscopy or lab procedures billed under Part B while the patient is in a swing bed to keep Medicare from denying the service because it overlaps with SNF service dates?
13. Are surgeries excluded from consolidated billing while in swing bed?
14. We have heard that Hospice services are not covered under swing bed coverage. We assume this means that if the patient is under the care of a Hospice, the swing bed cannot bill for SNF services. We sometimes admit a terminally ill patient under a SNF level of care who has opted to be admitted to a swing bed rather than home or a nursing home for hospice services. Is this O.K.?
15. Are there liability issues to consider for swing bed patients leaving the hospital (for example if they fall and fracture a hip while they are away)?
16. If a CAH is using method II billing, can they bill for Part B services separately (for example lab and x-ray)?
17. Is ambulance transportation covered for swing bed?
18. Can a hospitalist be billed under Part A? If so, should it be billed on a 1500 form or a UB04?
19. Does the last day of any billed charges belong on the bill (e.g. pharmacy)?
20. When we go to the PPS hospital in an attempt to educate them about the incentive for them to transfer patients to a CAH swing bed, they want to know how this is billed. Can you help with this? Also, can you tell us where we can find which DRGs are included in this incentive program?
21. If we have the ambulance take a swing bed patient to another town for a test, do we pay the ambulance for the transfer and then bill Medicare under our Part B provider number?
22. Can a patient be receiving Part A and Part B services at the same time? If they are in a Part A bed (i.e. swing bed), can Part B services be a part of the bill?
23. If a patient requires an MRI, CT or surgical procedure at another facility, does the hospital bill on their 18x TOB, or does the facility performing the service bill?

Answers

1. **Should all labs and X-rays be billed under Part B?**

   When the beneficiary in a swing bed ***is not entitled to Part A benefits***, limited benefits are provided under Part B. When no Part A payment is possible, some or of all services may be medically necessary and can be covered as ancillary services under Part B. Diagnostic x-rays, lab and other diagnostic test maybe billed by the SNF to Part B when there are no Part A benefits.

   It's difficult to make an all-inclusive statement like this. For example, when the beneficiary in a swing bed is not entitled to Part A benefits, limited benefits are provided under Part B.

   When no Part A payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. Diagnostic X-rays, lab and other diagnostic tests may be billed by the SNF to Part B when there are no Part A benefits.

   If the patient has Part A and Part B benefits and if a service is provided that is on the exclusion list, it will be included in consolidated billing and paid in the CAH's all-inclusive rate under Part A.

2. **As a CAH, should all ancillary services be billed separately with a bill type 221?**

   From Section 20.1.2 of the Medicare Claims Processing Manual: Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital. In general, bypasses also allow CT scans, Cardiac Caths, MRI, Radiation Therapy, Angiography, and certain outpatient surgeries to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service.

3. **What services are excluded from the Swing Bed Part A benefit?**

   Certain outpatient hospital services (along with ambulance transportation that convey a beneficiary to a hospital or CAH to receive the additional services) are excluded from coverage under SNF PPS and are billed separately. The additional services are:

   - Cardiac catheterization services
   - Computerized axial tomography (CT scans)
   - Magnetic resonance imaging (MRIs)
   - Radiation therapy
   - Ambulatory surgery involving the use of a hospital OR
   - Emergency services
   - Angiography services
   - Lymphatic and venous procedures
   - Ambulance related to an excluded service

   See Section 20.1.2 of the Medicare Claims Processing Manual.

4. **Does non-hospice end of life care qualify for swing bed coverage?**

   From Section 30 of the Medicare Benefit Policy Manual: Care in a SNF is covered if all of the following four factors are met:

   - The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
   - The patient requires these skilled services on a daily basis (see §30.6); and
   - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
   - The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

   If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled.

5. **If a patient is at a swing bed facility for therapy, but also needs chemotherapy and goes to another facility to receive chemo and then back to the swing bed the same day, do the charges for the chemo get billed by the chemo rendering provider/ facility or do they bill the swing bed facility and it bills the charges? If the latter, do these charges by the swing bed qualify for billing under Part B?**

   If in doubt how to bill specific services, consult your Fiscal Intermediary. From Section 20.3 of the Medicare Claims Processing Manual: the following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for consolidated billing, and are referred to as "Major Category III" for consolidated billing edits applied to claims submitted to FIs.

   - An ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;
   - Certain chemotherapy and chemotherapy administration services. The chemotherapy administration codes are included in SNF PPS payment for

beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy;

- Certain radioisotope services;
- Certain customized prosthetic devices;
- **All services** provided to risk based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

The HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for FIs can be found.

6. **If a swing bed stay overlaps months, should the last day of the month go on the first bill and then the date of admission is the first day of the month?**

   Facilities should bill for the first day of swing bed, but should not bill for the last day of swing bed, regardless of the day of the month. For example, if a patient is admitted to swing bed on November 1 and discharged on November 30, the bill should indicate services for dates November 1-29.

7. **We are a CAH that owns a Rural Health Clinic (RHC). If our swing bed patient is going from the swing bed to the RHC for casting, how should it be billed?**

   From Section 20.1.1 of the Medicare Claims Processing Manual: Effective January 1, 2005, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a Federally Qualified Health Center FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. Accordingly, under section 410 of the MMA of 2003, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 71x and 73x, respectively, to bill for these RHC/FQHC services.

8. **How should swing beds handle procedures or specialist visits such as colonoscopy, EGD or cardiologist?**

   Medicare beneficiaries in a Part A covered SNF stay which includes medical services as well as room and board. If the procedure in not included in the "exclusion" list, it is generally included in the per diem, and is included in consolidated billing.

   The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non- covered stay. Exception: a limited number of services specifically excluded from consolidated billing and therefore separately payable. For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

   - Physicians professional services;
   - Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
   - Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
   - Erythropoietin for certain dialysis patients;
   - Certain chemotherapy drugs;
   - Certain chemotherapy administration services;
   - Radioisotope services; and
   - Customized prosthetic devices.

   See Section 10.2 of the Medicare Benefit Policy Manual.

9. **Are wound vac & related supplies part of the Swing Bed Part A or are they billed under Part B?**

   From Section 10 of the Medicare Claims Processing Manual: Any DME or oxygen furnished to inpatients in a covered Part A stay is included in the SNF PPS rate. The definition of DME in *§1861(n)* of the Social Security Act provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also.

10. **If a swing bed patient is treated in the emergency department and returns to a swing bed, can this be part of the original swing bed admission as long as the emergency department visit is billed under Part B?**

    From Section 20.1.2.2 of the Medicare Claims Processing Manual: Emergency room services performed in hospitals, including CAHs, are excluded from SNF CB for beneficiaries that are in skilled Part A SNF stays. Hospitals report emergency room

(ER) services under the 045X (Emergency Room -"x" represents a varying third digit) revenue code with a line item date of service (LIDOS) indicating the date the patient entered the ER. Services related to the ER encounter are also excluded from the SNF CB provision.

Where services related to the ER encounter span more than one service date, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. The reporting of the ET modifier will alert CWF that these are related ER services performed on subsequent dates so the SNF CB edits in CWF will be bypassed.

11. What type of paper work needs to be done for a temporary leave (for example swing bed to acute)?

From Section 40.3.4 of the Medicare Claims Processing Manual: Medicare systems are set up so that the SNF need not submit a discharge bill when the situation is that the beneficiary (who leaves the SNF and then returns by midnight of the same day) receives outpatient services from a Medicare participating hospital, CAH, or other appropriate provider during his/her absence. Edits allow hospitals and CAHs to bill for these services for a beneficiary in a Part A PPS stay. Receipt of outpatient services from another provider does not normally result in a SNF discharge.

12. Is a special code or just a different bill type needed for a radiology, colonoscopy or lab procedures billed under Part B while the patient is in a swing bed to keep Medicare from denying the service because it overlaps with SNF dates of service?

From Section 20.1.2 of the Medicare Claims Processing Manual: The following services are ***not*** included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them. This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility. In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.

- Certain cardiac catheterizations;
- Certain computerized axial tomography (CT) scans;
- Certain magnetic resonance imaging (MRIs);
- Certain ambulatory surgeries involving the use of a hospital operating room; For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the carrier. Hospital outpatient charges are billed to the FI;
- Certain radiation therapies;
- Certain angiographies, and lymphatic and venous procedures;
- Emergency services;
- Ambulance services when related to an excluded service within this list; and

- Ambulance transportation related to dialysis services.

These relatively costly services are beyond the general scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for excluded radiation therapy itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered beyond the general scope of services delivered by SNFs. The hospital or CAH must bill the FI for the services. Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital.

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- Note that anesthesia, drugs incident to radiology and supplies (revenue codes 037x, 0255, 027x and 062x) will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.

In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed in the table in the Medicare Claims Processing Manual, Section 20.1.2.1) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

13. **Are surgeries excluded from consolidated billing while in swing bed?**

    See the answer to Question 12.

14. **We have heard that Hospice services are not covered under swing bed coverage. We assume this means that if the patient is under the care of a Hospice, the swing bed cannot bill for SNF services. We sometimes admit a terminally ill patient under a SNF level of care who has opted to be admitted to a swing bed rather than home or a nursing home for hospice services. Is this O.K.?**

    From Section 20.2.2 of the Medicare Claims Processing Manual: Hospice care related to a beneficiary's terminal condition is excluded from SNF PPS and consolidated billing. Hospice services for terminal conditions are identified with the following types of bill: 81X or 82X. Services unrelated to the beneficiary's terminal condition are designated by the presence of condition code 07. Such unrelated services are included in SNF PPS and consolidated billing.

15. **Are there liability issues to consider for swing bed patients leaving the hospital (for example if they fall and fracture a hip while they are away)?**

    Check with your liability coverage provider.

16. **If a CAH is using method II billing, can they bill for Part B services separately (for example lab and x-ray)?**

    From Section 20.1.2 of the Medicare Claims Processing Manual: Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital.

17. **Is ambulance transportation covered for swing bed?**

    Ambulance transportation is covered to admit a patient to a swing bed and to discharge the patient to their home.

18. **Can a hospitalist be billed under Part A? If so, should it be billed on a 1500 form or a UB04?**

    From Section 20.1.1 of the Medicare Claims Processing Manual: Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their intermediary. CAHs must bill the professional fees using revenue codes 96x, 97x, or 98x on an 85x type of bill (TOB). Like professional services billed to the carrier, the specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing.

19. **Does the last day of any billed charges belong on the bill (e.g. pharmacy)?**

    From Section 40.6.4 of the Medicare Claims Processing Manual: SNFs show non-covered charges for denied or non-covered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and completes the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used to report periods of non-covered care where the SNF is liable. Occurrence code A3 is used to indicate the last date for which benefits are available or the date benefits were exhausted

20. **When we go to the PPS hospital in an attempt to educate them about the incentive for them to transfer patients to a CAH swing bed, they want to know how this is billed. Where can we get this information and specifics about eligible DRG codes?**

    Ask your FI as they each have different processes.

21. **If we have the ambulance take a swing bed patient to another town for a test, do we pay the ambulance for the transfer and then bill Medicare under our Part B provider number?**

    From Section 20.3.1 of the Medicare Claims Processing Manual: In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier or intermediary (as appropriate) directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only:

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF after discharge, to the beneficiary's home (the first character (origin) of any HCPCS ambulance modifier is N (SNF)) (the second character (destination) of the HCPCS ambulance modifier is R (Residence)), and date of ambulance service is the same date as the SNF through date. Note: this includes beneficiaries discharged home to receive services from a Medicare-participating home health agency under a plan of care;
- The ambulance trip is to a hospital based or non-hospital based ESRD facility (the first character (origin) of the HCPCS ambulance modifier is N(SNF) the second character (destination) HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility)) for the purpose of receiving dialysis and related services excluded from consolidated billing.
- The ambulance trip is from the SNF to a Medicare participating hospital or a CAH for an inpatient admission (the first character origin (origin) of the HCPCS ambulance modifier is N (SNF) (the second character (destination) of the HCPCS modifier (destination) is H).
- The ambulance trip after a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services. (See section 20.1.2 of the Medicare Claims Processing Manual for a list of other excluded services).

22. Can a patient be receiving Part A and Part B services at the same time? If they are in a Part A bed (i.e. swing bed), can Part B services be a part of the bill?

A patient cannot receive Part A and B services at the same time from the same provider number. The provider number is the key. You are submitting the swing bed Part A claim under your swing bed provider number. The hospital provider number is submitting the Part B claim for the ancillary services. So make sure your hospital's charge master is up to date so when you submit the Part B claims for lab, radiology and ER on your hospital's provider number they will have the correct CPT, revenue codes and your charges are where they need to be.

23. If a patient requires an MRI, CT or surgical procedure at another facility, does the hospital bill for those services on their 18x TOB, or does the facility performing the service bill?

From Section 20.1.2 of the Medicare Claims Processing Manual: Those services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them.

Appendix E – References/Other Resources

1. Program Memorandum Intermediaries—Transmittal A-01-09; January 16, 2001; Change Request 1509, "Exemption of Critical Access Hospital Swing Beds From Skilled Nursing Facility Prospective Payment System" http://www.cms.hhs.gov/transmittals/downloads/A0109.pdf
2. McKesson InterQual, Products – Level of Care, Subacute & SNF. (800) 522-6780 or http://www.mckesson.com/payers/decision-management/decision-management-interqual/interqual-criteria/interqual-level-of-care-criteria/
3. MCG Health; a division of Milliman USA. (888) 464-4746 or http://www.careguidelines.com/
4. Medicare Learning Network® (MLN) Catalog of Products located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
5. Critical Access Hospitals Center located at http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html
6. Swing Bed Providers located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html
7. CMS Region VIII Denver Regional Office Rural Health Coordinator – Lucretia Knight, e-mail: lucretia.knight@cms.hhs.gov, telephone (303) 844-7037, states: Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming

Appendix F – Patient Admission Packet

See the following pages for examples of the Patient Admission Packet documents listed below.

- Cover Page – document acknowledging that the Hospital has informed the patient orally and provided a written copy of the certain documents pertaining to rights and policies.
- Advance Directive Information – explanation of advance directives including facility responsibilities, the limits of advance directives, and examples of how advance directives may be used.
- Notice of Non-Coverage on Admission – informing patients that Medicare may not cover the service they are being admitted for.
- Grievances and Complaints Information – information and instructions for the patient regarding filing grievances and/or complaints
- Applying for Medicare/Medicaid Benefits – information to the patient about Medicare and Medicaid programs and how to apply for benefits

Example of Cover Page

State and Federal laws require (Insert Name of Hospital), a Critical Access Hospital Swing Bed facility, to provide patients with certain information at the time of admission. This packet is intended to comply with these laws. By signing this document, you acknowledge that the Hospital has informed you orally and provided a written copy of the following documents. Also, the Hospital has given you an opportunity to ask any questions you may have regarding the documents listed below. You may address further questions, at a later date, to the administrator.

I received copies of the following documents at the time of my admission to the Facility and had them explained to me in a language that I could understand.

1. Resident's rights
2. A description of the facility's policy regarding the formation of advance directives
3. A list of attending physicians who treat patients at the Facility
4. Information given in advance of making health care decisions
5. Participating in planning care and treatment
6. Notice of Privacy Practices
7. A description of the facility's admissions, discharge and transfer policies including a Notice of Non-Coverage on Admission form.
8. A description of the facility's policies and rules governing resident conduct and behavior
9. Use of restraints
10. Facility's responsibility for preventing patient abuse
11. Staff treatment of patient's property and patient funds
12. Activity assessment and plan
13. Dental services
14. A description of the facility's policy regarding grievances and complaints

Signature _____ Date _____

Print Name _____

Relationship to Resident _____

Example of Advance Directives Information

The Critical Access Hospital Swing Bed will make available to you medical and nursing care consistent with sound medical and nursing practice and the resources of the facility. We recognize your right to make decisions regarding your own treatment and to formulate advance directives, if you have the ability to do so. In the event you are incapable of making medical decisions or incapable of communication at the time of admission, appropriate decisions shall continue to be made in your best interests, through the joint efforts of the attending physician, your surrogate decision-maker or family, and the interdisciplinary care team, all as permitted by state and federal law.

Although information is provided to you about advance directives and health care decisions, it is not to be considered as either medical or legal advice. Such consultation, if needed or desired, should be sought from a qualified physician or attorney.

You have the right to make choices about your medical care, including the right to accept or refuse life-sustaining treatments. If you desire, the social worker will help you prepare instructions to guide your physician and other health care persons in providing care should you become unable to make your own decisions. Facility staff are not permitted to act as witnesses to advance directives completed by residents of the facility.

You will be asked for a copy of your executed advance directive, if any, to place in your medical record. It is understood that if you have not executed a directive, this does not create the belief that you do not want a treatment decision to be made to withhold or withdraw life-sustaining procedures. We may indicate your directive through symbols or phrases in our effort to comply with your wishes. If you object to such indications, please notify the Administrator or Director of Nursing.

Your physician will write an order with the content of your advance directive, and your chart will be marked to indicate this. The staff has been trained on advance directive issues, and every effort will be made to comply with yours in emergency situations. An advance directive is not a requirement of admission to this facility. However, we strongly encourage you to consider the benefits of having such a document.

The withholding or withdrawing of life support systems is intended to be accomplished appropriately. Requests for the removal of life supports will be discussed with you or your duly authorized representative, your family, your physician, and members of the interdisciplinary team. Decisions regarding the withholding or withdrawing of treatments will be made, consent obtained and necessary orders written, only after a full discussion of the benefits, risks, and options of the particular treatment in light of your medical condition and prognosis and in compliance with existing state law. The facility will honor your decision or the decision of a proper substitute decision-maker if you do not wish to be resuscitated. Any conflicts concerning the withholding or withdrawing of life supports will be forwarded to the appropriate decision-makers. If we are unable to honor your requests, we will assist in transferring you to another facility that may be more consistent with your wishes.

Model Hospital-Issued Notice of Non-coverage Continued Stay (Swing Bed Only)

(Attending Physician Concurs)

(Patient Changes from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Number Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear (insert beneficiary's name):

This notice is to inform you that we have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed). Your attending physician has been advised and has concurred that beginning (specify date of first non-covered acute care day) further (specify services to be furnished or condition to be treated) (specify is/are medically unnecessary) or (could be furnished safely in another setting). This determination was based upon our understanding and interpretation of available Medicare policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on (specify date).* If you leave the hospital on (specify date), you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

_____

* Insert: the date following the day of receipt of the hospital notice.

Page 2 - Hospital-Issued Notice of Non-coverage

However, this notice is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State) and to make that determination.

- **If you disagree with our conclusion:**
  - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- **If you do not request an immediate review:**
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- **QIO Review Results:**
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on (specify date).*
- **QIO Address:**

  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

Chairperson of Utilization Review Committee, Medical Staff, etc.

---

* Insert: the date following the day of receipt of the hospital notice.

Example of Grievances and Complaints Information

It is the policy of the facility to support each patient's right to voice grievances and to ensure that after a grievance has been received, the facility will actively resolve the issue and communicate the resolution's progress to the patient and/or patient's family in a timely manner. The Administrator is ultimately responsible for the resolution of all grievances and/or complaints. Any patient, his or her representative, family member, employee, or appointed advocate may file a grievance without fear of threat or reprisal. All grievances and complaints are investigated, resolved, and documented.

1. If the patient, or a person acting on the patient's behalf, has a complaint, a staff member should encourage and assist the patient, or patient representative, to file a written grievance using the Grievance/Complaint Report.
2. Grievances and complaints may be submitted orally or in writing. The patient, or the person acting on the patient's behalf, should be encouraged to sign written complaints or grievances. If a grievance is submitted orally, the facility employee taking the grievance must write it up on the report form.
3. A copy of the written grievance is to be forwarded to the facility's administrator within 24 hours of receipt.
4. Upon receipt of the grievance, the Administrator will refer it to the appropriate department head. The department head will submit a written report of findings to the Administrator within three working days. The investigation and report should be completed using a Grievance/Complaint Report.
5. The Administrator will review the finding with the person investigating the complaint to determine what corrective actions and resolutions need to be made.
6. The Administrator will document receipt of all grievances on the Grievance QA&A Log. The report will be used for tracking or trending as part of the facility's Quality Assessment and Assurance program.
7. The patient or patient representative will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. This report will be completed by the Administrator, or his or her designee, within 3-5 working days of the receipt of the grievance.
8. Copies of all reports must be signed and will be made available to the patient or person acting on behalf of the patient. The original reports are filed in a notebook labeled Grievance and maintained in the Administrator's office.
9. The Patient Council and/or Family Council are additional forums for voicing complaints and grievances. Complaints and grievances received from these Councils will be acted upon in accordance with this policy.
10. If the patient is not satisfied with the resolution or the recommended actions, he or she may contact the Company Hotline telephone number (800-275-9575) through which grievances can also be registered directly to the corporate offices.

Example of Applying For Medicare/Medicaid Benefits Information

Medicare: Medicare is a federal government program providing financial assistance for medical care. The program is designed to help people age 65 and older as well as certain younger disabled people. More specifically, Medicare is a federal health insurance program. It is administered at the federal level by the Centers for Medicare and Medicaid Services (CMS), a part of the Department of Health & Human Services (HHS). Local social security administration offices take applications for Medicare and provide information. Monthly premiums need to be paid to obtain Medicare insurance.

Medicare has two parts – hospital insurance (Part A) and medical insurance (Part B). The hospital insurance (Part A) can help pay for inpatient hospital care and may help pay for a skilled nursing facility for a limited amount of time, if certain conditions are met. The medical insurance (Part B) can help pay for physician services, outpatient hospital treatment, and a number of other medical services and supplies.

Medicare A and B will pay for a portion of your stay if you meet certain criteria. To receive Medicare Part A benefits: you must have been hospitalized for three consecutive nights within 30 days of your admission, you must need daily skilled nursing or rehabilitation services related to your stay, and you must not be receiving benefits under any other insurance plan for Medicare to be considered your primary payer.

You have a maximum of 100 days of coverage for each benefit period if you qualify. Medicare has very specific guidelines for defining a benefit period. For the first 20 days of the benefit period, Medicare A pays for covered items and services provided to you in their entirety with certain restrictions: for example, Medicare will not pay for a private room if it is not medically necessary, and Medicare will not pay for a private telephone. For the 21st day through the 100th day, Medicare requires you to pay the facility a co-pay. The amount of the co-pay is established annually by the government. If you have additional insurance that covers the co-pay, the facility will bill that plan for you.

Medicare Part B insurance covers certain services when you are not being covered under Medicare Part A. Medicare Part B will cover rehabilitation therapies, certain equipment, and certain medical supplies. There are requirements that must be met before Medicare Part B will pay. There is an annual deductible and then you are responsible for 20% of the charged services you receive. If you have additional insurance that covers your deductible or 20% co-pay, the facility will bill that plan for you as a courtesy. If payment is not received within 60 days of filing, you are responsible for the charges.

Medicaid: For low-income individuals, the Medicaid program may pay for all or part of health care expenses. Medicaid may also pay some health care expenses not covered by Medicare. The application process for Medicaid is extremely detailed and has numerous regulations that, if not addressed completely, may affect eligibility. It is important to have a professional guide you through the process. There are a number of community agencies that offer assistance with this matter. A Medicaid application must be filed at your county Human Services office. If you are unable to file the application, a family member or friend can do it for you. The hospital can also assist you with the application.

Appendix G – Jimmo v. Sebelius Settlement Agreement
Program Manual Clarifications Fact Sheet

***Jimmo v. Sebelius* Settlement Agreement**
Program Manual Clarifications Fact Sheet

Overview:

As explained in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet (available online at http://www.cms.gov/Medicare/Medicare-Fee-for- Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf), the Centers for Medicare & Medicaid Services (CMS) is issuing revised portions of the relevant program manuals used by Medicare contractors. Specifically, in accordance with the settlement agreement, the manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The Settlement Agreement:

The settlement agreement itself includes language specifying that "**Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage**."

Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the manual revisions contained in Change Request (CR) 8458 do not represent an *expansion* of coverage, but rather, provide clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the *existing* Medicare policy. Similarly, these revisions do not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must to be reasonable and necessary to diagnose or treat the beneficiary's condition. The following are some significant aspects of the manual clarifications:

- **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.** There are situations in which the patient's potential for improvement would be a reasonable criterion to consider, such as when the goal of treatment is to restore function. We note that this would always be the goal of treatment in the inpatient rehabilitation facility (IRF) setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered. However, Medicare has long recognized that there may be situations in the SNF, home health, and outpatient therapy settings where, even though no improvement is expected, skilled nursing and/or therapy services to prevent or slow a decline in condition are necessary because of the particular patient's special medical complications or the complexity of the needed services.

- The manual revisions clarify that a beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage in this context, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, such coverage would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of non-skilled personnel.

- Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves. The manual revisions serve to reflect and articulate this basic principle more clearly. Therefore, denial notices for claims involving maintenance care in the SNF, HH, and OPT settings should contain an accurate summary of the reason for the determination, which should always be based on whether the beneficiary has a *need for skilled care* rather than on a lack of improvement.

Appropriate Documentation:

Portions of the revised manual provisions now include additional information on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the terms of the settlement agreement do not include an explicit reference to documentation requirements as such, we have nevertheless decided to use this

opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received — which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.

Forthcoming Activities:

As discussed in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet, CMS is planning to conduct additional educational outreach and claims review activities in the near future pursuant to the settlement agreement.

Appendix H – Sample Swing Bed Documentation Forms

See the following pages for examples of the documentation forms listed below.

- Swing Bed Skilled Nursing or Rehabilitation Services Certification – the provider needs to certify the patient meets skilled medical criteria at specific intervals. Although this specific form is not required, the information is required to be documented in the patient's medical record. This form ensures the documentation is complete and timely for all Swing Bed patients.
- Patient Tracking Form for Swing Bed Admission –The staff receiving information about a potential admission to Swing Bed can use this form to determine if patient meets program eligibility criteria.
- Patient Transfer Form for Swing Bed Admission – This form includes all medical information needed to determine if patient meets medical criteria for admission to Swing Bed. It may be given to hospitals that routinely transfer patients to Swing Bed to ensure appropriate admission and complete documentation.
- Patient Documentation: The following tools meet documentation requirements for Swing Bed admissions:
  - Swing Bed Assessment
  - Swing Bed Patient Activity Plan
  - Swing Bed Care Plan
  - Swing Bed Team Meeting Care Plan Update

Swing Bed Skilled Nursing or Rehabilitation Services Certification

I certify that _____requires the following post hospital extended care services: _____

_____

_____

on an inpatient basis because of his/her need for skilled nursing or rehabilitation services on a daily basis for the following medical condition(s): _____

_____

which he/she received inpatient hospital services from _____ to_____. He/She is unable to receive these services on an out-patient or in-home basis for the following reasons: _____

_____

_____

_____

Attending Physician

Signature: _____ Date:_____

NOTE:

Recertification (recert.) must be made no later than day 14 of Swing Bed, and then at intervals not exceeding day 30, 60 and 90. The recertification statement may be included in the physician's progress notes and must contain the following:

I. Reasons for continued need for skilled services
II. The estimated period of time the patient will need to remain in Swing Bed
III. Any plans, where appropriate for home care

Recert	Date Recert Needed	Date Recert Completed	Recert Reviewed
14 Day	_____	_____	_____
30 Day	_____	_____	_____
60 Day	_____	_____	_____
90 Day	_____	_____	_____

Patient Tracking Form for Swing Bed Admission

Patient: _____

Anticipated Date of Admission: _____

Reason for Admission: _____

Insurance: _____

Number of Skilled (Swing) Days Available in Benefit Period: _____

Dates of Acute Hospitalization **(Do Not Include Observation Days):** _____

Transferring Physician Name: _____

Accepting Physician Name: _____

Case Manager/Nursing Supervisor: _____

Contact Person at Transferring Hospital: _____

Once admitted:

- ☐ Pay Source Determination
- ☐ Copy of Medicare and/or Medicaid cards (front and back)
- ☐ Copy of Other Insurance Cards (front and back)
- ☐ Copy of Patient Transfer Form
- ☐ Admission Packet Presented & Signed Receipt

Patient Transfer Form to Critical Access Hospital

Patient Name _____ DOB
Transfer From
Date _____ Time
Transfer To
Dates of Stay _____ _____
Admitted Discharged
Physician _____ Phone
Will Follow: Yes ____ No ____
Patient Name _____ DOB _____
Contact _____ Phone
Reason for Transfer _____
_____
_____
_____
_____
Diagnosis: (1) _____ (2) _____

PATIENT CHARACTERISTICS

Height _____ Weight _ B/P _____
_____ Temp. _____ Pulse _____
_____ Resp: _____ Incontinence
Bladder Yes _____ No _____
Bowel Yes _____ No _____
Date of Last B.M. _____
Fall Risk: Low ___ Mod. ___ High ___
Aspiration Risk: Low ___ Mod. ___ High ___
Skin Status: Rash _____ Excoriations _____
Pressure Ulcers _____ Stasis Ulcers _____
Bruises _____ Location _____
Wounds _____

Pain Scale _____
Allergies _____
Diet Order _____
Psychosocial Info _____
Additional Comments _____
_____
_____

REQUIRED TRANSFER DOCUMENTS

Attach Face Sheet _____
H&P _____
Advanced Directives _____
Labs/X-ray Reports _____
Physician Orders _____
Medication/Treatments _____
Rehabilitation Services _____
Discharge Notes _____
All Progress Notes _____
Copy of Chart Preferred _____

SENSORY/LANGUAGE

Sight	Hearing	Communication
__ Adequate	__ Aid R/L	__ Speaks Well
__ Glasses	__ H.O.H	__ Nonverbal
__ Contacts	__ Part. Deaf	__ Aphasic
__ Blind R/L	__ Tot. Deaf	__ Garbled
		__ Read/Write

Language _____ __ Sign

MENTAL STATUS

	Current	Baseline
Alert	_____	_____
Confused	_____	_____
Strikes	Out	_____
Oriented	_____	_____
Depressed	_____	_____
Comatose	_____	_____
Forgetful	_____	_____
Withdrawn	_____	_____
Noisy	_____	_____
Wanderer	_____	_____
Climbs out of Bed		_____
Other	_____	_____

APPLIANCES/PROSTHESES (S)ent/(N)eeded

Cane _____ Contact Lens _____
Dentures U/L _____ Glasses _____
Prosthesis _____ (type) _____
Crutches _____ Wheelchair _____
Walker _____ Other _____
Restraints (kind) _____

FUNCTIONAL LEVELS

	Dependent	Independent	Needs Assistance
Bed Activity	_____	_____	_____
Personal Hygiene	_____	_____	_____
Dressing	_____	_____	_____
Eating	_____	_____	_____
Transfer	_____	_____	_____
Locomotion	_____	_____	_____
Weight Bearing	_____	_____	_____
Rehab Potential	_____	_____	_____
Activity Tolerance	_____	_____	_____
Personal Hygiene	_____	_____	_____

Name of Person Completing Report Phone
_____ _____
Called To _____ Phone _____
Faxed To _____ Phone _____

Swing Bed Assessment

Patient: _____

Room: _____

Database

Medical Diagnoses:

Vital Signs: _____ Height: _____ Weight: _____

O^2 Sat: _____% ☐ Room Air ☐ _____ ☐ Nasal Cannula ☐ Other: _____

Prior Living Situation:

☐ Home Independent
☐ Home w/someone checking in
☐ Living with a person who is: ☐ Home full time ☐ Out of home for work/other
☐ Assisted Living ☐ Long Term Care
☐ Other: _____

Prior Level of Function:

☐ Independent ☐ Assist with ☐ Self-care ☐ Cleaning ☐ Shopping ☐ Driving
☐ Assist Other: _____ ☐ Dependent

Current Health Conditions: **Care Plan? ☐ YES ☐ NO**

☐ Cardiac Arrhythmia	☐ Breathing Difficulty	☐ Edema
☐ Vertigo/syncope	☐ Dehydration	☐ Nausea/vomiting
☐ Indigestion/reflux	☐ Weight gain/loss	☐ Constipation/diarrhea
☐ Dysuria/retention	☐ Bleeding: _____	☐ Pain: _____
☐ Skin Impairment: _____		

Special Treatments & Procedures: **Care Plan? ☐ YES ☐ NO**

☐ O^2 Therapy	☐ Nebulizers	☐ Suction
☐ IV Therapy	☐ Telemetry	☐ Tube feeding
☐ BG Monitoring	☐ Blood Transfusion	☐ Pain control
☐ Indwelling catheter	☐ Wound care	☐ Bowel/bladder prog.
☐ Routine injections	☐ IM ⑤SC	

☐ Monitoring acute medical condition: _____
☐ Monitoring medication effects: _____
☐ Other: _____

Precautions: _____

Allergies: _____

Fall Risk:	☐ Insignificant	☐ Low	☐ Medium	☐ High
Weight Bearing Status:		☐ Full	☐ WBAT	☐ Partial _____
	☐ Right LE	☐ Left LE	☐ TDWB	☐ Non-WB

Current Medications: **Care Plan?** ☐ **YES** ☐ **NO**

Planning: **Care Plan?** ☐ **YES** ☐ **NO**

Discharge Plan:
☐ Patient ☐ Family:
☐ Home Independent ☐ Home with Home Health
☐ Home with someone checking in ☐ Home with some routine help
☐ Living with a person who is: ☐ Home full time ☐ Out of home for work/other
☐ Assisted Living ☐ Long Term Care
☐ Other: _____

Rehabilitation Potential for Discharge Plan: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Discharge Plan Needs:
☐ Home Eval ☐ Patient Teaching
☐ Caregiver Teaching ☐ Home Health through _____
☐ Other: _____
☐ Equipment: _____

Cognition/Memory: **Care Plan?** ☐ **YES** ☐ **NO**

Orientation ☐ Person ☐ Weekday ☐ Date ☐ Location ☐ Situation

Testing Results: Mini Mental: _____ Adapted FAST: _____
Allen Cognitive Level: _____ Other: _____

Memory: Short Term: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Long Term: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Decision Making:
☐ Independent ☐ Assist In New Situations Only
☐ Decision poor; requires cues, supervision
☐ Dependent on Another, rarely or never makes decisions

Delirium:
☐ Easily Distracted/difficulty paying attention
☐ Altered Perception or awareness of surroundings, such as hallucinations
☐ Disorganized, nonsensical, irrelevant speech
☐ Restless, frequent position changes, repetitive physical movement or calling out
☐ Lethargic, Staring into space, little body movement

Mood, Behavior, Psychosocial Functioning: **Care Plan?** ☐ **YES** ☐ **NO**

☐ Friendly	☐ Cooperative	☐ Quiet	☐ Withdrawn	☐ Tearful
☐ Anxious	☐ Agitated	☐ Calls Out	☐ Wanders	☐ Insomnia
☐ Verbally Abusive		☐ Physically Abusive		☐ Resists Care
☐ Socially Inappropriate		☐ Repetitive Statements		☐ Easily Annoyed
☐ Other: _____				
Support System:	☐ Family	☐ Church	☐ Other: _____	
Coping Skills:	☐ WFL	☐ Denial	☐ Other: _____	

Communication/Hearing: **Care Plan?** ☐ **YES** ☐ **NO**

Speech/Language:
☐ WFL ☐ Aphasia ☐ Dysarthria
☐ Other: _____

Able to understand
☐ WFL ☐ Usually ☐ Sometimes
☐ Rarely ☐ Unable

Communication/Hearing (continued)

Hearing:	☐ WFL ☐ Hears Most 1:1	☐ Significant Deficit	
	☐ Has Hearing Aides ☐ R ☐ L	☐ Uses Hearing Aides ☐ R ☐ L	
	☐ Reads Lips ☐ Written Messages	☐ Other: _____	
Method of Communication:	☐ Verbal	☐ Gestures	☐ Writes Messages
	☐ Other: _____		
Able to make needs/wants known:	☐ WFL ☐ Rarely	☐ Usually ☐ Unable	☐ Sometimes

Visual Abilities:		**Care Plan?**	☐ **YES** ☐ **NO**
☐ WFL	☐ WFL with Correction	☐ Able to See Newsprint	
☐ Able to See Headlines	☐ Able to See to Move about Room/Hospital		
☐ Sees Shadows/Outlines	☐ Sees Nothing		
Visual Aides: ☐ Glasses ☐ Contacts	☐ Magnifier _____x	☐ Large Print	

Physical Functioning and Self-Care **Care Plan?** ☐ **YES** ☐ **NO**

Physical Activity Tolerance:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	
Bed Mobility:	☐ Uses Bed Rails	☐ Uses Trapeze	☐ I	☐ SBA	
	☐ CGA ☐ Min A	☐ Mod A ☐ Max A	☐ Total A		
	☐ A of 1	☐ A of 2	☐ A of 3+		
	Verbal Cues:	☐ None ☐ Min	☐ Mod	☐ Max	
Transfer: ☐ I	☐ SBA ☐ CGA	☐ Min A ☐ Mod A	☐ Max A	☐ Total A	
	☐ A of 1	☐ A of 2	☐ A of 3+		
	Verbal Cues:	☐ None ☐ Min	☐ Mod	☐ Max	
	☐ Stand Pivot	☐ Mechanical Lift	☐ Walker Used		
	Other: _____				
Mobility:	☐ Ambulatory	☐ Non Ambulatory	☐ I	☐ SBA	
	☐ CGA ☐ Min A	☐ Mod A ☐ Max A	☐ Total A		
	☐ A of 1	☐ A of 2	☐ A of 3+		
	Verbal Cues:	☐ None ☐ Min	☐ Mod	☐ Max	
Mobility Device:	☐ None ☐ Cane	☐ Quad Cane	☐ Seated Walker		
	☐ Front Wheeled Walker	☐ Wheelchair			
	☐ Other: _____				
	☐ New Device	☐ Used Device for 90+ Days			
Dressing: ☐ I	☐ SBA ☐ CGA	☐ Min A ☐ Mod A	☐ Max A	☐ Total A	
	☐ A of 1	☐ A of 2			
	Verbal Cues:	☐ None ☐ Min	☐ Mod	☐ Max	
Nutritional Status:	☐ Excellent	☐ Good ☐ Fair	☐ Poor		
Eating Intake: ☐ I	☐ SBA ☐ CGA	☐ Min A ☐ Mod A	☐ Max A	☐ Total A	
	☐ Set Up	☐ NPO			
	Verbal Cues:	☐ None ☐ Min	☐ Mod	☐ Max	
	Daily Intake:	Food _____%	Fluid _____cc		
Oral Status:	☐ No Problem	☐ Chewing Problem	☐ Oral Pain		
	☐ All Natural Teeth	☐ Some Missing Teeth			
	☐ Dentures ☐ Upper	☐ Lower ☐ Edentulous, but no dentures used			
	☐ Other: _____				

Physical Functioning and Self-Care (continued)

Swallowing: ☐ WFL ☐ Dysphagia/Impaired
Verbal Cues: ☐ None ☐ Min ☐ Mod ☐ Max

Diet: Texture: ☐ Regular ☐ Mech. Soft ☐ Pureed
Liquids: ☐ Thin/Reg. ☐ Nectar ☐ Honey ☐ Pudding
☐ ADA _____cal. ☐ Tube Feed ☐ Other: _____

Continence/Bowel & Bladder:

☐ Continent Bowel	☐ Continent Bladder
☐ Occ. Inc. Bowel	☐ Occ. Inc. Bladder
☐ Frequent Inc. Bowel	☐ Frequent Inc. Bladder
☐ Usually Inc. Bowel	☐ Usually Inc. Bladder
☐ Catheter	☐ Other: _____

Toilet Transfers: ☐ I ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A
☐ Total A ☐ A of 1 ☐ A of 2 ☐ A of 3+
Verbal Cues: ☐ None ☐ Min ☐ Mod ☐ Max
☐ BSC ☐ Toilet
☐ Full Size Inc. Prod ☐ Pull on Inc. Prod ☐ Pad Inc. Prod

Toilet Hygiene: ☐ I ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A
☐ Total A ☐ A of 1 ☐ A of 2 ☐ A of 3+
Verbal Cues: ☐ None ☐ Min ☐ Mod ☐ Max

Groom/Hygiene: ☐ I ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A
☐ Total A ☐ A of 1 ☐ A of 2 ☐ A of 3+
Verbal Cues: ☐ None ☐ Min ☐ Mod ☐ Max

Bathing: ☐ I ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A
☐ Total A ☐ A of 1 ☐ A of 2 ☐ A of 3+
Verbal Cues: ☐ None ☐ Min ☐ Mod ☐ Max
☐ Stands ☐ Shower Bench ☐ Rolling Shower Chair

Leisure Activity **Care Plan?** ☐ **Yes** ☐ **No**

Preferred Time: ☐ Morning ☐ Afternoon ☐ Evening ☐ None
General Interests: ☐ Family/friends visits ☐ Family/friends calls ☐ Mail
☐ TV ☐ Radio ☐ Music Performances
☐ Spiritual/Religious ☐ Other: _____

Source(s) of Information for Assessment:

☐ Patient ☐ Family ☐ Direct Observation ☐ Documentation
☐ Staff Communication ☐ Other: _____

Signatures

Patient:	_____	___/___/___	_____	___/___/___
Family:	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___

Swing Bed Patient Activity Plan

Patient Name: _____

Date of Assessment: _____

Assessment of Patient's Activity Needs: _____

Activity Plan of Care: _____

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care –Week 1:

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care –Week 2:

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care –Week 3:

Patient/Family Signature: _____

Staff Name (printed) & Title: _____

Staff Signature & Date: _____

Swing Bed Care Plan

Patient: _____

Room: _____

Services: ☐ Skilled Nursing ☐ PT ☐ OT ☐ ST
☐ Psychologist ☐ Dietary Consult ☐ Activities ☐ Social Services
*See individual Treatment/Care Plans and Team Meeting Care Plan Updates as well

Patient Strengths/Preferences:

Discharge Plan: ☐ Patient ☐ Family _____
☐ Home Independent ☐ Home with Home Health
☐ Home with someone checking in ☐ Home with some routine help
☐ Living with a person who is: ☐ Home full time ☐ Out of home for work/other
☐ Assisted Living ☐ Long Term Care ☐ Other: _____

Discharge Plan Needs: ☐ Home Eval ☐ Patient Teaching
☐ Caregiver Teaching ☐ Home Health through _____
☐ Other: _____
☐ Equipment: _____

Date: ___/___/___ Problem: _____
Team Goal / Timeframe:

Interventions:

Outcome:

Date: ___/___/___ Problem: _____
Team Goal / Timeframe:

Interventions:

Outcome:

Date: ___/___/___ Problem: _____

Team Goal / Timeframe:

Interventions:

Outcome:

Date: ___/___/___ Problem: _____

Team Goal / Timeframe:

Interventions:

Outcome:

Date: ___/___/___ Problem: _____

Team Goal / Timeframe:

Interventions:

Outcome:

Date: ___/___/___ Problem: _____

Team Goal / Timeframe:

Interventions:

Outcome:

Signatures

Physician:	_____	___/___/___	_____	___/___/___
Patient:	_____	___/___/___	_____	___/___/___
Family:	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___

Swing Bed Team Meeting Care Plan Update

Patient: _____

Room: _____

Date: ____/____/____

Services Changed	☐ No Change		
Health Conditions	☐ No Change	☐ Improved	☐ Declined
Special Treatments and Procedures:	☐ No Change	☐ Improved	☐ Declined
Precautions:	☐ No Change	☐ Improved	☐ Declined
Medications:	☐ No Change	☐ Improved	☐ Declined
Discharge Plan:	☐ Anticipated Discharge Date: __/__/__		
Discharge Needs:	☐ No Change		
Cognition/Memory:	☐ No Change	☐ Improved	☐ Declined
Decision-Making:	☐ No Change	☐ Improved	☐ Declined
Mood, Behavior, Psychosocial Functioning:	☐ No Change	☐ Improved	☐ Declined
Speech/Language:	☐ No Change	☐ Improved	☐ Declined
Hearing:	☐ No Change	☐ Improved	☐ Declined
Vision:	☐ No Change	☐ Improved	☐ Declined
Physical Activity Tolerance:	☐ No Change	☐ Improved	☐ Declined
Bed Mobility:	☐ No Change	☐ Improved	☐ Declined
Transfer:	☐ No Change	☐ Improved	☐ Declined
Mobility/Device:	☐ No Change	☐ Improved	☐ Declined
Oral Status/Swallowing:	☐ No Change	☐ Improved	☐ Declined
Nutritional Status:	☐ No Change	☐ Improved	☐ Declined
Diet:	☐ No Change	☐ Improved	☐ Declined
Continence:	☐ No Change	☐ Improved	☐ Declined
Self-Care Skills:	☐ No Change	☐ Improved	☐ Declined
Leisure Activities	☐ No Change	☐ Improved	☐ Declined
Other:	☐ N/A		

Signatures

Patient:	_____	__/__/__	_____	__/__/__
Family:	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__
	_____	__/__/__	_____	__/__/__