

FIRST EDITION – 2020



Swing Bed Manual

For Rural Hospitals

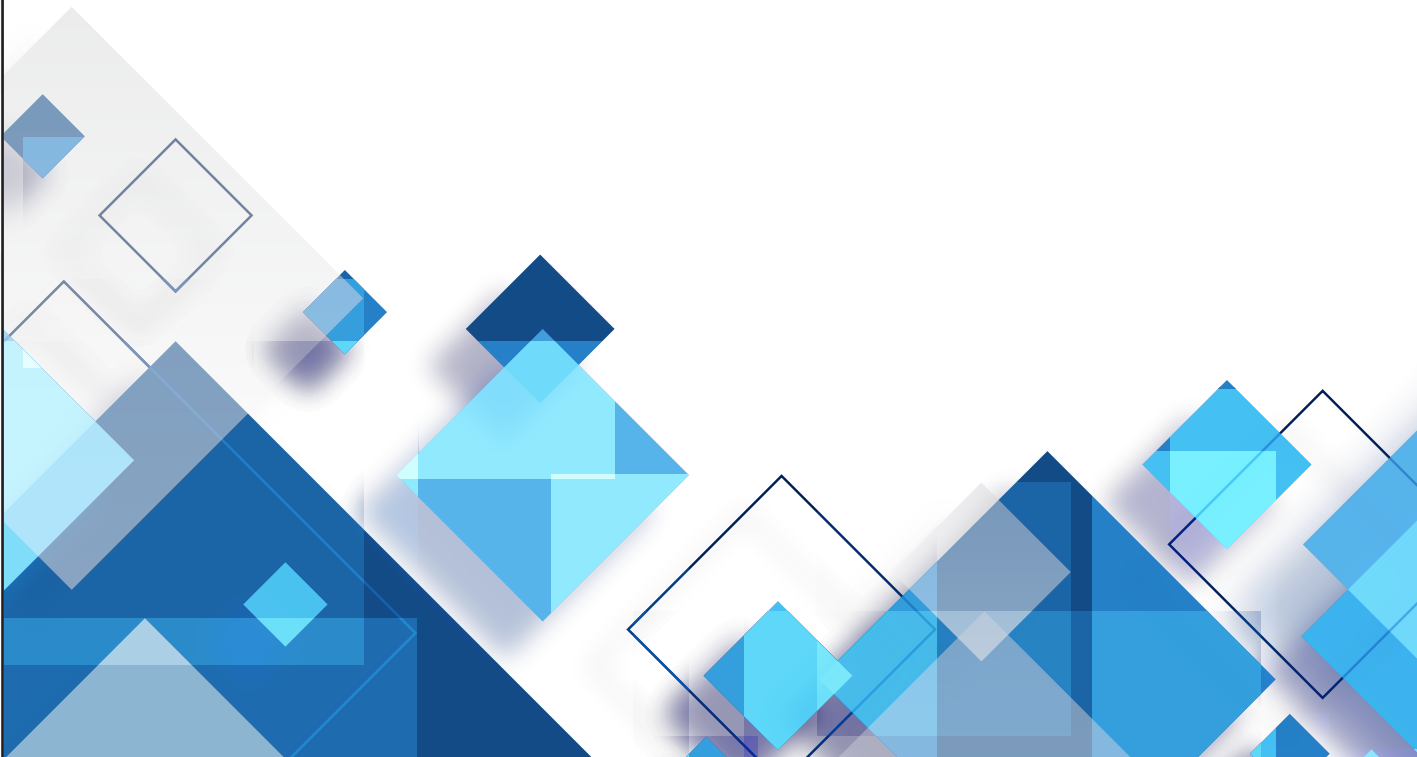


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INTRODUCTION TO CAH SKILLED NURSING SERVICES

HISTORY AND PURPOSE OF THE SWING BED PROGRAM

The history of the swing bed program has been misunderstood by some. Many assume that the beginning of “swing bed” came around the same time as the creation of the critical access hospital program (CAH). However, this is not true. About 17 years before the creation of the CAH program, the national swing bed program found its formal beginning with the 1980 Omnibus Budget Reconciliation Act (Public Law 96-499). Prior to the 1980 act, healthcare surrounding post-acute care went through several transformations.

Before the Medicare and Medicaid programs were created, acute and long-term care was often provided in the same hospital bed, with patients charged different rates accordingly. Once Medicare and Medicaid emerged, hospital reimbursement and differential pricing gained regulatory scrutiny. Eventually alternate options for long-term care were developed, known as the extended care facility (ECF) or also known now as the skilled nursing facility (SNF). Patients could transfer to an ECF to continue receiving nursing care once they were no longer in need of acute care.

Soon in the early 1970s, bed availability in rural ECFs became limited, and rural hospital beds were under occupied. In response, the Utah Cost Improvement Project (UCIP) was started in 1973 and funded by the Health Care Finance Administration (HCFA). The project studied care provided through long-term care beds placed within rural hospitals. It also tested methods for reimbursement from Medicare and Medicaid for these services, termed the “carve out” method. Three additional HCFA funded projects were started in 1976 and 1977 and were termed the Reducing Acute Care Costs (RACC) demonstrations. Through research and evaluation, these four demonstrations received large support both publicly and privately, and proved their

approach to be cost-effective. As a result of this work, the 1980 Omnibus Budget Reconciliation Act was passed into legislation.

The 1980 Act introduced the term “swing bed” and formalized the beginning of the swing bed program that was then made available throughout all rural hospital settings. The term “swing bed” identified the extended care (skilled care) a patient could receive immediately following the acute level of care. Under the swing bed program, the patient could now stay within the same hospital, and receive extended care without discharging out to an ECF. Also, the 1980 legislation outlined reimbursement for these services through Medicare and Medicaid, and eventually became the final accepted regulations, with exception of a few added amendments in 1983.

CHAPTER ONE: UNDERSTANDING SWING BEDS

USE OF SWING BEDS IN A RURAL HOSPITAL

CAHs can use their inpatient beds interchangeably as acute or as swing beds. It is, however, a discharge and admission when going between the two licensure levels, and a swing bed has a different reimbursement structure.

Skilled nursing may be provided in a hospital or in a nursing home, but a CAH swing bed (or PPS swing bed) or a skilled nursing facility must be certified.

The distinction blurs with CAH swing beds considered a part of the CAH regulations and in some circumstances following Medicare's long term care regulations.¹ CAH swing beds differ from Rural Hospital (PPS) swing beds by the fact they are not required to complete an MDS assessment to document the skilled requirement for a comprehensive assessment process. By not being mandated to use an MDS, the CAH swing bed bears the onus for medical necessity documentation from all disciplines to support payment from Medicare for the post-acute care and length of stay.

Neither is reimbursement based on the completion and submission of the MDS. It is most important that a CAH swing bed program utilize multiple sources for reimbursement, including transmittals and regulations from CMS, and by directly contacting your fiscal intermediary (MAC). CAH services are reimbursed on a cost methodology (see Chapter 11 for further details).

CAH swing beds are not bound by the CAH acute annual average length of stay of 96 hours or less. Instead, the length of stay is based on medical necessity. CAH swing bed programs tend to be like the Rural Hospital (PPS) length of stay, and less than the SNF skilled patient stays.

There are requirements to be met, both to gain certification and to retain licensure to provide swing bed services. Those include many regulatory and compliance guidelines of which your staff should be made aware through ongoing training and, where needed, leadership understanding of the limitations of skilled nursing. Going back to the swing bed designation, at a minimum the hospital must:

- 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 healthcare services to patients in the area.

¹ *Medicare State Operations Manual, Appendix W: Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing Beds in Critical Access Hospitals*

- 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 or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less (excluding beds that are within distinct part units [DPU])
- Furnish 24-hour emergency care services, using either on-site or on-call staff
(C-0280 485.635(b)(c)(i))

TO DO OR NOT TO DO WITH A SWING BED

One of the foibles of swing beds is the opportunity for providers to consider this an “ongoing” acute stay. It is not. It is a different licensure defined as “post-acute”.

CAH swing beds have continued that “habit” by admitting patients that aren’t classified at a skilled nursing level. To understand skilled nursing, leadership must understand Medicare intent – why is there skilled nursing level of care in the first place? And while discussing Medicare, insurances and bundling initiatives may veer from specific Medicare directives but the intent for this level of care remains basic.

Skilled care is defined as care that can only be safely and effectively performed under the supervision of specific professionals who must treat, manage, and evaluate a patient’s condition(s) daily. Basics include the following:

- For Medicare a patient must have Part A coverage and days left in the benefit period (substitute your insurance language as needed).
- For Medicare A, there is a three-midnight census qualifying hospital stay. For other insurances, it can be less than three days, or no hospital stay required.
- A physician determines the need for “daily skilled care”, which is provided under the supervision of a physician and involves skilled nursing care and/or skilled therapy. For this setting, even a skilled therapy patient requires nursing 24-7 or they would be more appropriate in an outpatient therapy or home health setting.
- The skilled services must be related to a medical condition that was either
 - a hospital-related medical condition, or
 - a condition that started while the patient received skilled nursing services for a hospital-related medical condition.

The admissions criteria (policy) set by a swing bed program should conform with Medicare intent for the patient to be treated at this healthcare level.

VALUE OF SWING BED PROGRAMS FOR RURAL HOSPITALS

For most CAHs there are more benefits than detriments to a swing bed program, though it is important to always consider that for any program not in compliance with the regulations (state and federal) associated with a program receiving government reimbursement, the penalties can be steep. But consider what it can add:

- A program for short-stay programming helps community members get additional time for quality of life and safety without transferring to another facility.
- Swing Beds (skilled nursing) are one of the few places in the U.S. healthcare system where the time as an inpatient is based on medical necessity, not a predetermined regulatory requirement.
- An opportunity to build a community coalition for continuity of care for those living in your market area is enhanced not only by swing beds, but by the hospital taking the lead in the effort to champion the process.
- A swing bed program coordinates with your outpatient services, any rural health clinics, and your available physician services. A swing bed program may also help draw specialists (i.e., surgeons) if they know they have input in the care delivered to their patients.
- With or without decreasing acute census, swing bed censuses add an additional revenue source for the hospital.
- Swing beds can also help a CAH stay compliant with the average annual 96-hour length of stay restrictions by more timely change to skilled from acute, with ongoing care at the skilled level for those not ready to go home or go home independently or home to an elderly spouse.

The bottom line must be tempered by the community needs and the health benefits derived from a patient being able to return home from a tertiary hospital to heal closer to family, friends, and other support groups. What may come of this interim time period between hospital and home is improved quality of life and, most importantly, safety concerns being addressed.

If the patient has been in your hospital, it is easier to stay in the same bed, with the same staff than transfer to a skilled facility – at least for a short stay.

IMPORTANCE OF RAI MANUAL AND SWING BED MDS FOR CAHS

More than 95% of the skilled nursing settings in this country must complete the MDS assessment schedule to pass survey, to get reimbursement. While CAH swing bed programs are not required to complete the MDS assessment schedule, in fact the Resident Assessment Instrument Manual (RAI) is the only document that defines Medicare intent for skilled level of care. The RAI can provide the same definition and clarification to CAH swing bed programs without the necessity of completing all the required documents. Using both the RAI Manual and the Swing Bed MDS as training tools for a CAH swing bed program helps define admissions criteria, medical necessity documentation, and keeps with the CMS message of a holistic approach to health care in this setting.²

As examples of the value of this as a CAH training tool:

- “The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to patients with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans.”³
- “This interdisciplinary process also helps to support the spheres of influence on the patient’s experience of care, including workplace practices, the nursing home’s cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.”⁴
- “The MDS contains items that reflect the acuity level of the patient, including diagnoses, treatments, and an evaluation of the patient’s functional status.”⁵
- “This section includes items about functional abilities and goals. It includes items focused on prior function, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.”⁶

Detail is provided for assessing pain or determining a fever or shortness of breath – at least three items that routinely must be assessed in a skilled nursing setting. There are Federal definitions for all healthcare settings, and the RAI Manual provides the Federal verbiage for

² <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHS>

³ RAI Manual, version 17.1, October 2019, Chapter 1, 1.1.

⁴ RAI Manual, version 17.1, October 2019, Chapter 1, 1.1.

⁵ RAI Manual, version 17.1, October 2019, Chapter 1, 1.3

⁶ RAI Manual, version 17.1, October 2019, Chapter 3, Section GG

skilled nursing. And the document gets more detail with every change. As an example of new items for this version⁷:

- J2100 – Recent Surgery Requiring Active SNF Care
- O0425 – Updated rational for health-related Quality of Life
- I0020 – Examples of Primary Medical Conditions covering the skilled nursing stay

The size and breadth of the manual and associated Swing Bed MDS do not allow for an all-at-once review of the material. It is recommended that by first determining the primary patient admissions to a CAH swing bed, a training schedule can be set up for leadership and staff. By doing so, the use of MDS language and understanding Medicare coverage guidelines help staff write appropriate medical necessity documentation; assist in determining the function gain of a patient (now a key component in evaluating patient outcomes); and prepares the team for state and federal surveys, which are now occurring in swing bed programs.

MARKETING SWING BED PROGRAMS/DATA COLLECTION

Marketing is not sales nor public relations nor advertising. Marketing focuses on a way of business communication that sets a message to the desired market. What is best about your swing bed program? What does it offer? Who should use these services? In this case, the healthcare entity thinks about their service line in terms of customer needs and satisfaction. Often in health care it is a way to explain a service to the lay population. Marketing differs from sales, which is the technique of getting people to exchange value (usually cash) for a product. It is not necessarily concerned with value. Healthcare marketing involves people getting services they need, at a time when they need them most.

When marketing swing beds, the goal is to both explain the specific service(s) while anticipating patient needs. The value is understanding what the consumer wants in a service, but in the case of swing beds it goes beyond that because swing beds are not a commonly described healthcare service. The healthcare facility must also understand the specific market – and since many users of swing beds are elderly, what needs to be explained to that population. Even further work is done in establishing “target” markets – for instance, not just elderly, but elderly who have needs for wound care or post-surgery care.

In more recent years, a key component of any marketing plan has been data drive. It is necessary to market swing beds to ACOs, referring hospitals, primary care physicians, and specialists, as well as to the general public. Data is a way to “picture” the types of patients accepted into the service, the average length of stay, the primary diagnoses covered by a swing bed program, the cost per beneficiary episode, and any other information that describes

⁷ RAI Manual, version 17.1, October 2019, Chapter 3

what you are doing. Less specific but equally important is the information on program quality, patient satisfaction, and patient outcomes.

In small communities, one unique marketing approach is to begin by using employees as brand ambassadors – give them the details they need to explain the service. Using **Grocery Store Marketing™** allows all employees, in any department, to be knowledgeable enough to explain swing beds when they are in the grocery store or at church or a school function. It empowers employees by giving them basic information and contact referral information to pass on, through direct communication or social media, the purpose of swing beds. Another method that works well in small communities is telling patient stories. By putting them in a format (one page or email) where they can be passed on at health fairs or to physicians, success stories help patients, families, and physicians understand the program.

The key to a good marketing program is always based on statistical information. It is important in working with partner hospitals, physicians, and insurance companies that the swing bed program can be defined in graphs and data (i.e., cost, patient type). It is not unusual for programs to track 5-7 key demographic or financial statistics to be able to present. Showing the program through universal measures “markets” the swing bed program.

CHAPTER TWO: REGULATIONS AND GUIDELINES

FEDERAL REGULATIONS

Any CAH Swing Bed survey will be based on regulatory requirements, and then extended to quality of care provided and proper billing. Each program must meet basic regulatory components that are listed below.⁸ In addition to the specifics in Appendix W of the State Operations Manual (SOM), CAH programs must also reference Appendix A of SOM.⁹

Conditions of Participation for CAH Swing Beds:

The following was amended in November 29, 2019, as CMS outlined¹⁰:

- *We are removing the cross reference to § 483.10(f)(9) at § 482.58(b)(1) (for hospital swing bed providers) and § 485.645(d)(1) (for CAH swing bed providers); the repealed provisions gave a resident the right to choose to, or refuse to, perform services for the facility if they so choose.*
- *We are removing the cross-reference to § 483.24(c) at § 482.58(b)(4) (for hospital swing bed providers) and § 485.645(d)(4) (for CAH swing bed providers) requiring that the facility provide an ongoing activity program based on the resident's comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation.*
- *We are removing the cross-reference to § 483.70(p) at § 482.58(b)(5) (for hospital swing bed providers) and § 485.645(d)(5) (for CAH swing bed providers requiring facilities with more than 120 beds to employ a social worker on full-time basis).*
- *We are removing the cross-reference to § 483.55(a)(1) at § 482.58(b)(8) (for hospital swing bed providers) and § 485.645(d)(8) (for CAH swing bed providers) requiring that the facility assist residents in obtaining routine and 24-hour emergency dental care.*

CAHs must be substantially in compliance with the Conditions of Participation (CoPs) found at 42 CFR 485.645(d)(1-9):

- Residents' rights: (§ 483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), (e)(4), (f)(4)(ii), (f)(4)(iii), (f)(9), (g)(8), (g)(17), (g)(18) introductory text, (h) of this chapter)
- Admission, transfer, and discharge rights: (§ 483.5 definition of transfer & discharge, § 483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) of this chapter)

⁸ Appendix W https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

⁹ Appendix A of SOM either https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

¹⁰ Federal Register: Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, 09/30/19

- Freedom from abuse, neglect, and exploitation: (§ 483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter)
- Patient activities (with exceptions for director of services): (§ 483.24(c) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of § 483.24(c)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.
- Social services: Social services (§ 483.40(d) and § 483.70(p) of this chapter)
- Comprehensive assessment, comprehensive care plan, and discharge planning (with some exceptions): (§ 483.20(b), and § 483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under § 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b) of this chapter)
- Specialized rehabilitative services: (§ 483.65 of this chapter)
- Dental services: § 483.55 of this chapter)
- Nutrition: (§ 483.25(g)(1) and (g)(2) of this chapter)

Skilled Nursing and Survey

All CAH surveys are unannounced. CAH swing bed care is regulated by both the CAH requirements and the swing bed requirements at 42 CFR Part 485. The actual swing bed survey requirements are referenced in the Medicare Nursing Homes requirements at 42 CFR Part 483. Section 1883 of the Act authorizes payment under Medicare for post-hospital SNF services provided by any CAH that meets the requirements found in the swing bed CoP at 42 CFR 482.645. By regulation, the Secretary has specified these requirements at 42 CFR 485.645 as the following:

- The CAH has a Medicare provider agreement;
- The total number of beds that may be used at any time for furnishing swing bed services or acute inpatient services does not exceed 25 beds; and
- The CAH meets the swing bed CoP on Resident Rights; Admission, Transfer, and Discharge Rights; Freedom from Abuse, Neglect and Exploitation; Patients Activities; Social Services; Comprehensive Assessment, Comprehensive Care Plan, and Discharge Planning; Specialized Rehabilitative Services; Dental Services; and Nutrition. Use the interpretive guidelines from SOM Appendix PP to evaluate compliance with the individual referenced requirements from 42 CFR 483.

Additionally, it is expected that the following information will be readily available or posted (check with state guidance) for swing bed patients:

- Posting Last Survey
- Posting Staffing Schedule
- Grievances and Complaints information
- Posting Ombudsman Contact Information
- Posting Medicaid Information (if applicable)

Policies and Procedures

Clinical and financial policies and procedures must be in place for all services and systems and take into consideration all emergency situations. Appendix B has a list of suggest swing bed policies, but it is only a partial list due to policies that may be in place for the CAH.

Compliance and Ethics Program

CAHs have unique compliance components because they are not under the PPS system. While many components of the hospital compliance and ethics program may apply, CAHs with swing beds must consider the unique items specific to swing beds (i.e. SNF rules on admission and discharge). There is no specific compliance program guidance from the Office of Inspector General (OIG) for CAHs. Having said that, with more scrutiny from the OIG and through swing bed state surveys, programs should follow the compliance guidelines for skilled nursing.

As part of the Requirements of Participation (RoP) for Skilled Nursing, published October 2016, there must be a Compliance and Ethics Program. Starting November 28, 2019, CMS and state survey agencies will be authorized to issue survey deficiencies under federal Ftag F895 to facilities that do not have an effective Compliance Program. Skilled nursing directives are specific to these requirements:

- Written policies and procedures related to compliance and ethics
- High-level personnel involvement for oversight of the program
- Sufficient resources and authority
- An effective communication strategy that includes employees, volunteers, and contractors
- Effective monitoring and auditing procedures to detect potential and actual violations
- Methods for reporting potential or actual violations, including an anonymous method
- Evidence of consistent enforcement of Compliance and Ethics policy and procedures
- Evidence of proper action taken following a violation to prevent reoccurrence

Governing Board Requirements

The Governing Body of a Critical Access Hospital or individual responsible for the CAH, consistent with the requirement at §485.627(a) must review and approve patient care policies and procedures. It is expected this would include swing bed services.

The CMS regulations are as follows:

- 485.635(a)(2) – patient care policies are developed with the advice of members of the critical access hospital’s (CAH) professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).
- 485.635(a)(4) – patient care policies are reviewed at least annually by the group of professional personnel and reviewed as necessary by the CAH.
- The CAH’s written policies governing patient care services must be developed with the advice of members of the CAHs professional healthcare staff. This advisory group must include:
 - At least one MD or DO; and
 - One or more physician assistants, nurse practitioners, or clinical nurse specialists, at least one of these non-physician practitioners if these professionals are included in the CAH’s healthcare staff, as permitted at §485.631(a)(1).
 - A CAH with no non-physician practitioners on staff is not required to obtain the services of an outside non-physician practitioner to serve on the advisory group.
 - The advisory group not only makes recommendations for new CAH patient care policies but is also expected to review the existing patient care policies at least annually and, if it concludes that changes are needed, recommend those changes.
 - Policies must be reviewed and, as applicable, revised more frequently when required, for example, in response to a change in Federal or State regulations to which the CAH is subject.

Critical access hospitals must maintain documentation that provides evidence that the advisory group has conducted reviews and made recommendations regarding policies. Even as policies are updated by clinical and financial staff, the content of the written policies must be finalized by the CAH’s governing body or the individual responsible for the CAH, consistent with the requirement at §485.627(a). If recommendations of the advisory group are rejected, the governing body must include in the record of its adoption of the final written policies its rationale for adopting a different policy than that recommended.

State Licensing Regulations

In addition to federal regulatory guidelines, each state develops its own code and regulations for skilled nursing services. Much of it is based on the State Operations Manual (SOM) which addresses CAH swing beds (W) and survey (PP). Every state will have Administration Codes (dealing with physician services, medical records, etc.) and Statutes (licensing, regulatory enforcement, rules and standards, etc.). Those residing in Certificate of Need (CON) states will have additional considerations to address. It is best to check with the appropriate state office.

Standards of Care

Minimum standards of care for Critical Access Hospitals are both federal and state. The federal requirements are to meet the conditions of participation while states will have specific items for their state (i.e., facilities with ten or fewer beds, that are located in frontier areas having fewer than six persons per square mile, and who have one medical provider regularly available in the area may provide emergency services through a registered nurse if they have requested and been granted a waiver by the state survey agency for Medicare and Medicaid.¹¹)

Person-Centered Care

Person-centered care directed at all nursing home residents (and thus all skilled nursing level patients) addresses a long-standing CMS directive to achieve the highest level of physical, mental, and psychosocial well-being that is individually practical. In addition, the staff places a premium on active listening and observing, so staff can adapt to each resident's changing needs regardless of cognitive abilities. CMS has addressed changes through policies directed at targeting unnecessary hospital readmissions and infections, improving the quality of care, and strengthening safety measures for residents. In 2019, the final rule was directed at:

- Strengthening the rights of nursing home residents, including prohibiting the use of pre-dispute binding arbitration agreements.
- Ensuring that nursing home staff members are properly trained on caring for residents with dementia and in preventing elder abuse.
- Ensuring that nursing homes take into consideration the health of residents when making decisions on the kinds and levels of staffing a facility needs to properly take care of its residents.
- Ensuring that staff members of nursing homes have the right skill sets and competencies to provide person-centered care to residents. The care plans developed for residents will take into consideration their goals of care and preferences.
- Improving care planning, including discharge planning for all residents with involvement of the facility's interdisciplinary team and consideration of the caregiver's capacity,

¹¹ *State of Montana, Minimum Standards for Critical Access Hospitals*, <http://www.mtrules.org/gateway/RuleNo.asp?RN=37.106.704>

giving residents information they need for follow-up after discharge, and ensuring that instructions are transmitted to any receiving facilities or services.

- Allowing dietitians and therapy providers the authority to write orders in their areas of expertise when a physician delegates the responsibility and state licensing laws allow.
- Updating the nursing home's infection prevention and control program, including requiring an infection prevention and control officer and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

CAH swing beds should be addressing the above through new/adjusted policies, specific staff training, and programs to address infection control, improving care planning at a minimum.

Local and National Coverage Determinations

Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation.¹² Information has been addressed in the Federal Register (2013), through the Medicare Modernization Act, and in a 2002 review of both national and local coverage determinations.

Local coverage determinations (LCDs) are defined in Section 1869(f)(2)(B) of the Social Security Act (the Act). This section states: "For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A)." Currently these are up to the MAC (Medicare Administrative Contractor) in the jurisdiction related to the Critical Access Hospital. Someone within the organization must monitor both NCDs and LCDs for new releases.

LTC/Resident Rights

Somewhere along the line, CMS could have separated skilled care from long-term care and swing beds from both – it did not occur. When in doubt, swing bed providers must go back to long-term care (particularly for survey) and skilled nursing to determine Medicare intent for their programs. One of the most important of these regulations have to do with rights – remembering that long-term care demands strict adherence because it is the resident's "home". While swing beds are a short-stay option, the intent behind the laws require diligent review of how the mandates are met.

¹² Medicare Coverage Determination Process, <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html>

State and Federal laws require the swing bed program 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. The patient or representative must sign off agreeing that they both had the material explained to them and that they understood the contents. More recently CMS has taken this a step further with the baseline care plan rules that require that the patient/patient representative are consulted and confirm that the patient's goals have been included in the care plan. There is additional benefit to this process IF the swing bed program not only lists the requirements they must meet, but places responsibility on the patient for participation in their care (i.e., attending all scheduled therapy sessions). Finally, remember the swing bed program was built for Medicare beneficiaries – it is their right to receive the care within the boundaries of medical necessity (now including functional gain) and their participation in the process.

The patient must continue to meet Medicare criteria and swing bed staff must notify patients and/or their representatives what is appropriate care for this level, the expected discharge, and other information key to understanding services and length of stay expectations. The process begins at admission, when an explanation of the Medicare and Medicaid application process may be given to patients and/or representative. The information is not intended to be placed bedside, and although not a Federal requirement, it sets the tone for participation in a swing bed stay. Information should be specific to federal requirements and also informational (i.e., television stations available). Here are some of the areas to be covered:

1. Patient Rights and Notice of Rights and Services including abuse, neglect, and exploitation
2. How to handle grievances
3. Visiting hours, food trays for family, and other locally specific services
4. Advance Directives
5. Informed consent
6. Participation in the care planning process, including the expectation of patient goals being identified and met where possible
7. Privacy and Confidentiality
8. Admission, Transfer, and Discharge Rights
9. Patient Behavior and Facility Practices
10. Staff Treatment of Patients
11. Activities and calendar schedules
12. Dental Services

Examples of how some of the material may be handled (which should mirror a swing bed program's policy) might include:

- Patient Rights - 483.10 Patient Rights and 483.10(b) Notice of Rights and Services
 - Explanation of patient rights communicated to the patient/patient representative in an understandable manner, including access to an interpreter, if necessary (that is not only for language barriers, but cultural concerns, hearing/eyesight issues)
 - The State Operations Manual, Appendix W details patient rights which included 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
 - Right for the patient to say who or who may not attend the care plan meeting
 - Having and using personal possessions in the facility
 - The right of religious liberties
- Advance Directives - 483.10(b)(8)
 - A detailed, understandable, explanation of Advance Directives should be included in the Patient Information Packet.
 - If a patient does not have Advanced Directives, the facility's responsibilities to provide written instruction and oral explanation is required.
 - If a patient believes they have a written will or a durable power of attorney or a healthcare surrogate, efforts should be made to obtain copies prior to discharge.
 - 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 a client has advance directives.
- Informed Consent - 483.10(d)
 - One of the greatest protections for skilled patients is the requirement that the doctor or treating professional obtain the informed consent of the resident prior to initiating any new medication or treatment. "Informed consent" generally requires that:
 - The professional clearly explain the procedure or medication to the patient and take steps to ensure the resident understands the necessity for the treatment or medication

- The patient understands the potential side effects or risks
 - The patient has had an opportunity to obtain a second opinion or speak with a trusted loved one, if desired
 - The patient is afforded an opportunity to ask the professional questions
 - The patient's consent for the procedure or treatment is obtained
- Under this directive, a patient has the right to choose a physician, and facilities must work with the patient/patient representative to explain a swing-bed setting, hospital privileges, and perhaps the role of the hospitalist.
- Informed in Advance - 483.10(d) 2)
 - The patient must receive information necessary to make healthcare decisions in a timely manner.
 - This includes 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.
- Participating in Planning Care and Treatment - 3483.10(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.
 - Now the patient must also be involved in setting personal goals that are reflected in the baseline care plan and the therapy plan of care. The patient/patient representative must sign off on the baseline care plan prior to discharge – noting that it does reflect the goals of the patient.
- Privacy and Confidentiality - 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.
 - Confidentiality of personal and clinical records does not apply when the patient is transferred to another healthcare institution or records release is required by law.
 - HIPAA training should be in place for all employees.
- Admission, Transfer, and Discharge Rights
 - Patients and/or their representatives need to be notified in writing when an admission is not covered, or coverage is ending (see below for beneficiary and liability notices).
 - The State Operations Manual, Appendix W, 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
 - 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.
- 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
 - Sufficient preparation for the patient regarding the move, including safe transportation. The patient and/or representative need to be engaged in selecting the new placement facility.
- 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. Prior to drawing up the discharge summary, the patient and/or representative should be included in a post discharge plan of care.
- THE OMBUDSMAN MUST BE INVOLVED IN ALL INVOLUNTARY DISCHARGES such as patient is a harm to himself or others. The Ombudsman becomes the patient advocate in these situations.
- Abuse - 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.
 - All abuse must be reported to the Ombudsman and the State.
- Staff Treatment of Patients - 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.
- Training for all staff, and proof of that training, must be maintained.
- The swing bed program should follow the state mandated requirements for timely reporting of any incidents.
- Activities - 483.15(f) *(Note: Pending removal of all or some parts of this requirement with 9/28/2019 updates; elements of performance not yet released as of this printing)*
 - The facility must provide ongoing, multifaceted activities that are directed by a qualified professional.
 - A comprehensive assessment of each patient should be completed to determine what activity will meet their interests and well- being.
 - An individualized care plan should be in place.
 - A calendar must be provided to all patients and hung where it is easily visible to patients/patient representatives.
- Dental Services *(Note: Pending removal of all or some parts of this requirement with 9/28/2019 updates; elements of performance not yet released as of this printing)*
 - 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.

Beneficiary/Liability Notices

The importance of these notices has increased significantly in recent years, because of a November 2017 mandate for a new survey process review to make sure facilities were in compliance, and then a May 2018 directive brought about because of the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN).

Beneficiary notices have been developed by CMS through different regulations. Some notices only apply to traditional Medicare Part A beneficiaries while the other notices apply to both traditional Medicare Part A beneficiaries and Medicare Advantage enrollees. They are designed to:

- Inform the beneficiary of potential liability for items or services that will not be covered by Medicare.
- Inform the beneficiary when the provider or health plan determines that the beneficiary no longer meets skilled criteria.

The SNFABN is to be issued, to traditional Medicare Part A beneficiaries (not to Medicare Advantage enrollees), when the CAH believes that Medicare will not pay or will no longer continue to pay for a skilled stay, when it is determined that a beneficiary does not require daily skilled nursing or rehabilitation services. The requirement to meet a skilled level of care is no longer applicable.

It is not required to be issued when the reason for non-coverage is related to the beneficiary not meeting the “technical” criteria for skilled coverage i.e., no 3-day qualifying hospital stay, no benefits available, not admitted within 30 days of hospital discharge).

An SNFABN can be issued at admission when the patient meets the technical criteria (i.e., the qualifying 3-day hospital stay) but does not meet the standard for inpatient (swing bed) nursing or skilled rehabilitation daily.

The more common usage of an SNFABN occurs when it is determined that Medicare Part A services will end. Issuing the SNFABN at this time is to notify the beneficiary of their potential financial liability for any items or care received once the Medicare stay ends.

The second requirement is for a NOMNC (Notice of Medicare Non-Coverage) or CMS 10123 to be provided to a beneficiary when it is determined that the beneficiary no longer meets skilled coverage, and Medicare A services will terminate. The NOMNC is provided to both Medicare A beneficiaries and Medicare Advantage plan enrollees.

It is required to be issued at least two days prior to the last day of skilled coverage. It is not required to be given to the beneficiary if the ending of skilled coverage is due to exhaustion of available benefits.

Because both requirements came from different regulations, there are times when both the NOMNC and SNFABN would be provided to the beneficiary. One example would be when Part A coverage is ending because the beneficiary will no longer be covered under Part A and the SNFABN is issued to notify the patient of potential financial liability if they continue to stay in the skilled setting after Medicare coverage ends.

It is recommended that an SNFABN be provided along with the NOMNC should a beneficiary decided to appeal the ending of his/her Medicare benefits. The beneficiary has the right to contact the QIO (different in each jurisdiction) saying they disagree with the decision to end their Part A coverage. In this case, a DENC (Detailed Explanation of Non-Coverage) or CMS 10124 is used to explain the specific reasons for ending the covered service(s). According to CMS, a Medicare provider or health plan (Medicare Advantage) must provide a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the

termination of services in these settings. The DENC must be provided no later than close of business of the day of the QIO's notification. The importance of the SNFABN is that while the QIO reviews, there is the potential for services that would be provider (skilled nursing) liability, while with the SNFABN, the patient is liable for any expenses should the QIO agree with the skilled nursing findings.

The admissions criteria (policy) set by a swing bed program should conform with Medicare intent for the patient to be treated at this healthcare level.

CHAPTER THREE: COVERAGE FOR CAH SWING BEDS

MEDICARE A, MEDICARE ADVANTAGE, AND INSURANCE

Most Americans qualify for Medicare at age 65 (permanently disabled and ESRD being examples of exceptions) and can sign up for Medicare A and B. An individual can elect to opt out also. For skilled nursing currently, there is a required three midnight census stay required. Medicare A does cover the first 20 days of a skilled stay before the Medicare A co-pay kicks in on day 21. The complete list included these elements in 2019:

1. The patient must 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.
6. The patient's condition meets criteria to necessitate daily inpatient skilled nursing rehabilitation or combination of these services.

Medicare Advantage plans are run by private insurance companies, but the plans are regulated by the Federal government. These plans are mandated to offer comparable coverage, but most plans include additional services such as prescription drug coverage (available as an add-on under Medicare D) or fitness plans/services or vision/dental. There is no commonality, even between advantage plans, on the need for a three-midnight hospital stay. And all plans differ on the co-pay arrangement, sometimes requiring patients to pay the co-pay from day one.

There are different types of Advantage plans, some of which include:

- HMOs – Health Maintenance Organizations most often will have the lowest premiums and out-of-pocket expenses, but cost is controlled by requiring all plan participants to get health care (other than emergency room) from providers within network. If a patient elects to go outside of network there can be a hefty penalty or no insurance payment to cover that service.
- Special Needs Plans (SNPs) – limit enrollment to people with certain conditions, or who live in a nursing facility, or are eligible for both Medicare and Medicaid.
- Preferred Provider Organizations – PPOs allow a patient to select any provider who accepts the plan, but the cost to the patient is lower if they chose an in-network provider.
- Private Fee-for-Service plans – PFFS allow a patient to get health care from any provider who will accept the PFFS plan; however, even if they participate in Medicare there is no guarantee the provider will participate in this program.

Because younger than 65 are increasingly having joint replacement, chronic conditions, and other surgeries, insurance plans can also agree to cover skilled nursing services, including swing beds. But facilities can never assume the patient plan does cover skilled nursing. Most insurance plans are built on a RUGs model (until the October 2019 change to PDPM) or a tiered level of services (usually no more than four tiers) based off of the RUG classifications.

Depending on the plan, long term care insurance can cover skilled nursing, nursing home as well as some plans have options for adult day care, respite care, assisted living, dementia care, and hospice services.

BENEFICIARY RIGHTS

Federal law and state laws require the swing-bed program to provide specific information to the patient and/or representative at the time of admission. Most SNFs and SWBs put together a packet that includes the required information as well as material specific to the program. The packet must be reviewed with the patient, allowing them time to ask questions prior to the patient or patient representative signing off on the packet and often individual sections of the material. The signature(s) indicates the patient was given the material, reviewed it, and understood the contents.

It is important for patients and/or their representatives to understand that the patient must participate in his/her treatment program and demonstrate progress 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.

It is important for patients and/or their representatives to understand that the patient must participate in treatment required for a swing-bed stay. The patient must continue to show progress, or the care cannot continue indefinitely. The skilled setting is not one where patients necessarily make it back to total independence. It is a short stay which may require additional time in home health and/or outpatient services. The SWB program must explain this to the patient, and the patient must continue to meet Medicare criteria. It is a beneficiary's right to get the care needed to return to the highest practical level of care to maintain safety and improve quality of life.

Often this requires education of physicians on appropriate admissions, expected length of stay under a Medicare Part A program, and his/her involvement in determining the expected discharge disposition. Family and patient expectations must also be realistic. This can be achieved through community education as well as one-on-one with the patient before or at the time of acceptance into the swing-bed setting.

While there is no specific Federal package of information, both Federal and State regulations may dictate much of the information to be provided once the patient has been admitted. Basics include:

1. Patient Rights and Notice of Rights and Services
2. Advance Directives
3. Consent to treat
4. Consent to bill
5. Care planning and person-centered care
6. Privacy and Confidentiality
7. Grievance policies and contact personnel
8. Admission, Transfer, and Discharge Rights
9. Expectations of Patient participation and behavior
10. Freedom from abuse, neglect and exploitation
11. Agree to be photographed as per hospital policy
12. List of services including therapy, dental care, etc.
13. Staffing and Ombudsman information
14. Activities and Activities Calendar
15. Facility-specific information – social services contact, things such as television stations, menus, other services, etc.
16. SWB programs must also provide to patients a Privacy Act Statement (regarding health care records), specifically to let them know the MDS data is being transmitted and submitted to CMS.¹³

Key elements of a patient's satisfaction and appropriate outcomes starts with basics.

1. Staff training on the rights of the patient as well as competency-based training for any needs a patient might have.
2. Explanation of patient rights and options if they feel their rights are not being met. Appendix W (SOM) provides examples of patient rights that can be used in staff training but also could be used in the information packet, so a patient understands his/her own responsibility in the process as well as that of the staff.
3. Basic rights include: the right to choose who can be in their care plan meetings (including family members); communication privacy (phone and iPad), particularly in a world where everyone has one; making sure a patient's picture is not taken, let alone used, without prior permission; the right to send/receive mail without its being opened; and patient voting rights. Visitation hours should be listed and explained to patients and family. Please make sure your staff – and ultimately the patient – has these rights and and more explained clearly.

¹³ RAI Manual, Chapter 1, Page 1-16 thru 1-18

Along with patient rights, it is important that federally mandated information is explained and gathered. That includes advanced directives – living will, power of attorney, and any information on a healthcare surrogate – which must be signed off and the appropriate copies of documents gathered. The patient has a right to choose his/her own physician, so explaining if a physician does not have hospital privileges or the facility uses hospitalists must be explained in the admission packet.

Additionally, there are consents, which are expanded to the right of the patient to know about his/her medical condition(s), risk involved with any treatment or surgery, and financial costs that may be out of pocket. In today's world of person-centered care, the SWB program must find ways to be concise while clearly explaining the material. This includes the use of interpreters, including for those who do not hear well or see clearly.

Patients also have the right to understand transfer and discharge rights. They must be notified in writing when an admission isn't covered, and again given the right to appeal to the QIO if the patient believes they still meet Medicare criteria prior to discharge (see Chapter 2, Beneficiary and Liability Notices). Appendix W, SOM, defines transfer and discharge as any movement to a bed outside the certified bed, whether it is in the same physical plant or elsewhere. There are times when a patient must be transferred, and this should be done with notification to the Ombudsman, who acts as the patient advocate. This would include things such as the patient is a harm to others or himself; or if the care in the swing bed can no longer cover all of a patient's needs

If a transfer is due to a significant change in condition, a physical assessment must have been completed, with the care plan updated to make the decision on keeping or sending the patient elsewhere. An immediate transfer is initiated in an emergency.

Other than an emergent situation, there must be sufficient effort made to prepare the patient for the move, including his/her understanding of the situation, need for transportation, notification of the physician, etc. Documentation must support that an anticipated discharge was discussed with the patient and patient representative. A discharge summary must clearly define the reason for the discharge, how the new setting (medical or otherwise) will support the patient, and that any continuing care needs have been addressed. It is imperative that documentation of patient/patient representative involvement in the discharge be documented.

Staff treatment of patients has been scrutinized and regulated specifically through CFR § 483.95 training requirements and in § 483.13 regarding patient rights. These rights cover misappropriation of private property to abuse and neglect. Training requirements must be clearly documented that swing bed beneficiary rights have been discussed with the patient.

Training must be made available for new hires, and routinely for employees, volunteers, and others coming into contact with patients. As an example, the skilled requirements for Trauma Informed Care include requiring providers to assess patients for past trauma, and to develop a care plan inclusive of specific needs. Additionally, the regulation mandates staff competency in recognizing and caring for trauma survivors.¹⁴ Exploitation (taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion¹⁵) itself, including procedures for reporting incidents, and now more specifically how skilled nursing will deal with dementia patients, must be discussed and a plan put in place. Any investigation and the results must be reported in accordance with State law, including the State survey agency, within five workdays of the incident.

ELIGIBILITY AND TIMEFRAMES

There are several sources available for clinical eligibility at a skilled level, beginning with the RAI Manual definitions, and then more specifically with Milliman Care guidelines or InterQual level of care guidelines, which are based on “evidence-based” care. In October 2019, the introduction of PDPM to the PPS skilled definition raised the level of accuracy of ICD-10 coding. The above-mentioned sources should assist a swing bed program in defining medical necessity documentation for all admissions and aid in setting up a self-audit process. For skilled care, the requirement of an Interdisciplinary Team (IDT) increases the need for plan-of-care coordination across disciplines, leading to an appropriate length of stay, discharge plan, and documentation that defines medical necessity documentation.

Medicare Skilled Nursing (including Swing Beds) benefit covers 100 days of skilled nursing care per benefit period. A benefit period is defined as consecutive dates during which covered services are furnished to the patient. For Medicare Skilled Nursing Care, the benefit period starts the day the Medicare beneficiary receives covered skilled inpatient or extended care services by a qualified skilled nursing provider.

The benefit period (100 days) ends when:

- a 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 long-term care but did not receive skilled care for 60 consecutive days.

¹⁴ §483.25(m) Trauma-informed care and §483.21(b)(iii) (3) Comprehensive Care Plans

¹⁵ CFR Title 42, Chapter IV, Subchapter G, Part 483, Subpart B, Section 483.95(c)

For skilled nursing services there is no “lifetime” benefits or no limit to the number of benefit periods available to a beneficiary. The beneficiary, as state above, must have 60 days with no skilled services to regain a new 100-day benefit period, and the beneficiary must pay the deductible and co-pays required (CMS website lists the General Eligibility requirements.) To enter skilled services, after the 60-day break, a new three-day qualifying period must occur. (Beginning in 2019 this requirement could be adjusted, but it will be fully detailed by CMS.)

More importantly, for a swing bed program (any skilled nursing program), it is critical in accepting an admission that available Medicare days be checked. That in of itself does not guarantee Medicare reimbursement, so it is also recommended that a swing bed program consider a policy for patients who have had recent repeated Medicare skilled nursing stays that requires verbal confirmation from the patient/patient representative regarding the use of skilled nursing (days or facilities) in the last 100 calendar days. That allows a secondary confirmation to be secured regarding coverage days available for a swing bed stay.

Looking at a single SNF/SWB admission prior to the expected current admission, the covered days will be dependent on days used and how long a lapse in care has occurred.

Less than 30 days	<ul style="list-style-type: none"> • Medicare will cover additional skilled care (up to the days available in a 100-day period), and no new 3-day hospital stay is required to qualify IF it is related to the original qualifying hospital stay. • Since the break in SNF care lasted for less than 60 days in a row, the maximum coverage available would be the number of unused SNF benefit days remaining in the current period (SWB stay of 25 days within the last 30 days means the patient has 75 days left under the current 100 day benefit).
30 days but less than 60 days	<ul style="list-style-type: none"> • Medicare requires a new 3-day qualifying hospital stay, which may or may not be related to a recent acute stay. • The current 100-day benefit period continues since this admission would be within 60 days of the beginning of the benefit period. The maximum coverage (days available) would be subtracting any days (in one or more skilled stays) since the benefit period began.
60 days but less than 100 days	<ul style="list-style-type: none"> • Medicare requires a new 3-day qualifying hospital stay, which may or may not be related to a recent acute stay. • The current 100-day benefit period continues since this admission would be within 100 days of the beginning of the benefit period. The maximum coverage (days available) would be subtracting any days (in one or more skilled stays) since the benefit period began.
100 days	<ul style="list-style-type: none"> • There must be at least 60 days with no skilled services to regain a new 100-day benefit period.

In 2019, a beneficiary under Medicare A must have had a three-day (three midnights) qualifying acute inpatient admission prior to an SNF/SWB admission. This requirement is met even if the beneficiary has been in more than one hospital, as long as the combined hospital stays total 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. A qualifying stay can also occur in a psychiatric hospital, but it is less likely that this patient will meet Medicare A admission criteria for a “skilled” benefit. 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.

Chapter 8 also states, “Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as a person who appears at a hospital’s emergency room seeking examination or treatment or is placed on observation has not been admitted to the hospital as an inpatient; instead, the person receives outpatient services. For purposes of the SNF benefit’s qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission. See 31 Fed. Reg. 10116, 10118-19 (July 27, 1966).”

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. SNF/SWB coverage must be related to the condition for which the beneficiary received qualifying acute care services.

Other services and considerations include:

- As a practical matter, the daily skilled services can only be provided on an inpatient basis in an SNF/SWB. Consideration must be given to the patient’s condition and to the availability and feasibility of using more economical alternative facilities and services.
- Hospice is covered in an SNF only if the SNF has a contract with a Medicare-certified hospital. The hospice benefit may not pay for room and board, unless you have skilled care needs not related to the terminal illness, at which time the patient Medicare A could pay for those needs. (Medicare Advantage may have in-network providers.)
- 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. Medicare does not reimburse the CAH for the hospice or respite services. The CAH must negotiate such payments with hospice through a

contractual agreement.^{16 17}

- Maintenance care may not be easily defined in an SWB setting.
 - In 2014 the Medicare Benefit Policy Manual was revised as part of the Settlement Agreement in the Jimmo v. Sebelius case, which required a Medicare clarification that an “improvement standard” did not exist and that coverage was not based on the patient’s ability to make progress. As part of the clarification, Transmittal 179 was issued on January 14, 2014 containing all of the revisions and clarifications in the Medicare Benefit Policy Manual, including those for skilled nursing patients under Medicare Part A and Part B.
 - For skilled care, this did little more than reiterate the previously defined Medicare statement that “To be considered skilled, therapy services must....be provided with the expectation, based on restoration potential, that the condition will improve materially in a reasonable and predictable period of time; OR the services must be necessary for the establishment of a safe and effective maintenance program; OR the services must require the skills of a therapist to perform the maintenance program.”¹⁸

If a CAH swing bed admits these patients, there should be specific policy regarding the relationship with the Medicare-contracted services and/or the types of patients that the facility is willing to accept.

¹⁶ Medicare Benefit Policy Manual, Chapter 9, Sections 40.2.2 and 40.1. at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>

¹⁷ 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

¹⁸ Medicare Benefit Policy, Section 30.4.1.1, Transmittal 73, June 29, 2007

CHAPTER FOUR: SWING BED ADMISSIONS

THE SWING BED PATIENT

A swing bed patient can come to the rural hospital from one of two sources: (1) he/she can be a patient of that hospital, who underwent an uncomplicated hospital stay and needs extra time for healing; or (2) a patient from the rural hospital's market area returning from tertiary care, needing the next level of rehab or wound care, as an example.

Care in an SNF/SWB is covered if all the following four factors are met¹⁹:

1. 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); the services are ordered by a physician and are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in an SNF for a condition for which he received inpatient hospital services;
2. The patient requires these skilled services on a daily basis (see §30.6); and
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. (See §30.7.)
4. 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 are not met, a stay in an SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for an SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

The swing bed is a post-acute level of care – skilled nursing – under the same care regulations as skilled nursing facilities (SNFs). The care focuses on the immediate needs of a patient beyond the hospitalization, and the fact that as a “practical matter” the patient is unable to go home because of the complexity of needs beyond what can be offered through home health or outpatient services.

At a minimum, the patient requires 24/7 nursing care. CAH swing bed patients can be more medically complex patients needing IV therapy, nursing care recovering from surgery or a surgical wound. Nursing Services can include teaching and observation post the hospital stay.

¹⁹ Medicare Benefit Policy Manual, Chapter 8, 30 - Skilled Nursing Facility Level of Care - General (Rev. 1, 10-01-03) A3-3132, SNF-214

Specific services depend on the CAH's SWB admissions policy, but tracheostomy patients or patients requiring CPAP or BiPAP services, those needing decubitus care or IV feeding or catheter teaching or care can get the assistance they need at this level.

Patients almost always need some skilled rehab, and most CAH swing bed programs offer Physical Therapy, Occupational Therapy, and add Speech Language Pathology to the department services. In addition to post orthopedic surgery or those needing to regain safe function before returning home, therapy services also assist with quality of life activities such as being able to feed themselves or bath themselves.

Respiratory therapy, Dietary services and the availability of other ancillary services provide patients with the safety net of hospital services as they get ready to return to the home setting.

POLICY AND PROCEDURES FOR ADMISSIONS

CAH swing bed care is regulated by both the CAH requirements and the swing bed requirements at 42 CFR Part 485. The actual swing bed survey requirements are referenced in the Medicare Nursing Homes requirements at 42 CFR Part 483. Section 18883 of the Act authorizes payment under Medicare for post-hospital skilled services provided by any CAH that meets certain requirements.

Part of the requirements for any healthcare entity is a full and up-to-date set of policy and procedures. *(see Appendix B for a list of recommended policies)*

Swing bed admissions require the same criteria be met as those going into a skilled facility. The one variance is a swing bed program is better placed to accept more medically complex patients that area skilled facilities may not admit (i.e., new trach patients, BiPAP and CPAP). All policies and procedures must address the swing bed Conditions of Participation (CoP):

- Patient rights
- Admission, Transfer and Discharge Rights
- Freedom from abuse, neglect, and exploitation
- Patient Activities
- Social Services
- Comprehensive assessment, comprehensive care plan, and discharge planning
- Specialized Rehabilitation Services
- Dental Service
- Nutrition

Key requirements at admission that must be completed timely include, but are not limited to:

- **PHYSICIAN CERTIFICATION** – Upon acceptance to the Medicare Part A Swing Bed Program, the attending physician will complete the required Medicare Part A Physician Certification form. This form **MUST** be completed prior or as soon as possible to SWB admission but not later than the next physician visit to the patient. 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 14th day of inpatient extended care services. Subsequent recertifications must be made at intervals not exceeding 30 days. Non-compliance is a technical denial, which means there is no appeal process if any of the required information is missing. ALL claims related to the stay will be denied payment.
- **ADMISSION ORDERS** – Upon acceptance and at the time of admission into the Medicare Part A Swing Bed Program, the attending physician and the admitting nurse will compile all clinical information and legal documents (i.e., advance directives) for the patient's admission orders. These SWB Admission Orders must be signed and dated by the admitting nurse once completed on the day of admission, and by the attending physician as soon as possible as per facility policy and procedure.
- **COMPREHENSIVE ASSESSMENT** – The assessment, which is designed to be an interdisciplinary approach to care, must be completed by regulation within 14 calendar days of admission.²⁰ However, because of the shorter length of stay, most swing-bed policies require it to be completed within 24 to 48 hours. The intent of Medicare is that patients be assessed timely, and all individual assessments are reviewed by the team for consistency and appropriateness. This assessment must include:
 - Activity Pursuit
 - Cognitive Patterns

²⁰Medicare 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/som107_Appendicestoc.pdf

- Evaluation of the patient's ability to make decisions, including healthcare 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 healthcare 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 patient assessment protocols
- Identification and Demographic Information (would be on patient face sheet)
- Medications

- 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 healthcare 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
- **ADMISSION NURSE ASSESSMENT** – Each SWB admission will be assessed by a registered nurse upon arrival or soon thereafter using the SWB Admission Nursing Assessment, with tools such as a Braden Scale or fall risk tool. The admission nursing assessment triggers opportunities for discipline specific referrals and are expected to be made by the admitting nurse as part of the SWB admission process. There should be an initial scoring of the patient's ability to complete Activities of Daily Living and Functional Gain.²¹ These scores can be tracked by nursing and therapy, but nursing tracking 24-hours a day is critical to defining patient needs and potential length of stay. Documentation for problem condition items regarding fever, vomiting, symptoms of dehydration and internal bleeding will be addressed in a variety of locations including physician notification, physician orders, physician notes, nurse notes, medication and treatment records, skilled status flowsheets, and lab reports. Additional historic information regarding these conditions may also be found in other documentation that

²¹ Sections G and GG of the MDS

is part of the SWB medical record. The admission nursing assessment assists in identifying skilled status needs of the patient. Once the admission assessment is complete, it is to be signed/date/timed by the assessing registered nurse and placed in the medical record.

- **ATTENDING PHYSICIAN** – Attending physicians will document patient examinations using the H&P with updates in the physician’s progress notes. Medicare Part A requires physician documentation in order to accurately bill the SWB stay regarding physician exams, among other reasons. A physician examination can include exams provided by medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law and facility policy.
- **THERAPY PLAN OF CARE** – Under the October 2019 changes to PDPM, more timely completion of all discipline plans of care should be monitored. This is particularly important with the functional gain status requirements at admission and discharge. This should never be done at the convenience of a therapy service. Late week admission is common to skilled nursing settings, and for a patient not to have an eval and plan of care completed, and if no care is to be done for 2 or more days, the admission should be reconsidered.
- **ACTIVE DIAGNOSES** – This list is intended to code diseases that have a direct relationship to the patient’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of any assessment is to generate an updated, accurate picture of the patient’s current health status. Methods used to assist in compiling the active diagnoses list will include review of the medications ordered by the physician (each of which must have diagnoses for use under Medicare Part A regulatory guidelines); history and physical reports; the discharge summary; recent radiology or other such testing, each with a diagnosis; and recent lab reports.. This list should contain diagnoses related to the skilled nursing and therapy status needs related to SWB program placement.
- **MEDICATION RECONCILIATION** – A swing bed stay represents an opportunity to have the time for a review of all medications (types, dosages, etc.). It is recommended at admission that a pharmacist review all meds to make recommendations to the attending physician for changes in dosage, types of medications, and reduction in medications. While not directly related, swing bed stays also require vaccines to be given or documentation to show why they have not been. In addition to flu and pneumonia, TB is required. Getting referrals from other hospitals should trigger a review to make sure a two-step process was completed, if required.

Hospital policies may not cover all the concerns and processes and outcomes mandated for the swing bed. That should lead to a review of all policies on a routine basis (at least annually), particularly as CMS regulations change. As an example, the wording for exploitation was added to skilled nursing and is meant to protect patients during the length of their stay.

The other source of policy coverage comes from the State Operations Manual, Appendix W. This section details surveyor guidance, including “If swing bed patients are present during the on-site inspection, conduct an open record review and an environmental assessment. Include patient interviews and observations of care and services. However, if no swing bed patients are present during the on-site inspection, review at a minimum two closed records for compliance with swing bed requirements. Additionally, review policies, procedures, and contracted services to assure that the CAH has the capability to provide the services needed.”²²

As a suggestion for an active policy combined with a process, an admissions checklist can be developed. It serves as a reminder for those who may be called to do an admission (i.e., after hours) but also as a potential audit. As an example (which needs to be modified to the specific swing bed program to reflect admissions policy, state regulations, etc.):

²² *State Operations Manual, Appendix W (Rev. 183, 10/12/18), CAH Swing Bed Module*

ADMISSIONS CHECKLIST²³

CAH Swing Bed

- _____ 1. *Begin discharge planning*
- _____ 2. *Pre-admission completed (costing of patient, skill level, RUG, ADL score)*
- _____ 3. *MC/Insurance card copies*
- _____ 4. *Eligibility determination completed (including 3 midnight acute stay)*
- _____ 5. *Level of care determination (Medicare coverage decision)*
- _____ 6. *Practical matter documentation (Social services admission notes)*
- _____ 7. *Patient Consent to Bill*
- _____ 8. *Patient Consent to Treat*
- _____ 9. *Physician certification of medical necessity/re-certification when appropriate*
- _____ 10. *Medical predictability, if needed*
- _____ 11. *Privacy Act notification*
- _____ 12. *Letter to inform patient of coverage/non-coverage items, services and charges*
- _____ 13. *If no therapy orders, screen for rehab*
- _____ 14. *Physician order to admit to Medicare*
- _____ 15. *Admissions face sheet*
- _____ 16. *ICD-10 sequenced cumulative list*
- _____ 17. *Determine number of benefit days*
- _____ 18. *Determine if in skilled facility/hospital in the last 60 days*
- _____ 19. *Hospital stay dates*
- _____ 20. *H&P (new or last 30 days signed/dated by physician AND hx discharge summary)*
- _____ 21. *Baseline care plan completed within 48 hours with patient signature*
- _____ 22. *Physician orders, including appropriate therapy orders if needed*
- _____ 23. *DNR/ Advanced Directives, etc.*
- _____ 24. *Nursing assessment initial completed within 8 hours*
- _____ 25. *Work on reducing Medication - number and cost*
- _____ 26. *Patient Information*
- _____ 27. *Patient Rights*
 - _____ *Abuse and Exploitation Policy*
 - _____ *Discrimination Policy*
 - _____ *Grievance Policy*
 - _____ *Bill of Rights*
 - _____ *Care Team*
 - _____ *Facility Policies*

²³ Kerry Dunning LLC

PRE-ADMISSION SCREENING PROCESS

When the nursing home industry was changing to a new system (RUGs, 1998), a significant change was made in determining what type of patients to admit to a skilled bed. Many SNFs established policies of going to area hospitals to see patients before they would admit them to their skilled program.

With the 2019 change to PDPM, the most major change to occur in skilled nursing since 1998, many facilities were again determining best options for accepting patients that met criteria and were short-term candidates with good opportunity for functional gain.

While CAH SWBs have more leeway financially in taking patients with medically complex issues, the swing bed admission and consequent stay must meet medical necessity guidelines. Admitting from the same CAH information is more readily available. The decision to get additional information of a potential admission from a referring hospital raises other issues. Tools that can be used to create or update a pre-admission checklist include the SNF Transfer Checklist from the Quality Improvement Organization.²⁴

To get the preferred swing bed patients, the hospital must provide referring hospitals with the SWB admissions criteria and/or a more detailed capabilities list. The list can include CAH SWB information such ability to accept bariatric patients, respiratory therapy (CPAP, BiPAP, Nebulizers), ostomies, a new tracheostomy, tube feeders, or wound vac. These are patients that may not be as easily accepted by area nursing homes – though an SWB should work with the community to coordinate services.

Increasingly, the need to know all medications (reconciled med list), having informed consents for psychotropic drugs, IV antibiotic therapy, and documentation of culture and antimicrobial susceptibility test results will also help an SWB program in accepting patients.

Begin with information about your program in a standardized format to be able to communicate with all referring hospitals.

TRANSFERS FROM OTHER ACUTE CARE FACILITIES

Once the determination has been made to accept patients, it is necessary to assure the patient is stable and the CAH SWB can meet the needs of the patient. Remember, this is two-way communication, with the SWB staff able to determine if they can meet needs and the hospital providing the necessary information. It is not always a nurse-to-nurse communication, yet determination of the level of care (that the patient is post-acute) is important.

²⁴ <https://www.hsag.com/globalassets/care-coordination/rrppsnttransferchecklist508.pdf>

Basics in accepting a patient from a referring hospital again means a checklist would be beneficial in making sure it is an appropriate admission and assist staff in gathering all necessary information. Some of the basics include:

- Verifying the payor source and that pre-certification has been arranged for insurance patients
- Alert an attending provider and secure his/her willingness to accept the admission
- A method to ensure the facility can meet the staffing needs for each patient accepted and the total number of patients in swing beds
- Having arrangements for meeting medications needed at admission
- Working with nursing, therapy and other ancillary services on potential assessments that must be done timely
- Have a plan for SWB staff knowing admissions criteria, and other needs that must be addressed prior to admission
- Ensure that the facility can meet any special equipment needs (specialized beds, wound vacs, bariatric wheelchairs)
- Both a financial and clinical representative will be available at the arrival of the swing bed patient to make sure the patient understands expectations of being in a skilled setting

CHAPTER FIVE: DOCUMENTATION BASICS

SWING BED DOCUMENTATION REQUIREMENTS

In February 2002, CMS analyzed the significance of the full Minimum Data Set (MDS) reporting requirement for Critical Access Hospitals 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.

However, the best training tool for swing bed staff is using the Swing Bed MDS (an updated copy is always located in CMS MDS assessments). Along with the Resident Assessment Instrument (RAI) Manual, Swing Bed programs should follow requirements for skilled-nursing facilities when setting up basic documentation requirements for the program.

There are some basics for all swing bed programs, including:

- There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to skilled-care or swing bed status regardless of whether the patient stays in the same facility or transfers to another.
- If the patient does not change facilities, the same chart can be utilized but the swing bed section of the chart must be separate with appropriate admissions orders, progress notes, and supporting documentation.
- There is no length of stay restriction for any CAH swing bed patient.

At a minimum, SNF/Swing Bed documentation is expected to reflect the need for the care provided.²⁵ When considering requests for documentation from a fiscal intermediary, Noridian Healthcare Solutions lists the following to be sent:

- Legible handwritten physician and/or clinician signatures
 - Signature logs and Signature Attestation Statement [PDF] should be submitted when physician and/or clinician signatures are illegible.
- Valid electronic physician and/or clinician signatures
 - If an electronic health record is used, the Electronic Order Signature Process Form [PDF] should be submitted to verify the provider's Electronic Ordering System is secure.
- Physician or Non-Physician Practitioner (NPP) order for date of service

²⁵ Noridian Healthcare Solutions, *Jurisdiction E – Medicare Part A*;
<https://med.noridianmedicare.com/web/jea/topics/documentation-requirements/skilled-nursing-facility-snf>

- Signed and dated physician certification (and recertification, if applicable) for skilled level of care
 - If not signed and dated timely, letter of delay that is signed and dated by physician must be submitted.
- Records of patient's condition before, during, and after this billing period to support medical necessity and reason the service was provided
 - Hospital discharge summary and transfer form
 - Emergency room record
 - Hospital history and physical
 - Nurses and nurse aid notes
 - Physician progress notes
 - Operative reports
 - Treatment records
 - Care plan
 - Consultation reports
 - Medication administration record (MAR)
- Records supporting skilled level of care
 - History and physical exam pertinent to patient's care, including response of changes in behavior to previously administered skilled services
 - Skilled services provided
 - Patient's response to the skilled services provided during current visit
 - Plan for future care based on rationale of prior results
 - Complexity of service to be performed
- Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST/SLP), Respiratory Therapy records, if applicable
 - Initial evaluation
 - Plan of care
 - Progress reports
 - Treatment encounter notes
 - Discharge summary
 - Therapy minute logs
- Documentation for look back period for each Minimum Data Set (MDS) billed, if applicable
 - May be prior to billing period
- Quality Improvement Organization (QIO) letter, if applicable
- Itemization of services
- Advance Beneficiary Notice of Noncoverage (ABN), if applicable

MSP AND PHYSICIAN CERTIFICATION

In addition to the above, there are two additional audits that routinely occur with the fiscal intermediaries wanting to make sure the information has been collected and accurately recorded:

1. Medicare Secondary Payer Questionnaire (MSP): It has been designed to determine if Medicare has primary payment responsibility. The MSP was designed to protect Medicare Trust Funds by determining if other insurance should be primary (i.e., auto insurance in case of a car accident). The questionnaire covers Working Aged (Medicare beneficiaries still employed), disability, end stage renal disease, and worker's compensation. The MSP is typically done in registration for the emergency department or admission to the hospital but **MUST** be repeated when a patient is placed in a swing bed.
2. Physician Certification: The Medicare requirements for physician certification are clearly defined in Title 42 of the Code of Federal Regulations (42CFR 424.10, 424.11, and 424.20). In reference to timeliness, 42 CFR, 424.20 (b) and (d) specify the time frames for certifications and for the initial and subsequent recertifications. The certification must be obtained at admission, or as soon thereafter as is reasonable; and the 1st recertification is required no later than the 14th day of post-hospital Skilled Nursing Facility (SNF) care. If the certification is not obtained, it is a technical denial, meaning there is no appeal process to recoup the funds withheld from the facility.

There are three reasons for documentation: (1) clinical, which is required to support the services provided; (2) regulatory, which meets CMS and/or state regulations; and (3) compliance – the documentation needed to support billing as well as other regulatory requirements. Medicare Benefit Policy Manual (CMS Pub. 100-02) states that all services billed to Medicare must meet the criteria of "medically necessary and reasonable." To determine whether a service is reasonable and necessary, each beneficiary's unique medical condition must be addressed through documentation.

SKILLED DOCUMENTATION

To be "skilled", the complexity of the services prescribed for the resident can only be performed safely under the general supervision of skilled-nursing or skilled-rehabilitation personnel. Skilled-care coverage may be necessary to improve the resident's current condition, to maintain the resident's current condition, or slow further decline of the resident's condition. Nursing documentation must maintain a standard to meet the skilled level of determination. The medical record should provide a clear picture, to anyone reviewing the claim, of how the resident is accomplishing the goals.

The facility must maintain clinical record on each resident in accordance with accepted professional standards and practices that are:

- Complete
- Accurate
- Readily accessible
- Systematically organized

The clinical record must contain:

- Sufficient information to identify the resident
- A record of the resident's assessments
- The Plan of Care and services provided
- Results of any preadmission screening required by the State
- Progress notes

Medicare defines necessary documentation for skilled therapy services as:

- Services must be considered under accepted standards of medical practice.
- Services must be at a level of complexity and sophistication OR the condition of the resident must be of a nature that requires the judgment, knowledge and skills of a therapist.
- Services must be related to an active written treatment plan designed by a physician.
- The resident's condition should improve in a reasonable period of time OR the services are needed to set up a safe and effective maintenance program related to a specific disease state.
- The frequency and duration of the therapy services must be reasonable for the treatment of the resident's condition.

PHYSICIAN DOCUMENTATION

Physician involvement is a requirement and attending physicians/physician extenders should determine the clinical decision-making for patients under their care. They

can provide a high level of knowledge, skill, and experience needed in caring for a medically complex population. The facility must arrange for the medical care of each resident and arrange for the physician to take responsibility of patient care, agreeing to visit the resident as often as necessary to address resident medical care needs. The physician should:

- Maintain a schedule of visits appropriate to the resident's medical condition depending on the patient's medical stability, recent and previous medical history.

- Participate in admission and period review of all medications while monitoring all medications for possible adverse drug reactions.
- The physician is required to participate in the facility's Interdisciplinary Team (IDT) meetings, which are at least weekly – and document any recommended order changes.
- Determine progress of each patient's condition at the time of the regulatory visit by evaluating the patient, talking with staff as needed, talking with responsible parties and/or family as indicated.
- Maintain progress notes that cover pertinent aspects of the resident's condition and current status and goals. The physician shall also provide documentation needed to explain medical conclusions and decisions.

Other disciplines will also need to complete appropriate documentation to industry standards. This can include, but is not limited to, dietary, social services, care planning, discharge planning, social services, respiratory therapy, other ancillaries (lab, radiology), activities, mental health, and dental health.

Examples of “best practice” documentation forms are located in Appendix G.

CHAPTER SIX: THERAPY

ADLs – NURSING AND THERAPY

Underpinning all skilled services in any skilled-nursing setting are four coverage factors. If any of the four are not met, then the care does not rise to the level of skilled services. Those four coverage factors are²⁶:

1. 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; are ordered by a physician and the services are rendered for a ²⁷condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in an SNF for a condition for which he/she received inpatient hospital services.
2. These skilled services are required on a daily basis.
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF.
4. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are 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.

Medicare has determined there needs to be an “inherent complexity” for skilled services – in this case, the question a skilled facility or swing bed program must determine is could that service be delivered with the same outcome in a home health or outpatient therapy setting instead of an inpatient (which SNF/SWB is) setting and cost. In the judgment of the therapists (Physical Therapy, Occupational Therapy, Speech Pathology), there is an expectation that the patient has potential to benefit from skilled services.

Therapy services cannot proceed without a written order of a physician as well as the promise that services will be provided by qualified personnel.²⁸ Specific Therapy orders are to include necessity, duration, and frequency for all patients receiving therapy. Guidance can be found in the Medicare Benefits Policy Manual 30.2.2 (Specificity of Orders).

Skilled physical therapy services must meet the following conditions:

First, 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

²⁶ Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care - General. (Accessed April 1, 2019)

²⁷ Medicare Benefit Manual 30.4.1.1 – General (Rev.73, Issued: 06-29-07, Effective: 07-30-99, Implementation: 10-01-07)

²⁸ SOM and 483.45

approved by the physician after any needed consultation with the qualified physical therapist. The SNF standard has become one in which physicians sign the therapist POC, in case a physician did not do an adequate job developing the plan of care in his/her documentation.²⁹

The above paragraph references the need for a physician to sign the therapy plan of care, which is combined with the therapy evaluation. It must be signed timely, particularly as skilled therapy services often begin immediately after admission.

Next, the general principles of medical record documentation are available in CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services.

Novitas, a Medicare Administrative Contractor (MAC)³⁰ defines the care of a patient to begin when a physician certifies the plan of care AND there is evidence of physician involvement through a signed and dated order, and there are conference notes/team meeting notes.

The plan of care has minimal requirements of: (1) diagnoses; (2) short term/long term treatment goals; and (3) type, amount, duration, and frequency of therapy services. Payment may be denied if the physician/NPP does not certify the plan of care.

DAILY SKILLED DOCUMENTATION

In order to avoid an error and the denial of services, when submitting documentation for review, be sure to: (1) have established a complete initial plan of care, making certain to include a therapist signature with professional identification (i.e. PT, OT, etc.), and have the date the plan was established; (2) ensure that the plan of care is certified (recertified when appropriate) with a physician/NPP signature and date; and (3) clearly document when the plan of care has been modified, including how it was modified and why the previous goals could not be met.³¹

Regulation also requires a patient-centered care plan, from each discipline working with a Medicare patient, which must detail short-term and long-term goals, the prior level of function (PLOF), and current level of function (CLOF) so goals are set on the individual needs of the patient and developed by a qualified therapist. Those goals define the intent and scope of the skilled therapy.

The plan of care and ensuing treatment must meet medical necessity standards. Factors included in substantiation of medical necessity include: (1) patient diagnoses, complicating factors, age; (2) severity, time since onset/acuity, self-effacing/motivation; (3) cognitive ability, prognosis, and/or (4) medical, psychological, and social stability. It should be added that the

²⁹ CMS Pub 100-01, Chapter 4, Section 40-40.6

³⁰ Defined at cms.gov as a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.

³¹ Plan of Care Requirements Bulletin (October 4, 2012)

diagnosis of dementia does not automatically disqualify a beneficiary from receiving skilled therapy.³²

Therapy documentation establishes the variables influencing a patient's condition that add up to justifying the need for billing and quantifying patient progress toward the established goals. Every "page" of record must be legible and inclusive of appropriate patient identification. The record must include the dates/outcomes of clinical visits and procedure codes.

NCD/LCD

National Coverage Determination (NCD) and Local Coverage Determination (LCD) must be reviewed routinely by any skilled nursing therapy team. NCDs are developed by CMS to describe Medicare coverage nationwide for specific procedures or devices. They outline the conditions for which the service can be/will not be covered.

LCDs are defined in Section 1869(f)(2)(B) of the Social Security Act (the Act). This section states: "For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A)."

In rare instances, if there is contradicting information in the NCD and LCD, the NCD overrides the LCD.

As an example, there is an updated LCD for outpatient therapy that describes the coverage limits of outpatient physical and occupational therapy under Medicare Part B. It includes specific conditions under which certain physical and occupational therapy services may be considered covered by Medicare.

RESIDENT ASSESSMENT INSTRUMENT (RAI) MANUAL

While Critical Access Hospital swing bed programs are not required to complete an MDS, it is helpful to use the MDS (SP item set for swing beds) and the RAI Manual as training tools. These documents set Medicare expectations, and provide CAH swing beds with direction on CMS, MAC, and survey (state and federal) expectations.

In MDS, Section O, Medicare states: "Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which

³² www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPFS/downloads/jimmo-factsheet.pdf

contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.”³³

Section O also reiterates the standards for care as well as specific steps to take for assessment of patient needs. The section will also discuss PPS swing bed program need for documentation of minutes of therapy provided. CAH swing beds, because they are not required to complete the MDS, currently have a standard of providing time in, time out, and treatment time for each patient encounter. The RAI also provides the basics for PPS or CAH swing bed programs, such as counting family education if the resident/patient is present. For each of the disciplines Section O reiterates that the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist.

DISCHARGE PLANNING

Therapy must provide key information as the Interdisciplinary Team (IDT) determines the discharge plan and the timing of a discharge. However, therapy is a piece of the team decision. Too many times the needs for patients overnight have not been taken into account. What therapy and nursing must mutually provide to the IDT considers a 24-hour look at patient needs. The therapy plan of care and treatment needs to incorporate nursing observations, particularly from second shift in their assessment of the patient. This includes but is not limited to

- Support system including caregivers
- Home environment, including potential safety issues
- Ability to complete self-care items safely and reflecting quality of life
- Working with the IDT to understand financial and social barriers to returning home and staying home
- Providing information on clinical needs after discharge, from the need for outpatient therapy to equipment

Part of the therapy plan of care should also address necessary skills needed when the patient returns home, and that must include cognitive abilities, education level, understanding of treatment choices, and/or any cultural or religious beliefs that may impact participating in therapy services.

Therapists have a unique opportunity to positively enhance the discharge planning process.

³³ RAI Manual, version 1.17.1, October 2019, Page O-15

HOME VISITS

Home visits were common in the 1990s but faded away as a practice before discharge from skilled nursing facilities. Most providers stopped the practice, perhaps due to time constraints, or maybe uncertainty regarding the MDS changes under the then new Resource Utilization Group (RUGs) reimbursement system.

In today's world of ED and rehospitalization penalties, and falls being a primary culprit in both of those penalties, home visits³⁴ seem to be regaining traction. With the changes to PDPM³⁵, the increasing importance of scoring functional gain, and the need for realism in what a patient faces when they go home alone or to an elderly spouse, home visits are becoming part of the services provided by a skilled nursing facility/swing bed therapy program.

There should be clear medical necessity for the home visit. Not all patients require or even need a home visit to be included in their care plan. The visit usually entails an hour in the home (plus transport time) with a therapist.

Other discussion should occur specific to:

- Arrangement for transportation
- Organization of the home visit in time to address clothing, shoes, getting into the home, which family members will be involved, etc. (Remember that in person-centered care, the patient has the choice on who or whether or not to include family members.)
- Planning for the trip will include determining key parts of the patient's every day schedule to be considered (ADLs necessary to accomplish tasks, from walking from the bedroom to the bath, making a cup of coffee, evaluating the height of furniture, using a washer/dryer, or the width/number of stairs).
- One of the goals – other than adjustment to therapy goals – would be to identify equipment or adaptations to the home that can be started/completed before the patient discharges home.

Opportunities provided by a home visit include:

- Therapists actually visit the home and set up the final stages of therapy in the facility/swing bed based on knowing where they are being discharged to and what safety concerns must be addressed.

³⁴ This discussion is related to Medicare A patients being treated in a skilled nursing facility or a swing bed program (PPS or CAH). Always make sure to check with insurance for specific coverage rules.

³⁵ While PDPM represents a change to clinical and financial requirements only for PPS SNFs and Swing Beds, CAH Swing Bed programs must understand the changes because they represent Medicare "intent" for skilled nursing care

- This is a service provided by a PT or OT, and their unique approach to making the home safe.
- Travel time is not time that can be counted, with one exception. If the patient receives patient education during the trip, a reasonable amount of time can be counted. This also will not occur with every patient.
- Remember that car transfers can be practiced going and coming, if that is a service the patient needs.
- While this will not occur at the beginning of a skilled stay when the goals are set for functional gain (Section GG on the MDS), it will assist in determining actual gains made while in the program. It can also help determine the additional time (days) needed before discharge and help therapists write clear documentation on return to prior level of function.
- For coding, the time would be recorded under what was done with the patient in the home, most likely ADLs. This provides additional documentation for the need of skilled physical therapy and/or occupational therapy services.
- No special policy is needed to cover this service, though it should be listed in your rehab policies with an outline of the services that could be provided in the home. It is a service that can be unique to the swing bed program.
- It is a service that can be used to “market” the SNF or Swing Bed program – a program literally “going the extra mile” to make sure the patient obtains the highest level of function possible when returning home or to assisted living or other settings.

The clinical benefit for a home visit is to try to address any barriers found, decrease the likelihood of a return to the hospital or skilled program, and to help the patient realize they can go home again (safely).

CHAPTER SEVEN: DISCHARGE PLANNING

Hospital swing bed care is regulated by both the hospital requirements at 42 CFR Part 482 (reprinted at Appendix A of the State Operations Manual (SOM)) and the swing bed requirements at 42 CFR 482.66. The actual swing bed survey requirements are referenced in the Medicare Nursing Home requirements at 42 CFR Part 483. Section 1883 of the Act authorizes payment under Medicare for post-hospital SNF services provided by any hospital that meets certain requirements.

By regulation, the specified requirements at 42 CFR 482.66 include the hospital meeting the swing bed CoP on Resident Rights; Admission, Transfer, and Discharge Rights; Resident Behavior and Facility Practices; Patient Activities; Social Services; Discharge Planning; Specialized Rehabilitative Services; and Dental Services.

DISCHARGE PLANNING

Discharge planning represents a key time period for a patient, both regarding the safety to return home (or another setting), and more importantly, to ensure that all information available and necessary for that patient is being presented to him/her and/or a caregiver. The possibility of poor discharge planning or poor recovery at home comes when there is missing information at discharge – from diagnoses to planned follow-up care. Many patients do not understand the healthcare system, or processes for getting assistance with supplies, or how to inform their physicians of issues. Patients have difficulties paying for medications, or even more prevalent, being able to keep up with times to take medications because of the total number of prescriptions.

There is also a responsibility of the discharging hospital or swing bed program to make sure communication with the next level of care goes smoothly. If there are gaps in documented care needs, the next level after discharge may not be ready to care for the patient.

CMS AND DISCHARGE PLANNING

CMS has, and will continue to, updated discharge planning FTags – the federal identification of violations during state/federal surveys. These tags are accompanied by interpretive guidelines that assist facilities/swing bed programs in understanding the expectations for providing skilled-nursing services.

Conditions of Participation require that a registered nurse, a social worker, or other appropriately trained personnel must create and supervise the development of the discharge planning evaluation. Included in this planning is the likelihood of specific services that will be needed by the patient. At this time, an evaluation is also made regarding the support services a

patient will have at home, whether that be from a service (i.e., home health), family member, or paid caregiver.

Discharge planning is based on the medical record but should involve the physician, IDT, and the patient or an individual acting on his/her behalf. As the patient is involved, this also is the time when the swing bed program must provide a list of Home Health Agencies (HHA) and SNFs in the area, or in the area where the patient resides. These lists are provided only to patients for whom home health care or post-hospital extended care services are indicated.

OMBUDSMAN NOTIFICATIONS (VOLUNTARY AND INVOLUNTARY DISCHARGE)

The State Operations Manual also includes specific information on admission, transfer, and discharge rights from a swing bed program.³⁶ Part of these regulations is the requirement that the Office of the State Long Term Care Ombudsman be notified of a transfer or discharge. Ombudsmen have separated the need for voluntary (i.e., discharge home) and involuntary (i.e., need for psych services), and reporting. Each swing bed program should contact their area Ombudsman, to determine the involvement of the Ombudsman prior to an involuntary discharge. Ombudsmen serve as the representative for the patient, making sure their rights are met and processes are followed.

CMS recommendations for discharge planning from skilled nursing include:

- Develop discharge planning policies and procedures with input from the medical staff.
- Assume every inpatient requires a discharge plan to reduce the risk of adverse health consequences post-discharge and the risk of readmission.
- Discharge planning should come from Interdisciplinary Team interaction.
- Discharge planning should reflect the individual needs of each patient and not be a set of standardized statements.
- Person-centered care requires involvement of the patient/patient representative in the process.
- Provide a discharge planning tool to patients and their family or other support persons to help reinforce the discharge plan .
- Discharge planning means partnerships with post-hospital providers and community services, such as skilled nursing facilities/long-term care, home health, Hospice and others.

³⁶ §482.58(b)(2) Admission, transfer, and discharge rights (§483.5 definition of transfer and discharge, §483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7))

PATIENT ASSISTANCE

A swing bed program should support all patients during and after a discharge by:

- Scheduling follow up with the patient's primary care physician
- Assisting in filling prescriptions prior to discharge
- If applicable, arranging remote monitoring technologies or utilizing telehealth services
- Follow-up with the patient 24 to 72 hours after discharge to make sure there are no complications, confusion about patient needs, and/or concerns with barriers in the home to follow up once every 7 days for at least 30 days.
- Educating patients and caregivers on the possibility of returning to the swing-bed program within 30 days, if related to the original hospital stay and there is medical necessity.

Person-centered care also provides the patient with the opportunity to decide who should/should not be involved in the discharge planning process. If the patient chooses not to include a family member in the process, the swing bed program must honor that choice.

Discharge planners and IDT must remember that patient preferences are to be honored. There may also be variations in discharge planning in health plans have specific requirements that differ from traditional Medicare.

All swing bed programs should review discharge planning processes on a regular basis. Information from follow-up telephone calls should be shared with IDT and leadership teams to ensure ongoing quality improvement.

APPENDIX

APPENDIX A: MINIMUM DOCUMENTS (EMR/PAPER)

Reminder: Each state has its own requirements, so the state website provides the most updated information needed for a swing bed program.

Activities Assessment

Meetings: Care Plan IDT, Morning Meetings

Notice of Medicare Non-Coverage (NOMNC), DENC and SNFABN

Patient/Resident Rights

Physician Certification Form

Practical Matter Suggested Statements

APPENDIX B: SWING BED POLICIES AND PROCEDURES

Reminder: Each state has its own requirements, so the state website provides the most updated information needed for a swing-bed program.

Listed below are recommended policies for CAH Swing Bed programs (that would be in conjunction with hospital policies):

Abuse, Neglect, and Exploitation

Activity Director**

Activity Program**

Admission Agreement

Admission Orders

Admission Policy

Advanced Directives

Assessments

Behavior Management

Baseline Care Plan – to be completed within 48 hours of admission and involves the patient

Care Plan Meetings/Patient Involvement

Comprehensive Care Plan

Case Management

Change of Condition

Dental Services

Dietary Services and Dietitian

Discharge Planning

Discharge Summary

Documentation Requirements

Drug Regimen Review

Grievances

HIPAA Privacy

Interdisciplinary Team/Patient Involvement

Liability Notices and Appeal to QIO Process

Licensure and Certifications

Medication Administration

Medical Director and Attending Physician

Medication Refusal

***** May change pending Interpretive Guidance from CoP updates released on 9/2019***

Ombudsman
Pain Management
Patient Fall Risk
Patient Rights and Responsibilities
Personal Property
Photographs
Physician Care
Physician Certification/Recertification
Practical Matter
Progress Notes
Quality Improvement (QAPI)
Restraints
Social Services
Staffing
Swing Bed Coordinator
Swing Bed Process
Swing Bed Services and Information Letter
Therapy Services and Staffing
Transfers and Discharges/Ombudsman Notification
Transportation for Outside Medical and Dental Care
Volunteers

APPENDIX C: SUPPLEMENTARY INFORMATION

Reminder: *Each state has its own requirements, so the state website provides the most updated information needed for a swing bed program.*

Activities and Programming

Assessing ADLs

Daily Documentation/Words to Avoid

Functional Gain Documentation

Medication Reviews at Admission

Pain Management Plans

Self-Audits

APPENDIX D: SOURCES AND RESOURCES

Reminder: Each state has its own requirements, so the state website provides the most updated information needed for a swing bed program.

42 CFR Part 485 Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs): This sets forth the conditions that a hospital must meet to be designated as a CAH. [[58 FR 30671](#), May 26, 1993, as amended at [62 FR 46037](#), Aug. 29, 1997]. **§ 485.645 Special requirements for CAH providers of long-term care services (“swing-beds”)** A CAH must meet requirements in order to be granted an approval from CMS to provided post-hospital SNF care, as specified in in [§409.30](#) of this chapter, and to be paid for SNF-level services.

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).

CMS Internet Only Manual, Publication 100-04, Claims Processing Manual, Chapter 4, Section 240 and 250

CMS Swing Bed Website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/SwingBed.html>

CMS Website: SNF PPS Swing Bed/Rural Hospitals with Swing Beds:

Medicare Benefit Policy Manual: Chapter 8, Section 20.1: Coverage of Extended Care (SNF) Services Under Hospital Insurance (updated 11/01/18)

Medicare Benefit Policy Manual: Chapter 9: Sections 40.2.2 and 40.1.5

Medicare Claims Processing Manual: Chapter 1, Section 50.2-50.2.3

Medicare Claims Processing Manual: SNF Inpatient Part A Billing, Chapter 6, Section 10.2, 30, 30.4, 40.8, 40.8.2, 40.9

MLN Booklet: Critical Access Hospital, ICN 006400 August 2017

MLN Matters: Hospital and Critical Access Hospital (CAH) Swing Bed Manual Revisions: MLN Matters Number MM10962; CR Transmittal R4157CP, Release Date: November 2, 2018 and Implementation Date April 1, 2019

MLN Matters: Swing Bed Services: ICN 006951, updated November 2017

Noridian CAH Swing Bed Billing Chart, updated October 15, 2018

Ombudsman – Illinois:

<https://www2.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/default.aspx>

QAPI Tools & Resources: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html>

State Operations Manual: Appendix PP – Guidance to Surveyors for Long Term Care Facilities

State Operations Manual: Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 183, 10-12-18)

State Operations Manual: Chapter 2: The Certification Process (updated 06/14/19)

State Operations Manual: Chapter 7: Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities

APPENDIX E: TERMS AND ABBREVIATIONS

ADC – Average Daily Census

ALOS – Average Length of Stay

BAA – The Business Associate Agreement is for a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. A covered healthcare provider, health plan, or healthcare clearinghouse can be a business associate of another covered entity. The Privacy Rule lists some of the functions or activities, as well as the particular services, that make a person or entity a business associate, if the activity or service involves the use or disclosure of protected health information.

CAH – Critical Access Hospital

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations, often in front of the numerical code specific to different healthcare settings.

CMS – Centers for Medicare and Medicaid Services originally recognized as HCFA (Health Care Financing Administration)

CON – Certificate of Need

CoP – Conditions of Participation and Conditions for Coverage (CfC) must be met by healthcare organizations in order to begin and continuing participating in the Medicare and Medicaid programs. They represent health and safety standards, quality standards and protections for the resident/patient.

CPT – Current Procedural Terminology is a formal classification system to standardize terminology and coding for all medical services and procedures.

DENC – Detailed Explanation of Non-Coverage

DSM-5 – The last edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

ESRD – End Stage Renal Disease when the kidney impairment is irreversible and requires a regular course of dialysis or renal transplantation to maintain life.

FTag – Federal tag given by state surveyors during or post survey which cites a facility for not meeting Federal regulations that govern long term care facilities. They are used by each state Department of Health and CMS to survey quality of care provided to residents in long term care facilities and in skilled nursing.

HMO – Health Maintenance Organization

ICD-10-CM – International Classification of Diseases, 10th edition, Clinical Modification

Joint Commission – The Joint Commission is an independent group that administers voluntary accreditation programs for healthcare entities. CMS has allowed TJC to complete initial Medicare surveys for swing bed programs.

LCD – Local Coverage Determination

Long Term Care – Can be a facility for aging and/or a range of continuous health care or social services for those with chronic physical or mental impairments, or both. LTC provides for basic needs and promotes optimal functioning.

LTC – Long Term Care

Managed Care – An arrangement for health care in which an organization, such as an HMO, another type of doctor-hospital network, or an insurance company, acts an intermediary between the person seeking care and the provider (hospital, physician, swing bed, etc.).

MDS – Minimum Data Set, an assessment completed by a PPS SNF or SWB program providing both clinical information and is the resource for reimbursement.

Medicaid – Title XIX of the federal Social Security Act and 42 CFR 430 to 456 pays for medical care for low-income persons and is a state-administered program.

Medicare – Title XVIII of the Federal Social Security Act and 42 CFR 405 to 424 set up insurance-like payments for medical care of persons aged 65 and over. It is administered by Federal Social Security Administration.

NCD – National Coverage Determination

NHA – Nursing Home Administrator (licensed)

NOMNC – Notice of Medicare Non-Coverage

OBRA – The Omnibus Budget Reconciliation Act has set forth for over 20 years the federal standards for care of residents in nursing homes. This Act is interpreted with the U.S. Code of Federal Regulations (42 CFR Part 483).

Ombudsman – a person or program designed to improve quality of life for long-term care/skilled nursing residents/patients by advocating for and protecting their health, safety, welfare, and rights.

OIG – Office of Inspector General, the investigative body which pursues healthcare fraud and other issues.

PACE – Program of All-Inclusive Care for the Elderly

PDPM – Patient-Driven Payment Model is new Medicare patient system replacing RUGs as a way of calculating skilled nursing home reimbursement by determining multiple factors driving patient need for this level of care.

PFFS – Private Fee-for-Service plans allow patients to get care from any provider than accepts this plan, but doctors are not required to accept the plan even if the patient participates in Medicare.

PPOs – Preferred Provider Organizations allow patients to see any provider who accepts the plan but the cost is lower if you utilize the services on in-network providers.

QAPI – Quality Assurance/Performance Improvement programs critical to improving the quality of life, and quality of care and services delivered in nursing homes.

QIO – Quality Improvement Organization

RAI – Resident Assessment Instrument authority is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the that the MDS be used in conducting assessments of nursing home residents.

RoP – Requirements of Participation for skilled nursing facilities which is the equivalent of CoPs for swing bed programs.

RUGs – Resource Utilization Group is a listing of classifications that define the underlying illnesses, the complexity of care, and the need for services to improve their health. It has been both the survey and reimbursement tool for skilled nursing since 1998.

Skilled Nursing Facility – is a type of nursing home recognized by the Medicare and Medicaid systems as meeting long term healthcare needs for individuals who have the potential to function independently after a limited period of care.

Skilled Nursing Facility – is a type of nursing home recognized by the Medicare and Medicaid systems as meeting long term healthcare needs for individuals who have the potential to function independently after a limited period of care.

SNF – Skilled Nursing Facility

SNFABN – Skilled Nursing Facility Advanced Beneficiary Notice

SOM – The State Operations Manual contains instructions for interpreting law and implementing regulations.

Special Needs Plan – is a type of HMO which limits enrollment to patients with certain conditions or who live in a nursing facility or who are eligible for both Medicare and Medicaid.

NOTES



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