HealthTech

Everything you ever wanted to know about Swing Bed Part 1: The Basics

Carolyn St.Charles
Chief Clinical Officer, HealthTech |February 9, 2024

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a Bachelor's Degree in Nursing from Northern Arizona University.

Carolyn St.Charles, RN, BSN, MBA
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

Learning Objectives

1. Identify the CMS regulatory sources applicable to Swing Bed
2. Recognize at least two (2) types of patients appropriate for Swing Bed that do not require rehabilitation as the primary reason for admission
3. Describe at least three (3) critical documentation elements for showing that criteria for continue stay is being met
4. Describe the elements for completing and updating the multi-disciplinary plan of care
5. Explain Swing Bed discharge requirements, including notification of the ombudsman, choice of post-acute care provider, and updating the multi-disciplinary plan of care.

Disclaimer

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive.

HealthTech and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof.

HealthTech does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel.

HealthTech recommends that hospitals, clinics, their respective personnel, and all other third-party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.

HealthTech

Reimbursement

January – April webinars

All webinars are recorded for on-demand viewing.

Care Coordination - What's new in 2024 for programs and reimbursements?

Presenter: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting.
Date: Jan 18, 2024 | **Time:** 12pm CST
URL: https://bit.ly/3U083iW

Everything you ever wanted to know about Swing Bed! Part 1: The Basics – Meeting Swing Bed Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Feb 9, 2024 | **Time:** 11am CST
URL: https://bit.ly/47v1R5D

Everything you ever wanted to know about Swing Bed! Part 2: Beyond basics

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Mar 8, 2024 | **Time:** 11am CST
URL: https://bit.ly/3vGEadh

Everything you ever wanted to know about Swing Bed! Part 3: Strategies to hardwire your Swing Bed program for success

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Apr 12, 2024 | **Time:** 11am CST
URL: https://bit.ly/3S31QAp

Adaptive leadership in a changing environment

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE.
Date: Apr 26, 2024 | **Time:** 12pm CST
URL: https://bit.ly/3Shw6sg

Medicare Reimbursement

In accordance with the Balanced Budget Act (BBA) of 1997, the SNF-level services of non-CAH swing bed facilities are covered under the SNF prospective payment system (PPS) effective with cost reporting periods beginning on or after July 1, 2002. This applies to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals.

The SNF-level services of CAHs with swing beds are exempt from the SNF PPS, in accordance with the Benefits Improvement and Protection Act of 2000 and the Medicare Modernization Act of 2003, and are instead **paid based on 101 percent of reasonable cost**.

However, as of April 1, 2013, CAH reimbursement is subject to a 2% reduction due to sequestration. In some states, CAHs may also receive cost-based reimbursement from Medicaid.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed

Medicare Reimbursement

60 - Swing-Bed Services (Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Swing-bed services must be billed separately from inpatient hospital services.

Note that CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m),

and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)).

Certified registered nurse anesthetist services paid on a pass-through basis are also to be included on the CAH swing-bed bill.

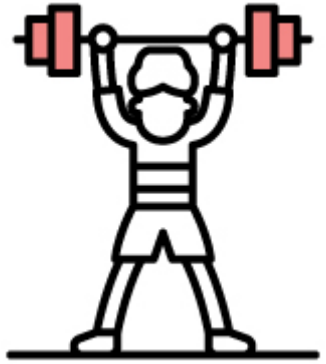
Source: Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing

Swing Bed Billing and Reimbursement

Medicare Benefit Policy Manual Chapter 3
Duration of Covered Inpatient Services

Medicare Claims Processing Manual Chapter 6
SNF Inpatient Part A Billing and SNF Consolidated Billing

Medicare Benefit Policy Manual Chapter 8 (Admission Criteria and Certification)
Coverage of Extended Care (SNF) Services Under Hospital Insurance



HealthTech

Conditions of Participation

Swing Bed Conditions of Participation

CMS revised regulatory rules in October 2018, with additional changes in November of 2019. The rules were published in February of 2020 in the Conditions of Participation

1. Appendix W Critical Access Hospitals (Rev. 200, 02-21-20)
2. Appendix PP Long Term Care Facilities (Rev. 211, 02-03-23)

Interpretive Guidelines for Appendix W are in Appendix PP.

CMS has said they have no intention of writing interpretative guidelines for Swing Bed.

Appendix W ---- 12 Tags for Swing Bed OTHER Regs. in Appendix W also apply

C-1600 §485.645 **Special Requirements** for CAH Providers of Long-Term Care Services (“Swing-Beds”)

C-1602 §485.645(a) **Eligibility**

C-1604 §485.645(b) Facilities Participating as **Rural Primary Care Hospitals** (RPCHs) on September 30, 1997

C-1606 §485.645(c) **Payment**

C-1608 §485.645(d) **SNF Services.**

C-1610 (§485.645(d)(2) **Admission, Transfer and Discharge Rights**

C-1612 §485.645(d)(3) **Freedom from abuse, neglect and exploitation**

C-1616 §485.645(d)(4) **Social Services**

C-1620 §485.645(d)(5) **Comprehensive assessment, comprehensive care plan, and discharge planning**

C-1622 §485.645(d)(6) **Specialized Rehabilitative Services**

C-1624 §485.645(d)(7) **Dental Services**

C-1626 §485.645(d)(8) **Nutrition**

There are NO Interpretive Guidelines in Appendix A or Appendix W for Swing Bed

C-1626 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).

Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health.

Interpretive Guidelines §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

Appendix PP
Interpretive Guidelines

F-800 (Rev. 173, Issued: 11-22-17, Food and nutrition services
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

INTENT §483.60
To ensure that facility staff support the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet.

GUIDANCE §483.60
This requirement expects that there is ongoing communication and coordination among and between staff within all departments to ensure that the resident assessment, care plan and actual food and nutrition services meet each resident's daily nutritional and dietary needs and choices. While it may be challenging to meet every residents' individual preferences, incorporating a residents' preferences and dietary needs will ensure residents are offered meaningful choices in meals/diets that are nutritionally adequate and satisfying to the individual. Reasonable efforts to accommodate these choices and preferences must be addressed by facility staff. Also, cite this Tag if there are overall systems issues relating to how the facility manages and executes its food and nutrition services.

Appendix PP ---- 22 Tags
Rev. 211, 02-03-23

- §483.5 Definitions
- §483.10 Resident Rights
- §483.12 Freedom from Abuse, Neglect, and Exploitation
- §483.15 Admission Transfer and Discharge Rights
- §483.20 Resident Assessment
- §483.21 Comprehensive Person-Centered Care Plans
- §483.24 Quality of Life
- §483.25 Quality of Care
- §483.30 Physician Services
- §483.35 Nursing Services
- §483.40 Behavioral health services
- §483.45 Pharmacy Services
- §483.50 Laboratory Radiology and Other Diagnostic Services
- §483.55 Dental Services
- §483.60 Food and Nutrition Services
- §483.65 Specialized Rehabilitative Services
- §483.70 Administration
- §483.75 Quality Assurance and Performance Improvement
- §483.80 Infection Control
- §483.85 Compliance and Ethics Program
- §483.90 Physical Environment
- §483.95 Training Requirements

HealthTech

Medicare Swing Bed Criteria (Other payors – their rules)

Medicare Benefits Manual Chapter 8
Coverage of Extended Care (SNF) Services Under Hospital Insurance

10 - Requirements - General
10.1 - Medicare SNF PPS Overview
10.2 - Medicare SNF Coverage Guidelines Under PPS
10.3 - Hospital Providers of Extended Care Services
20 - Prior Hospitalization and Transfer Requirements
20.1 - Three-Day Prior Hospitalization
20.1.1 - Three-Day Prior Hospitalization - Foreign Hospital
20.2 - Thirty-Day Transfer
20.2.1 - General
20.2.2 - Medical Appropriateness Exception
20.2.2.1 - Medical Needs Are Predictable
20.2.2.2 - Medical Needs Are Not Predictable
20.2.2.3 - SNF Stay Prior to Beginning of Deferred Covered Treatment
20.2.2.4 - Effect of Delay in Initiation of Deferred Care
20.2.2.5 - Effect on Spell of Illness
20.2.3 - Readmission to a SNF
20.3 – Payment Bans
20.3.1 - Payment Bans on New Admissions
320.3.1.1 - Beneficiary Notification
20.3.1.2 - Readmissions and Transfers
20.3.1.3 - Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period
20.3.1.4 - Payment Under Part B During a Payment Ban on New Admissions
20.3.1.5 - Impact of Consolidated Billing Requirements
20.3.1.6 - Impact on Spell of Illness
30 - Skilled Nursing Facility Level of Care - General
0.1 – Administrative Level of Care Presumption
30.2 - Skilled Nursing and Skilled Rehabilitation Services
30.2.1 - Skilled Services Defined
30.2.2 - Principles for Determining Whether a Service is Skilled
30.2.2.1 – Documentation to Support Skilled Care Determinations
30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services
30.2.3.1 - Management and Evaluation of a Patient Care Plan
30.2.3.2 - Observation and Assessment of Patient's Condition
30.2.3.3 - Teaching and Training Activities
30.2.4 - Questionable Situations
30.3 - Direct Skilled Nursing Services to Patients
30.4. - Direct Skilled Therapy Services to Patients
30.4.1 – Skilled Physical Therapy
30.4.1.1 - General
30.4.1.2 - Application of Guidelines
30.4.2 - Speech-Language Pathology
30.4.3 - Occupational Therapy
30.5 - Nonskilled Supportive or Personal Care Services
30.6 - Daily Skilled Services Defined
30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"
30.7.1 - The Availability of Alternative Facilities or Services
30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case
30.7.3 - Whether the Patient's Physical Condition Would Permit
Utilization of an Available, More Economical Care Alternative
40 - Physician Certification and Recertification for Extended Care Services
40.1 - Who May Sign the Certification or Recertification for Extended Care Services
50 - Covered Extended Care Services
50.1 - Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse
50.2 - Bed and Board in Semi-Private Accommodations Furnished in Connection With Nursing Care
50.3 - Physical, Therapy, Speech-Language Pathology and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision
50.4 - Medical Social Services to Meet the Patient's Medically Related Social Needs
50.5 - Drugs and Biologicals
50.6 - Supplies, Appliances, and Equipment
50.7 - Medical Service of an Intern or Resident-in-Training
50.8 - Other Services
50.8.1 - General
50.8.2 - Respiratory Therapy
60 - Covered Extended Care Days
70 - Medical and Other Health Services Furnished to SNF Patients
70.1 - Diagnostic Services and Radiological Therapy
70.2 - Ambulance Service
70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services
70.4 - Services Furnished Under Arrangements With Providers

Skilled Level of Care

30 - Skilled Nursing Facility Level of Care - General (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132, SNF-214

Care in a SNF is covered if <u>all of the following four factors are met</u>:

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)
    - are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services

2. The patient requires these skilled services on a daily basis (see §30.6); and

Skilled Level of Care cont.

3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7)

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.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

3-Day Stay

20.1 - Three-Day Prior Hospitalization (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals.

In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.

Time spent in observation status 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.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Treatment of Condition Received During Hospital Stay

20.1 - Three-Day Prior Hospitalization (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Principles for Determining if a Service is Skilled

30.2.2 - Principles for Determining Whether a Service is Skilled

If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;

e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service.

While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Medicare Daily Skilled Care

30.6 - Daily Skilled Services Defined (Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a *7* days a week basis.

Skilled Restorative Nursing – Skilled Nursing

- A skilled restorative nursing program to positively *affect* the patient's functional well-being, **the expectation is that the program be rendered at least 7 days a week.**

Skilled Rehabilitative Therapy

- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and **receive those services on at least *5* days a week**. (If therapy services are provided less than *5* days a week, the "daily" requirement would not be met.)

Maintenance Therapy

- Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Non-Skilled Supportive or Personal Care

30.5 - Nonskilled Supportive or Personal Care Services (Rev. 1, 10-01-03) A3-3132.4, SNF-214.4

General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance.

This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel.

It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Non-skilled Supportive or Personal Care Services Examples

30.5 - Nonskilled Supportive or Personal Care Services (Rev. 1, 10-01-03) A3-3132.4, SNF-214.4

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

- Administration of routine oral medications, eye drops, and ointments (the fact that patients cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);
- Changes of dressings for uninfected post-operative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
- Routine care of the incontinent patient, including use of diapers and protective sheets;
- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction);
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Skilled Care

1. Management and Evaluation of Plan of Care
2. Observation and Assessment of the Patient Condition
3. Teaching and Training
4. Direct Skilled Therapy
5. Other Considerations

- Services Provided on an Inpatient Basis As a Practical Matter
- Availability of Alternative Facilities or Services

There are MANY!!!! examples in the Medicare Benefit Manual Chapter 8

Skilled Nursing or Skilled Rehab

30.2.3.1 Management and Evaluation of Plan of Care
The development, management, and evaluation of a patient care plan, based on the physician's orders and supporting documentation, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety.

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Direct Skilled Nursing Examples

- Intravenous or intramuscular injections and intravenous feeding
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day
- Naso-pharyngeal and tracheotomy aspiration
- Insertion, sterile irrigation, and replacement of suprapubic catheters
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception)
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception)
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception)
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training program
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Medicare Benefit Policy Manual Chapter 8 30.3

Direct Skilled Therapy

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist
- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally 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 qualified therapist for the performance of a safe and effective maintenance program. NOTE: See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition
- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable

Medicare Benefit Policy Manual Chapter 8 30.4.1

Teaching and Training

30.2.3.3. Teaching and Training
Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.

Some examples are:
• Teaching self-administration of injectable medications or a complex range of medications;
• Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
• Teaching self-administration of medical gases to a patient;
• Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
• Teaching patients how to care for a recent colostomy or ileostomy;
• Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
• Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
• Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
• Teaching patients the proper care of any specialized dressings or skin treatments.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.3 Skilled Nursing

30.3 Skilled Nursing
Services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.4.1.1 Direct Skilled Therapy Services

30.4.1.1. Skilled physical therapy services must meet all of the following conditions:

• The services must be directly and specifically related to an **active written treatment plan** that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is **approved by the physician** after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

• The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the **judgment, knowledge, and skills of a qualified physical therapist;**

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.4.1.1 Direct Skilled Therapy Services

30.4.1.1. Skilled physical therapy services must meet all of the following conditions:

• The services must be provided with the expectation, based on the **assessment made by the physician** of the patient's **restoration potential**, that the **condition of the patient will improve materially in a reasonable and generally 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 qualified therapist for the performance of a safe and effective maintenance program**. NOTE: See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.

• The services must be considered under accepted standards of medical practice to be **specific and effective treatment for the patient's condition**; and,

• The services must be **reasonable and necessary** for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.7 Services Provided on an Inpatient Basis As a Practical Matter

Example: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training.

Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because sufficient supervision and assistance could not be arranged for the patient in his home.

Rationale Skilled Care: In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.7.1 Availability of Alternative Facilities or Services

Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community.

Rationale Skilled Care: **Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed. In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered.** Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.7.2 Availability of Alternative Facilities or Services

If a patient's condition requires **daily transportation** to the alternative source of care (e.g., a hospital outpatient department) by ambulance, **it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.**

Rationale for Skilled Care: If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.7.2 Availability of Alternative Facilities or Services cont.

HOWEVER -----

The fact that Medicare cannot cover such care is irrelevant. The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to **receive the services needed on a more economical basis from an independently practicing physical therapist.**

However, the fact that Medicare payment could not be made for the services because an expense limitation (if applicable) to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF**. In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.**

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Documentation Essentials

In all of the examples – the common element is **documentation that a skilled need exists**.

For Medicare – Utilization Review (UR) functions for determining medical necessity and continued stay, are internal processes.

Typically we do this quite well for observation and acute stay patients – but not so well for Swing Bed patients.

Without adequate documentation – the stay MAY be denied if there is an audit by the fiscal intermediary.

HealthTech

Pre-Admission

Admission Criteria

Example of Hospital Swing Bed Admission Criteria	

Payor
Will consider all patients with Medicare, Medicare Advantage, Medicare / Medicaid, or other private payors.
 	
Patients with the following care needs can be accepted
• *Physical Therapy*
• *Occupational Therapy*
• *Speech Therapy*
• *IV Antibiotics*
• *Wound Care*
• *Education / Training*
  ○ *Diabetic teaching*
  ○ *Care of colostomy*
  ○ *Complex medication management*
  ○ *Monitoring signs & symptoms (weight, blood pressure, etc.)*
• *Management of Plan of Care / Skilled Observation*
• *Tube Feedings / PEG*
	Patients with the following diagnosis can be accepted
	• *Weakness / Failure to Thrive / Weight Loss*
	• *Orthopedics (Fractures, Post-Surgery)*
	• *Post-Stroke*
	• *CHF*
	• *Pneumonia*
	• *Covid-19*
	
	Patients with the following care needs will be reviewed on a case-by-case basis
	• *Dialysis (incidental to other reason for admissions) only if patient is sufficiently mobile to be transported by family in private car or by public transportation.*
	• *TPN – IF pre-made from manufacturer*
	
	Patients with the following care needs cannot be accepted
	• *Pediatrics*
	• *Severe or unmanaged mental illness*
	• *History of violent behavior*

Admission Criteria

Review and ensure concurrence from

- CEO – CFO – CNO
- Providers
- Nursing
- Rehab (PT, OT, Speech)
- Dietician
- Pharmacist
- Case Management

Ensure that you have the staff and equipment to care for the patients included. If you do not have the capacity currently – ask what it would require to take these types of patients in the future.

Identify who reviews potential admissions

- Provider
- Nursing
- Rehab (PT, OT, Speech)
- Dietician
- Pharmacist
- Case Management

Note: The fewer individuals that have to review the patient information – the more quickly a decision can be made. Consider separating admission criteria into three categories:
1 – Concurrence of Case Management required (only)
2 – Concurrence of Case Management and Provider required (only)
3 – Concurrence from all team members required

Use a Pre-Admission Checklist

If possible, request the entire medical record and not just the H&P or discharge summary for external referrals	
Name and Age	Attending Physician
Date of admission and reason for admission to acute care	Anticipated discharge date from acute care
Stated reason for admission to Swing Bed	
Acute Care Stay ☐ Surgical procedures ☐ Major complications or adverse events that occurred during the hospital stay ☐ Medications including IVs ☐ Nutritional status ☐ Functional status ☐ Continence	☐ Skin (including any skin breakdown) ☐ Wounds ☐ Mental status / Cognition ☐ Behavior ☐ Fall risk ☐ Ventilator weaning record (if applicable) ☐ Restraints during any point in hospital stay
Swing Bed Care Needs ☐ IV Therapy ☐ Simple Wound Care ☐ Complex Wound Care ☐ Ventilator Weaning ☐ Teaching / Training ☐ Nutrition Deficit	☐ PT/OT to increase ADLs / Functional status ☐ Speech Therapy thru-out Swing Bed stay ☐ Swallow exam(s) ☐ Special Equipment (i.e., specialty bed, wound vac, etc.) ☐ Non-formulary medications ☐ Other (i.e., dialysis, etc.)
Prior Living Arrangement ☐ Home ☐ Assisted Living ☐ Group Home ☐ Long Term Care ☐ Homeless ☐ Other	Anticipated Living Arrangement ☐ Home ☐ Assisted Living ☐ Group Home ☐ Long Term Care ☐ No clear plan ☐ Other
❑ Family support structure and willingness to accept Swing Bed admission	❑ Payor authorization or Medicare benefit days available

Use a Pre-Admission Checklist

MEDICARE	
☐	The patient requires skilled nursing or skilled rehabilitation services
☐	There is a physician order for skilled services
☐	Services are for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services
☐	Services are required at least 7 days per week for skilled nursing
☐	Rehabilitation if required, is available at least 5 days per week
☐	If Physical Therapy is required, it is available at the frequency and duration required by the patient
☐	If Occupational Therapy is required, it is available at the frequency and duration required by the patient
☐	If Speech Therapy is required, it is available at the frequency and duration required by the patient
☐	As a practical matter, the daily skilled care can only be provided on an inpatient basis
☐	The services are reasonable and necessary for treatment of the patient's illness or injury
☐	3-Day inpatient qualifying stay within the last 30 days
☐	Benefit Days available

Provide Choice of Post-Acute Providers

C-1425 *"The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences."*

Federal Register: *"Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH, data on quality measures and data on resource use measures. We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process."*

Source: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

HealthTech

Swing Bed Admission

Admission Processes

- ❑ Discharge order from acute care (if inpatient in the same facility)
- ❑ New Medical Record Number – or – clear separation of Swing bed record from acute care record
- ❑ Physician admission order, orders for care (activity, medications, diet, etc.), and new history & physical
- ❑ Physician certification
- ❑ Patient Admission Notices, including patient rights, choice of physicians, and financial obligations,
- ❑ Admission Assessment (multi-disciplinary)
- ❑ Baseline Plan of Care

Medical Record

C-1102 §485.638(a)

When a patient reimbursement status changes from acute care services to swing bed services, **a single medical record may be used for both stays as long as the record is sectioned separately**.

Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.

(Most facilities open a new medical record with a new medical record number)

History and Physical

C-1114 §485.638(a)(4)(ii)

Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

Interpretive Guidelines §485.638(a)(4)(ii) All or part of the history and physical exam (H & P) may be delegated to other practitioners in accordance with State law and CAH policy, but the MD/DO must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P.

Certification

Note: Edited – not all text included

40 - Physician Certification and Recertification of Extended Care Services

Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.

There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met. Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services Table of Contents

Certification

40.1 - Who May Sign the Certification or Recertification for Extended Care Services

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 physician extender (that is, a nurse practitioner (NP), a clinical nurse specialist (CNS) or, effective with items and services furnished on or after January 1, 2011, a physician assistant (PA) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services

Certification

Note: Edited – not all text included

40.2 - Certification for Extended Care Services

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF (or for a new condition that arose while in the SNF for treatment of that ongoing condition).

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable

The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services

Certification

Note: Edited – not all text included

40.3 - **Recertifications for Extended Care Services**

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 recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress notes.

40.4 - Timing of Recertifications for Extended Care Services (Rev. 1, 09-11-02)

The first recertification must be made no later than the 14th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

Subsequent recertifications must be made at intervals not exceeding 30 days.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services

Initial Certification - Example

Patient Name: _____ **Admission Date:** _____ **Health Insurance:** _____

Reason for Admission:	
Goals for Admission:	Specific Form Not Required
Expected Length of Stay:	
Admission to swing bed is for the same condition(s) for which the Patient received inpatient hospital services	☐ **YES** ☐ **NO** (if no, please explain)
CERTIFICATION Required at time of admission	I certify that services are required to be given on a daily basis which, as a practical matter, can be only be provided in a swing bed or skilled nursing facility.

_____ Physician Signature

_____ Date and Time

Patient Admission Notices / Disclosures

- ❑ Description of Swing Bed (Recommended)
- ❑ Patient Rights and Responsibilities (Required)
- ❑ Visitation Rights (May be part of Patient Rights document)
- ❑Advance Directives (Required)
  - A description of hospital policies regarding advance directives
  - Information - If the patient does not have an Advance Directive
  - Copy of Advance Directive placed in the medical record if the patient has an advance directive
- ❑ Choice of physicians – and - Information on how to contact all providers including consultants (Required)
- ❑ Financial Obligations (Required)
- ❑ Transfer and discharge rights (Required – may be part of Patient Rights)
- ❑ Notice of privacy practices (Required – may be the same as provided to all patients)
- ❑ Hospital responsibility for preventing patient abuse – how to report abuse (Recommended)
- ❑ Information for reporting abuse and neglect (Required)
- ❑ Contact information for Hospital and State Agencies including State Ombudsman (Required)

Patient Admission Notices / Disclosures Example Signature Page

Signature Page

NAME OF HOSPITAL is required to provide you with certain information at the time you are admitted to a Swing Bed.

By signing this document, you acknowledge that ***Name of Hospital*** has gone over the documents listed below verbally in a language that you can understand and provide you with a written copy. ***Name of Hospital*** has given you the opportunity to ask any questions you may have. You may ask any questions you have at any time during your stay.

- ☐ Swing Bed General Information
- ☐ *Advance Directives
- ☐ Rights and Responsibilities
- ☐ *Choice of Physician
- ☐ Provider Contact Information
- ☐ Financial Obligations
- ☐ Privacy Practices
- ☐ Abuse and Neglect
- ☐ Transfer and Discharge
- ☐ Contact information for Hospital, QIO, and State Ombudsman

Patient Printed Name ---- Patient Signature ---- Date

Name and title of person who reviewed information with patient ---- **Date**

Patient Admission Notices / Disclosures Patient Rights

C-1608 §485.645(d) SNF Services.
The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) **Resident Rights** (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter).

F-941
Facilities must inform residents in a language they can understand of their total health status and to provide notice of rights and services both orally and in writing in a language the resident understands

Swing Bed Patient Rights

1. If you are adjudged incompetent under the laws of a State by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under State law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

2. Your wishes and preferences must be considered in the exercise of rights by the representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process. In the case of a patient representative whose decision-making authority is limited by State law or court appointment, you retain the right to make decisions outside the representative's authority.

3. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

4. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights.

5. You have the right to be supported by the facility in the exercise of your rights.

6. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

7. You have the right to be informed, in advance, of changes to your plan of care.
8. You have the right to request, refuse, and/or discontinue treatment.

9. You have the right to participate in or refuse to participate in experimental research

10. You have the right to formulate an advance directive

11. You have the right to choose an attending physician. You have the right to be informed if the physician you have chosen is unable or unwilling to be your attending physician, and to have alternative physicians discussed with you, and to honor your preferences, if any, in identifying options.

12. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

13. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other residents.

14. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

15. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.
16. You have the right to secure and confidential personal and medical records.

17. You have the right to personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each resident.

18. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

19. You have the right to be informed in writing, if you have Medicaid insurance, at the time of admission or when you become eligible for Medicaid of:
    - The items and services that are included in nursing facility services under the State plan and for which you may not be charged
    - Those other items and services that the Hospital offers and for which you may be charged, and the amount of charges for those services
    - Be informed when changes are made to items and services

16. You have the right to be informed before, or at the time of admission, and periodically during your stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per-diem rate.

17. You have the right to access stationery, postage, and writing implements at your own expense.

22. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with State law.

23. You have the right to contact the Office of the State Long-Term Care Ombudsman.

24. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility are endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if you do not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claims and you refuse to pay for your stay.
    - The facility ceases to operate

25. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility

26. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.

Patient Admission Notices / Disclosures Financial Obligations

C-1608 §483.10(g)(17): The facility must—

(i) Inform each **Medicaid-eligible resident**, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—

(A)The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

C-1608 §483.10(g)(18): The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under **Medicare/Medicaid** or by the facility's per diem rate

Patient Admission Notices / Disclosures Financial Obligations

There are no length of stay restrictions for Swing Bed – as long as patient meets skilled criteria

However, for Medicare patients, co-pay is required from Day 21 – 100 and after day 100, all costs

Skilled Nursing Facility (Swing Bed) stay In 2023, you pay

- $0 for the first 20 days of each benefit period
- $200 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of the benefit period

Make sure you are providing both Medicare and Medicaid information – and update Medicare co-pay every year

Patient Admission Notices / Disclosures Choice of Providers

C-1608 §483.10(d) Choice of attending physician.
The resident has the right to choose his or her attending physician.
(1) The physician must be licensed to practice, and

(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

Patient Admission Notices / Disclosures Provider Contact Information

C-1608 • §483.10(d) Choice of attending physician.

(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

HealthTech

Assessment and Plan of Care

Comprehensive Assessment

C-1620 §485.645(d)(5): Comprehensive assessment, comprehensive care plan, and discharge planning (§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).

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. Discharge potential
17. Review of PASSAR – if one has been done

Comprehensive Assessment

C-1620 §485.645(d)(5)

When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter **do not apply to CAHs**.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a “significant change” means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months

Comprehensive Assessment

Time frames for the assessment must be appropriate for the length of stay in your facility.

If your average length of stay is 12 days (as an example) – the assessment should be completed within 24 – 48 hours. Some organizations allow 72 hours to span a weekend if necessary.

Important

1) The assessment should be multi-disciplinary (not just nursing)
2) The assessment forms the basis for the multi-disciplinary plan of care

Trauma Informed Care

C-1620 §483.21(b)
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) **Be culturally-competent and trauma-informed.**

Appendix PP F-656 and PP F-699 Care Planning Cultural Preferences and Trauma

- Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?
- For residents with a history of trauma, does the care plan describe **corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident?**

The goal is not therapy but rather to eliminate or mitigate triggers that could cause re-traumatizing of the resident

Comprehensive Assessment

Assessment	Example of Assessment Questions	Primary	Secondary
Customary Routine	❑ Time wake up ❑ Time go to sleep ❑ Naps ❑ Time eat meals (Bkf / Lunch / Dinner ❑ Other	Activities Nursing	
Cognitive Patterns	❑ Cognition Measurement Tool at end	Provider	Nursing
Communication	❑ Ability to express ideas and wants, consider both verbal and non-verbal expression. ❑ Understood. ❑ Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. ❑ Sometimes understood - ability is limited to making concrete requests. ❑ Rarely/never understood.	Nursing	Provider
Vision	❑ Corrective Lenses ❑ Cataracts ❑ Blind	Nursing	

Baseline Plan of Care
Only in Appendix PP

F-655 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1)

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

- (A) Initial goals based on admission orders.
- (B) Physician orders.
- (C) Dietary orders.
- (D) Therapy services.
- (E) Social services.
- (F) PASARR recommendation, if applicable

INTENT §483.21(a) Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

Barriers to developing an effective Multi-Disciplinary Plan of Care

1 – The IDT regulations were written for LTC and Skilled Nursing (they do apply to Swing Bed). In LTC and Skilled Nursing the MDS guides the process but it not required for CAH Swing Beds.

2 – Nursing staff (in particular) are not used to – or educated about how to write goals that are measurable and time-limited.

3 – Although we frequently have "*informal*" conversations about patients – we usually don't have formal meetings with the intent of developing a comprehensive plan of care that includes all disciplines. Even we do bedside rounding – we don't use that to develop a multi-disciplinary plan of care.

4 – Documentation templates are not set up for multi-disciplinary documentation. ***It's Tough!*** LTC and Skilled Nursing can use the MDS process which makes it easier.

5 – It takes time! Especially with a short length of stay ------- organizing the team – holding the meetings – documenting – ALL must be done in a relatively short period of time.

6 –Scheduling meetings at a time that everyone on the team can attend.

The Multi-Disciplinary Plan of Care starts with the Comprehensive Assessment

C-1620 §485.645(d)(5) Comprehensive assessment, comprehensive care plan, and discharge planning (§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).

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. Discharge potential
17. Review of PASSAR – if one has been done

Multi-Disciplinary Plan of Care

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes **measurable objectives and timeframes** to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's **highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's **exercise of rights** under §483.10, including the right to refuse treatment under §483.10(c)(6).

(1) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record

Multi-Disciplinary Plan of Care

C-1620 §483.21(b) Comprehensive care plans
(2) In consultation with the resident and the resident's representative(s)—

(A) The **resident's goals for admission and desired outcomes.**

(B) The **resident's preference and potential for future discharge**. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality

(i) Be provided by qualified persons in accordance with each resident's written plan of care

(iii) **Be culturally-competent and trauma-informed**

Multi-Disciplinary Plan of Care

C-1620 §483.21(b
(2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment.
7-DAYS IS TOO LONG FOR Swing Bed

(ii) **Prepared by an interdisciplinary team**, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments

C-1620: ..... 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).

Other Members of the Interdisciplinary Team

Case Manager / Discharge Planner
These individuals are almost always included! They are a critical part of the team.

Pharmacy
If there is a complicated medication regimen or the patient is receiving antibiotics or is receiving psychotropic drugs ---- include the pharmacist.

Cardiopulmonary
For patients who are on oxygen or have a respiratory-related diagnosis – include cardiopulmonary.

Nursing Manager
If at all possible include the nursing manager – they can support nursing staff and provide education as needed.

Business Office / Finance
Some organizations include a representative from finance to assist with financial questions.

Sample IDT Agenda

Discharge Plan

- Any update on discharge plans?
- Has anything changed?
- Does the discharge plan or timeline need to be modified?

Long Term Goals

- Review Long Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Can the patient sustain the goals if they are discharged today, or do they need additional time in the hospital to ensure there is a safe discharge?

Short Term Goals

- Review Short Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Are there any other goals that need to be added?
- If there are rehabilitation goals, how is nursing supporting the goals?

Nutrition and Hydration

- Has the patient experienced a weight loss or gain since the last meeting, and how much has the weight changed?
- If more than 5% has the dietician assessed the patient and what are the recommendations?
- Is there documentation in the medical record regarding nutrition and hydration?

Patient Input

- Does the patient agrees with the goals and plan?
- Ask the patient to discuss any issues or provide feedback for the team

Multi-Disciplinary Plan of Care Example

Discharge Goal: Ms. Love's goal is to be discharged to the Assisted Living where she resided before the hospital admission.

Long Term Goal (*To be achieved before discharge):*
Ms. Love will check blood sugars and administer insulin independently before discharge.

Responsible Discipline(s): Nursing and Pharmacy

Short Term Goals

1) Ms. Love will demonstrate appropriate techniques and times for checking blood sugar within two days of admission.
2) Ms. Love will identify the correct dose of insulin based on blood sugar within three days of admission.
3) Ms. Love will demonstrate drawing up insulin and administering insulin using sterile technique within four days of admission.
4) Ms. Love will identify signs and symptoms of hypoglycemia and hyperglycemia and what actions to take within five days of admission

Multi-Disciplinary Plan of Care Example

MULTI-DISCIPLINARY CARE PLAN						
Long Term Goal	**Short Term Goals**	**Interventions**	**Discipline Responsible**	**Date**	**Date**	**Date**
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	1. OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modify
		2. Nursing will que patient to dress each morning Saturday - Sunday	Nursing			
	Patient will be independently put on shoes within 7 days (April 3)	1. OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy			
		2. Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing			
	Patient will undress independently within 7 days and put on pajamas (April 3)	1. OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy			
		2. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing			

Post Plan of Care in Patient's Room And/Or Have Patient Sign Plan

F-553 §483.10(c)(2)

The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

HealthTech

Continued Stay

C-1620 Reassessment after Significant Change

A "**significant change**" may include, but is not limited to, any of the following, or may be determined by a MD/DO's decision if uncertainty exists.

Deterioration in two of more activities of daily living (ADLs), or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent. For example, pronounced deterioration in function and communication following a stroke.

Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb. Temporary loss of ability, such as during an acute illness, is not included.

Deterioration in behavior or mood, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention.

Deterioration in a resident's health status, where this change places the resident's life in danger (e.g., stroke, heart disease, metastatic cancer); where the change is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or change that is associated with an initial diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time (e.g., Alzheimer's disease or diabetes); or the onset of significant, unplanned weight loss (5% in the last 30 days, 10% in the last 180 days).

Frequently Missed ---- Discuss as part of IDT Meetings

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(1) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must—

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(3) Not employ or otherwise engage individuals who—

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(b) The facility must develop and implement written policies and procedures that:
(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving **abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,** are reported i**mmediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury,**

or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the **administrator** of the facility and to other officials (including to the **State Survey Agency and adult protective services** where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report **the results** of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within **5 working days of the incident**, and if the alleged violation is verified appropriate corrective action must be taken.

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.

Examples of individual failures include, but are not limited, to the following:

- Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Sexual abuse: non-consensual sexual contact of any type with a resident.

Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Exploitation: taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.

Misappropriation of resident property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

Action Steps

1. Conduct criminal background checks on ALL employees and providers.

2. Implement written policy specific to Swing Bed (not general abuse policy).

3. Annual education for ALL staff regarding recognizing and reporting abuse, neglect, exploitation and misappropriation of property.

4. Consider simulation / drill.

Nutrition – Regulatory Requirements

C-1626 §483.25(g)
Based on a resident's comprehensive assessment, the facility must ensure that a resident—
(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health.

F692 §483.25(g)
(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet

Nutrition – Regulatory Requirements

F-692
INTENT §483.25(g)
The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional and hydration status and that the facility:

- Provides nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment;

- Recognizes, evaluates, and addresses the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration; and

- Provides a therapeutic diet that takes into account the resident's clinical condition, and preferences, when there is a nutritional indication.

Nutrition Action Steps

Even for patients that are found to not be at nutritional risk at the time of admission….. assessment of nutrition and hydration should be ongoing

Recommend:

1) Documentation of oral intake (percent of meals consumed) for all patients.

2) Weekly weights for all patients.

3) Twice weekly weights if patient is at nutritional risk.

4) Assessment of hydration as part of nursing daily assessment (dry lips, skin, etc.).

5) Weekly dietician assessment.

6) Adherence to dietician recommendations – and documentation that recommendations were followed.

Dental Regulatory Requirements

C-1624 §485.645(d)(7)

The facility must assist residents in obtaining routine and 24-hour emergency dental care.
(a) Skilled nursing facilities. A facility-

(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;
(4) Must if necessary or if requested, assist the resident—
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services location; and

(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

Dental Action Steps

1) Make sure you have a facility policy for lost or damaged dentures – this was a new requirement in 2020.

2) At the time of admission, if the patient has dentures, document the condition of dentures (i.e., broken teeth, etc.), how dentures fit, etc.).

3) Ensure if the condition of the dentures are creating problems with nutrition – that there is a referral to a dentist.

Medication Management Regulatory Requirements

There are no specific requirements in Appendix W related to medication medication for Swing Bed patients.

However, all of the requirements for medication management in Appendix W would apply – as appropriate to the patient.

Medication Management Regulatory Requirements

Appendix PP F-56 §483.45(c): Requires monthly Pharmacist Drug Regimen Review

F-758 §483.45(c)(3) Psychotropic Drugs

- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

- Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

- PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

- PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Medication Management Regulatory Requirements

INTENT: F-757 §483.45(d) Unnecessary drugs and F-758 §483.45(c)(3) Psychotropic Drugs

The intent of these requirements is that:

- each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being;

- the facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and

- PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited

Medication Management Action Steps

Strongly recommend that for any patient with a complex medication regimen or any patient that is receiving psychotropic drugs:

1) Follow the requirements in Appendix PP

2) Active involvement of pharmacist including drug regimen review at least weekly

HealthTech

Discharge

Choice of Post-Acute Providers

C-1425 (Rev.) (8) *"The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences."*

Federal Register: *"Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH, data on quality measures and data on resource use measures. We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process."*

Source: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

Discharge Rights

C-1610 §485.645(d)(2) Admission, Transfer and Discharge Rights

§483.15(c)(1) Transfer and discharge—(1) Facility requirements—
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.

Required Discharge Information

C-1610 §483.15(c)(2)
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information.
(C) Advance Directive information.
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals.
(F)All other necessary information, including a copy of the resident's **discharge summary**, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

Required Discharge Information

C-1620: §483.21(c)(2)

(i) A **recapitulation of the resident's stay** that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results

(NOTE – USUALLY IN DISCHARGE SUMMARY)

(ii) A **final summary of the resident's status** to include items in paragraph **(b)(1) of §483.20**, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

> **§483.20(b)(1) Comprehensive assessments** The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.

(iii) **Reconciliation of all pre-discharge medications** with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A **post-discharge plan of care** that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services

Notice Before Discharge

C-1610 §483.15(c)(5)
Revised Appendix PP F-623: Content of Discharge Notice

- Discharge notice must include all of the following
  - The specific reason for the transfer or discharge
  - The effective date of the transfer or discharge;
  - The **specific** location (**such as the name of the new provider or description and/or address if the location is a residence**) to which the resident is to be transferred or discharged;
  - An explanation of the right to appeal **the transfer or discharge** to the State;
  - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
  - Information on how to **obtain** an appeal form;
  - Information on obtaining assistance in completing and submitting the appeal hearing request; and
  - The name, address (**mailing and email),** and phone number of the representative of the Office of the State Long-Term Care ombudsman

Notice Before Discharge Example
There is NO CMS form

Date: **Name:** **Admission Date:**

Your discharge from the Swing Bed program is expected to occur _____ (*When)*

You are being transferred or discharged because: (*Specific reason)*

You are being transferred or discharged to _____ *(Location*) (*If the location is a residence the location must be included)*

If you disagree with the transfer or discharge, you can file an appeal by contacting:
State Division of Health (*name/ mailing address / email address),* or
State-Long Term Care Ombudsman (*name/mailing address/email address/phone)*

You can access an appeal form at**:** *(name/web site/Email/phone)*

If you need assistance in obtaining, completing, or submitting the appeal request you can contact (*name/mailing address/email address/phone)*

Patient Signature / Date

Timing of Discharge Notice

There is not a specific time to deliver the notice if the patient has been in Swing Bed < 30 days

C-1610 §483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least **30 days** before the resident is transferred or discharged.
§483.15(c)(1) Transfer and discharge—(1) Facility requirements—

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (**B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility**; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.

Notice of Medicare Non-Coverage

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711
260.2
The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy).

A **NOMNC** must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B.

A **NOMNC** must be delivered by the SNF when both Part B therapies are ending. Skilled Nursing Facilities includes beneficiaries receiving Part A and Skilled Nursing Facilities **includes beneficiaries receiving Part A and B services in Swing Beds.**

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf

Notice of Medicare Non-Coverage

CMS Form Instructions for NOMNC

The NOMNC must be delivered at least **two calendar days** before Medicare covered services end or the second to last day of service if care is not being provided daily.

Note: The two day advance requirement is not a 48 hour requirement.

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf

Appeal

C-1610 §483.15(c)(1)

The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

Notify Ombudsman

C-1610 §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. **The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**

Send the Discharge Notice you provide to patient

Appendix PP F-623 §483.15(c)(3)

The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately transferred or discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for ombudsman notification in their state

THANK YOU

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868