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SWING BED
WHAT'S NEW
WHAT'S CHANGED
WHAT'S THE SAME

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Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. 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.

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Sept 2025 – Jan 2026 webinars

All webinars are recorded for on-demand viewing

New CoPs for safe obstetrical care

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: September 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oI6G5i

HR 101: What matters most

Presenter: Kimberly Butts - Human Resources
Date: September 19, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3V8TIjw

QAPI that matters

Presenter: Susan Runyan, Chief Executive Officer - Runyan Health Care Quality Consulting
Date: October 3, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45oIi15

An innovative approach to rehab in a CAH Swing Bed program

Presenter: Stephen Leone, PT - CEO of Rural Health Resources
Date: October 17, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oFNkxO

Swing Bed What's New? - What's Changed? - What's the Same?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: October 24, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Ve3iS9

Care Coordination service lines & you

Presenter: Marcella A Wright, DNP, MS, RN, Director Care Coordination & LEAN Consulting
Date: November 7, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Jko8wF

Non-Certified / Long-Term Swing Bed

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: December 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45WBzLZ

Tools to increase employee engagement: Lessons from a 99th percentile hospital

Presenter: Scott Manis - Regional Vice President
Date: January 9, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3UAFRlR

REH 101: A compliance guide for Rural Emergency Hospitals

Presenter: Cheri Benander, RN MSN, CHC, C-NHCE, HACP-CMS
Date: January 23, 2026 | **Time:** 12pm CST
URL: https://bit.ly/41PxdUt

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Description

Swing Bed continues to be a critical program and revenue source for Critical Access Hospitals. However, because the Swing Bed regulatory requirements are different than those for other acute care, it continues to be an area of confusion.

The webinar will review the current Conditions of Participation (CoPs) and changes within the last year, including admission criteria, patient disclosures at admission and discharge, and documentation. The webinar will discuss discipline-specific responsibilities and approaches to working as a team.

Learning Objectives

1. Identify the Medicare criteria for admission to the Swing Bed
2. Describe which Swing Bed regulations apply to patients who do not have primary Medicare as their payor
3. Outline patient admission and discharge disclosures
4. Describe elements of the multi-disciplinary plan of care and why it's important
5. Identify at least three (3) standards in Appendix PP that apply to Swing Bed patients

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What's New
What's Changed

What's New

1. Billing instructions for when a patient has a change of status review on their qualifying inpatient hospital stay

2. Swing bed services and the 96-hour certification requirement time exemption

3. Home health and swing bed patients

4. TEAM Care Model

MLN006951 May 2025
https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

MLN Matters
Implementing the Transforming Episode Accountability Model: Skilled Nursing Facility 3-Day Rule Waiver
https://www.cms.gov/files/document/mm14098-implementing-transforming-episode-accountability-model-skilled-nursing-facility-3-day-rule.pdf

Billing - Change of Status

We require a 3-consecutive-day inpatient hospital or CAH stay before admitting a Medicare patient to a swing bed in any hospital or CAH. The patient's swing bed stay must normally be within the same spell of illness as the qualifying hospital stay.

If the 3-day qualifying hospital stay was subject to a change of status review, we provide additional billing instructions for swing bed providers to alert their Medicare Administrative Contractor of the patient's appeal and the Quality Improvement Organization's decision to uphold the patient's inpatient status for the qualifying hospital stay.

MLN006951 May 2025
https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

Billing - Change of Status

Per 42 CFR 405.1210(b), hospitals must notify patients of their appeal rights when the patient's status changes from inpatient to outpatient receiving observation services.

The Medicare Change of Status Notice (MCSN) (CMS-10868) satisfies the requirement. See MLN Matters Article MM13846 for information on the MCSN process.

Patients receiving an MCSN may appeal and have the QIO review to determine if their inpatient admission satisfied relevant criteria for Part A coverage.

Further, patients asking for an appeal will have the QIO review whether the URC's decision to change the patient from inpatient to outpatient receiving observation services was incorrect.

These changes in status might also affect Medicare coverage of the patient's post-hospital extended care services provided by a SNF.

MLN Matters: Billing Instructions: Expedited Determinations Based on Medicare Change of Status Notifications https://www.cms.gov/files/document/mm13918-billing-instructions-expedited-determinations-based-medicare-change-status-notifications.pdf

96 Hour Average Length of Stay

A CAH may normally maintain no more than 25 inpatient beds.

A CAH with Medicare swing bed approval may use any of its inpatient beds for either inpatient or SNF-level services. A CAH may also operate a DPU (rehabilitation or psychiatric), each with up to 10 beds; however, it may not use a bed within these units for swing bed services.

CAHs don't include time spent providing skilled nursing swing bed services in their required 96-hour annual average length of stay calculation.

MLN006951 May 2025 Swing Bed Services
https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

Home Health

Swing Bed Patients and Home Health Care Medicare patients can’t receive swing bed services and home health (HH) care simultaneously.

We’ll reject the HH claim if you bill an HH PPS claim with dates of service that fall within the dates of a swing bed claim (not including dates of admission, discharge, and any leave of absence).

See MLN Matters® article MM13812 for the telehealth exceptions to this rule.

MLN006951 May 2025 Swing Bed Services
https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

TEAM Care Overview

The CMS Innovation Center is launching a mandatory, **episode-based payment model** called **TEAM** to reduce Medicare spending, improve the quality of care, and further advance care coordination across acute and post-acute care settings

Under TEAM, participating acute care hospitals will be accountable for the episode's cost and quality of care for 5 selected surgical procedures in either an inpatient facility or a hospital outpatient department.

The hospital's accountability for the episode of care will span from the time of surgery through the first 30 days after the Medicare patient receives an outpatient procedure or leaves the hospital.

MLN Matters
Implementing the Transforming Episode Accountability Model: Skilled Nursing Facility 3-Day Rule Waiver
https://www.cms.gov/files/document/mm14098-implementing-transforming-episode-accountability-model-skilled-nursing-facility-3-day-rule.pdf

TEAM Care Goals

Each episode includes all items and services related to the initial inpatient stay or outpatient procedure, encompassing both facility and professional services.

TEAM aims to foster greater patient care engagement so providers consider patient needs and preferences that may lead to shorter lengths of stay in both acute care hospitals and post-acute care settings.

We anticipate that patients in an episode under TEAM will benefit from:

- Enhanced communication and coordination among health care providers
- Improved discharge planning and facility transfers
- Reduction in unnecessary or redundant procedures
- Fewer avoidable readmissions
- More efficient use of post-acute care services
- Overall higher quality of care through the episode

TEAM Care Procedures

Episodes of Care Episodes start with a hospital inpatient stay, called an anchor hospitalization, or a hospital outpatient procedure, called an anchor procedure, for one of these 5 surgical procedures:

- Lower extremity joint replacement
- Surgical hip femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- Major bowel procedure

Participating Hospitals

Over 700 hospitals either mandatory or voluntary

More information including list of participants can be found at:

https://www.cms.gov/priorities/innovation/innovation-models/team-model

https://www.cms.gov/files/document/team-model-fs.pdf

TEAM Care 3-Day Qualifying Stay

To enhance care coordination across the post-acute spectrum and support participating hospitals in managing patient care, we're conditionally waiving certain Medicare payment requirements for patients in TEAM episodes starting for dates of service on or after January 1, 2026.

Specifically, per regulations at 42 CFR 512.580(b), we're **waiving the requirement for a 3-day inpatient hospital stay** prior to a Medicare-covered SNF stay for eligible TEAM patients

TEAM Care Criteria

Effective for episodes starting on or after January 1, 2026, until December 31, 2030, patients in a TEAM episode of care may receive SNF or swing bed services without meeting the 3-day hospital stay requirement.

Payment of SNF services claims from qualified SNFs or providers with swing bed arrangements will be subject to these criteria:

- The hospital stay wouldn't meet the 3-day rule requirement. If the stay meets the requirement, the waiver isn't necessary

- The discharge must be from a hospital participating in TEAM. We post and regularly update a list of participating hospitals on the TEAM webpage

- The participating hospital must have discharged the patient for 1 of the 5 TEAM episode categories prior to the start of SNF services

- The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient

TEAM Care Criteria, cont.

- The patient must meet eligibility criteria for TEAM at the time of SNF admission, including:
  - Have Part A and Part B and not be a part of a managed care plan
  - Medicare is the primary payer
  - Not have ESRD as a basis for eligibility
  - Not covered under a United Mine Workers of America health care plan

- The waiver only applies if the SNF is qualified to admit patients under TEAM. We identify qualified SNFs by their star rating and post a list on the TEAM webpage. Qualified SNFs have an **overall rating of 3 stars or better for at least 7 of the last 12 months.**

- We don't subject providers furnishing SNF services under swing bed arrangements to the star rating requirement

TEAM Care Criteria, cont.

- Demonstration code A9 is present in the treatment authorization code field (2300 REF02 Segment, where REF01=P4 for electronic claims)
- The type of bill is 21X or 18X (including CAHs)
- Occurrence span code 70 isn't present or is less than 3 calendar days, excluding the day of discharge
- The admit date is on or after January 1, 2026, and before December 31, 2030.

Impact on Swing Bed

1. PPS Hospitals will be incentivized to send more patients to a skilled nursing facility rather than a CAH Swing Bed due to costs (or perceived costs)

Impact: Decreased volume

2. CAH Swing Beds do not have publicly available outcome data they can share with PPS hospitals.
    - So PPS hospitals may not be aware that even though costs are higher, length of stay and readmissions usually lower - which can decrease overall costs

Impact: Decreased volume

What Can You Do --- NOW

1. Review the list of procedures and see how much of your volume is based on those procedures

2. Review the list of participating hospitals and determine if they are one of your referral sources

3. If not already --- begin collecting outcome data that includes at a minimum:
   - Length of Stay
   - Readmissions
   - Overall cost (what Medicare pays you) which would then be passed on to the PPS Hospital

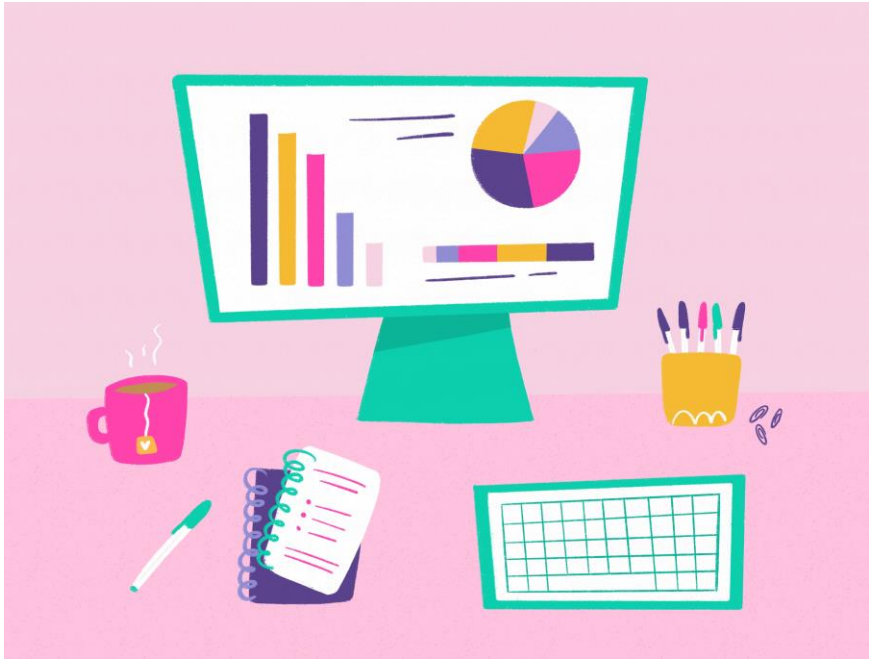
4. Build a compelling case for WHY you are still a good referral choice and share with referral hospitals

AND REMEMBER --- PATIENT'S STILL HAVE A CHOICE OF POST-ACUTE PROVIDERS

What Can You Do --- NOW

Even if you're not affected.....

Begin collecting data as the list of procedures and participating hospitals is likely to increase in the future



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What’s The Same

Everything Else – So A Brief(?) Overview

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Regulatory Requirements

Swing Bed Conditions of Participation Appendix W and Appendix A

The Conditions of Participation Appendix W and Appendix A outline the regulatory requirements for the care of a patient in a Swing Bed

Requirements apply to **ALL** Swing Bed patients regardless of payor

The Interpretive Guidelines for the care of Swing Bed patients are in Appendix PP (Long Term Care Facilities)

NO Interpretive Guidelines in Appendix W or Appendix A

C-1626 §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.

Which Interpretive Guidelines Apply?

Abuse, Neglect, Exploitation, and Misappropriation of Property	C-1612		F540 F600 F602 F603 F-04	F605 F606 F607 F609 F943
Activities	No specific requirement other than to meet psychosocial needs		F561	F679
Admission Process and Disclosures	C-1102		F555	F635
Baseline Plan of Care	NA		F655	
Certification and Recertification			F712	
Change in Condition			F726	
Choice of Physician	C-1608		F555	
Culturally Competent Trauma-Informed Care	C-1620		F699	
Dental Services	C-1624		F791	
Discharge	C-1610	C-1620	F550 F622	F623 F624

Which Interpretive Guidelines Apply?

Education and Competency		F726 F730 F895 F940 F941	F942 F943 F944 F945 F947 F949
Financial Obligations	C-1608	F582	
Initial Assessment	C-1620	F636	F637
Interdisciplinary Plan of Care	C-1620	F553 F656	F657 F675
Medication Management	All requirements in Appendix W apply	F605	F756
Privacy and Confidentiality	C-1608	F540	
Reassessment After Significant Change	C-1620	F637	

Which Interpretive Guidelines Apply?

Resident Rights	C-1608	C-1612	F550 F551 F552 F553 F554 F555	F557 F558 F559 F561 F562 F563
Pharmacist Assessment / Medication Management	All requirements in Appendix W apply		F755 F756 F757	F758 F756
Physician Visits			F712	
Rehabilitation	C-1622		F825	
Therapeutic Leave	C-1620		F625	F626
Nutrition	C-1626		F692 F800 F803 F805 F806 F807	F-07 F808 F809 F810 F813 F814
Social Service	C-1616		F745	
Visitation	C-1056		F563	F564

Which Requirements Apply to Non-Original Medicare?

All….. Except

1) Admission Criteria
   - 30-day inpatient stay
   - 3-day qualifying stay
2) What's Covered (Services)
3) Co-Pay
4) Delivery of NOMNC

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Medicare Admission Criteria

Admission Criteria

The criteria for admission and continued stay are specific to patients with traditional Medicare.

Other payors have their own

admission and length-of-stay rules


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

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(Rev. 12283; Issued: 10-05-23)

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For Example

Other payors can admit a patient to a swing bed from home or the emergency department or a provider office.....

without a 3-day qualifying stay which is required for traditional Medicare

Four Basic Criteria for Swing Bed

Medicare Benefits Manual Chapter 8
30 - Skilled Nursing Facility Level of Care – General

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

Four Basic Criteria, 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.

Treatment of the Same Condition As Hospital Stay

Medicare Benefits Manual Chapter 8
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.

30-Day Rule

Medicare Benefits Manual Chapter 8
20.1 - Three-Day Prior Hospitalization

The beneficiary must also have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §20.2.2 applies.

30-Day Rule Exception

Medicare Benefits Manual Chapter 8
20.2.2.1

An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

Readmission within 30 Days

Medicare Benefits Manual Chapter 8
20.2.3

If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met.

The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days after the first day of noncoverage.

Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.

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Skilled Care

Principles for Determining Skilled Services

Medicare Benefits Manual Chapter 8
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.

Skilled Nursing and Skilled Rehab

Medicare Benefits Manual Chapter 8
30.6 - Daily Skilled Services Defined

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-day-a-week.

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.)

Skilled Nursing Examples

Medicare Benefits Manual Chapter 8
30.3 Direct Skilled Nursing Services to Patients

1. Intravenous or intramuscular injections and intravenous feeding
2. Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day
3. Naso-pharyngeal and tracheotomy aspiration
4. Insertion, sterile irrigation, and replacement of suprapubic catheters
5. Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception)
6. Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception)
7. 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)
8. 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
9. Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
10. 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.

Skilled Therapy

Medicare Benefits Manual Chapter 8
30.4.1 General

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.

Maintenance Therapy

Medicare Benefits Manual Chapter 8
30.4.1.2 Application of Guidelines

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.

NOT Skilled Care

Medicare Benefits Manual Chapter 8
30.5 - Nonskilled Supportive or Personal Care Services A3-3132.4, SNF-214.4

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

1. 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);
2. General maintenance care of colostomy and ileostomy;
3. Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);
4. Changes of dressings for uninfected post-operative or chronic conditions;
5. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
6. Routine care of the incontinent patient, including use of diapers and protective sheets;
7. 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);

NOT Skilled Care cont.

8. Routine care in connection with braces and similar devices;
9. Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
10. 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);
11. Assistance in dressing, eating, and going to the toilet;
12. Periodic turning and positioning in bed; and
13. 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.)

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As A Practical Matter....

Services Provided on an Inpatient Basis As a Practical Matter

Medicare Benefits Manual Chapter 8
30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are **not available on an outpatient basis** in the area in which the individual resides **or transportation** to the closest facility would be:

- An excessive physical hardship - or
- Less economical – or
- Less efficient or effective than an inpatient institutional setting

Alternative Facilities or Services

30.7.1 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 non-coverage 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.

30.7.2 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.

30.7.3 More Economical Care
In determining the practicality of using more economical care alternatives, the A/B MAC (A) considers the patient's medical condition. **If the use of those alternatives would adversely affect the patient's medical condition, the A/B MAC (A) concludes that as a practical matter the daily skilled services can only be provided by a SNF on an inpatient basis.**

Alternative Facilities or Services

HOWEVER -----
30.7.1: 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.

Documentation

In all of the examples, the common element is documentation that a skilled need exists – and that services are **not available or feasible on an outpatient basis!**

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

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Pre-Admission

Initial Review

All Potential Patients

- Comprehensive review of needs --- NO SURPRISES
- Needs can be met
- Team or at a minimum Care Manager and Provider agree to admission

Medicare

- 4 basic criteria met
- Medicare days available
- Inpatient within the last 30 days (or documented exception)
- Same condition as inpatient stay

Other Payors

- Pre-Authorization

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.

Swing Bed Quality and Resource Use Data

Swing Bed: There is NO comparable / publicly available data for Swing Beds

Options

1. Provide patients with your internally collected data (recommended)

2. Provide patients with information from Hospital Compare (if available)
https://www.medicare.gov/care-compare/

3. Disclose that Swing Beds do not have publicly available data

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Admission

Distinct / Separate 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)

New 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

Certification

Medicare General Information, Eligibility, and Entitlement Chapter 4
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.

Note: Edited – not all text included

Certification, cont.

Medicare General Information, Eligibility, and Entitlement Chapter 4
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, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant)

who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Certification, cont.

Medicare General Information, Eligibility, and Entitlement Chapter 4
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

Note: Edited – not all text included

Initial Physician Certification

Patient Name **Admission Date**

I certify that _____ (name of patient) requires skilled care on a daily basis that as a practical matter can only be provided in an inpatient setting.

The Swing Bed admission is for an ongoing condition for which the patient was receiving inpatient hospital services before admission to Swing Bed.

The reasons the patient is being admitted to Swing Bed is for: (list reasons)

Expected length of stay ***Last two are only required at recertification – but recommended***

Expected discharge disposition (i.e., SNF, LTC, Assisted Living, Home)

Recertification

Medicare General Information, Eligibility, and Entitlement Chapter 4
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.

CANNOT BE SIGNED BY NP OR PA WITH DIRECT EMPLOYMENT RELATIONSHIP WITH HOSPITAL

Note: Edited – not all text included

Physician Re-Certification

Patient Name **Admission Date**

Reason(s) for continued Swing Bed Stay

Estimated Time patient will continue to need Swing Bed care

Expected discharge disposition (i.e., SNF, LTC, Assisted Living, Home)

Timing of Certification and Recertification

Medicare General Information, Eligibility, and Entitlement Chapter 4
40.2 - Certification for Extended Care Services

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. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

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Admission Notices and Disclosures

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 the 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)**

Patient Admission Notices / Disclosures, cont.

- ❑ 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

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
- $209.50 per day for days 21–100 of each benefit period (2025)
- 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.

C-1608 • §483.10(d) Contact Information
(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.

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Admission Assessment

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.**

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.

The assessment should be multi-disciplinary (not just nursing)

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

A Word About Activities

There is no requirement in Appendix W to provide activities.. It was removed in 2020….

However, CMS stated..

IF the patient needs activities, then the facility is expected to provide them!

You must still meet psychosocial needs

MORE ABOUT ACTIVITIES LATER

Comprehensive Assessment Example

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	

Plan of Care

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

(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

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.

Multi-Disciplinary Plan of Care
What works for you?

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 room And/Or have patient sign plan And/Or document patient approved

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.

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Abuse, Neglect, Exploitation, Misappropriation of Property

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.

Discharge

Choice of Post-Acute Providers (AGAIN)

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 Information

C-1610 §483.15(c)(2)

When the facility transfers or discharges a resident ……

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

Discharge Information

C-1610 §483.15(c)(2)
(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

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.

About the Comprehensive Assessment

It’s really not practical to complete all of the comprehensive assessment AGAIN!

At a minimum….

1. Review each goal
2. Document if it was met – or not met – and why
3. Forward to the next post-acute care provider

Discharge Information

C-1620: §483.21(c)(2)

(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

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.**

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.**

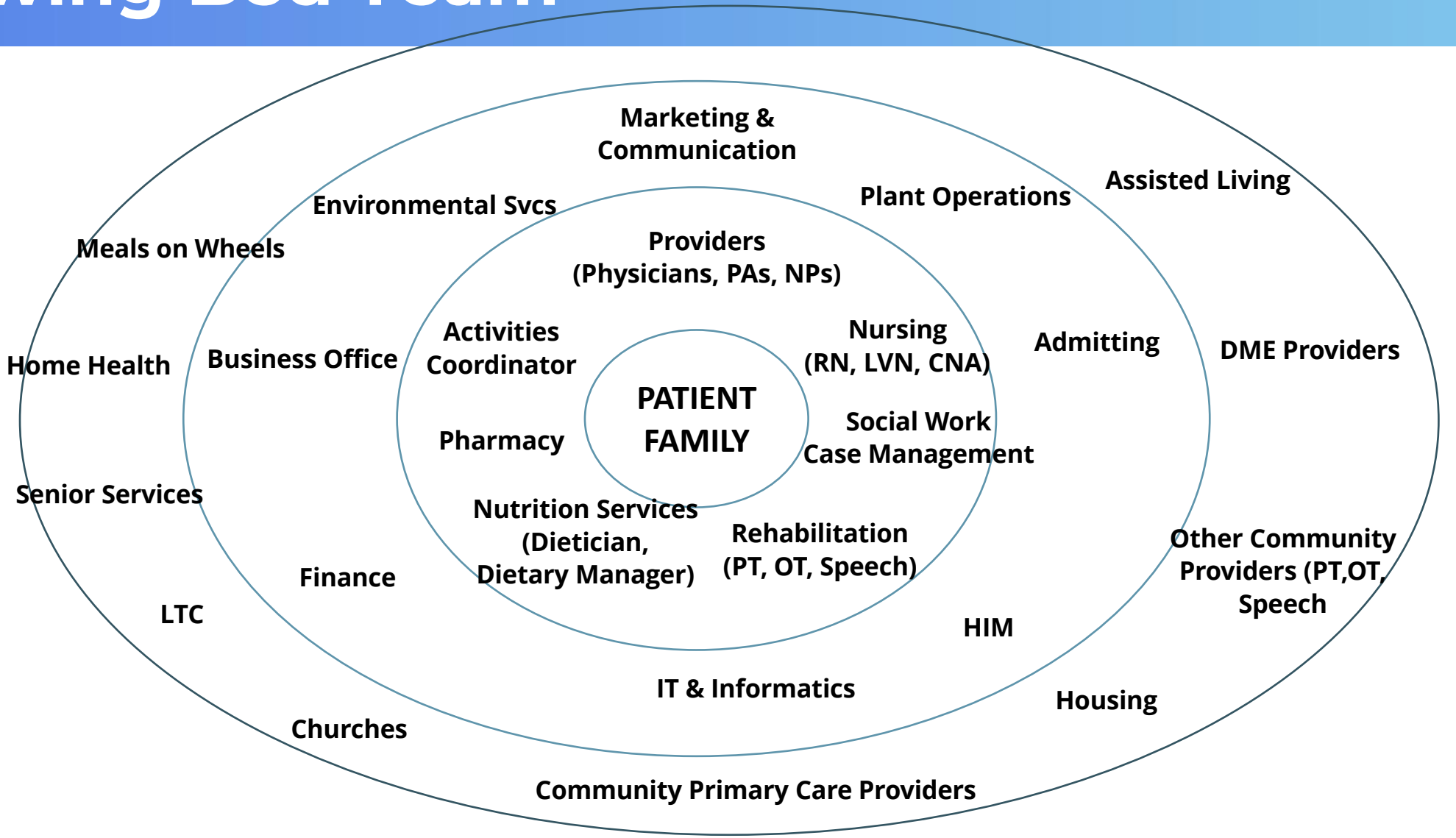
Send the Discharge Notice you provide to patient

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

Team Approach

Swing Bed Team



Meet as a team to discuss the program

Define Roles – Everyone Plays

Establish clear expectations / time frames

Time frames have been established and are measured for:

- Response to referrals
- Completion of initial assessment by each membe multi-disciplinary team
- Development of the plan of care that is measurable and time limited
- Attendance at IDT meetings
- Communication with patient and concurrence with Plan of Care

There are set times each week for IDT conferences

Celebrate

Don’t forget providers
Don’t forget direct care staff

Celebrate

Don’t forget providers
Don’t forget direct care staff

Questions!