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SWING BED
An Important Resource for Critical Access Hospitals
Part 1

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January 2026

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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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 acute care, it continues to be an area of confusion.

Part 1 will review the most recent Swing Bed Conditions of Participation (CoPs), State Operations Manual Appendix PP, and Medicare Benefit Policy Manuals, including Chapter 8.. The webinar will review criteria for swing bed admission; financial considerations including per-diem reimbursement and what services can be billed separately; pre-admission and admission processes including physician certification; multi-disciplinary assessment and plan of care; and discharge processes.

Learning Objectives

Upon completion of the webinar, the participant will be able to:

1. Identify where to find Swing Bed regulatory requirements
2. State at least four criteria required to admit a Medicare patient to Swing Bed
3. Describe which Swing Bed regulations apply to patients who do not have primary Medicare as their payor
4. Describe the admission, continued stay, and discharge processes including patient disclosures and notification of the ombudsman at discharge
5. Identify strategies for developing a multi-disciplinary plan of care

Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing

Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: February 13, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4r6lvOt

Compassion fatigue – Building resilience

Presenter: Brian Merry, M.Ed., CEMSO, NRP - Director of EMS
Date: March 6, 2026 | **Time:** 12pm CST
URL: https://bit.ly/49KJOvp

Swing Beds: An important resource for CAH - Part 1

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 3, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4qwYF3R

Swing Beds: An important resource for CAH - Part 2

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 17, 2026 | **Time:** 12pm CST
URL: https://bit.ly/45Pyq08

Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3Nx2nMa

Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3NtJUA9

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Swing Bed Resources

CMS Resources - Swing Bed

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

TEAM (Transforming Episode Accountability Model)
https://www.cms.gov/priorities/innovation/innovation-models/team-model

Swing Bed Providers
https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/swing-bed-providers

CMS Resources - Manuals

Medicare Claims Processing Manual
Chapter 3: Inpatient Hospital Billing
8/14/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

Medicare Claims Processing Manual
Chapter 4: Part B Hospital (Including Inpatient Hospital Part B and OPPS)
11/22/2024
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

Medicare Claims Processing Manual
Chapter 6: SNF Inpatient Part A Billing and SNF Consolidated Billing
2/21/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

Medicare Benefit Policy Manual
Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance
10/5/2023
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

CMS Resources - Manuals, cont.

Medicare Benefit Policy Manual Chapter 10: Ambulance Services
11/26/2025
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c10.pdf

Medicare Claims Processing Manual Chapter 30: Financial Liability Protections
10/31/2024
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

Other Resources

The Swing Bed Program: Impacting Patients, Providers, and Community
https://youtu.be/74ZeMBvcdnQ

RHIhub Understanding the Rural Swing Bed: More than Just a Reimbursement Policy - The Rural Monitor
https://www.ruralhealthinfo.org/rural-monitor/swing-beds/

Post-Acute Care in Rural Areas: The Role of *Swing Beds and Nursing Homes*
Rural Health Research Gateway
https://www.ruralhealthresearch.org/assets/5641-26183/post-acute-care-swing-bed-recap.pdf

Colorado Swing Bed Manual (2025)
Cost for non-members
https://coruralhealth.org/product/2025-cah-swing-bed-manual

ICAHN Swing Bed Manual (2025)
Not on web site yet
https://icahn.org/

Critical Access Hospital (CAH) Swing Bed Comprehensive Management Training: From Soup-To-Nuts – Idaho (2024)
Very comprehensive
https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=29067&dbid=0&repo=PUBLIC-DOCUMENTS

Montana Swing Bed Manual (2022)
Some references not current – but still good information
https://mtpin.org/education-meetings/education/swing-bed-resources/

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Medicare Other Payors What Regulations Apply?

Difference Between Medicare and Other Payors

Which Swing Bed requirements DO NOT APPLY TO payors other than Medicare

Admission criteria

Length of stay

Physician certification and recertification

Patient financial obligations

What can be billed in addition to basic swing bed care

NOMNC

Everything else applies

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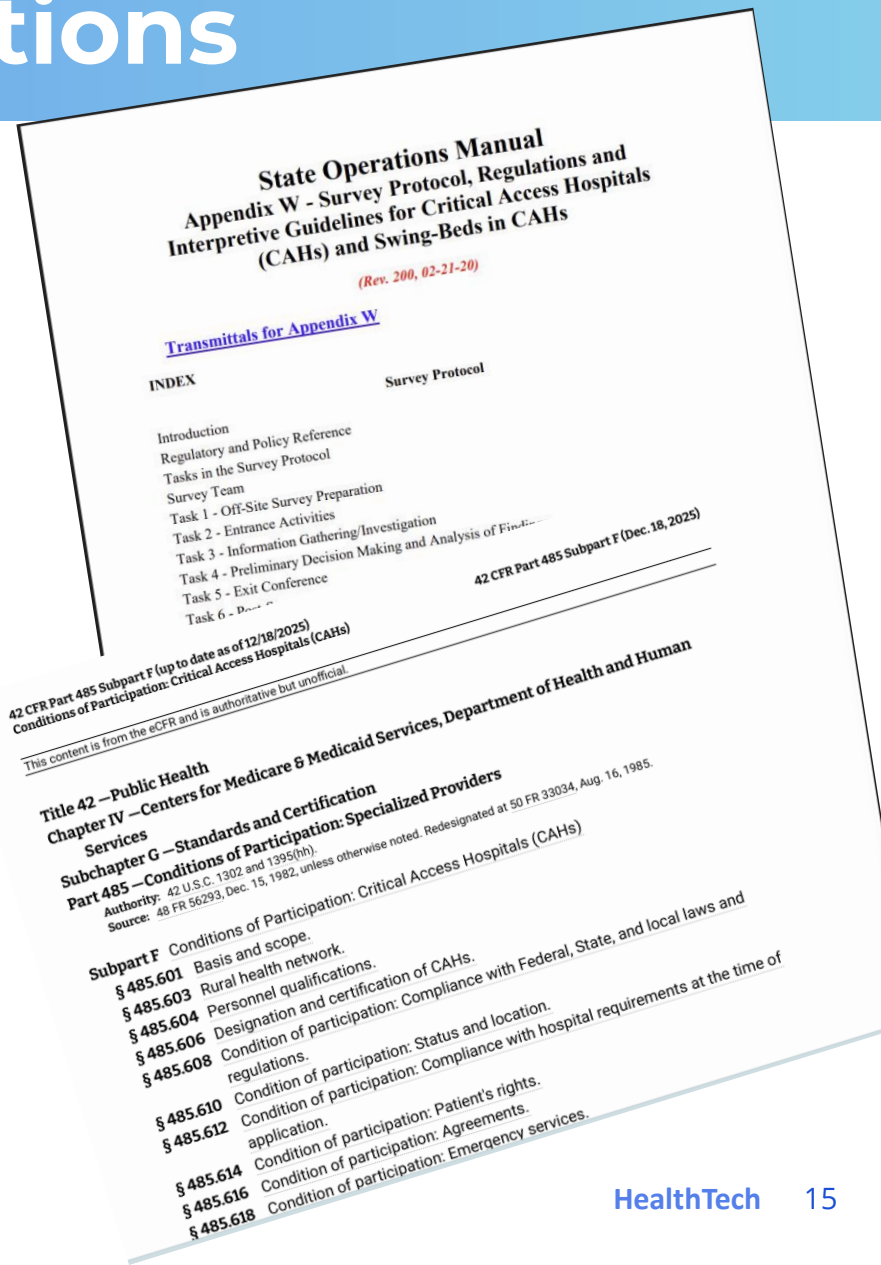
Where to Find Swing Bed Conditions of Participation

Appendix W - 2/1/2020
And - Code of Federal Regulations

State Operations Manual - Appendix W was last published in 2020
Appendix W does not include all current CoPs

The most current CoPs are published in the eCFR
(CFR does not have interpretive guidelines)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F


State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findi...
Task 5 - Exit Conference
Task 6 - Post-...

42 CFR Part 485 Subpart F (up to date as of 12/18/2025)
Conditions of Participation: Critical Access Hospitals (CAHs)

42 CFR Part 485 Subpart F (Dec. 18, 2025)

This content is from the eCFR and is authoritative but unofficial.

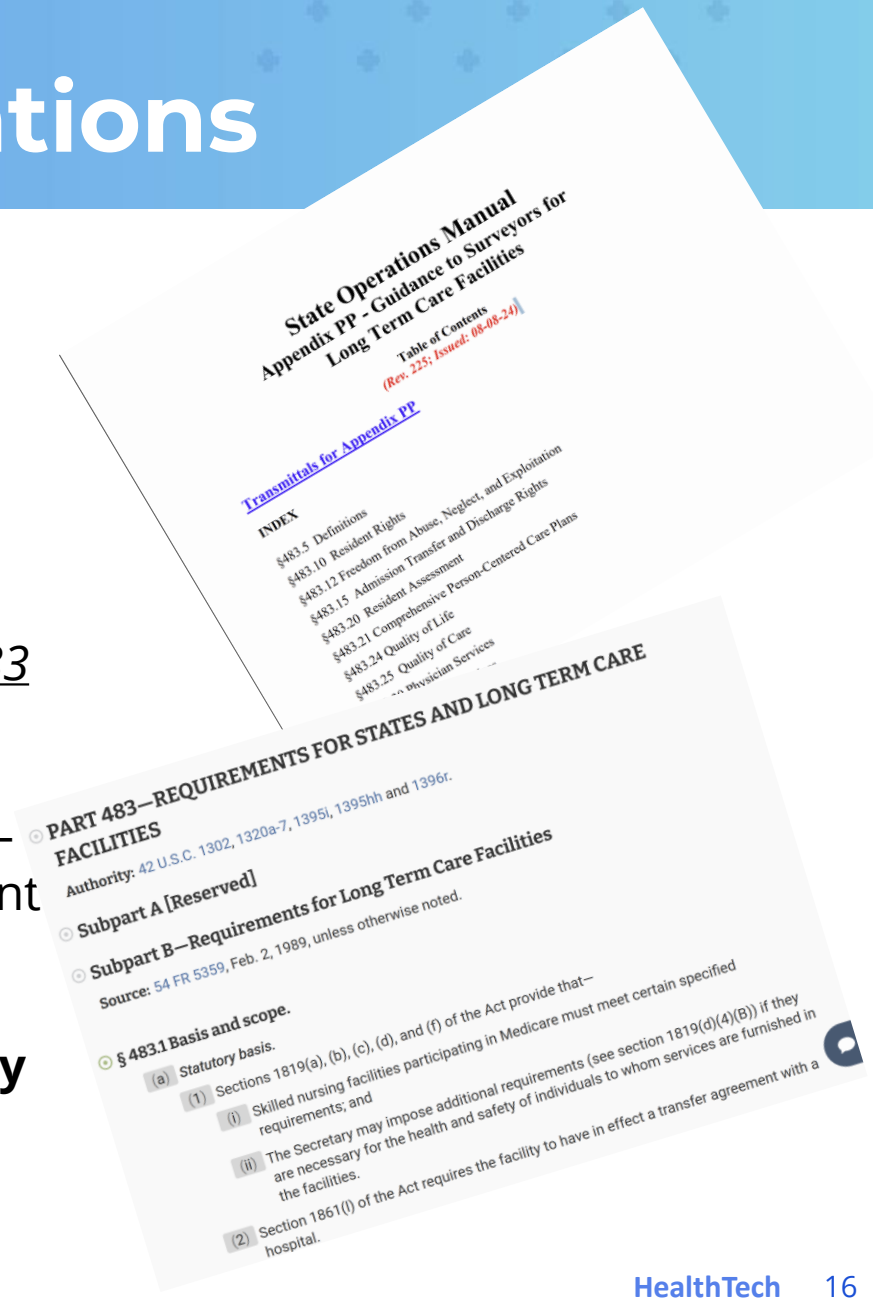
Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter G —Standards and Certification
Part 485 —Conditions of Participation: Specialized Providers
Authority: 42 U.S.C. 1302 and 1395(hh).
Source: 48 FR 56293, Dec. 15, 1982, unless otherwise noted. Redesignated at 50 FR 33034, Aug. 16, 1985.

Subpart F Conditions of Participation: Critical Access Hospitals (CAHs)
§ 485.601 Basis and scope.
§ 485.603 Rural health network.
§ 485.604 Personnel qualifications.
§ 485.606 Designation and certification of CAHs.
§ 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.
§ 485.610 Condition of participation: Status and location.
§ 485.612 Condition of participation: Compliance with hospital requirements at the time of application.
§ 485.614 Condition of participation: Patient's rights.
§ 485.616 Condition of participation: Agreements.
§ 485.618 Condition of participation: Emergency services.

Appendix PP - 8/8/2024
And - Code of Federal Regulations

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities was last published 08-08-24

The most current CoPs are published in the CFR
(CFR does not have interpretive guidelines)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483


State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents
(Rev. 225; Issued: 08-08-24)
Transmittals for Appendix PP
INDEX
§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
PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES
Authority: 42 U.S.C. 1302, 1320a-7, 1395i, 1395hh and 1396r.
Subpart A [Reserved]
Subpart B—Requirements for Long Term Care Facilities
Source: 54 FR 5359, Feb. 2, 1989, unless otherwise noted.
§ 483.1 Basis and scope.
(a) Statutory basis.
(1) Sections 1819(a), (b), (c), (d), and (f) of the Act provide that—
(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and
(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.
(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.

So…… you need to use the State Operations Manual Appendix PP – **AND THE** -- CFRs to ensure you are compliant with the most current regulatory requirements!

The good news is that Appendix PP is updated more frequently than Appendix W

Did Requirements for Swing Bed Change since 2020?

C-1622 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.645(d)(6) Specialized Rehabilitative Services (§483.65 of this chapter).

§483.65 (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a less intensity as set forth at §483.120(d), are required in the resident's comprehensive plan of care, the facility must— (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. (b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

KINDA' BUT NOT REALLY

Interpretive Guidelines §485.645(d)(6) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(6) Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

CFR Updated Version still refers to Appendix PP - But No Text in CFR

eCFR

§485.645 Special requirements for CAH providers of long-term care services ("swing-beds")

(d) SNF services.
The CAH is substantially in compliance with the following **SNF requirements** contained in subpart B of part 483 of this chapter:

(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, and (h) of this chapter).

APPENDIX W

C-1608 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §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).

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf.

Appendix PP Long Term Care Conditions of Participation

- §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

Only SOME of the CoPs in Appendix PP Apply to Swing Bed

42 CFR Part 483 Subpart B: Requirements for States and Long Term Care Facilities (12/04/2025)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483

Stay Current

- Sign Up to Receive Notices
  - and/or
- Check Periodically for Updates

- Department of Health Newsletters

- Hospital Association Newsletters (State and National)

- Industry Newsletters

- Rural Health Network

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Conditions of Participation

Appendix PP Applicable to Swing Bed

§485.645(d)(1): The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

Rights and Responsibilities

- §483.10(b)(7) – Right to Make Decisions
- §483.10(c)(1) – Informed of Rights
- §483.10(c)(2)(iii) – Informed in Advance
- §483.10(c)(6) – Right to Refuse
- §483.10 Introductory text, (h) of this chapter) – Privacy and Confidentiality
- §483.10(d): Choice of Physician
- §483.10(e)(2) – Personal Possessions
- §483.10(e)(4) – Share a Room
- §483.10(f)(4)(ii) – Immediate Access to Visitors
- §483.10(g)(8) – Mail
- §483.10(g)(17) –Financial Obligations

Appendix PP Applicable to Swing Bed

§483.5 §483.15(c)(1) – Reasons for Transfer or Discharge. Not Discharge if Appeal Pending

- §483.15(c)(2): Documentation Requirements for Transfer and Discharge
- §483.15(c)(3): Notice before transfer. Notify Ombudsman
- §483.15(c)(4: Timing of notice
- §483.15(c)(7): Orientation for Transfer or Discharge
- §483.15(c)(8): Notice in advance of facility closure

§483.12(a)(1): Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion

- §483.12(a)(2): Free from Restraints
- §483.12(a)(3)(i): Not employe individuals found guilty of abuse….
- §483.12(a)(3)(ii): Not employ individuals with finding in State nurse aid registry
- §483.12(a)(3)(iii): Not employee individuals with disciplinary action against license for abuse
- §483.12(a)(4): Report to nurse state registry or licensing authority knowledge of actions by court of law that found unfitness for service

Appendix PP Applicable to Swing Bed

Abuse

- §483.12(b)(1): Prohibit Abuse
- §483.12(b)(2): P&P to investigate allegations of abuse
- §483.12(c)(1): Prevent abuse while investigation in process. Report within 2 hours if allegation of abuse or bodily injury
- §483.12(c)(2): Thoroughly investigate all allegations
- §483.12(c)(3): Prevent further abuse while investigation in process
- §483.12(c)(4): Report investigations to State within 5 working days

Social Services

- § 483.40(d): Provide medically related social services to attain or maintain highest practicable physical, mental and psychosocial wellbeing of each resident

Assessment, Care Plan, Discharge

- § 483.20(b): Elements of comprehensive assessment
- § 483.21(b): Development of comprehensive care plan (Includes members of team who must be involved in developing care plan)
- § 483.21(c)(2): Elements of discharge summary

Appendix PP Applicable to Swing Bed

Rehab

- § 483.65: Provide rehab services if needed by patient. Provide services under written order of a physician

Dental

- § 483.55(a)(2): May charge a Medicare resident for dental services
- § 483.55(a)(3): Policy for when lost or damaged dentures is the facility responsibility
- § 483.55(a)(4): Make appointments and arrange for transportation
- § 483.55(a)(5): Refer for dental services with in 3 days. If doesn't occur document why. Provide for nutrition and hydration
- § 483.55(a)(5): Requirements for Medicaid patients

Nutrition

- § 483.25(g)(1): Maintain acceptable parameters of nutritional status
- § 483.25((g)(2): Offered sufficient fluid intake

Detail / Interpretive Guidelines in Appendix PP

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Medicare Coverage

Medicare Benefit & Coverage Manuals

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

Post-hospital extended care services furnished to inpatients of a SNF or a swing bed hospital are covered under the hospital insurance program.

Such a hospital, known as a swing bed facility, can “swing” its beds between the hospital and SNF levels of care, on an as-needed basis, if it has obtained a swing bed approval from the Department of Health and Human Services.

When a hospital is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules.

The regulations frequently use term SNF which also includes Swing Bed

Medicare Benefit & Coverage Manuals

Medicare Claims Processing Manual Chapter 3
Duration of Covered Inpatient Services

Medicare Claims Processing Manual Chapter 4
Part B Hospital (Including Inpatient Hospital Part B and Outpatient Hospital Prospective Patient System (OPPS)

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

Medicare Benefit Policy Manual Chapter 8 (Admission and Continued Stay Requirements)
Coverage of Extended Care (SNF) Services

Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections
Claims data, including Required Patient Notices

Swing Bed Reimbursement: Medicare

30.1.2 The SNF-level services provided by a CAH, are paid at **101% of reasonable cost**. Since this is consistent with the reasonable cost principles, A/B MACs (A) will now pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

CAHs are paid a **per-diem** amount established by the annual cost report for Medicare patients

Usually slightly less than the per-diem rate for Medicare inpatients

Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

CAH Swing Bed: Original Medicare






Bill for ALL Services Provided in Swing Bed

(some services are included in daily room rate such as nursing)

Hospital reimbursed based on per-diem rate established by the annual cost report

Patient Responsibility: Co-Pay (Each Benefit Period)

No co-pay first 20 days

Co-pay $217 days 21 – 100 in 2026

CAH Swing Bed: Other Payors






Bill for ALL Inpatient Services

(some are included in daily room rate such as nursing)

Hospital reimbursed based on the negotiated rate

Patient Responsibility varies by payor

CAH Swing Bed: Medicare Managed Care






Bill for ALL Inpatient Services

(some are included in daily room rate such as nursing)

Hospital reimbursed based on the negotiated managed care rate

Patient Responsibility varies by Managed Care Plan

Bundled Billing

60 - Swing-Bed Services
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).

A single payment for the combined cost of eligible services and supplies (treatments, tests, and procedures) provided during a defined episode of care)

This payment can cover **multiple providers** involved in the episode of care.

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

Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

What Can You Bill as a Part B (OP) Claim

NOTHING (MAYBE)

CAH Swing Bed cannot exclude services (bill separately) under bundled billing the same way a SNF is allowed under consolidated billing

All services / care provided to the Swing Bed patient must be included on the Swing Bed bill AND reimbursed at 101% of cost

Drugs	NO
X-Ray / MRI	NO
Surgical Debridement	NO

Potential Exclusions
Check With Your Fiscal Intermediary!

10.12 Outpatient non-diagnostic services that are related to an inpatient admission must be **bundled with the Part A billing for the inpatient stay.**

.....all outpatient non-diagnostic services, **other than ambulance and maintenance renal dialysis services**, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed to Part A with the inpatient stay.

Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Payment Window for Outpatient Services Treated as Inpatient Services
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

Can You Discharge from SB – Schedule an OP Procedure & then Readmit to SB

NO!

Unless of course they meet inpatient criteria and you are discharging from Swing Bed and admitting to Inpatient

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Pre-Admission

Comprehensive review of patient needs including medical records (if possible)

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

Review facility admitting criteria (can you provide the care the patient needs)

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*

Review Medicare criteria or obtain pre-authorization

Traditional Medicare – Internal Review

1. Medicare criteria
2. Benefit days
3. Discus financial obligations with patient

Other Payors – Pre-Authorization

Review SB program with patient (including financial responsibilities)

Meet with family or representative to explain Swing Bed rules to review Swing Bed expectations if at all possible

Provide choice of Post-Acute Providers (if inpatient at your facility)

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

Nursing Home Compare

For Skilled Nursing Facilities (SNF) quality and resource data is published on Nursing Home Compare (https://www.medicare.gov/care-compare/).

The information is not organized as quality and resource use measures. However, resource use is typically defined as spending per beneficiary and preventable readmissions.

Quality measures are generally related to care processes and outcomes, including functional status, skin integrity, falls or injuries, cognitive function, and medication management.

It is important to note that out of the seventeen indicators listed on Nursing Home Compare, six of the seventeen or 35% are related to improvements in functional status.

Nursing Home Compare

Overall rating

Above average

The overall rating is based on a nursing home's performance on 3 sources: health inspections, staffing, and quality measures.

Learn how Medicare calculates this rating

Health inspections

Above average

View Inspection Results

Staffing

Above average

View Staffing Information

Quality measures

Above average

View Quality Measures

Example of Quality & Resource Use Data Handout for Patients

Facility Name	Overall Star Rating	Health Inspections	Quality Data				Resource Use Data	
			Overall Quality Rating	Short-Stay Quality Rating	Nursing Hours Per Patient Day	# of Patients	Return to prior residence	Readmission < 30 days
Hospital Swing Bed Program	NA*	NA*	NA*	NA*	12.0	6	74%	10%
Facility 1	1	1	1	1	4.1	66	40%	23%
Facility 2	3	3	3	3	4.2	43	45%	28%
Facility 3	5	5	5	5	4.5	25	50%	15%
Facility 4	1	1	1	1	4.0	46	30%	28%
Facility 5	2	2	2	2	3.8	52	55%	26%

You can also use an I-pad to go to Nursing Home Compare. (Pre-load those in your area.) But if you do this make sure you document. Ensocare for example has this option.

If you develop a handout make sure you update whenever Nursing Home Compare data is updated.

HealthTech

Medicare Admission Criteria

Remember
Other Payors - Their Rules

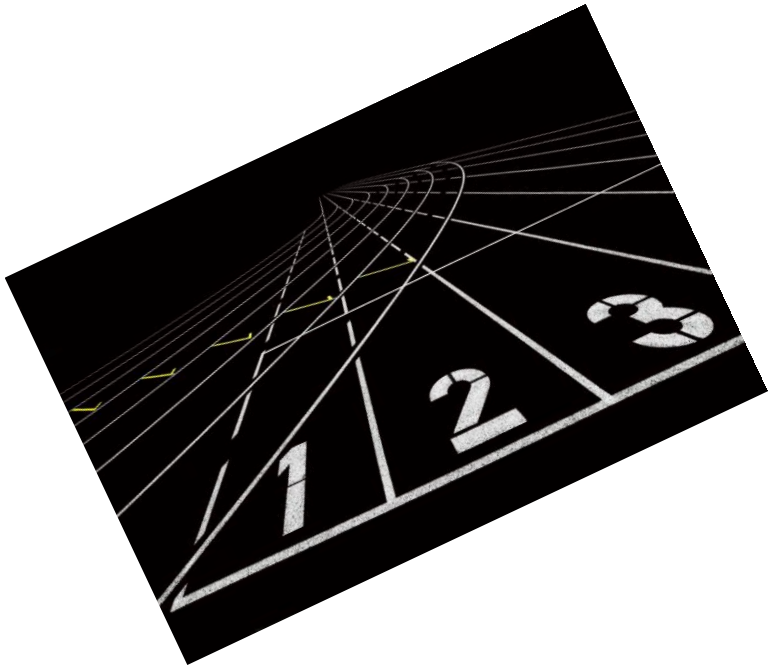
3-Day Prior Hospitalization within 30 days

20.1 - Three-Day Prior Hospitalization

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

TEAMS Model

If a PPS Hospital is participating in the CMS TEAMS (Transforming Episode Accountability) Model the **3-day stay can be waived**. Applies only to patients with traditional / original Medicare

- Coronary Artery Bypass Graft (CABG)
- Lower Extremity Joint Replacement (LEJR)
- Major Bowel Procedure
- Surgical Hip/Femur Fracture Treatment (SHFFT)
- Spinal Fusion

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

Treatment of Condition Received During Hospital Stay

20.1 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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

30-Day Rule

20.1
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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Readmission within 30 Days

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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

30-Day Rule Exception

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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Swing Bed Criteria

Medicare Benefits Manual Chapter 8 has information and examples for both admission and continued stay

The criteria for admission and continued stay is 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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Skilled Level of Care

30 - Skilled Nursing Facility Level of Care

Care in a SNF is covered if all of the following FOUR factors are met:

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

Principles for Determining if 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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Medicare Daily Skilled Care

30.6

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.

30.6

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.)

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Services Provided on an Inpatient Basis As a Practical Matter

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

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Types of Skilled Care

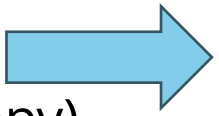
Types of Skilled Care

30.2.3.1	**Management and Evaluation of Plan of Care**
30.2.3.2	**Observation and Assessment of the Patient Condition**
30.2.3.3	**Teaching and Training**
30.3	**Direct Skilled Nursing Services to Patients**
30.4.1	**Skilled Rehabilitation**

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

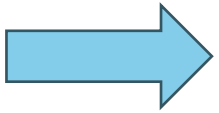
Types of Skilled Care

- Skilled Rehabilitation
- Direct Skilled Nursing (i.e., wound care or IV therapy)



Majority of patients usually in one of these categories

- Teaching & Training
- Management & Evaluation of Plan of Care
- Observation & Assessment of the Patient Condition



Rarely admit patients for these reasons

Teaching and Training Examples

- 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
- Teaching patients the proper care of any specialized dressings or skin treatments.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

Teaching and Training Documentation

The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training

The medical record should also describe the reason for the failure of any educational attempts, if applicable

It is **CRITICAL** that the physician's attestation for admission (reason for admission to Swing Bed) clearly states the need for education

It is **CRITICAL** that the nursing or rehabilitation documentation include a **detailed education plan** that includes What – When – Return Demonstration or evidence of understanding

This is NOT the same as your day of discharge brief education with a handout!

Skilled Nursing

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** 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
7. 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
8. Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
9. 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 (Rev. 12283; Issued: 10-05-23)

Skilled Therapy

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.

Medicare Benefit Policy Manual Chapter 8 (Rev. 12283; Issued: 10-05-23)

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

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Admission

Admission Checklist

- ❑ Choice of Post-Acute Care Provider (NA if transfer from another hospital)
- ❑ 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
- ❑ Advance Directives
- ❑ New History and Physical
- ❑ New Admission Orders
- ❑ Choice of Physician
- ❑ Physician Contact Information
- ❑ Physician Certification
- ❑ Patient Admission Notices

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.

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

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

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.

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

Timing of Certification

424.20(b) At Admission

424.20(d)(1) Within 14-Days

424.20(d)(2) Every 30-days

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

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Patient Required Notices

Patient Admission Notices / Disclosures

- ❑ Description of Swing Bed *(Recommended)*

- ❑Patient Rights and Responsibilities **(Required)**

- ❑Advance Directives **(Required)**
  - A description of hospital policies regarding advance directives
  - Information provided about Advance Directives - if the patient does not have an Advance Directive
  - Copy of Advance Directive placed in the medical record if the patient has executed 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 Rights: Use Large Font

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 Rights: Provide in language(s) appropriate to your for your population

Usted tiene derecho a estar libre de maltrato, negligencia, apropiación indebida de bienes y explotación. Esto incluye, entre otros aspectos, la libertad de no ser sometido a castigos corporales, aislamiento involuntario ni a ninguna restricción física o química que no sea necesaria para el tratamiento de sus síntomas médicos.

Advance Directives

§489.102 Requirements – *Summarized*

(a)(1)(ii) Written policies including policy regarding limitations for honoring advance directive

(a)(2) Document if patient has an advance directive

(a)(3) Not condition care based on if patient has or has not executed an advance directive

(a) (a)(4) Comply with state law

(b)(5) Staff education

(b)(6) Community education

(e) Provide information at the time of admission

Title 42 Chapter IV Subchapter G Part 489 Subpart I §489.102
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-I/section-489.102

Financial Obligations Medicaid & Medicare

§485.645(d)(1) -- §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.

Financial Obligations
Medicaid & Medicare

§485.645(d)(1) -- §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.**

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

Medicare Co-Pay

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 **2025**, you pay

- $0 for the first 20 days of each **benefit period**
- $217 per day for days 21–100 of each benefit period (2026)
- All costs for each day after day 100 of the benefit period

Make sure you update Medicare co-pay every year -- Increases every year in January

If days have already been used in benefit period – co-pay will start at remaining days

Choice of Providers

§485.642(a)(8) -- §483.10(d)(1-5)

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.
(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.
(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.

Choice of Physician/Provider

The _____ Physician Group is designated as the attending physician(s) for Swing Bed patients. On nights and weekends, coverage is provided by ER physicians. If you are OK with the Physician Group and ER physicians, please check below:

NAME OF Physician Group

The Physician Group includes:
Include the names of all providers (physicians, NPs, and PAs) in the group
Or provide names of providers who care for Swing Bed patients

If you prefer a different physician, please let us know which physician you prefer. Please note that the physician must have privileges to practice at **NAME OF HOSPITAL** and must agree to be your primary physician.

I would like _____to be my physician while I am a patient in Swing Bed.

Provider Contact Information

We understand you may want to contact your physician or other providers who are caring for you.

You may also contact the physician(s) or other provider(s) directly by calling the number(s) below:

Provider Name:
Contact Info:

Provider Name:
Contact Info:

Provider Name:
Contact Info:

It is not confidential; you may also let the nursing staff or any member of the care team know that you would like to speak to your physician, and they will call the physician for you.

Admission Documents Signature Page

Signature Page

NAME OF HOSPITAL is required to provide you information when 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

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Admission Assessment

Comprehensive Assessment

§485.645(d)(5) -- §483.20(b)(1)

A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

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 (C-1620 483.21(b)

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

Activities

There is no longer a requirement for a “formal” activities program in Appendix W.

However, CMS expects that IF a patient needs activities for psycho-social reasons, activities will be provided.

The activities assessment can be completed by a nurse, OT, or an activities professional.

The plan for activities can be included in the nursing care plan or another document.

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Continued Stay

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Multi-Disciplinary Plan of Care

Care Planning Starts with the Comprehensive Assessment

§485.645(d)(5) -- §483.20(b)

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 PASARR (§483.21(b)

Person-Centered

§485.645(d)(5) -- §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.

Physical, Mental & Psychosocial Well-Being

§485.645(d)(5) -- §483.21(b) Comprehensive care plans

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;

Exercise of Rights

§485.645(d)(5) -- §483.21(b) Comprehensive care plans

The comprehensive care plan must describe the following:

(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).

Patient Admission & Discharge Goals

§485.645(d)(5) -- §483.21(b) Comprehensive care plans

(iv) 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.

I'M GOING HOME!

Culturally-Competent Trauma-Informed Care

§485.645(d)(5) -- §483.21(b)(3) Comprehensive care plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must -

(iii) Be culturally-competent and trauma-informed

Probes

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?**

Timelines

§485.645(d)(5) -- §483.21(b) Comprehensive Care Plan

(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

§485.645(d)(5)
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.**

Interdisciplinary Team

Interdisciplinary Team

§485.645(d)(5) -- §483.21(b)(2) Comprehensive Care Plan

(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.

REMINDER
Patient Goals – Not Team Goals

- Focus on **WHY** the patient is in Swing Bed
- Patient's goals for admission
- Patient's goals for outcomes
- Patient's preferences for discharge

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Measurable Goals and Timelines

Measurable Objectives and Timeframes

§485.645(d)(5) -- §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.**

What Does Measurable Mean?

Measurable

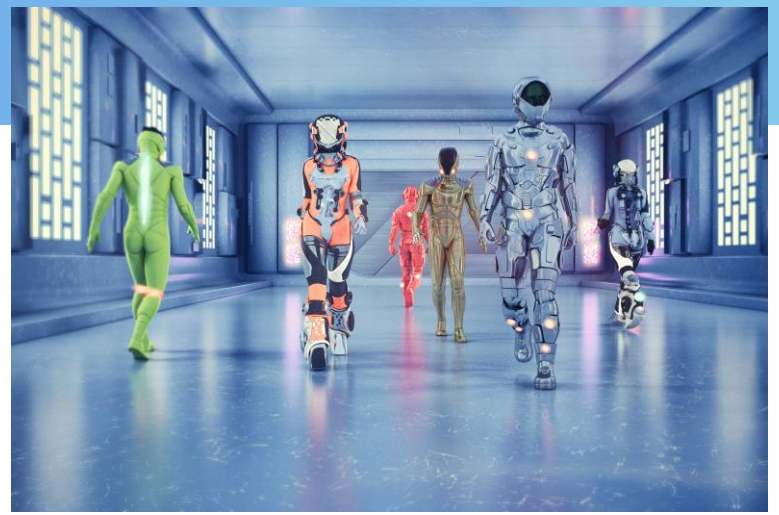
- Will administer own insulin independently
- Will walk 30 feet with a front wheel walker
- Will dress independently every morning including shoes

What Does Time Limited Mean?

Time Limited

- Will administer own insulin independently within one week (7 days)
- Will walk 30 feet with a front wheel walker within two weeks (14 days)
- Will dress independently every morning including shoes within 2 ½ weeks (21 days)

Walking Rounds



Many facilities have Walking Rounds…. Which are GREAT!!!

But… unless ALL required disciplines are present

And… there is a multi-disciplinary plan of care developed during walking rounds or shortly after with the team present…

Walking Rounds would not meet the requirements

Example #1

Patient Discharge Goal: Home with wife

Long-term goal: Will be independent in all aspects of care at home

Example Goal 1: Patient will be able to dress independently within 2 weeks and before discharge

Example Goal 2: Patient will receive 14 days of antibiotic therapy

Example Goal 3: Patient will improve nutritional status as evidenced by an increase in BMI to 20 within 2 weeks and before discharge

Example Goal 4: Patient will give insulin independently, including accurately checking blood sugar, understanding dose based on blood sugar, when to administer, how to administer within 2 weeks, and before discharge

Example #2

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN and IDT Note

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 ☐ Modified	☐ 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			

Example #3

Use progress notes or other chart form
and have each discipline document before IDT meeting

Patient Name
Date of Meeting
Long-Term Discharge Goal

Rehabilitation **Long Term Goal**			
Short Term Goal	**Intervention**	**Time to Complete**	**Progress/Update**

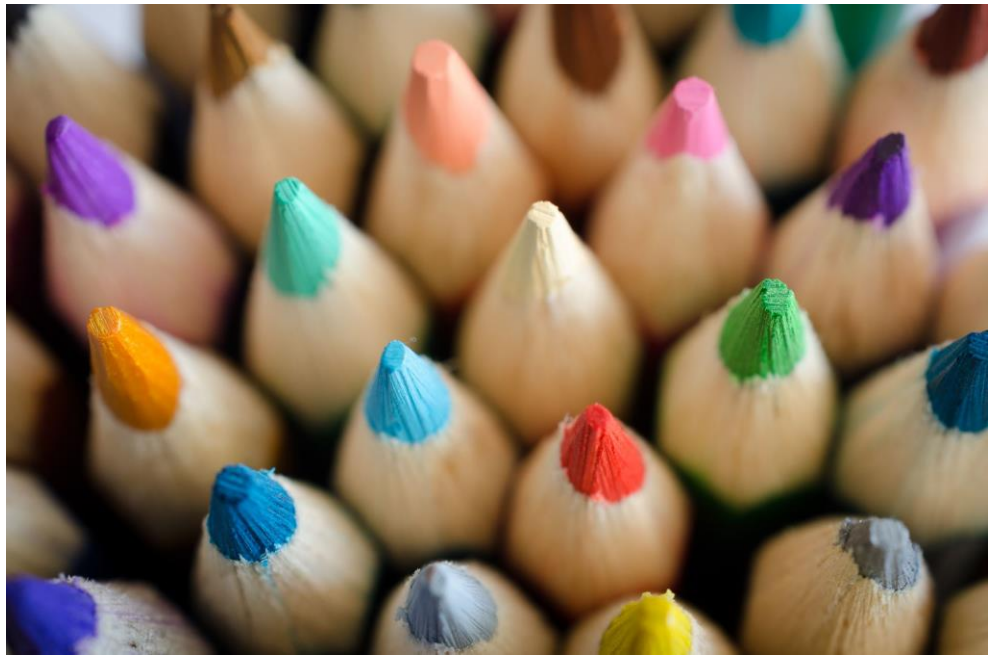
Example #4

Patient Name **Reason for Admission to Swing Bed** **Date of Admission** **Expected Date of Discharge** **Expected Discharge Location (as stated by patient)**			
	Week 1	**Week 2**	**Week 3**
Case Management			
Nursing			
Nutrition			
PT			
OT			
Speech			

SO.....

Most of these examples rely on paper (hard copy) documentation

Consider developing an EMR dot phrase smart phrase



WHY can’t we just use individual disciplines documentation????

You can ---- kinda’

1) Include at least goals and progress (Met/Not Met/In progress) in IDT plan

2) Refer back to Rehab plan, Nursing Plan, or Dietary Plan for specifics

Post Plan of Care in Patient's Room or Give Patient a Copy

Include both Long Term Goal and Short Term Goals for day or week.

If you don't post in the patient's room (*which you should*) – give patient a copy of goals

§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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Discharge

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Discharge Rights

Discharge Rights

§485.645(d)(5) -- §483.15(c)(1-5)

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;

Discharge Rights, cont.

§485.645(d)(5) -- §483.15(c)(1-5)

(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.

(ii) 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.

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Choice of Post-Acute Provider

Choice of Post-Acute Providers

§485.642(a)(8) -- §483.21(c)(1)

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

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Information to Post-Acute Care Provider at Transfer or Discharge

Required Information

§485.645(d)(5) -- §483.15(c)(2): ..... 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

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Transfer and Discharge Notices

Notice Before Transfer or Discharge

§485.645(d)(5) -- §483.15(c)(3): 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.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.

(iii) Include in the notice the items described in paragraph **(c)(5)** of this section

Notice Before Transfer or Discharge

§485.645(d)(5) -- §483.15(c)(3): 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.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.

(iii) Include in the notice the items described in paragraph **(c)(5)** of this section

Timing of Transfer or Discharge Notice

§485.645(d)(5) -- §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.

(ii) 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. Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; 42 CFR 483.15(c)(4)(ii)(C) (enhanced display) page 27 of 148 42 CFR Part 483 (up to date as of 12/18/2025) Requirements for States and Long Term Care Facilities 42 CFR 483.15(c)(4)(ii)(D)

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days

Notice Before Transfer or Discharge

§485.645(d)(5) -- §483.15(c)(5): Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long Term Care Ombudsman

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.

- 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).

Notice of Medicare Non-Coverage, cont.

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711: 260.2

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.**

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.

Ombudsman

§485.645(d)(5) -- §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.**

§483.15(c)(3)-(6)

Guidance - Notice of Transfer or Discharge and Ombudsman Notification
Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state

Send the Discharge Notice to the Ombudsman that you provide to the patient

Appeal

§485.645(d)(5) -- §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.

Orientation for discharge

§483.15(c)(7): Orientation for transfer or discharge.

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand

Discharge

Have a weekend and holiday plan

Part 2 - April 17

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