YOUR
SWING BED
QUESTIONS
ANSWERED!
Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and critical access hospitals
- Example managed hospital client includes Barrett Hospital and Healthcare in Dillon, MT. Ranked as a Top 100 Critical Access Hospital for 8 years in a row
- Example technology and AR services client includes two-hospital NFP system in southeast GA with numerous associated physician practices

Preferred vendor to:

- California Critical Access Hospital Network
- Western Healthcare Alliance Partner with Illinois Critical Access Hospital Network
- Vizient Group Purchasing Organization
### Areas of Expertise
**Strategy - Solutions - Support**

<table>
<thead>
<tr>
<th>Governance &amp; Strategy</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Executive management &amp; leadership development</td>
<td>- Performance optimization &amp; margin improvement</td>
</tr>
<tr>
<td>- Community health needs assessment</td>
<td>- Revenue cycle &amp; business office improvement</td>
</tr>
<tr>
<td>- Lean culture</td>
<td>- AR outsourcing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Clinical Care &amp; Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Executive and interim recruitment</td>
<td>- Continuous survey readiness</td>
</tr>
<tr>
<td>- CEOs, CFOs, CNOs</td>
<td>- Care coordination</td>
</tr>
<tr>
<td>- VP and Department Directors</td>
<td>- Swing bed consulting</td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR TODAY’S WEBINAR

☐ You may type a question in the text box if you have a question during the presentation.

☐ We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.

☐ You may also send questions after the webinar to our team (contact information is included at the end of the presentation).

☐ The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

HealthTechS3 hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive. HealthTechS3 and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof. HealthTechS3 does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel. HealthTechS3 recommends that hospitals, clinics, their respective personnel, and all other third party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.
Your Swing Bed Questions Answered
Date: October 4, 2019  Time: 1:00 pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
HealthTechS3

CMS Changes, CoPs and Discharge Planning Requirements – What do They Mean for Your Organization?
Date: October 18, 2019  Time: 12pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
HealthTechS3

Chronic Care Management Coding: How to Deal with Combo Codes and The Impact on Revenue
Date: October 24, 2019  Time: 12:00 pm CST
Presenters: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting, HealthTechS3
Julianna Seaman, CCS, CCS-P, Coding and CDI Director, eCatalyst Healthcare Solutions

Best Practices from Nurse Leaders
Date: November 1, 2019  Time: 1pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
HealthTechS3

Diversity and Inclusion at the Hospital Senior Leadership Team Level
Date: November 15, 2019  Time: 1:00 pm CST
Presenter: Peter Goodspeed, MBA, VP of Executive Search, HealthTechS3

Understanding Lean and Using a Kaizen Event to Improve Multi-Department Processes
Date: November 21, 2019  Time: 12pm CST
Presenters: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting, HealthTechS3
Tracy Clarno, PMP, CPHQ, Think Lean Consulting

Planning for a Successful Hospital Survey
Date: December 6, 2019  Time: 1pm CST
Presenter: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
HealthTechS3
https://bit.ly/2mMPeCb

8 Critical Strategies for Interim Executives
Date: December 11, 2019  Time: 12pm CST
Presenter: Mike Lieb, Vice President – Interim Services, HealthTechS3

Team-Based Care and Achieving Optimal Performance
Date: December 19, 2019  Time: 12pm CST
Presenters: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting, HealthTechS3
Kara Beech, Beech Creative Group
https://bit.ly/2l7ZFzT

ALL WEBINARS ARE RECORDED
Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St.Charles conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn also has extensive experience in working with rural hospitals to both develop and strengthen Swing Bed programs.

carolyn.stcharles@healthtechs3.com
360-584-9868
Regulatory Resources

Appendix W (CAH)

Appendix A (Hospital)

Appendix PP (Long Term Care)

Medicare Benefits Manual Chapter 8

Changes published September 30, 2019
Omnibus Burden Reduction Final Rule CMS – 334
Discharge Planning

-
CoPs Swing Bed (October 2018)

1. Resident Choice of Physician - Clarification
2. Timelines for Reporting Abuse - New
3. PASARR – Clarification
4. Plan of Care – Additional language and Clarification
5. Provide Culturally-Competent and Trauma Informed Care – New
6. Reconciliation of Pre-Discharge Medications with Post-Discharge Medications – New
7. Dental Care – Clarification of Timelines
8. Transfer & Discharge – Information at Discharge and Ombudsman Notification - New
Hospital and CAH Swing-Bed Providers

- We are removing the cross reference to § 483.10(f)(9) at § 482.58(b)(1) (for hospital swing-bed providers) and § 485.645(d)(1) (for CAH swing-bed providers); the repealed provisions gave a resident the right to choose to, or refuse to, perform services for the facility if they so choose.

- We are removing the cross-reference to § 483.24(c) at § 482.58(b)(4) (for hospital swing-bed providers) and § 485.645(d)(4) (for CAH swing-bed providers) requiring that the facility provide an ongoing activity program based on the resident’s comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation.
  - *because the patient’s activity needs are addressed in the nursing care plan*

- We are removing the cross-reference to § 483.70(p) at § 482.58(b)(5) (for hospital swing-bed providers) and § 485.645(d)(5) (for CAH swing-bed providers requiring facilities with more than 120 beds to employ a social worker on full-time basis).

- We are removing the cross-reference to § 483.55(a)(1) at § 482.58(b)(8) (for hospital swing-bed providers) and § 485.645(d)(8) (for CAH swing-bed providers) requiring that the facility assist residents in obtaining routine and 24-hour emergency dental care.
  - *because of the existing requirement for hospitals and CAHs to provide care in accordance with the needs of the patient (emergent and non-emergent)*
You asked a lot of questions!

Pre-Admission

Admission

Continued Stay

Discharge
Pre-Admission
What swing bed policies do we need?

**Pre-Admission**
1. Pre-Admission processes including process for accepting patients
2. Admission criteria

**Admission - Patient**
1. Admission packet and admission processes including patient disclosures, orders, medical record, etc.
2. Patient Rights, including freedom from restraints
3. Privacy and confidentiality, including visitation
4. Reporting abuse
5. Filing a complaint
6. Patient financial obligations
7. Patient choice of physician and how to contact provider(s)

**Admission**
1. Physician orders
2. Medical Record
3. Multi-disciplinary assessment including assessment of trauma
4. PASARR (Review)

**Continuing Care**
1. Multi-disciplinary care conferences including who attends
2. Multi-disciplinary plan of care including who develops plan
3. Activities
4. Nutrition
5. Dental care
6. Leave of absence (if allowed by facility)

**Discharge**
1. Discharge or transfer patient notifications, including notification of ombudsman
2. Discharge or transfer notifications for next provider of care
3. Medication reconciliation

Don’t forget the admission packet!
Can we combine swing bed policies with acute care?

Pre-Admission
1. Pre-Admission processes including process for accepting patients
2. Admission criteria

Admission - Patient
1. Admission packet and admission processes including patient disclosures, orders, medical record, etc.
2. Patient Rights, including freedom from restraints
3. Privacy and confidentiality, including visitation
4. Reporting abuse
5. Filing a complaint
6. Patient financial obligations
7. Patient choice of physician and how to contact provider(s)

Admission – Team
1. Physician orders
2. Medical record
3. Multi-disciplinary assessment including assessment of trauma
4. PASARR (Review)

Continuing Care
1. Multi-disciplinary care conferences including who attends
2. Multi-disciplinary plan of care including who develops plan
3. Activities
4. Nutrition
5. Dental care
6. Leave of absence (if allowed by facility)

Discharge
1. Discharge or transfer patient notifications, including notification of ombudsman
2. Discharge or transfer notifications for next provider of care
3. Medication reconciliation

\textbf{Answer: Maybe}

\textbf{Some Swing Bed regulatory requirements ---- are NOT applicable to acute care}

- Patient Rights
- Visitation
- Financial Obligations
- Choice of physicians
- Contact information for providers
- Multi-disciplinary care conferences and development of plan of care
  - Culturally competent trauma-informed care
    - PASARR
    - Discharge
Are critical access hospitals required to have a social service worker on staff for the swing bed program?

**Answer:** NO – but you must provide medically-related social services

**CAH:** C-0386 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)

§485.645(d)(5) Social Services (§483.40(d) and §483.70(p) of this chapter).

§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident.

§483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

1. An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and
2. One year of supervised social work experience in a health care setting working directly with individuals.

**Hospital:** A-1570 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)

§482.58(b)(5) Social services (§483.40(d) and 483.70(p))

- §483.40 (d): The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident.
- §483.70 (p): Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:
  1. An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and
  2. One year of supervised social work experience in a health care setting working directly with individuals.
Are there clear requirements for patients to be admitted to swing bed besides the three night stay by Medicare?

Answer: **YES**

1. The patient has Medicare Part A and has benefit days available
2. Medicare age or disability/disease eligibility requirements must be met
3. There must be a three-day qualifying stay (observation doesn’t count)
4. Swing Bed admission condition is the same as the qualifying stay condition
5. Patient must be admitted to Swing Bed within thirty days of discharge from acute care
6. The patient’s condition meets criteria to necessitate inpatient skilled nursing services

Medicare Benefit Policy Manual – (Rev. 242, 03-16-18)
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
Are there any changes in qualifications for swing bed admissions?

Answer: NO for Medicare ---- but it depends on the payor

30.2.1 - Skills of qualified technical or professional health personnel

30.2.1 - Provided directly by or under the general supervision of skilled nursing or skilled rehabilitation personnel

30.2.2 - Complexity of services provided

30.2.3.1 - Management and Evaluation of a Patient Care Plan

30.2.3.2 - Observation and Assessment of Patient’s Condition

30.2.3.3 - Teaching and Training Activities

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 249, 11-02-18)
30.2.1 - Skilled Services Defined: Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

• Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and

• Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.
Medicare Skilled Criteria

30.2.2 - Principles for Determining Whether a Service is Skilled

If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient’s particular medical condition is a valid factor in deciding if skilled services are needed, a patient’s diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.
Medicare Skilled Criteria

30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE: When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel. (See §30.5.)

A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes.
Medicare Skilled Criteria

30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE:
Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient’s condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. The documentation needs to support the severity of the circulatory condition that requires skilled care (see section 30.2.2.1).

In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient’s total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.
Medicare Skilled Criteria

30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE:
An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient’s condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient’s progress, and to evaluate the need for changes in the treatment plan.

As discussed in section 30.2.2.1 below, the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.

The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.
Medicare Skilled Criteria

30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE:
A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient’s record.
Medicare Skilled Criteria

30.2.3.1 - Management and Evaluation of a Patient Care Plan

EXAMPLE:
An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient’s condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient’s recovery and safety. The management of this plan of care requires skilled nursing personnel until such time as skilled care is no longer required in coordinating the patient’s treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.
Medicare Skilled Criteria

30.2.3.1 - Management and Evaluation of a Patient Care Plan

EXAMPLE:
An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient’s immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient’s medical safety. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient’s recovery and medical safety in view of the patient’s overall condition.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient’s treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, or skin breakdown, is both reasonable and necessary. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A patient has been hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient’s treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient’s oral intake is required to prevent dehydration. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.
Medicare Skilled Criteria

30.2.3.2 - Observation and Assessment of Patient’s Condition

EXAMPLE:
A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient’s recovery and medical safety in view of the patient’s overall condition, to maintain the patient’s current condition, or to prevent or slow further deterioration in the patient’s condition.
Medicare Skilled Criteria

30.2.3.3 - Teaching and Training Activities

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

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

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.
Medicare Skilled Criteria

30.2.3.3 - Teaching and Training Activities

EXAMPLE:
A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving. This refusal continues, notwithstanding efforts to counsel the patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences. The patient’s response to the recommended treatment plan as well as to all educational attempts is documented in the medical record.
How do you qualify a patient for swing bed that does not need PT/OT/Speech (skilled nursing only)?

**Answer: Many of the skilled care examples do not include rehab**

30.2.1 - Skills of qualified technical or professional health personnel

30.2.1 - Provided directly by or under the general supervision of skilled nursing or skilled rehabilitation personnel

30.2.2 - Complexity of services provided

30.2.3.1 - Management and Evaluation of a Patient Care Plan

30.2.3.2 - Observation and Assessment of Patient’s Condition

30.2.3.3 - Teaching and Training Activities

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 249, 11-02-18)
Can a patient be admitted to swing bed if the problem seems to be more social than actually needing therapy?

Answer: Maybe to develop a maintenance program – but not specifically for social needs

Example: Patient admitted to hospital after a total knee replacement and met PT goals after day 2 or 3 post-op. Patient is partially blind and lives at home by himself and also has mobility problems due to arthritis on his hip. If he is not a safe discharge due to those limitations, can the patient be admitted to swing bed for continued therapy.

30.4.1 – Skilled Physical Therapy (Rev. 1, 10-01-03) A3-3132.3A, SNF-214.3.A
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.
Are there any restrictions on having patients come to swing bed to transition to long term care?

Answer: No ---- IF the patient meets skilled criteria in swing bed
You cannot transfer (skilled to skilled) unless it is the patient’s request
How can we have better updates on criteria for swing bed from the insurance companies because they are really controlling what we are doing?

*Answer: A challenge for sure!*

*Thoughts:*

1. *Include criteria in payor contracts*

2. *Ask insurance companies for criteria they use for swing bed*
What’s the best way to check if the patient has available swing bed days?

**Answer: Noridian Medicare Portal**

https://med.noridianmedicare.com/web/jea/topics/nmp/end-user-manual#eligibility

“The only issue is that if a patient is coming from another skilled bed to me and they (the facility) haven’t billed out yet I just have to minus the days that are shown to get a rough estimate. For instance if I know that a patient was in a Reno skilled bed for 2 weeks and are coming to me now I minus 14 from whatever number pops on Noridian. So if they still have their hundred, I just take it down to I still have 6 days for days 1-20 and about 80 for the rest.” Alicia
Admission
What should go in the admission packet?

Information provided both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act.

Such notification must be made prior to or upon admission and during the resident’s stay.

Receipt of such information, and any amendments to it, must be acknowledged in writing.

A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits.

- Description of Swing Bed
- Resident Rights and Responsibilities
- A description of Hospital’s policies regarding advance directives
- A list of attending physicians who treat patients
- Resident Choice of physicians
- Information on how to contact providers (ALL)
- Financial Obligations
- Transfer and Discharge policies
- Notice of privacy practices
- How to file grievance or complaint
- Hospital responsibility for preventing patient abuse
- Information for reporting Abuse and Neglect
- Contact information for Hospital and State Agencies including State Ombudsman
Is the SNF certification form also required for non-Medicare patients?

Answer: I'm not 100% sure what this is referring too ---- sorry!
If you are talking about need for skilled care – it depends on the payor
Do patients with managed Medicaid (California Health & Wellness) require an OBRA MDS?

Answer: Sorry ---- Don’t know
Do Medicare swing bed patients require a comprehensive assessment along with their Medicare assessment?

*Answer: Not sure of the context of the question*

If you are talking about a comprehensive assessment in addition to the MDS (RAI) – the MDS is the comprehensive assessment for hospitals with swing beds (not CAHs).

If you are talking about comprehensive assessment for patients in a CAH Swing Bed – only the comprehensive assessment is required.
Must we include specifically in the admission packet that the patient “has a choice” of provider, or can we get by with listing our hospitalists? We have three hospitalists who rotate weeks, and there really is no choice of providers since we do not have more than one provider available with privileges at any given time?

**Answer:** You must give patients a choice – but you can inform the patient of hospitalist names – and the rotation

**CAH:** C-0364 §483.10(d) Free Choice The resident has the right to-(1) Choose a personal attending MD/DO

**Hospital:** A-1511 §483.10(d) Free Choice The resident has the right to-(1) Choose a personal attending physician

The right of a LTC resident to choose his or her own attending physician is a long standing patient right, which was established at section 1819(c)(1)(A)(i) of the Act by section 4201 of the Omnibus Budget Reconciliation Act of 1987 and at section 1919(c)(1)(A)(i) by section 4211 of the Omnibus Budget Reconciliation Act of 1987. We included the right to choose a physician in this rulemaking in order to support the statutory requirement, and remind stakeholders that it is not a new requirement and therefore should add no new regulatory burden.

Federal Register /Vol. 81, No. 192 /Tuesday, October 4, 2016 /Rules and Regulations
Do swing bed admissions require PASRR screening?
If the patient has a PASARR what do we need to do?

Answer: A PASARR is not required – but you must incorporate it in the plan of care if the patient has a PASRR that has previously been completed

CAH: C-0388 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)
§483.21(b) Comprehensive care plans.
(1)(i): 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.
*NOTE: 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). Also, note that CAHs are not required to complete the PASARR. However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.

Hospital: A-1572 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)
§482.58(b)(6) Discharge planning (§483.20(e)
§483.20(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes—
(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.
(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
There have recently been changes with long-term care requirements and trauma assessments. Are swing bed patients included?

*Answer: Yes*

**CAH:** C-0388 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18)

§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:

(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.

Nothing specific in CoPs A – refers to appendix PP (next slide)
There have recently been changes with long-term care requirements and trauma assessments. Are swing bed patients included?

Long Term Care:  F699 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(m) Trauma-informed care  The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care 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.  

[§483.25(m) will be implemented beginning November 28, 2019 (Phase 3)]
Example of Questions to assess for Trauma
Mine ----- Not from CMS

1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?

2. Have you experienced the loss of a close friend, relative, or a pet that you loved recently?

3. Have you had any past trauma in your life that we should know about so we can better care for you?

4. If you have experienced some kind of trauma is there something that helps you feel better?

5. Is there anything we can do to help while you are in the (Hospital) - (Nursing Home)?

DON’T PROBE – IF THEY SAY NO – IT’S NO

*Trauma-Informed Care is a process, not a destination*
Continued Stay
Does a physician have to renew / reorder the admission to swing bed after 14 days?

Answer: CAH: Maybe but probably not - The need for continued swing bed care is a continuing process reviewed by the interdisciplinary team, including the physician, on a regular basis

Hospital: Yes

CAH: C-0350 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §485.645 Special Requirements for CAH Providers of Long-Term Care Services (“Swing-Beds”).

Interpretive Guidelines §485.645
The swing-bed concept allows a CAH to use their beds interchangeably for either acute care or post-acute care. A “swing-bed” is a change in reimbursement status. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.

Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however swing-bed patients are not SNF patients. Swing-bed patients in CAHs are considered to be patients of the CAH.
Does a physician have to renew / reorder the admission to swing bed after 14 days?

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.

The skilled nursing facility is responsible for obtaining the required certification and recertification statements and for retaining them in file for verifications, if needed, by the A/B MAC (A). The skilled nursing facility determines the method by which the certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and 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 a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed. See Pub. 100-08, Medicare Program Integrity Manual, chapter 6, section 6.3 regarding medical review of certification and recertification in SNFs.
Does a physician have to renew / reorder the admission to swing bed after 14 days?

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

The first recertification must be made no later than the 14th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan (if a UR review plan is in place), may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.
Activities – Just a Few Questions (?)

Who is responsible for documenting that activities are occurring?
   Answer: Your hospital policy will determine this

What discipline should be responsible for monitoring activities?
   Answer: Usually whoever is responsible for completing the activities assessment and plan

Where should the activity goals be located in the Plan of Care?
   Answer: They should be included – at least in general terms – in the multi-disciplinary plan of care. A more detailed plan can be included as part of the activities assessment. New regulations say, “nursing care plan”.

Should an activity coordinator/OT still be completing a formal activity assessment or can nursing screen the patient for customary activity routine?
   Answer: You can only have nursing complete the assessment – if it is under the direction/supervision of a qualified individual (i.e. certified activities professional, certified recreational therapist, occupational therapist)
Activities – Just a Few Questions (?)

What will be the expectation of activities for swing bed patients with the regulatory changes?

With the elimination of the ongoing activities' services regulation is there any regulations that speaks to meeting the activity interests and/or quality of life needs for the Swing Bed patient. My state still requires Activity services be offered. This seems to be a step backwards in the patient centered philosophy services. I do agree with the fact it does not need to be a direct parallel to the F680 regulation for long term care activity services.

Answer: You must still provide activities – that hasn’t changed

Can activities be carried out by volunteers?- Ex Pet Visits, conversing, spiritual visits.

Answer: Absolutely

If patients are provided a list of activities that the facility offers will that meet the requirements? Ex: Exercise opportunities, Senior Center/LTC/Assisted Living Activities, Outdoor options etc. So given that options are provided and the patient has the opportunity to select and attend activities of choice, if the patient chooses to stay in their rooms for their swing stay and only watch television and have family visits if this acceptable?

Answer: Maybe. There needs to be an effort to provide activities appropriate to the patient
What about readmission to SNF within 30 days – 20.2.3?

Answer: You can admit - under certain circumstances

20.2.3 - Readmission to a SNF (Rev. 242, Issued: 03-16-18, Effective: 06-19-18; Implementation: 06-19-18)
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. (See 20.2.2 and 20.2.2.3 above for situations where a period of more than 30 days between SNF discharge and readmission, or more than 30 days of noncovered care in a SNF, is followed by later covered care.)
What about readmission to SNF – 20.2.3?

1. Routine SNF Admission Directly From Qualifying Hospital Stay
   If the beneficiary is admitted to the SNF immediately following a 3-day qualifying hospital stay, there is a presumption that he or she meets the Medicare level of care criteria when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

2. Admission to SNF does not immediately follow discharge from the qualifying hospital stay, but occurs within 30 days (as required under the “30 day transfer” rule)
   If the beneficiary is discharged from the hospital to a setting other than the SNF, the presumption of coverage does not apply, even if the beneficiary’s SNF admission occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in the file.

3. SNF Resident is Re-Hospitalized and Then Returns Directly to the SNF
   If a beneficiary who has been in a covered Part A stay requires readmission to a hospital, and subsequently returns directly to the SNF for continuing care, there is a presumption that he or she meets the level of care criteria upon readmission to the SNF when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of that assessment, which must occur no later than the eighth day of the stay.
What about readmission to SNF – 20.2.3?

4. Routine SNF Admission Directly From Qualifying Hospital Stay, but Initial Portion of SNF Stay Covered by Another Insurer (Medicare as Secondary Payer)

When a beneficiary goes directly from a qualifying hospital stay to the SNF, but the initial portion of the SNF stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the primary insurer ends. Accordingly, the Medicare required schedule of assessments is not required to begin until the first day of Medicare coverage. If a beneficiary met the level of care criteria for Medicare coverage during the first 8 days of the stay following a qualifying hospital stay, and the other insurer covered this part of the stay, there is no presumption. If Medicare becomes primary before the eighth day of the stay following a qualifying hospital stay, the presumption would apply through the assessment reference date on the 5-day assessment or, if earlier, the eighth day of the stay.

5. Readmission to SNF Within 30 Days After Discharge From Initial SNF Stay – No Intervening Hospitalization

As noted in scenario 1, if a beneficiary is initially admitted to the SNF directly from the hospital for a covered Part A stay, the presumption for that stay is applicable when the beneficiary is correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care.

However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second SNF admission. (If the beneficiary is transferred to a hospital, and returns directly to the SNF, see scenario 3 above).
What about readmission to SNF – 20.2.3?

6. Initial, Non-Medicare SNF Stay Followed by Qualifying Hospitalization and Readmission to SNF for Medicare Stay
Dually eligible (Medicare/Medicaid) beneficiaries whose initial stay in the SNF is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the SNF following a qualifying hospitalization, when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. (Of course, in order to qualify for Medicare coverage upon readmission, the beneficiary must be placed in the portion of the institution that is actually certified by Medicare as a SNF.) No presumption of coverage applies when Medicare is the secondary payer for days 1 through 8 of the covered stay where Medicare becomes primary after day 8 due to a reversal or denial by the secondary insurer.

7. Transfer From One SNF to Another
There is no presumption of coverage in cases involving the transfer of a beneficiary from one SNF to another or from SNF-level care in a swing bed to a SNF. The presumption only applies to the SNF stay that immediately follows the qualifying hospital stay when the beneficiary is correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. Therefore, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption only applies if the beneficiary was receiving acute care (rather than SNF-level care) immediately prior to discharge from the swing-bed hospital.
What is needed as far as documentation goes if you get a patient that had a 3 day qualifying stay sometime in the month but did not come to the swing bed program directly from that hospital? Meaning they went home and came to the swing bed on the suggestion of their PCP but had a qualifying stay in the last 30 days.

**Answer:** Medicare: Patient must meet skilled criteria the same as if they were admitted to swing bed directly after an acute care stay

1. The patient has Medicare Part A and has benefit days available
2. Medicare age or disability/disease eligibility requirements must be met
3. There must be a three-day qualifying stay (observation doesn’t count)
4. Swing Bed admission condition is the same as the qualifying stay condition
5. Patient must be admitted to Swing Bed within thirty days of discharge from acute care
6. The patient’s condition meets criteria to necessitate inpatient skilled nursing services

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Table of Contents (Rev. 249, 11-02-18)
Will jRAVEN be updated to meet the PDPM criteria questions?

Answer: I’m not the expert on this – sorry!

There are two new item sets that have been created as a result of PDPM. First, the IPA has its own IPA item set. This item set contains merely payment items and demographic items, as necessary to attain a billing code under PDPM. Second, for states that rely on the RUG-IV assessment schedule for calculating case mix group for NF patients, CMS has created an optional assessment so that Medicaid payments are not adversely impacted when PDPM is implemented as of October 1, 2019. States will have the ability to determine the policy associated with this assessment to meet your Medicaid payment needs. The optional assessment will be in place from October 1, 2019 through September 30, 2020.

New MDS Item: Section I: SNF Primary Diagnosis

To capture the patient’s primary diagnosis, which is used to classify the patient into a PDPM clinical category, CMS added Item I0200B, which allows providers to report, using an ICD-10CM code, the patient’s primary SNF diagnosis. The item will ask “What is the main reason this person is being admitted to the SNF?” Item I0200B will be coded when Item I0020 is coded as any response 1 – 13.

New MDS Items: Section J: Patient Surgical History

New MDS Items: Section O: Discharge Therapy Items

New MDS Item: Section GG: Interim Performance

Existing MDS Items Added to PPS Item Sets: There will be several existing MDS Items added to the Swing Bed PPS Assessment

- K0100: Swallowing Disorder
- I4300: Active Diagnosis: Aphasia
- 0100D2: Special Treatments, Procedures and Programs: Suctioning, While a Resident
- I1300: Ulcerative Colitis or Crohn’s Disease or Inflammatory Bowel Disease is being added to the NP, SP, and IPA item sets, in order to capture this diagnosis for the NTA comorbidity score

Source: CMS Fact Sheet file:///C:/Users/carol/AppData/Local/Microsoft/Windows/INetCache/IE/DIED0WK3/PDPM_Fact_Sheet_MDS_Changes_Final%20(1).pdf
Do we only need a 5-day MDS and MDS at discharge? (If there isn’t a clinical change)

*Answer: I’m not the expert on this – sorry! But it appears the answer is Yes*

Under PDPM (effective October 1, 2019), there are 3 SNF PPS assessments: the 5-day Assessment, the Interim Payment Assessment (IPA) and the PPS Discharge Assessment. The 5 day assessment and the PPS Discharge Assessment are required. The IPA is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment.

5-day PPS Assessment Days 1-8
All covered Part A days until Part A discharge (unless an IPA is completed).

Interim Payment Assessment (IPA)
The date the facility chooses to complete the IPA relative to the triggering event that causes the facility to choose to complete the IPA.

PPS Discharge Assessment
PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date

*Source: CMS Fact Sheet*
file:///C:/Users/carol/AppData/Local/Microsoft/Windows/INetCache/IE/DIED0WK3/PDPM_Fact_Sheet_MDS_Changes_Final%20(1).pdf
Do we need consent for psychotropic medications or opioids?

Answer: There is nothing specifically in the CAH or Hospital Swing Bed regs. that address this. Although there are requirements for the patient to be “free from restraints.”

References are in Appendix PP regarding use of psychotropic drugs.
Does OT have to do a re-assessment at least every 21 days on a swing bed patient in a CAH?

Answer: No ---- why do you ask?
Can we stagger PT/OT on alternative days?

**Answer: Depends – but probably not**

30.6 - Daily Skilled Services Defined (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services.

However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a “daily basis.”

To meet this requirement, the patient must actually need skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is furnished each day, unless the patient's medical needs indicate that daily therapy is required.

For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the “daily basis” requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but when they are needed.

Unless there is a legitimate medical need for scheduling a therapy session each day, the “daily basis” requirement for SNF coverage would not be met.
What are some of the skilled needs we need to keep a patient in swing bed during the dying process. Are giving pain medications, anxiety medications buccal route acceptable?

Answer: *Patient would still need to meet skilled need – and – there would need to be documentation that care could not be provided in a less acute setting (i.e. LTC, Home Health, etc.)*
As a swing bed patient in a facility with CT/MRI capabilities if the physician feels a test needs to be completed should the patient be registered as an outpatient and billed accordingly or do you order the test on their swing bed account and it becomes part of their reimbursement for skilled services?

**Answer: It is part of the CAH bill**

**CAH:** Since a CAH is reimbursed under the cost methodology, the CAH will bill the CT scan on the swing bed claim, TOB 181.

Although the CT scan is considered a Major Category and is an “excluded” service under the SNF PPS consolidated billing requirements, CAHs are exempt from using the list and services provided while the patient is in a CAH’s swing bed should be included on the swing bed claim, regardless of the reason for the service, the findings, or if additional services were required.

Patients in a covered Part A swing bed stay are not responsible for Part B coinsurance and deductible.

Social Security Act §§ 1888(e)(7), 1883(b)(3), 42 CFR 413.114, MLN Matters SE0606
When looking at patients who are ordered medications that exceed your daily reimbursement rate are there any recommendations of how to accommodate those patient's in the program?

Answer: You are responsible for providing the necessary care
Discharge
Do we really have to notify the Ombudsman of the patient’s discharge?

Answer: YES – sorry

CAH: §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.
(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.

Hospital: §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.
(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.
Do we have to give the patient 30 days notice before discharge?

Answer: No – Maybe

CAH: §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) 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;
(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.

Hospital: §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) 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;
(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.
Conflicting reports about whether or not the “Important Message from Medicare” (IM) needs to be included or is a “generic” discharge notice sufficient. The IM is given on admission to all of our Medicare patients but unsure if needs to be at discharge also.

Answer: I do not believe that you need the I.M.

200.1 - Scope of the Instructions (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)
These instructions implement 42 CFR 405.1205 and 405.1206 which require hospitals to inform Medicare beneficiaries who are hospital inpatients of their right to a QIO review. These instructions delineate the expectations of beneficiaries (or their representative, if applicable), responsibilities of hospitals, and the role of the QIOs when the beneficiary requests an expedited review by a QIO of the discharge decision. For purposes of this instruction, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary. Hospitals Affected by these Instructions. The term hospital is defined in the regulation as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals. This means all hospitals paid under the Inpatient Acute Prospective Payment System (IPPS), sole community hospitals/regional referrals centers or any other type of hospital receiving special consideration under IPPS (for example, Medicare dependent hospitals, Indian Health Service hospitals); hospitals not under IPPS, including, but not limited to: hospitals paid under State or United States territory waiver programs, hospitals paid under certain demonstration projects cited in regulation (§489.34), rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children’s hospitals, and cancer hospitals. Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded. Hospital Inpatients who are Medicare Beneficiaries. These instructions apply to beneficiaries in original Medicare who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care. Medicare beneficiaries in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care. Definition of Discharge. The term “discharge” is defined as a formal release of a beneficiary from an inpatient hospital. This includes when the beneficiary is physically discharged

200.3 - Notifying Beneficiaries of their Right to an Expedited Review (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)
Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the beneficiary’s rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge
Conflicting reports about whether or not the “Important Message from Medicare” (IM) needs to be included or is a “generic” discharge notice sufficient. The IM is given on admission to all of our Medicare patients but unsure if needs to be at discharge also.

200.1 - Scope of the Instructions (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)
These instructions implement 42 CFR 405.1205 and 405.1206 which require hospitals to inform Medicare beneficiaries who are hospital inpatients of their right to a QIO review. These instructions delineate the expectations of beneficiaries (or their representative, if applicable), responsibilities of hospitals, and the role of the QIOs when the beneficiary requests an expedited review by a QIO of the discharge decision. For purposes of this instruction, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.

Hospitals Affected by these Instructions. The term hospital is defined in the regulation as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals. This means all hospitals paid under the Inpatient Acute Prospective Payment System (IPPS), sole community hospitals/regional referrals centers or any other type of hospital receiving special consideration under IPPS (for example, Medicare dependent hospitals, Indian Health Service hospitals); hospitals not under IPPS, including, but not limited to: hospitals paid under State or United States territory waiver programs, hospitals paid under certain demonstration projects cited in regulation (§489.34), rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children’s hospitals, and cancer hospitals.

Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded.

Hospital Inpatients who are Medicare Beneficiaries. These instructions apply to beneficiaries in original Medicare who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care. Medicare beneficiaries in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.

Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections
Table of Contents (Rev. 4197, 01-11-19) (Rev. 4250, 03-08-19)
Conflicting reports about whether or not the “Important Message from Medicare” (IM) needs to be included or is a “generic” discharge notice sufficient. The IM is given on admission to all of our Medicare patients but unsure if needs to be at discharge also.

§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;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.
SWING BED CONSULTING PACKAGE

1. Growth Strategies
2. Skilled Criteria
3. Policy and Procedures
4. Patient Admission Packet
5. Staff Education
6. Provider Education
7. Multi-disciplinary Assessment / Care Planning Tools
8. Annual Survey on-site
9. Quarterly reviews off-site
10. Unlimited telephone and e-mail support
Thank You

I hope this information has been helpful

Please contact me if you would like to schedule a review of your Swing Bed Program or have questions about the presentation

Stay Tune for a New Swing Bed Collaborative Opportunity Coming Soon!

Carolyn St.Charles
carolyn.stcharles@healthtechS3.com
Office: +360-584-9868
Cell: +206-605-3748