

IDAHO CRITICAL ACCESS HOSPITAL SWING BED MANUAL

Sponsored by



Bingham Memorial Hospital
Idaho State Office of Rural Health & Primary Care
Public Hospital Cooperative

Swing Bed Manual Table of Contents

I.	<i>Introduction — page 1</i>	
	A. Critical Access Hospital Program Description	1
	B. Federal Criteria	1
II.	<i>Critical Access Hospitals Swing Beds — page 2</i>	
	A. Definition of Swing Bed	2
	B. Medicare Swing Bed Benefit	2
	C. What is a Benefit Period	2
	D. Why Use Swing Beds (Advantages).....	2
III.	<i>Admission Criteria — page 3</i>	
	A. General Eligibility Criteria	3
	B. Information for Patients Admitted to Swing Bed	5
	C. Skilled Services Defined.....	5
	D. Guidelines for Determining Whether a Service is Skilled.....	6
	E. Examples of Skilled Nursing Services.....	7
	F. Skilled Rehabilitative Services	8
	G. Examples of Skilled Rehabilitation Services	8
	H. Situations/Services that are Not Skilled.....	9
	I. Continued Stay/Discharge.....	9
IV.	<i>Transfers from Other Acute Care Hospitals — page 10</i>	
V.	<i>Documentation Requirements — page 10</i>	
	A. Comprehensive Assessment.....	11
	B. Comprehensive Care Plan	13
	C. Conditions of Participation	14
	D. Discharge Summary	15
	E. Additional Considerations.....	15
VI.	<i>Appendices — page 17</i>	
	A. Regulations/Requirements	17
	B. Case Examples	18
	C. Questions and Answers	21
	D. References/Other Resources.	23

Financial support provided by the Rural Hospital Flexibility Grant Program.

This data is for informational purposes only. If any inaccuracies are identified, please contact the Colorado Rural Health Center at 1-800-851-6782.

Introduction:

Critical Access is a hospital licensure category created by the Balanced Budget Act of 1997. The Medicare Rural Hospital Flexibility Program was also created by Congress in 1997 to support any state that chooses to meet the Centers for Medicare and Medicaid Services (CMS) requirements for establishing such a program. Idaho created the Idaho Critical Access Hospital Program in 1999.

Designation as a Critical Access Hospital (CAH) creates an alternative for small, rural hospitals that includes: the potential for enhanced reimbursement from Medicare; an opportunity to better match the local community's needs to the hospital's capabilities; and establishment of the foundation for a rural health network.

The goal of this designation is to improve the financial viability and stability of the hospital and assure continued access to quality medical care in rural areas.

In Idaho a facility may be designated as a Critical Access Hospital if the facility:

- Is or has been a licensed participating provider in the Medicare program in the past 10 years;
- Offers 24-hour emergency care services determined by the State as necessary to ensure access to emergency care service in each area served by a Critical Access Hospital;
- Provides no more than 25 beds which may be used interchangeably as acute or Skilled Nursing Facility (SNF) level of care;
- Maintains an annualized average length of stay of no longer than 96 hours unless discharge or transfer is precluded by inclement weather or other emergencies;
- Meets staffing and other requirements as apply under §1861 (e) to a hospital in a rural area;
- Is a nonprofit or public hospital located in a rural area that:
 - ◆ Is more than 35 miles from any other hospital, or CAH; or
 - ◆ Is more than 15 miles from another hospital or CAH in mountainous terrain or areas with only secondary roads; or
 - ◆ Is State certified as a necessary provider of health care services to residents in the area. This designation was eliminated January 1, 2006. Facilities designated and certified under this waiver prior to January 1, 2006 were grandfathered.

Critical Access Hospital Swing Beds:

Critical Access Hospitals wishing to provide Swing Bed services must have Swing Bed certification from CMS and must have no more than 25 inpatient beds.

Swing Beds are defined as beds that may be used for either skilled nursing or acute care on an as needed basis. The facility must receive certification from Medicare to provide post-hospital SNF care.

The Medicare Swing Bed benefit includes 100 days of care in a skilled nursing facility (including Swing Bed stays) per benefit period. This service may be provided in a Swing Bed in a hospital setting or a long-term care facility offering skilled nursing services. The first 20 days are covered in full and a coinsurance is required for days 21–100.

A benefit period is a period of consecutive dates during which covered services are furnished to the patient. For SNF care under Medicare, the benefit period begins the day the Medicare beneficiary begins receiving covered inpatient or extended care services by a qualified provider (acute inpatient hospital or skilled nursing facility).

The benefit period ends:

- ◆ When the Medicare beneficiary has not received inpatient hospital or skilled nursing care for 60 consecutive days, beginning with the date the individual was discharged from care (hospital or SNF); OR
- ◆ If the Medicare beneficiary remained in the SNF, but did not receive skilled care for 60 consecutive days.

There is no limit to the number of benefit periods a Medicare beneficiary can have. Once a benefit period ends, the Medicare beneficiary must have another three-day qualifying hospital stay and meet other Medicare requirements listed under General Eligibility Criteria in this manual.

Why Use Swing Beds?

There are multiple advantages to the effective use of Swing Beds for the facility, the physician, the patient and the community.

Swing Beds can significantly improve the facility's financial viability since Critical Access Hospital Swing Bed services are reimbursed on a cost-related basis.

By utilizing Swing Beds, facilities with higher acute admission rates may be able to manage their acute inpatient beds more effectively and ensure compliance with the annual average 96-hour length of stay restriction.

Why Use Swing Beds (continued)

Swing Bed admissions can contribute to improved quality of care:

- ◆ In rural areas where access to services may be limited, patients ready for acute discharge from a facility may need more care and support than can be achieved through a discharge to home with home health services.
- ◆ In addition, staffing requirements in an acute facility are more stringent than those required in a long-term facility that also offers skilled nursing services, resulting in increased staff/patient ratios and more individual staff time for the patient.

Improved quality of life may result when patients are able to return to the community and the people they know, and are closer to family and their support system.

It is also easier for the family to visit and be more closely involved in the family member's recovery.

Psychologically and emotionally, Swing Bed admissions may be less traumatic and threatening for the patient.

Admission to a Swing Bed often feels like a continued hospital stay to the patient and offers a more positive hope for continued recovery and a return to independence.

Admission Criteria:

There are several resources available for admission guidelines and/or criteria (see Appendix D). Milliman Care Guidelines, or McKesson Interqual Level of Care guidelines for Subacute & SNF are two examples. The Medicare Fiscal Intermediary Manual, Part 3, Chapter II – “Coverage of Services”, includes extensive information, in particular about the level of services that are or are not considered skilled.

The following information is excerpted from the Medicare Intermediary Manual and the Medicare Learning Network's Swing Bed Facility Prospective Payment System – Train the Trainer Manual, Chapter II – “Clinical Criteria”. It is not intended to represent the sum total of information available about Swing Bed coverage issues or to constitute hard fast criteria for admission.

General Eligibility Criteria:

- The beneficiary must be enrolled in Part A and have benefit days available to use.
 - ◆ Medicare eligibility and benefit days may be verified by calling the Fiscal Intermediary's customer service number.
 - At Noridian Mutual Insurance Company, the number is 1-866-380-4741.

General Eligibility Criteria (continued)

- The beneficiary must have had a three-day (three midnights) qualifying acute inpatient admission prior to the admission to Swing Bed. This requirement can be met even if the beneficiary has been in more than one hospital as long as the hospital stays totaled three or more consecutive days. The three-day qualifying stay may take place in a participating general hospital – this would include rehabilitation hospitals/units as well as acute care hospitals. **Section 20.1, Chapter 8 of the Medicare Benefit Policy Manual** also specifies that the day of admission, but not the day of discharge, be counted as a hospital inpatient day. In addition, the discharge must have occurred on or after the first day of the month in which the individual reached age 65, or in a month for which he/she was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.
 - ◆ Observation stays may not be included in the three-day qualifying inpatient stay
 - ◆ Reference: <http://www.cms.hhs.gov/manuals/downloads/bp102c08.pdf>
- The services must be provided for a condition which was treated during the beneficiary’s qualifying inpatient stay, *or* arose while the patient was in the Swing Bed for treatment of a condition for which he/she was previously treated in a hospital.
- If there is no break in skilled care, another three-day qualifying stay is not necessary if a patient was readmitted to an acute care bed before “swinging” back to the Swing Bed as long as it is in the same benefit period.
- The Swing Bed services must be provided within thirty (30) days of discharge from:
 - ◆ An acute inpatient bed in the Swing Bed hospital; or
 - ◆ Discharge from another acute hospital; or
 - ◆ Discharge from a Swing Bed or skilled nursing facility.

The day of discharge is not counted in this thirty-day transfer period. The thirty-day period begins on the day after actual discharge. A patient discharged on July 1 and admitted to a Swing Bed on July 31, would meet the thirty-day requirement.

An exception may be made to permit a beneficiary to be admitted to a Swing Bed more than 30 days after hospitalization **if** the patient’s condition at the time of discharge from the acute facility makes a Swing Bed admission medically inappropriate immediately after discharge and **if** it is medically predictable at the time of discharge that he/she will require covered care within a pre-determined period of time.

- A new three-day qualifying stay is required when a new condition arises within this 30-day period before being admitted to a Swing Bed.
- The beneficiary has a need for skilled care on an inpatient basis. The beneficiary requires and receives daily skilled nursing services or skilled rehabilitation. If skilled rehabilitation services are not available on a “daily” (7 days a week) basis, a patient whose Swing Bed admission is based solely on the need for skilled rehabilitation services meets this requirement if he/she receives those services at least 5 days per week.

General Eligibility Criteria (continued)

- This “daily” requirement should not be applied so strictly that a patient would not meet the requirement because of an isolated break of a day or two during which no skilled services were provided. A patient who requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue resulting in a refusal to participate and suspension of services for a day or two. This may be appropriate; however, if the patient consistently refuses to participate in the treatment plan, continued stay in the Swing Bed will not meet criteria, regardless of the number of benefit days remaining.

As a practical matter, the daily skilled services can only be provided on an inpatient basis in a skilled nursing facility or Swing Bed. In making a “practical matter” determination, consideration must be given to the patient’s condition and to the availability and feasibility of using more economical alternative facilities and services.

EXAMPLE

A 75-year-old patient has a hip replacement at a large non-CAH facility following a fall and fracture. The patient lives 60 miles from the nearest hospital and requires physical therapy five days a week, but home health services are not available. The patient may be admitted to a swing bed in a CAH in his/her local community. As a practical matter, the patient can only receive these services from a skilled nursing facility or Swing Bed.

Information for Patients Admitted to a Swing Bed:

Patients and/or their representatives may assume that because Swing Beds are a Medicare benefit, admission to a Swing Bed is appropriate regardless of whether the patient meets criteria for admission. It is important for patients and/or their representatives to understand that the patient must meet and continue to meet criteria, participate in his/her treatment program, and demonstrate progress to continue to stay in the Swing Bed.

Skilled Services Defined:

Skilled nursing and/or skilled rehabilitation services are services that:

- Are ordered by a physician;
- Require the skills of qualified technical or professional health personnel; and
- Must be provided directly or under the general supervision of skilled personnel to ensure patient safety and achieve medically desired results.

Skilled technical or professional personnel may include registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists.

Guidelines for Determining Whether a Service is Skilled:

If the ***inherent complexity of the service*** is such that it can only be performed safely and/or effectively under the general supervision of skilled nursing or skilled rehabilitation personnel, it may be considered skilled.

A non-skilled service could be considered skilled when, because of ***special medical complications***, skilled personnel are required to perform or supervise the service, or to observe the patient.

Similarly, while having a whirlpool bath would not require skilled supervision, a qualified physical therapist may be required if the patient has a complicating condition such as circulatory deficiency, areas of desensitization or open wounds.

EXAMPLE

A cast on an extremity does not automatically require skilled care. However, if there is an acute pre-existing skin condition, pre-existing peripheral vascular disease or a need for special traction, skilled nursing or rehabilitation personnel may be required to observe for complications or adjust traction.

Management and Evaluation of a Patient Care Plan, based on physician orders, constitutes skilled nursing services if:

- The patient's physical or mental condition requires skilled nursing personnel to safely plan, monitor and manage care; or
- The plan involves a variety of personal care services and the aggregate of those services, in light of the patient's condition, requires the involvement of technical or professional personnel.

EXAMPLE

Skilled nursing services may not be required for a patient with organic brain syndrome who requires oral medication and a protective environment. Skilled management becomes necessary when the total of unskilled services, considered in light of the patient's overall condition, requires skilled nursing personnel to promote recovery and ensure patient safety (See also Appendix B for case examples).

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

The need for these services must be documented by physician orders or nursing/therapy notes. (See Appendix B for case examples).

Guidelines for Determining Whether a Service is Skilled (continued)

Teaching and Training activities are those activities requiring the skills of technical or professional personnel for teaching of self-maintenance programs. Examples are included below.

Examples of Skilled Nursing Services:

- Intravenous or intramuscular injections or intravenous feeding;
- Insertion, sterile irrigation, replacement and care of suprapubic catheters;
- Nasogastric tube, gastrostomy, or jejunostomy feedings equal to 26% of daily calories and a minimum of 501 ml of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Application of dressings with prescription medications and aseptic technique;
- Treatment of decubitus ulcers (Grade 3 or worse) or widespread skin disorder;
- Heat treatments ordered by a physician requiring observation to evaluate patient's progress;
- Initial phases of a regimen involving administration of medical gases;
- Professional observation when the patient's condition requires 24 hour nursing supervision, including:
 - ◆ Medical conditions such as uncontrolled diabetes or acute congestive heart failure episodes; or
 - ◆ Vital sign monitoring for special purposes, such as when the patient is on specific medications; or
 - ◆ Psychiatric conditions such as depression, anxiety, suicidal behavior, etc.
- Institution and supervision of bowel and bladder training program;
- Colostomy or ileostomy care in the early postoperative period in the presence of associated complications; and
- Teaching or Training:
 - ◆ Self-administration of injectable medications;
 - ◆ A newly diagnosed diabetic to administer insulin, prepare and follow a diabetic diet, and observe foot-care precautions;
 - ◆ Care for a recent colostomy or ileostomy;
 - ◆ Self-administration of medical gases;
 - ◆ Gait training and prosthesis care to a recent leg amputee;
 - ◆ Self-catheterization and self-administration of gastrostomy feedings, care and maintenance;
 - ◆ Care and maintenance of central venous lines or Hickman catheter;

Examples of Skilled Nursing Services: (continued)

- ◆ Care of braces, splints, orthotics, and associated skin care; or
- ◆ Specialized dressings and skin care.

Skilled Rehabilitative Services:

In general, therapy services must meet all of the following:

- Be directly and specifically related to an active treatment plan, designed by the physician after consultation with a qualified therapist; and
- Be of a level of complexity, or the patient's condition such that the judgment, knowledge and skills of a qualified therapist are required; and
- Be provided with an expectation that the condition of the patient will improve in a reasonable and predictable period of time, or the services must be required to establish a safe and effective maintenance program; and
- Be reasonable and necessary under accepted standards of clinical practice, in terms of the amount, frequency and duration of the services.

The deciding factor in determining whether rehabilitation services are skilled is not the patient's potential for recovery, but whether the services require the skills of a therapist or non-skilled personnel.

Examples of Skilled Rehabilitation Services:

- Assessment, both initial and ongoing of a patient's rehabilitation needs and potential;
- Gait evaluation and training when the ability to walk has been impaired by neurological, muscular or skeletal abnormality;
- Therapeutic exercises which, as a result of the type of exercise, or the condition of the patient, require supervision of a skilled physical therapist;
- Range of motion test and range of motion exercises when the exercises are part of active treatment for a specific disease state;
- Ultrasound, short-wave, diathermy;
- Occupational therapy with the objective of improving or restoring functions impaired by illness or injury, or where a function has been permanently lost or reduced by illness or injury.
- Design/fabrication and fitting of orthotics or self-help devices;
- Services for the treatment of dysphagia;
- Maintenance therapy if the therapy involves the use of complex, sophisticated procedures requiring the judgment and skill of a physical therapist to ensure safety and effectiveness of the therapy.

Situations/Services That May Be Considered Non-Skilled:

The following situations/services do not meet the criteria for Swing Bed care:

- Administration of oral medications, eye drops, and ointments;
 - ◆ Note: The fact that a patient cannot be relied upon to take medications or that state law may require medications to be dispensed by a nurse to institutional patients would not make this a skilled service;
- General maintenance care of colostomy or ileostomy;
- Routine services to maintain functioning of indwelling catheters, including emptying containers, cleaning, clamping tubing, etc;
- Dressing changes for non-infected postoperative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application of creams or treatment for minor skin problems;
- General maintenance care in connection with a plaster cast;
 - ◆ Note: Skilled supervision or observation may be required when the patient has pre-existing skin or circulatory condition or needs to have traction adjusted.
- Routine care of an incontinent patient, including diapers and protective sheets;
- Routine care in connection with braces or similar devices;
- Use of heat as a palliative or comfort measure, such as whirlpool or steam pack;
- Periodic turning and positioning in bed;
- General supervision of exercises taught to the patient or performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance;
- Routine administration of medical gases after a regimen of therapy has been established;
- Assistance in dressing, eating and going to the toilet;
- Preparation of special diets.

Continued Stay/Discharge:

Medicare benefits allow a patient to remain in a Swing Bed as long as he/she continues to meet all criteria and has benefit days available. Once the patient no longer meets criteria, Medicare will not reimburse for the services.

Transfers from Other Acute Care Hospitals:

In accepting transfers from other acute care hospitals, it is critical to ensure that the patient is stable enough for a Swing Bed setting and that the receiving facility is able to meet the needs of the patient. The discharge coordinator in the transferring facility, who may or may not be a nurse, may not be aware of all of the patient's needs and requirements, and may inadvertently transfer a patient who still requires a higher level of care.

Recommendations for Accepting Transfers include:

- Verify the pay source for the patient and ensure that the Swing Bed facility has the proper certification for the patient's pay source;
- Ensure that an attending physician has been identified at the receiving facility and, whenever possible, that contact between the transferring and receiving physicians has occurred;
- Dependent upon the type of skilled services to be provided, therapist to therapist, or nurse to nurse contact can ensure that the facility is able to provide the services required;
- Review the services required by the patient to ensure that the patient meets criteria for Swing Bed admission;
- Ensure that the facility can meet any special equipment needs (lifts, specialized beds, etc) that the patient may require;
- Ensure that the facility can meet staffing needs of the patient;
- Identify the medications required by the patient and determine whether these medications are available through the receiving facility's pharmacy;
- Ensure that the patient understands what is expected of him/her in terms of participation and progress, and that the patient has the desire and is able to participate actively in a treatment program.

Documentation Requirements:

In February 2002, CMS analyzed the significance of the full Minimum Data Set (MDS) reporting requirement for Critical Access Hospitals admitting patients to their Swing bed and concluded that completing a full MDS was a compliance burden which could be reduced without jeopardizing patient safety or health. CMS clarified that CAHs are required to complete a resident assessment and a comprehensive care plan for each Swing Bed patient and document the assessment in the patient's medical record.

Comprehensive Assessment:

A comprehensive assessment must be completed. CMS has given no additional guidance as to what format should be utilized, however, the documentation should be comprehensive; support the reason for the Swing Bed admission and the services the patient receives; clearly indicate both short and long-term goals; patient progress toward achieving those goals; and whether the patient continues to meet Swing Bed level of care criteria.

CMS has not specified required time frames for completion of the assessment. Due to the short length of stay associated with many Swing Bed admissions, it is suggested that this assessment be completed within 24 to 48 hours of the patient's admission to Swing Bed.

If the patient remains in the Swing Bed setting, a reassessment should be completed at least after 14 days, and following any significant changes in the patient's status, including deterioration or improvement that impacts more than one area of the patient's health status and requires interdisciplinary review or revision of the health care plan. At a minimum, a physician must reassess the patient every 30 days or as warranted based on the patient's medical condition.

Elements of the comprehensive assessment must include:

- Activity Pursuit
- Cognitive Patterns
 - ◆ Evaluation of the patient's ability to make decisions, including health care decisions, and his/her ability to participate in treatment activities.
 - ◆ An assessment of the patient's ability to problem solve, make decisions and respond to potential safety hazards.
- Communication
- Continence
- Customary Routine
 - ◆ The patient's ability to perform Activities of Daily Living (ADLs) including eating, drinking, bathing, dressing, grooming, transferring, ambulating, toilet use, and ability to speak or use communicative devices and language needs.
 - ◆ Assessment of the patient's ability to participate in activities aside from the ADLs. This should take into consideration the patient's normal everyday routines and activities that contribute to financial or emotional independence, pleasure, comfort, education, success, etc.
- Dental and Nutritional Status
 - ◆ Evaluation of eating habits or preferences, and dietary restrictions, if any.

Comprehensive Assessment: (continued)

- ◆ An evaluation of the condition of the patient's teeth, gums and oral cavity, particularly as these affect the patient's ability to eat and maintain nutritional status; and communicate with others, including family and health care providers. If the patient has, uses or needs dentures or other dental appliances, this should be noted.
- Discharge Potential
 - ◆ An assessment of the patient's discharge potential and projected length of stay.
- Disease Diagnoses and Health Conditions
 - ◆ A description of the patient's current medical diagnoses, including any history of mental retardation or current mental illness.
 - ◆ Objective information about the patient's current physical and mental status/abilities, including vital signs, clinical laboratory values or diagnostic tests.
 - ◆ Height, weight, and observation of the patient's nutritional status or needs.
- Documentation of participation in assessment
- Documentation of Summary Information regarding the additional assessment performed through the resident assessment protocols
- Identification and Demographic Information
- Medications
 - ◆ An evaluation of the over-the-counter and prescription drugs taken by the patient; including dosage, frequency of administration, potential drug interactions and allergies, and recognition of significant side effects most likely to occur.
- Mood and Behavior Patterns
- Physical Functioning and Structural Problems
 - ◆ Information about any sensory or physical impairments the patient may have, such as loss of hearing, poor vision, speech impairments, difficulty swallowing, loss of bladder or bowel control, etc.
 - ◆ An evaluation of the potential need for staff assistance or assistive devices, or equipment; including walking aids, dentures, hearing aids or glasses.
 - ◆ The patient's ability to improve his/her level of functional status and independence through rehabilitation programs.
- Psychosocial Well Being
 - ◆ Description of the patient's ability to deal with life, interpersonal relationships, goals and ability to make health care decisions, as well as overall mood and behavior.
- Skin Condition

Comprehensive Assessment: (continued)

- Special Treatments and Procedures
 - ◆ Assessment of the need for specialized skilled services such as skin care for decubitus; nasogastric feedings; or respiratory care.
- Vision

The assessment process must include direct observation and communication with the patient, as well as communication with licensed and non-licensed direct care staff members on all shifts. While many components of the assessment can be completed by the nursing staff, other professionals on the CAH interdisciplinary team are also required. The interdisciplinary team must include a physician, a registered nurse with responsibility for the patient's care, and other health care professionals as determined by the patient's needs including, physical therapist, occupational therapist, speech therapist, dentist, social worker, pharmacist, etc.

Tapping into the multiple members of the CAH team in preparing the assessment, whether as full-time or part-time staff members, or as consultants, is important in creating a comprehensive assessment upon which to base the care plan, and in ensuring a successful outcome for the patient and his/her family.

Comprehensive Care Plan:

The comprehensive care plan:

- Is developed along with the resident and the resident's family or other representative by the CAH interdisciplinary team including the physician, a registered nurse with responsibility for the patient and other staff in disciplines as determined by the resident's needs identified in the comprehensive assessment;
- Is based on needs identified in the comprehensive assessment;
- Includes measurable objectives and timeframes to meet these needs;
- Must be developed within 7 days after completion of the comprehensive assessment; and
- Is reviewed periodically by the interdisciplinary team after each reassessment.

The care plan must describe:

- Services that will be furnished to maintain or help the patient achieve their highest level of functioning; and
- Services that would be required but are not provided because the patient has exercised his/her right to refuse treatment.

Conditions of Participation:

The CAH must comply with the following:

- Organ, Tissue and Eye Procurement
 - ◆ CAH must have and implement written protocols that incorporate an agreement with Organ Procurement Organization (OPO);
 - ◆ CAH must incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;
 - ◆ CAH must ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;
 - ◆ CAH must encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors.
 - ◆ CAH must work cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.
- Dental Services - The facility must assist residents in obtaining routine and 24-hour emergency dental care.
 - ◆ Skilled Nursing Facilities
 - Must provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident;
 - May charge a Medicare resident an additional amount for routine and emergency dental services;
 - Must if necessary, assist the resident
 - In making appointments; and
 - By arranging for transportation to and from the dentist's office; and
 - Promptly refer residents with lost or damaged dentures to a dentist.
- Social Services
 - ◆ The facility must provide medically related social services to attain or maintain the physical, mental, and psychosocial well being of each resident.

Conditions of Participation: (continued)

- Program of Activities – Swing beds must provide “for” a program of activities appropriate for the patient.

Discharge Summary:

The physician must prepare a discharge summary whenever a CAH anticipates discharging a patient from the Swing Bed. The discharge summary should include:

- A summary of the patient’s stay in the Swing Bed and the services received;
- A summary of the patient’s health care status at the time of discharge;
- The patient’s destination upon discharge (e.g., to home with family, home with home-health, a long term care facility, etc); and
- A post discharge plan of care developed with the participation of the resident and his/her family that identifies the patient’s continuing care needs after discharge; how those needs will be met; and any preparation and education given to the patient and his/her family prior to discharge.

Additional Considerations:

Consolidating Billing: According to Section 10.2, Chapter 6 of the CMS Claims Processing Manual, consolidating billing applies to:

- Participating SNFs
- Short-term hospitals, Long-term hospitals, and Rehabilitation hospitals certified as Swing Bed hospitals, except CAHs certified as Swing Bed hospitals
- Reference: <http://www.cms.hhs.gov/manuals/downloads/clm104c06crosswalk.pdf>

Respite Care: Respite care is part of the hospice benefit, and is defined as "short-term inpatient care provided to an individual only when necessary to relieve the family members or other persons caring for the individual at home." Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. Therefore, respite care could be provided in a SNF or swing bed setting, if the swing bed meets the hospice standards.

- Reference: Medicare Benefit Policy Manual, Chapter 9, Sections 40.2.2 and 40.1.5, which can be found at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf>
- Reference: Section 2080, Chapter 8 of our State Operations Manual, which may be found at: <http://www.cms.hhs.gov/manuals/downloads/som107c08.pdf>

Additional Considerations: (continued)

Post-Acute Transfer Rule: PPS payment system differentiates between “discharged” and “transferred” patients for payment purposes:

- Discharge: Patient is formally released from a hospital or patient dies in the hospital after receiving inpatient services
- Transfer: 1) a patient is moved from one PPS hospital to another PPS hospital, 2) a patient is moved from one PPS hospital area or unit to another area or unit within the same hospital, and 3) a patient is moved from a PPS hospital to another hospital that is excluded from PPS – such as a CAH

PPS hospitals usually get paid the full DRG payment when patient is discharged, but hospitals do not usually get full DRG payment for transfers. Transferring hospitals are paid based on a **per diem** amount for each day the patient received services, with the total payment not to exceed the applicable DRG payment. The receiving hospital is entitled to the full DRG payment (PPS hospital) when patient is discharged, assuming patient is discharged. Patients were no longer considered “discharged.”

Inpatient Rehabilitation Facilities (IRFs):

- Long Term Care Hospitals
- Psychiatric Hospitals and Units
- Children’s Hospitals
- Cancer Hospitals
- Skilled Nursing Facilities
- Home Health within 3 days after discharge from hospital

Patients transferred to a Swing Bed for skilled nursing care are not included in definition of Post Acute Care Facility. Therefore, a PPS hospital will receive the full DRG payment when the patient is discharged to CAH swing beds.

Reference: CMS 1500 – F, Table 5 (beginning on page 341) identifies the specific DRGs affected by the Post-Acute Transfer Rule by indicating a “yes” under the Post Acute Care Transfer DRG column.

<http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1500f.pdf>

Appendix A – Regulations/Requirements

Federal:

1. **Public Law 42 CFR Part 485 – Subpart F.** [Conditions of Participation: Critical Access Hospitals (CAHs)] §485.601 in particular deals with the Conditions of Participation for Critical Access Hospitals. §485.645 – identifies special requirements for CAH providers of long-term care services.
2. **Public Law 42 CFR Part 409, Subpart C, Section 409.27; and 42 CFR Part 409, Subpart D, §§ 409.30 – 409.36. Subpart D** (Includes requirements for coverage of post-hospital SNF Care).

Note: Both sets of regulations cited above may be found at the following website:
<http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=200142>

3. **Medicare State Operations Manual, Appendix W** – “Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs”
http://www.cms.hhs.gov/manuals/downloads/som107ap_w_cah.pdf
4. **Medicare State Operations Manual, Appendix T** – “Regulations and Interpretive Guidelines for Swing Beds in Hospitals”
http://www.cms.hhs.gov/manuals/downloads/som107ap_t_swing_beds.pdf

State:

1. **Idaho Medicaid Provider Handbook**
http://healthandwelfare.idaho.gov/rainbow/documents/medical/Provider%20Handbooks/s3_011_ltc.doc
2. **Idaho Department of Health and Welfare Rules Governing Long-Term Care Provider Remedies**
<http://adm.idaho.gov/adminrules/rules/idapa16/0312.pdf>

Appendix B – *Case Examples*

The following examples demonstrate compliance with the Medicare regulations for the *Development, Management and Evaluation of a Patient Care Plan* for a patient in a swing bed. (excerpted from Publication 13 - **Medicare Intermediary Manual**, Part 3, and Chapter II –Coverage of Services):

Example 1: 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 the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

Example 2: 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 non-skilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

Case Examples (continued)

The following are examples of cases involving *Observation and Assessment of a Patient's Condition* (excerpted from Publication 13 - **Medicare Intermediary Manual**, Part 3, and Chapter II – Coverage of Services):

Example 1: 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.

Example 2: 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.

Example 3: A patient has undergone hip surgery and has been transferred to an SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

Example 4: 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.

Example 5: 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 an 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.

Case Examples (continued)

Examples of skilled rehabilitation services (excerpted from Publication 12 - **Medicare Skilled Nursing Facility Manual**, Chapter 2 – Coverage of Services):

Example 1: An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.

Example 2: A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

Appendix C – *Questions and Answers*

1. Why admit a patient to a Swing Bed facility when there is a nursing home with skilled nursing capabilities available?

Swing Bed services are a benefit recognized by Medicare and covered when skilled services, such as patient assessment, are required. While these services are frequently available in a long term care facility offering skilled services, the differences in staff/patient ratios offered by a Swing Bed facility may result in improved care, a speedier recovery and an improved outcome for frail, elderly patients.

2. Does a patient have to be moved from one bed to another if he/she is discharged from acute care and admitted to a Swing Bed status?

No. The patient does not have to be physically moved, however, the patient must be discharged from the acute admission and the acute medical record closed as with any other discharge from the hospital. A new medical record must be opened for the Swing Bed admission.

3. If both a Swing Bed in a Critical Access Hospital and a skilled nursing bed in a long term facility are available, does the patient have a “right” to be treated in the Swing Bed or choose which setting he/she prefers?

Post-hospital skilled nursing services are a benefit of the Medicare program and may be provided in a nursing facility approved by Medicare to provide such services, or in a Critical Access Hospital approved by Medicare to provide Swing Bed services. Regardless of which setting is used to provide these services, the patient must meet level of care and other criteria for skilled nursing services. However, the patient does have a right to choose providers and if more than one provider of skilled services is available, (nursing facilities and CAH Swing Beds), the patient should be allowed the right of choice.

4. When there are changes in the regulations or the interpretive guidelines for CAHs, how soon do we have to update our procedures/manuals?

There is no set deadline as to when this must happen. If the changes are minor, a word here or there or a clarification that does not change the scope of the program, it may be possible to delay making revisions. If the changes are significant, the policies/procedures should be updated as soon as possible. In any event, the changes should be made before the CAH recertification survey. Note: At this time, CAH recertification surveys are not conducted on a regular basis in Colorado.

Questions and Answers (continued)

5. Does Appendix T of the Medicare State Operations Manual – “Interpretive Guidelines for Swing Beds” apply to Critical Access Hospitals?

Appendix T – “Interpretive Guidelines for Swing Beds” applies only to hospitals that have Swing Bed reimbursement under SNF PPS regulations. The requirements for Swing Beds in Critical Access Hospitals are addressed in Appendix W – “Survey Tasks and Interpretive Guidelines for Critical Access Hospitals.”

6. What happens if a patient has been in the hospital for less than 3 days and requires admission to a Swing Bed?

Admission to a Swing Bed for a patient who has not met the qualifying requirement of a 3-day stay is not a covered benefit of the Medicare program.

7. What if the Medicare beneficiary stops getting skilled care in the SNF/Swing Bed or leaves the SNF/Swing Bed altogether? How does this affect Medicare SNF coverage if the Medicare beneficiary needs more skilled care in the SNF/Swing Bed later on?

It depends on how long the break in skilled care lasts. If the break in SNF/Swing Bed lasts for:

Less than 30 days	<ul style="list-style-type: none">■ Do not need a new 3-day hospital stay to qualify for coverage of additional SNF care.■ Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current period.
At least 30 days but less than 60 days	<ul style="list-style-type: none">■ Medicare will not cover additional SNF care unless there is a new 3-day hospital stay. The new hospital stay need not be for the same condition that was treated during the previous stay.■ Since the break in SNF care lasted for less than 60 days in a row, the current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in the current benefit period.
At least 60 days	<ul style="list-style-type: none">■ Medicare will not cover additional SNF care unless there is a new 3-day hospital stay. The new hospital stay need not be for the same condition that was treated during the previous stay.■ Since the break in skilled care lasted for at least 60 days in a row, this would end the current benefit period and renew the SNF benefits. This means that the maximum coverage available would be 100 days of SNF benefits.

8. Is there a minimum or maximum length of stay requirement for Swing Bed admissions?

No, not as long as the beneficiary meets the level of care criteria for Swing Bed admission and has benefit days available. (See “benefit period” on page 2 of this manual.)

Appendix D – *References/Other Resources*

1. Program Memorandum Intermediaries—Transmittal A-01-09; January 16, 2001; Change Request 1509
2. Critical Access Hospital Manual published by TrailBlazer Health Enterprises, LLC. (CMS contracted intermediary and carrier).
<http://trailblazerhealth.com/publications/training%20Manual/CAHManual.pdf>
3. Publication 07: Medicare State Operations Manual, Chapter 2—“The Certification Process,” and Chapter 7—“Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities.”
<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019027>
4. Publication 13: Medicare Intermediary Manual, Part 3: Chapter II—Coverage of Services: “Coverage of Extended Care Services Under Hospital Insurance.”
<http://www.cms.hhs.gov/manuals/pbm/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021918>
5. Publication 12: Skilled Nursing Facility Manual: Chapter 2 – Coverage of Services.
<http://www.cms.hhs.gov/manuals/pbm/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS021915>
6. McKesson InterQual, Products – Level of Care, Subacute & SNF. (800) 522-6780 or
<http://www.interqual.com/IQSite/products/level-care.aspx>
7. Milliman Care Guidelines; a division of Milliman USA. 1 (888) 464-4746 or
<http://www.careguidelines.com/>
8. Swing Bed Information from CMS:
http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp
(click on Swing Bed Manuals under Downloads)