Critical Access Hospital Swing Bed Manual

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Introduction

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

Designation as a Critical Access Hospital (CAH) creates an alternative for small, rural hospitals that includes the potential for enhanced reimbursement from Medicare and Medicaid, a better opportunity to meet 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. Critical Access Hospitals serve as the hub of an organized local system of care. They are an outgrowth of the Montana Medical Assistance Facility (MAF) Demonstration and the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) programs in the late 1980s and early 1990s.

In Montana, 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. These beds may be used interchangeably as acute, post CAH SNF or Skilled Nursing Facility (SNF) level of care with approval by the State Licensure Bureau. Any hospital-type bed located in or adjacent to any location where the bed could be used for inpatient care counts toward the 25 bed limit. Beds that do not count toward the 25 bed limit are:
  - Examination or procedure tables;
  - Stretchers;
  - Operating room tables located in the operating room and used exclusively to conduct surgery on a patient;
  - Beds in a surgical recovery room that are used exclusively for surgical patients during recovery from anesthesia;
  - Beds in an obstetric delivery room that are used exclusively for observation of OB patients in active labor and delivery of newborn infants (do count beds in birthing rooms where the patient remains after giving birth);
  - Newborn bassinets and isoletes used for well baby boarders;
  - Stretchers in emergency departments and
  - Beds in Medicare certified distinct part rehabilitation or psychiatric units.
- Maintains an annualized average acute care 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 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 ended on January 1, 2006. Facilities designated and certified under this waiver prior to January 1, 2006 are 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.

**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 Medicare 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.

Swing bed admissions can contribute to improved quality of care:
- In rural areas where access to services may be limited, patients ready for discharge from an acute care facility may need more care and support than can be achieved through a discharge to home with home health services or if these services are not available.
- In addition, staffing requirements in an acute facility are more stringent than those required in a long-term care facility that also offers skilled nursing services, resulting in increased staff/patient ratios and more individual staff time for the patient.

If the acute care hospitalization occurred out of town, 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. Many elderly patients view a stay in a skilled bed of a nursing facility as a step in the wrong direction and worry that they will not be able to return to independence. 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.

**Medicare Swing Bed Benefit**
**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 unit 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 qualifying three-day acute care hospital stay is required to be eligible for this benefit. See Appendix E.
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 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.

Medicare beneficiaries have an unlimited number of benefit periods. Once a benefit period ends, the Medicare beneficiary must have another 3-day qualifying hospital stay and meet other Medicare requirements listed under General Eligibility Criteria in this manual. See page 5 of this manual.

Montana Medicaid Swing Bed Benefit
Montana Medicaid generally follows Medicare requirements for swing bed services, with some important distinctions. The state mimics federal rules for facility eligibility to provide swing bed care, but Montana Medicaid provides payment for both skilled and intermediate level residents. Medicaid does not require a hospital stay prior to admission to a swing bed but does require a pre-admission screening. Medicaid requires transfer of a swing bed patient within 72 hours if an appropriate nursing facility is available within 25 miles of the swing bed provider.

The swing bed hospital is responsible to periodically canvass and determine bed availability at potential facilities. A transfer agreement or other arrangement with a nursing facility will fulfill this requirement. The swing bed hospital must keep documentation of its efforts to determine bed availability.

Swing bed providers may request a waiver of the 25 mile transfer requirements for their acute care clients under certain conditions. The waiver should be requested within the 72 hour period to assure the facility can bill Medicaid for services. The client’s attending physician must verify in writing that transfer to an appropriate nursing facility would endanger the client’s condition or the individual has a medical prognosis that his or her life expectancy is six months or less, if the illness runs its normal course. Approval must be obtained before billing Medicaid for the services. Administrative Rules of MT, Title 37, Chapter 40, Subchapter 4. (See Appendix A of this manual.)

Private Pay Swing Bed
Residents admitted to a swing bed under private payment arrangements are exempt from Medicare prior hospitalization requirements, and from Medicaid transfer and level of care requirements. If a person is admitted under a private pay arrangement, and then later becomes eligible for Medicare or Medicaid benefits, they become subject to payer requirements.
Admission Criteria

There are several resources available for Medicare admission guidelines and/or criteria. *Medicare Benefit Manual Chapter 8, Coverage of Extended Care (SNF) under Hospital Insurance* includes extensive information about the level of services that are or are not considered skilled. The following information is excerpted from this chapter. 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.

See Appendix A for this resource and the Montana Medicaid admission guidelines.

**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.
    - Noridian Administrative Services Call Center/Fargo, ND
      - Provider Services Part A . . . . . . . . . . . . . . . . (877) 908-8437
      - Noridian Administrative Services Call Center/Fargo, ND
      - Provider Services Part B . . . . . . . . . . . . . . . . . .(877) 908-8431

- The beneficiary must have had a three-day (three midnights) qualifying acute inpatient admission prior to the admission to swing bed. (See Appendix E) 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. 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.

- 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 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 unit for treatment of a condition for which he/she was previously treated in a hospital.

- 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 unit 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.

- 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.

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.

**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 unit 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.

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**

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.

**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. Physician orders or nursing/therapy notes must document the need for these services. (See Appendix B)

**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).
**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, such as bronchodilator therapy;
- 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;
  - 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 is 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 if 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:**

• 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 or reaches their 100th day of benefit eligibility, Medicare will no longer 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:

- 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 formulary;
- 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.
- Verify the pay source for the patient and ensure that the swing bed facility has the proper certification for the patient’s pay source.
Documentation

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 units 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. *Medicare State Operations Manual, Appendix W, “Critical Access Hospital”, Tag C360. (See Appendix A of this manual.)*

**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. *Tag C388*

While CMS has not specified required time frames for completion of the assessment, because of 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 must be completed within 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, the patient must be re-assessed at least once every 12 months. *Tag C389 and 390*

Elements of the comprehensive assessment must include:

1. Identification and demographic information.
2. Customary routine.
5. Vision.
6. Mood and behavior patterns.
7. Psychosocial well-being.
8. Physical functioning and structural problems.
10. Disease diagnoses and health conditions.
11. Dental and nutritional status.
12. Skin condition.
15. Special treatments and procedures.
16. Discharge potential.
17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
18. Documentation of participation in assessment.

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 the nursing staff can complete many components of the assessment, 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. **TAG C388**

**Comprehensive Care Plan**

**Tag C395-396**

**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 his/her 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.
• Dental Services - The facility must assist residents in obtaining routine and 24-hour emergency dental care. **Tag C404-408**
  o Critical Access Hospital Swing Bed Programs
    ▪ 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
  o The facility must provide medically-related social services to attain or maintain the physical, mental, and psychosocial well-being of each resident. **Tag C389**

**Discharge Summary**
**Tag C399**

A discharge summary must be prepared whenever a CAH anticipates discharging a patient from the swing bed. The discharge summary should include:

(1) A recapitulation of the resident’s stay;

(2) A final summary of the resident’s status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.
Appendix A – *Regulations/Requirements*

*Federal:*


*Note:* Find both sets of regulations cited above at the following website:

[http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=200142](http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=200142)

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


*State:*

1. Montana Department of Public Health and Human Services, Administrative Rules of MT, Title 37—see following link:

   Chapter 40, subchapter 4: Swing Beds-Senior and LTC

   Chapter 106, subchapter 6: Minimum Standards for Nursing Facilities
Appendix B – Case Examples

The following examples demonstrate compliance with the Medicare regulations for the Medicare Benefit Policy Manual, Chapter 8, Section 30.2.3.1 (See Appendix D)

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 a properly instructed person could perform any of the required services, 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 because 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.

The following are examples of cases involving Observation and Assessment of a Patient: Medicare Benefit Policy Manual, Chapter 8, Section 30.2.3.1 (See Appendix D)

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 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.

Examples of skilled rehabilitation: *Medicare Benefit Policy Manual*, Chapter 8, Section 30.2.3.1 (See Appendix D)

**Example 1:** An 80-year-old, previously ambulatory, post-surgical patient has been bed bound 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 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. Swing beds are a legitimate treatment option.

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?

Medicare Patients
The patient has 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. 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.

Medicare and Private-pay Patients
Medicaid patients do have the right to choose among providers unless state rules require the patient be transferred to a nursing facility. A Medicaid resident can choose among available nursing facilities when more than one option exists. A Medicaid patient may not choose to remain in a swing bed hospital if a nursing home bed is available within 25 miles.

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.


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.” (See Appendix A)

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. While not a Medicare benefit, the patient may still receive care-skilled or intermediate-using third party or private resources.

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**
  - Beneficiaries do not need a new 3-day hospital stay to qualify for coverage of additional SNF care for the same or related condition.
  - Since the break in SBF care lasted for less than 60 days in a row, the current benefit period would continue. This means the new maximum coverage available would be the number of unused SNF benefit days remaining in the current benefit period.

- **At least 30 but less than 60 days**
  - Medicare will 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**
  - 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 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?

For Medicare Patients
No, not as long as the patient meets the level of care criteria for swing bed admission and has benefit days available. (See “Benefit period” on page 3 of this manual.)

For Medicaid Patients
Montana Medicaid does not limit the number of days of swing bed care a resident may receive. Medicaid does require patient transfer in 72 hours if an appropriate NF bed is available within 25 miles of the swing bed hospital.
Appendix D – References/Other Resources


2. Medicare/CMS Publication 100-7:
   Chapter 2—“The Certification Process,”
   and
   Chapter 7—“Survey and Enforcement Process for SNFs and NFs.”

3. Medicare/CMS Publication 100-2: Medicare Benefit Manual, Chapter 8, Coverage of Extended Care (SNF) Under Hospital Insurance

4. McKesson InterQual, Products - Level of Care, Subacute & SNF
   Call (800) 522-6780 or


6. Montana Medicaid information: