HealthTech

Swing Bed Basics
1:00 – 2:00

Carolyn St.Charles
Chief Clinical Officer, HealthTech |November 2024

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a Bachelor's Degree in Nursing from Northern Arizona University.

Carolyn St.Charles, RN, BSN, MBA
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

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Objectives

Objective 1: Attendees will demonstrate how to find interpretive guidelines in Appendix PP.

Objective 2: Attendees will describe regulatory requirements for the multi-disciplinary plan of care, therapy services, and nutrition.

Objective 3: Attendees will list at least two (2) ways for providing and documenting activities.

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Agenda

Swing Bed Overview

- Regulatory Requirements and Resources

Intermediate Swing Bed

- Policies and Procedures

Activities

- Abuse, Neglect, Exploitation, and Misappropriation of Property

Consolidated and Bundled Billing

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Swing Bed Overview

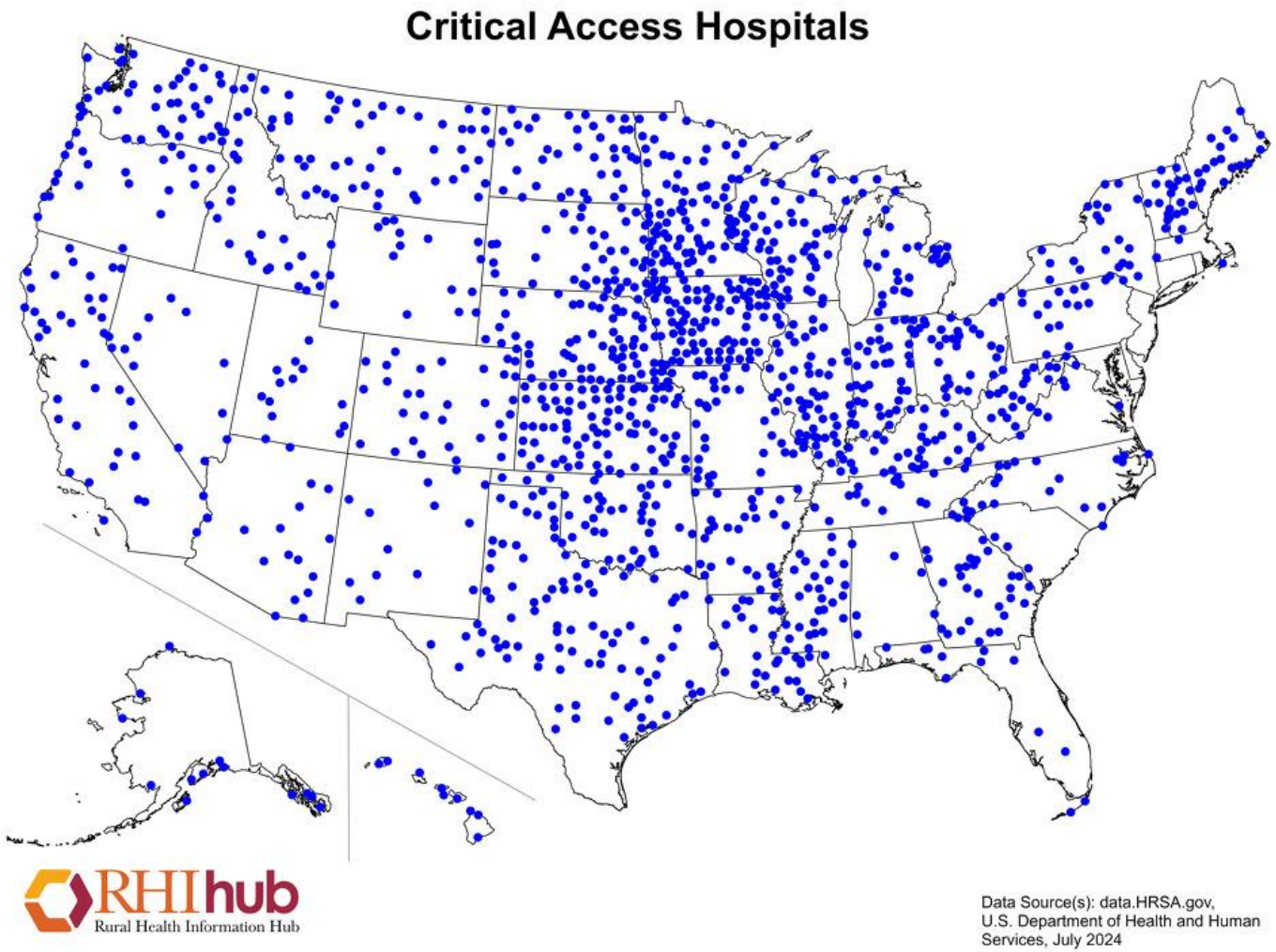
History

The swing bed was a solution offered by Dr. Bruce Walter, a physician who was Utah's director of Medicare services back in the late 1970s and early ‘80s to utilize beds in small hospitals

HCFA funded SNF beds in CAHs in 1973

Federal regulations for the program were published on July 20, 1982 and amended on September 1, 1983

Critical Access Hospitals in the U.S.



As of July 2024, there were **1,368** CAHs located throughout the United States. The **majority** have a swing bed program

Swing Bed Overview
C-1600 §485.645

The swing-bed concept allows a CAH to **use their beds interchangeably** for either acute care or post-acute care.

A “swing-bed” is a **change in reimbursement status**. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.

Swing-beds **need not be located in a special section of the CAH**. The patient need not change locations in the facility merely because his/her status changes unless the facility requires it.

The **change in status from acute care to swing-bed status can occur within one facility or the patient can be transferred from another facility for swing-bed admission**.

Swing Bed Overview
C-1600 §485.645

There is **no length of stay restriction** for any CAH swing-bed patient.

There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes. While there is no length of stay limit for patients in swing-bed status, the intended use for swing beds is for a transitional time period to allow the patient to fully recover to return home or while awaiting placement into a nursing facility. The CAH should document in the patient's medical record efforts made for nursing facility placement.

Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however **swing-bed patients are not SNF patients. Swing-bed patients in CAHs are considered to be patients of the CAH**.

Resources & Regulatory Requirements

Resources

1. National Rural Health Resource Center
https//www.ruralcenter.org

2. MLN Matters
Critical Access Hospital: MLN006400 March 2021

3. Swing Bed Providers
www.cms.gov/Medicare/Medicare-fee-for-service-payment/SNFPPS/SwingBed

4. ICAHN Swing Bed Manual
https://icahn.org/wp-content/uploads/2018/10/2020-Swing-Bed-Manual.pdfHealthTech Webinars

5. Colorado Swing Bed Manual
https://coruralhealth.org/swing-bed-manual#/

6. Montana Swing Bed Manual
https://mtpin.org/wp-content/uploads/2022/11/Montana-Flex-Swing-Bed-Manual-2022.pdf

Benefit and Claim Processing Manuals

Medicare Benefit Policy Manual Chapter 3
Duration of Covered Inpatient Services (Issued: 10-04-19)

Medicare Claims Processing Manual Chapter 4
Part B Hospital (Including Inpatient Hospital Part B and OPPS) (Issued: 03-21-24)

Medicare Benefit Policy Manual Chapter 6
Hospital Services Covered Under Part B (Issued; 12-21-23)

Medicare Benefit Policy Manual Chapter 8
Coverage of Extended Care (SNF) Services Under Hospital Insurance (Issued: 10-05-23)

Conditions of Participation

Conditions of Participation Critical Access Hospitals Appendix W

Conditions of Participation Appendix A

Conditions of Participation Long Term Care Facilities Appendix PP
Interpretive Guidelines for Swing Bed

Deemed status organizations are required to include CMS standards but may have additional standards

Appendix W ---- 12 Tags
Other standards in Appendix W also apply

The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

C-1600 §485.645 *Special Requirements* *for CAH Providers of Long-Term Care Services ("Swing-Beds")*

C-1602 §485.645(a) Eligibility

C-1604 §485.645(b) Facilities Participating **as** Rural Primary Care Hospitals (RPCHs) on September 30, 1997

C-1606 §485.645(c) Payment

C-1608 §485.645(d) SNF Services**.**

C-1610 (§485.645(d)(2) Admission, Transfer and Discharge Rights

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

C-1616 §485.645(d)(4) Social Services

C-1620 §485.645(d)(5) Comprehensive assessment, comprehensive care plan, and discharge planning

C-1622 §485.645(d)(6) Specialized Rehabilitative Services

C-1624 §485.645(d)(7) Dental Services

C-1626 §485.645(d)(8) Nutrition

Appendix A ---- 11 Tags
Other standards in Appendix W also apply

A-1500 (Rev.183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) Condition of Participation: §482.58 **Special requirements** for hospital providers of long-term care services ("swing-beds")

A-1501 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58 (a) **Eligibility.** A hospital must meet the following eligibility requirements:

A-1562 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §482.58(b) Skilled nursing facility services. The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter §482.58(b)(1) **Resident rights** (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), and (4), (f)(4)(ii) and (iii), (h), (g)(8) and (17), and (g)(18) introductory text of this chapter).

A-1564 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(2) **Admission, transfer, and discharge rights** (§483.5 definition of transfer and discharge, §483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7))

A-1566 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(3) **Freedom from abuse, neglect, and exploitation** (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c))

A-1567 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §482.58(b)(4) **Social services** (§483.40(d) of this chapter).

A-1568 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(4) **Patient activities** (§483.24(c))

A-1569 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §482.58(b)(5) **Discharge summary** (§483.20(l))

A-1570 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(5) **Social services** (§483.40(d) and 483.70(p)) • §483.40 (d)

A-1572 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(6) **Discharge planning** (§483.20(e))

A-1573 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §482.58(b)(7) **Dental services** (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).

A-1574 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(7) **Specialized rehabilitative services** (§483.65)

A-1576 (Rev. 183, Issued: 10-12-18, Effective: 10-12-18, Implementation: 10-12-18) §482.58(b)(8) **Dental services** (§483.55)

Differences
Appendix W and Appendix A

Appendix A **DOES NOT** have standards for:

- Comprehensive assessment
- Comprehensive care plan

Swing Beds in a rural hospital (not CAH) must complete and submit the Minimum Data Set Resident Assessment Instrument for reimbursement.

The most current version is MDS 3.0 RAI User's Manual version 1.19.1

There are NO Interpretive Guidelines in Appendix A or Appendix W for Swing Bed

C-1626 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).

Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health.

Interpretive Guidelines §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

Appendix PP
Interpretive Guidelines

F-800 (Rev. 173, Issued: 11-22-17, Food and nutrition services
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

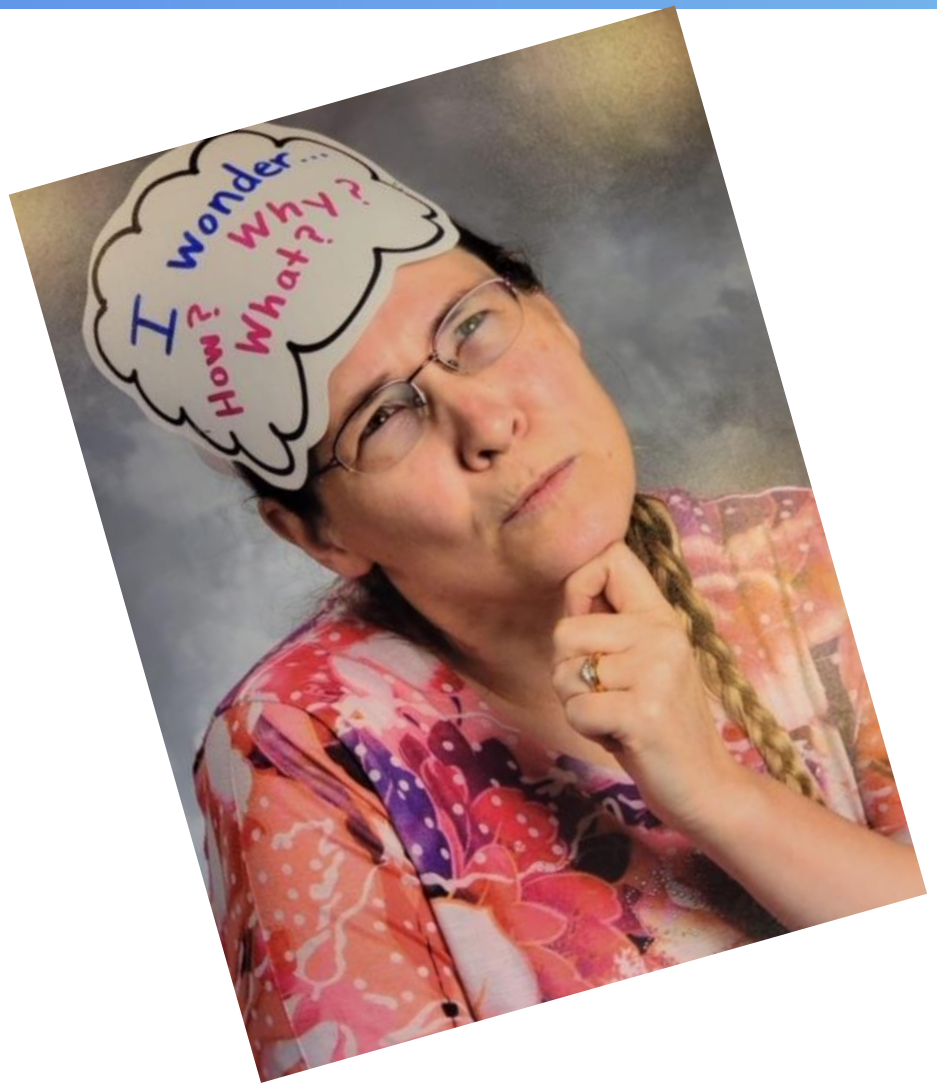
INTENT §483.60
To ensure that facility staff support the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet.

GUIDANCE §483.60
This requirement expects that there is ongoing communication and coordination among and between staff within all departments to ensure that the resident assessment, care plan and actual food and nutrition services meet each resident's daily nutritional and dietary needs and choices. While it may be challenging to meet every residents' individual preferences, incorporating a residents' preferences and dietary needs will ensure residents are offered meaningful choices in meals/diets that are nutritionally adequate and satisfying to the individual. Reasonable efforts to accommodate these choices and preferences must be addressed by facility staff. Also, cite this Tag if there are overall systems issues relating to how the facility manages and executes its food and nutrition services.

Appendix PP 22 Tags
Rev. 211, 02-03-23

- §483.5 Definitions
- §483.10 Resident Rights
- §483.12 Freedom from Abuse, Neglect, and Exploitation
- §483.15 Admission Transfer and Discharge Rights
- §483.20 Resident Assessment
- §483.21 Comprehensive Person-Centered Care Plans
- §483.24 Quality of Life
- §483.25 Quality of Care
- §483.30 Physician Services
- §483.35 Nursing Services
- §483.40 Behavioral health services
- §483.45 Pharmacy Services
- §483.50 Laboratory Radiology and Other Diagnostic Services
- §483.55 Dental Services
- §483.60 Food and Nutrition Services
- §483.65 Specialized Rehabilitative Services
- §483.70 Administration
- §483.75 Quality Assurance and Performance Improvement
- §483.80 Infection Control
- §483.85 Compliance and Ethics Program
- §483.90 Physical Environment
- §483.95 Training Requirements

Are you confused about which standards in Appendix PP apply?



Appendix W and Appendix PP Semi-Magic Crosswalk

Appendix W	Appendix PP	
C-1608§485.645(d)(1) Resident rights	F-550 F-551	
C-1610 §485.645(d)(2) Admission, Transfer, and Discharge Rights	F-550	
C-1612 §483.12(a)(1) Restraints	F-605	
C-1612 §485.645(d)(3) Freedom from abuse, neglect, exploitation and misappropriation of property	F-600 F-606 F-607	F-609 F-640 F-943
C-1616 §485.645(d)(4) Social Services	F-745	
C-1620 §485.645(d)(5) Comprehensive Assessment	F-636 F-637 F-641	
C-1620 §485.645(d)(5) Plan of Care	F-553 F-656	
C-1620 §485.645(d)(5) Reassessment after Significant Change	F-637	

Appendix W and Appendix PP Semi-Magic Crosswalk

Appendix W	Appendix PP	
C-1620 §485.645(d)(5) Culturally-Competent Trauma Informed Care	F-656 F-699	F-741 F-742
C-1620 §485.645(d)(5) Discharge Planning	F-622 F-623 F-624	
C-1610 §483.15(c)(3) Ombudsman	F-623	
C-1622 §485.645(d)(6) Specialized Rehabilitative Services	F-826	
C-1624 §485.645(d)(7) Dental Services	F-791	

Appendix W and Appendix PP Semi-Magic Crosswalk

Appendix W	Appendix PP	
C-1626 §485.645(d)(8) Nutrition	F-692 F-800 F-803 F-805 F-806 F-807	F-807 F-808 F-809 F-810 F-813 F-814
Medication Management Thru-out Appendix W	F-755 F-756	F -757 F-758
Activities No reference in Appendix W	F-679	

Crosswalk Detail
Culturally Competent Trauma Informed Care

F-656: Development or implementation of culturally competent and/or trauma-informed care plan interventions

F-699: Assessment of trauma and triggers that may be stressors or prompt recall of traumatic events.

F-741: These competencies and skill sets related to caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder

F-742: Appropriate treatment for patients with history of trauma

Crosswalk Detail
Medication Management

Medication management standards are present in Appendix A and Appendix W, but not specifically for Swing Beds. Appendix PP has standards related to psychotropic drugs, pharmacist review, and gradual dose reduction. **Important for intermediate or long-term patients.**

F-755: Basic medication management

F-756: Drug review by pharmacist once per month

F-757: Drug regimen free from unnecessary drugs (excessive dose, excessive duration, without adequate monitoring, without adequate indication, presence of adverse consequences

F-758: Use of psychotropic drugs including gradual dose reduction

Crosswalk Detail
Nutrition

F-692: Acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,

F-692: Sufficient fluid intake to maintain proper hydration and health;

F-800: Nourishing, palatable, well-balanced diet

F-803: Religious, cultural and ethnic needs

F-804: a nourishing, palatable, well-balanced diet

F-806: accommodates resident allergies, intolerances, and preferences;

Crosswalk Detail
Nutrition cont.

F-807: Maintain hydration

F-808: Therapeutic Diet

F-809: Regular meal times. No more than 14 hours between the evening meal and breakfast (16 hours if nourishing snack provided)

F-810: Assistive devices – special eating equipment and utensils

F-813: Policy for food brought to residents by family or visitors

Intermediate Care?

Something Else?

Long Term Care?

Intermediate
Swing Bed?

Intermediate Care Facility
Adult Care Homes

Article 9 Adult Care Homes

(4) "Intermediate care facility for people with intellectual disability" means any place or facility operating 24 hours a day, seven days a week, caring for four or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments caused by intellectual disability or related conditions, need services to compensate for activities of daily living limitations

Intermediate Swing Bed
Note… these are Medicaid regs.

Kansas Administrative Regulations

Agency 30 Article 5. Provider Participation, Scope of Services, and Reimbursements for the Medicaid (Medical Assistance) Program

(ggggg) “Swing bed” means a hospital bed that can be used interchangeably as a hospital, skilled nursing facility, or **intermediate care facility bed**……

Long Term Care
Note… these are Medicaid regs.

Kansas Administrative Regulations

Agency 30 Article 5. Provider Participation, Scope of Services, and Reimbursements for the Medicaid (Medical Assistance) Program

(5) **Long-term care services in swing beds** shall be provided pursuant to 42 CFR part 482, subpart E, revised October 1, 1999, which is adopted by reference.

42 CFR part 482, **Subpart E:** Requirements for Specialty Hospitals

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(a) If the hospital provides a long-term care service, such service shall be provided in a manner that meets the medical, rehabilitative, and social needs of the patient.

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(b) Scope of services.

(1) The long-term service shall have a written program of restorative nursing care. This program shall be an integral part of nursing services and shall be directed toward assisting the patient to achieve and maintain an optimum level of self-care and independence.

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(b) Scope of services.

(2) In addition to restorative services, the unit shall provide or arrange for specialized rehabilitation services by qualified personnel as needed by patients to improve and maintain functioning. Services shall include physical therapy, speech pathology, audiology, and occupational therapy and shall be provided by qualified personnel.

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(b) Scope of services.

(3) A written, overall care plan shall be developed for each long-term care patient from an interdisciplinary assessment of the patient. The interdisciplinary assessment shall consist of medical, nursing, dietary, activities, and psychosocial diagnoses or evaluation

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(c) Medical direction. A member of the medical staff shall be assigned responsibility for the medical direction of the service. The director shall be responsible for the overall coordination of medical care in the unit and shall participate in the development of policies and procedures for patient care, including the delineation of responsibilities of attending physicians.

Long Term Care Hospital regs.

Agency 28 Department of Health and Environment Article 34. Hospitals

28.34.29a Long-Term Care Unit

(d) Nursing services
(e) Restraints
(f) Patient care and hygiene
(g) Restorative nursing care
(h) Specialized rehabilitative services
(i) Social services

Without Dept. of Licensing Concurrence

Intermediate Care is a category for individuals with intellectual disabilities

Intermediate Care is **NOT** a type of Swing Bed care

Intermediate Care is **NOT** a category for private pay

Without Dept. of Licensing Concurrence

If you have long-term care patients in your Swing Bed as private pay, you would be expected to meet all of the **LTC** regs.

If you are caring for long-term patients in a Swing Bed with LTC insurance or Medicaid you should meet **ALL of the LTC regs. AND requirements for Medicaid including**:

- Leave of Absence
- Personal Funds
- Items facility can charge and not charge
- Advance Directives
- Pre-Admission Screening (PASARR)
- Transfer / Discharge Notice and Hearing

I’m sure there are many questions that I probably don’t have the answers to!

Let’s discuss more as part of the “Ask the Expert” session

At a minimum let’s compile questions for follow-up

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Policies & Procedures

Policies and Procedures
C-1008 §485.635(a)(2)

The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4)

These policies are reviewed **at least biennially** by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

Although a CAH's patient care policies are developed and periodically reviewed with the advice of members of the CAH's professional healthcare staff, **the final decision on the content of the written policies is made by the CAH's governing body** or individual responsible for the CAH, consistent with the requirement at §485.627(a). If recommendations of the advisory group are rejected, the governing body must include in the record of its adoption of the final written policies its rationale for adopting a different policy than that which was recommended.

First ..... Many Hospital Policies and Procedures Also Apply to Swing Bed

- ❑ Advance Directives
- ❑ Patient Grievance/Complaint
- ❑ Medication Management
- ❑ Restraints
- ❑ Infection Prevention
- ❑ Employee Health
- ❑ Quality Assurance Performance Improvement

ETC.

Pre-Admission and Admission Processes

- ❑ Choice of post-acute provider (Swing Bed, SNF, IRF)
- ❑ Swing Bed admission criteria
- ❑ Swing Bed admission processes
- ❑ Choice of physician and provision of contact information
- ❑ Physician certification
- ❑ Patient Disclosures
  - Advance Directives
  - Patient rights
  - Financial obligations
  - Personal Privacy and Confidentiality
  - Visitation
- ❑ History and Physical
- ❑ Admission orders

Admission Assessment and Continued Stay

- ❑ Comprehensive assessment (Does not apply to PPS Swing Bed)
- ❑ Comprehensive care plan including: disciplines involved and patient participation; frequency; documentation (Does not apply to PPS Swing Bed)
- ❑ Reassessment after significant change
- ❑ Culturally competent and trauma-informed care, including assessment of trauma
- ❑ Dental care
- ❑ Nutritional assessment and care
- ❑ Activities

Discharge

- ❑ Choice of post-acute provider (SNF/LTC, Home Health)
- ❑ Reassessment
- ❑ Medication Reconciliation
- ❑ Discharge or Transfer including:
  - Notice of Discharge
  - NOMNC
  - Information to the next provider of care
  - Discharge assessment and documentation
- ❑ Ombudsman notification of discharge or transfer

Other

- ❑ Abuse, Neglect, Exploitation, and Misappropriation of Property
- ❑ Personal property (may be part of patient rights)
- ❑ Transportation for outside medical and dental care
- ❑ Abuse, Neglect, Exploitation, and Misappropriation of Property

IF you provide Intermediate or Long-Term Care

- ❑ Policies required in Appendix PP
- ❑ Leave of Absence
- ❑ Personal Funds
- ❑ Items facility can charge and not charge
- ❑ Advance Directives
- ❑ Pre-Admission Screening (PASARR)
- ❑ Transfer / Discharge Notice and Hearing

Tip #1

Swing Bed Policies and Procedures **MAY** be combined
They don't all need to be separated

However…. Make sure you have **all** that are required. Use the checklist.

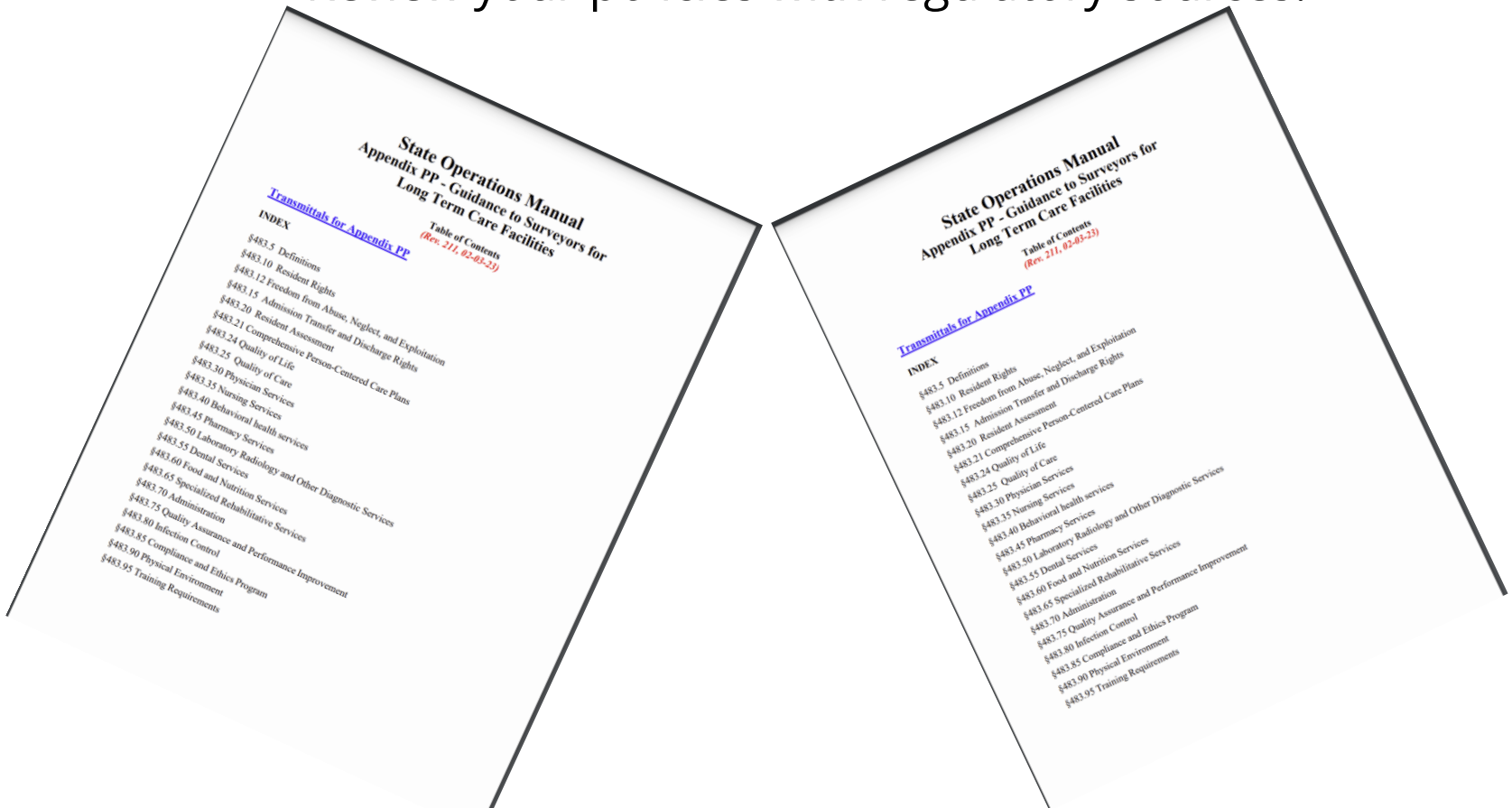
Tip #2

If you combine Hospital and Swing Bed policies, **MAKE SURE** you identify any differences:

- Patient disclosures at admission
- Assessment
- Care plans / Multi-disciplinary conferences
- Choice of physicians
- Discharge processes

Tip #3

Just because you have P&Ps ----
that doesn't mean they meet the regulatory requirements.
Review your policies with regulatory sources!



Tip #4

Actual practice must match the P&Ps.

Have staff read P&Ps and give feedback about if that is what they are actually doing --- or observe practice

Tip #5

Pay close attention to policies related to:

1. Patient disclosures
2. Physician certification
3. Assessment of trauma
4. Multi-disciplinary plan of care
5. Initial H&P and 30-day certification
6. Abuse, neglect, exploitation, and misappropriation of property
7. Ombudsman notification at discharge

Activities

Appendix A

A-1568 §482.58(b)(4) Patient activities (§483.24(c))

1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—

(i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is:

(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or

(C) Is a qualified occupational therapist or occupational therapy assistant; or

(D) Has completed a training course approved by the State.

Appendix W

No requirements in Appendix W EXCEPT……

When the requirement was removed, information in the Federal Register stated,

If the patient needs activities to meet psycho-social needs - the hospital must do an assessment and provide activities that are included in the nursing plan of care.

Appendix PP F-679
Activities Intent & Definitions

§483.24(c) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Intent §483.24(c)
To ensure that facilities implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a **resident's physical, mental, and psychosocial well-being and independence**. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

Definition §483.24(c)
Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is **intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health**. **These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence**

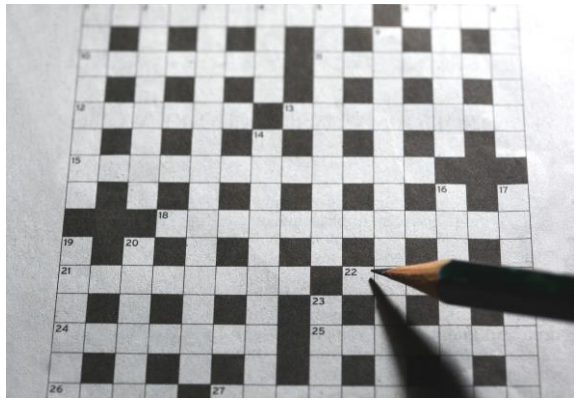
What To Do????

1. Swing Bed Rural Hospital (not CAH) ---- must provide activities per regulation

2. Swing Bed CAH

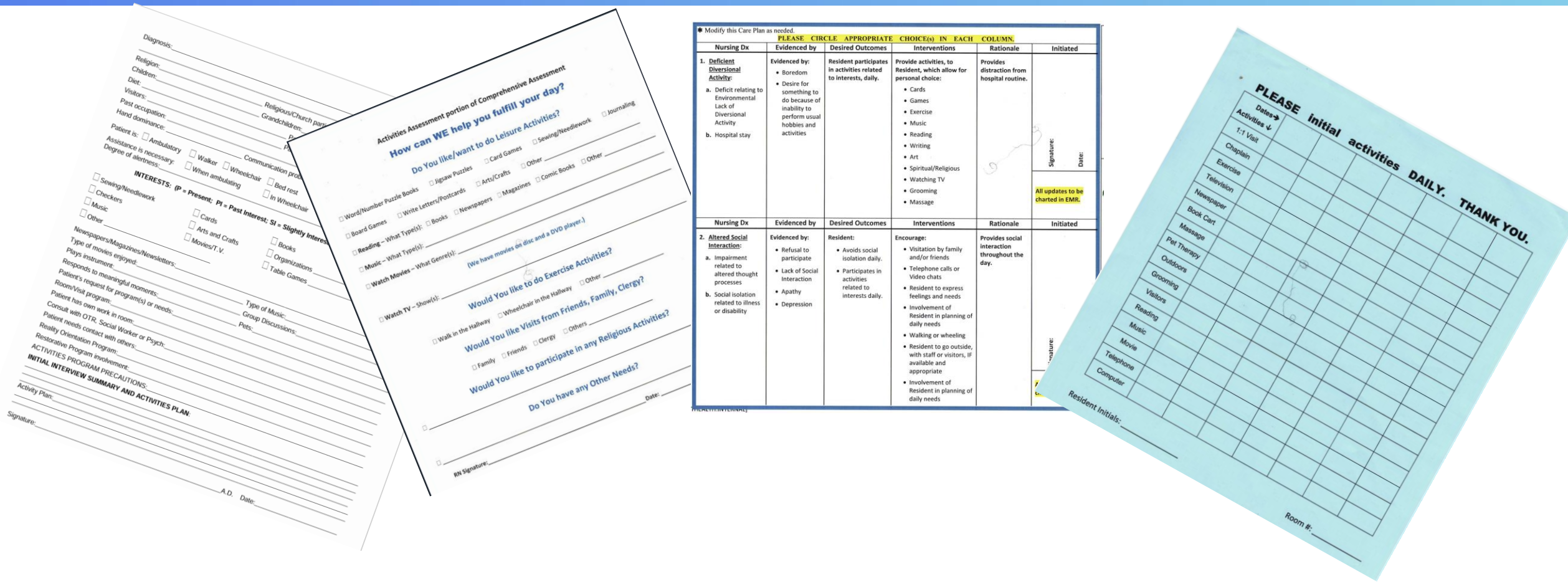
- Identify **WHO** will complete activities assessment
- Identify **WHO** will complete the activities plan
- Identify **WHO** will provide and document activities

Strongly recommend activities are offered to ALL Swing Bed patients



This is NOT Activities

Activities
Assessment – Plan - Documentation



Courtesy of Adventist Health
Howard Memorial

Abuse, Neglect, Exploitation, Misappropriation of Property

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(1) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must—

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §485.645(d)(3) Freedom from abuse, neglect and exploitation

§483.12(a)(3) Not employ or otherwise engage individuals who—

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

Reporting

C-1612 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving **abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,** are reported i**mmediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury**, to the **administrator** of the facility and to other officials (including to the **State Survey Agency and adult protective services** where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report **the results** of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within **5 working days of the incident**, and if the alleged violation is verified appropriate corrective action must be taken.

CRITICAL

All staff (regardless of department) **and providers** must be aware of definitions and how to recognize abuse, neglect, exploitation, and misappropriation of property

All staff (regardless of department) **and providers** must be aware of reporting requirements

Implement annual review and at orientation for new staff (including travelers)

THESE REGULATIONS ARE NOT THE SAME AS IDENTIFICATION AND REPORTING ABUSE OR NEGLECT THAT MAY BE IDENTIFIED IN THE EMERGENCY DEPARTMENT

Definitions at end of presentation

HealthTech

Consolidated and Bundled Billing

Reimbursement

In accordance with the Balanced Budget Act (BBA) of 1997, the SNF-level services of **non-CAH swing bed facilities** are covered under the SNF prospective payment system (PPS) effective with cost reporting periods beginning on or after July 1, 2002. This applies to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals.

The SNF-level services of CAHs with swing beds are exempt from the SNF PPS, in accordance with the Benefits Improvement and Protection Act of 2000 and the Medicare Modernization Act of 2003, and are instead **paid based on 101 percent of reasonable cost.**

However, as of April 1, 2013, CAH reimbursement is subject to a 2% reduction due to sequestration. In some states, CAHs may also receive cost-based reimbursement from Medicaid.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed

Consolidated Billing – Bundled Billing

Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing 10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

(However, while a **CAH's SNF-level swing bed services are <u>not subject to consolidated billing</u>, they remain subject to the bundling requirement for hospitals, as specified in the Medicare Claims Processing Manual, Chapter 3, §60).**

Bundled Billing

Medicare Claims Processing Manual, Chapter 3, §60)

10.5 - Hospital Inpatient Bundling
Hospital bundling rules **exclude payment** to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay.

CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, **all services** provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the **exceptions at 42 CFR § 411.15(m)(3))**

42 CFR § 411.15(m)(3)) Exceptions

(3) ***Exceptions.*** The following services are not excluded from coverage:

(i) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a reasonable charge or fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act, that are furnished after December 31, 1990.

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990

Rural (non-CAH) Swing Bed Hospital

Rural **(non-CAH)** swing bed hospitals that furnish SNF-level services are subject to both the **consolidated billing and hospital bundling requirements** (see §100.1); accordingly, as explained in the FY 2002 SNF PPS final rule (66 FR 39593, July 31, 2001), for the small number of services **(such as dialysis) that are excluded from consolidated billing but remain subject to hospital bundling,** the billing responsibility would remain with the rural swing bed hospital itself (in accordance with the hospital bundling requirement), but it would use a separate inpatient Part B claim to bill for those services outside of the bundled SNF PPS rate (in recognition of their exclusion from the consolidated billing requirement).

Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing Issued: 10-05-23)

So what does all that mean for CAH Swing Beds (Medicare)

You cannot submit a Part B bill while patients are in Swing Bed

All services/charges are included in Part A bill (with the exceptions noted for providers), including:

- Surgical debridement of wounds
- Telemetry (although really shouldn't be using in Swing Bed)
- EKG
- Dialysis
- ETC.

Questions?

THANK YOU

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

HealthTech

Abuse Definitions

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.

Examples of individual failures include, but are not limited, to the following:

- Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives

Abuse, Neglect, Exploitation and Misappropriation of Property

DEFINITIONS
Appendix PP §483.12(a)(1)

Sexual abuse: non-consensual sexual contact of any type with a resident.

Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Exploitation: taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.

Misappropriation of resident property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.