
Health Care
BKD
Everyone needs a trusted advisor. Who's yours?


TORCH
Optimizing Your Swing Bed Program's Potential
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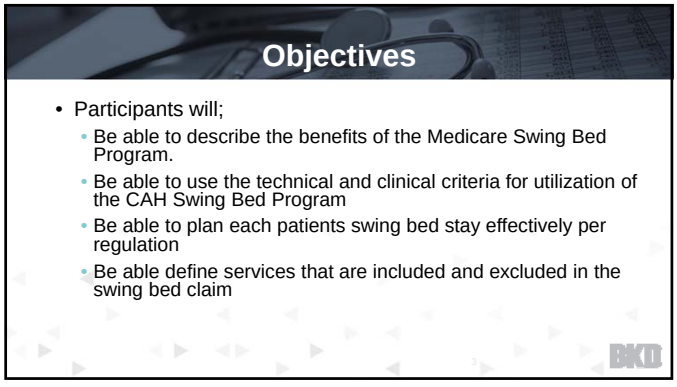
Objectives
• Participants will;
◦ Be able to describe the benefits of the Medicare Swing Bed Program.
◦ Be able to use the technical and clinical criteria for utilization of the CAH Swing Bed Program
◦ Be able to plan each patients swing bed stay effectively per regulation
◦ Be able define services that are included and excluded in the swing bed claim
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What is a Swing Bed

- Swing Bed is a term used to describe the use of inpatient hospital bed for either acute or skilled level of care
  - Applies to rural hospitals with fewer than 100 beds
  - Swing Bed status must be granted by CMS

Critical Access Hospital – Swing Bed

- The CAH has a Medicare provider agreement
- Total number of beds do not exceed 25 inpatient beds
- The CAH has not had a swing bed approval terminated within two years prior to application
- The CAH meets the swing bed conditions of participation for skilled nursing facility (SNF)

Swing Bed Requirements

- CAH swing beds treated as extended care SNF and subject to:
  - Part A coverage, deductible, coinsurance
  - Physician certification/recertification requirements
  - Exempt from SNF PPS Consolidated Billing
  - **No** Minimum Data Set (MDS) assessment required

Swing Bed Requirements

- Extended Care services must be provided directly or under arrangement,
  - Nursing care provided by or under the supervision of registered professional nurse
  - Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SLP)
  - Room and board

Swing Bed Requirements

- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment, furnished for use in swing bed
- Other services necessary to the health of the patients as are generally provided by a SNF

Operational Benefits of CAH Swing Bed

- Increased in-house services for the community
- Physicians can easily monitor their patients without moving them
- Keeps patients in the community
- Helps to manage Nursing hours with less drastic fluctuation due to low census
- Cost-based reimbursement
- No length of stay requirements
- Decreased rehospitalizations

Patient Benefits of CAH Swing Bed

- Improved patient care
  - Opportunity to identify patient needs to ensure safe and sustainable return home
  - More time for training, demonstration, return demonstration, education to patients and family and discharge planning
  - Increased patient/family satisfaction (“not thrown out”)
  - Willingness to go to a skilled level of care while meeting their needs for a longer inpatient stay

Swing-Bed Compliance

- Resident Rights;
  - Notice of Rights and Services
  - Free Choice
  - Privacy and Confidentiality
  - Work
  - Mail
  - Access to Visitation Rights
  - Personal Property
  - Married Couples

Swing-Bed Compliance

- Admission, Transfer and Discharge Rights
- Resident Behavior and Facility Practices
  - Restraints
  - Abuse
  - Staff treatment of residents

Swing-Bed Compliance

- Activities
  - Must be directed by a qualified professional
    - Stated certified
    - Therapeutic recreation specialist
    - OT/COTA
    - Activities Director (recognized accrediting body)

Swing-Bed Compliance

- Social Services
- Discharge Summary
- Specialized Rehabilitation Services
- Dental Services

Swing-Bed Compliance

- Federal Register: Appendix W
  - Regulations and Interpretive Guidelines for CAH
    - Index: 485.608 – 485.643
  - Regulations and Interpretive Guidelines for Swing beds in CAHs
    - Index: 485.645 and 483.10 – 483.55

Coverage Criteria

Medicare Benefits

- Enrolled in Medicare Part A
  - Has days available to use
    - 100 days total for skilled care per spell of illness
  - First 20 days at 100%
  - Day 21 to 100 is 80% covered with 20% payable by secondary insurance or self pay
  - These days are accumulative for the same or new condition in a consecutive stretch of days

Technical Eligibility

- Patient must be Medicare Part A eligible
- Three consecutive day qualifying stay in acute hospital (3 midnights) within the last 30 days
- Has skilled needs related to the condition which was treated or arose during the qualifying stay
- Has days in benefit period

30-Day Transfer Rule

- Transfer to skilled care services within 30 days after discharge from qualifying hospital stay;
  - Discharge from an inpatient bed
  - Discharge from another acute hospital
  - Discharge from another swing bed
  - Discharge from SNF
- Day of discharge is not counted in the 30 days

Medical Appropriateness Exception

- Transfer to SNF must occur within 30 days of discharge from hospital stay
- Exceptions
  - When continuation of treatment initiated during the hospital stay is necessary & proper documentation is obtained from the physician before hospital discharge & SNF admission

Medical Appropriateness Exception

- When an established pattern of treatment for a particular condition indicates a covered level of SNF care will be required within a pre-determinable time frame (as such, the treatment is considered “medically predictable”)
- When the patient begins receiving such care within that predetermined time frame

Example: Hip Fracture

- Hospital discharge summary must include language to describe the treatment & timeframe
  - "Skilled therapy services will be required & should begin in 4 – 6 weeks, when weight bearing can be tolerated"

Four Factors of Clinical Eligibility

1. The patient requires skilled nursing or rehabilitation, i.e., services that must be;

- Are ordered by a physician
- Require the skills of a qualified technical or professional health personnel.
- Must be provided directly by or under general supervision of skilled nursing or rehabilitation personnel to ensure patient safety and to achieve the medically desired result.
- For a condition, which arose while receiving care for a conditions for which he received inpatient hospital services.

Four Factors of Clinical Eligibility

2.The patient requires these services on a daily basis;

- Skilled Nursing Services 7 X week
- Skilled Rehabilitation Services at least 5 X week

3. As a practical matter, considering economy & efficiency, the daily skilled services can be performed only on an inpatient basis in a SNF

4. The services must be reasonable and necessary for the treatment of a patient's illness or injury. The services must be reasonable in terms of duration and quantity

Factors Determination

- If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered
- The MAC will first consider whether a patient needs skilled care.
- If a need for skilled service does not exist, then the "daily" and "practicable matter" requirements are not addressed

Determining Skilled Services

- Skilled level of care is usually required because of the patient's condition, which may:
  - Be unstable
  - Require complex treatment
  - Be associated with multiple unskilled problems which demand professional management
  - Be a chronic situation that confines the patient and requires ongoing nursing decisions about services on a daily basis or
  - Terminal, meeting the requirements of skilled care.

Skilled Nursing Services

- Direct Skilled Nursing Services
- Care Plan Management
- Observation and Assessment
- Teaching and Training

Direct Skilled Nursing Services

- IV medication such as antibiotics for infections
- Daily respiratory therapy requiring inhalation meds
- Naso-pharyngeal and tracheostomy suctioning
- Unstable nutritionals support requiring enteral tube feeding – PEG or NG
- Diabetic requiring frequent insulin changes, diet modification
- IV hydration
- Wound care

*not an all inclusive list

Care Plan Management

- A care plan must be developed for every patient admitted to the SNF. Care Plan management defined as skilled nursing is as follows:
  - When the patient's condition requires skilled nursing personnel to:
    - Meet medical needs
    - Promote recovery
    - Ensure Medical safety

Care Plan Management

- An aged patient recovering from pneumonia, is lethargic, disoriented and has residual chest congestion and is confined to bed due to weakness. To decrease the chest congestion, the physician has prescribed frequent position changes. While the chest congestion alone would not represent a high risk factor, the patients immobility, weakness and confusion represent a high probability of relapse. In this situation, skilled overseeing of the non-skilled services would be necessary pending the elimination of the chest congestion, to assure the patient's medical recovery and safety.

Observation and Assessment

- When reasonable probability for complication or potential for further acute episodes exists, skilled nursing personnel are required
  - To identify and evaluate the need for modification of treatment
  - To initiate additional medical procedures
  - Until the treatment regimen is essentially stabilized

Observation & Assessment

- A patient with ASCVD and CHF requires close observation by skilled nursing personnel to monitor for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine if the digitalis dosage should be reviewed, or if other therapeutic measures should be considered until the patient's treatment regimen is essentially stabilized.

Observation & Assessment Patient Types

- Seizure Disorder
- Nutritional risk
- Dehydration
- Medication management
- URI
- Blood sugar control
- Peripheral vascular disease

Observation & Assessment

- Beware! Psychiatric Diagnoses
  - Skilled observation may be required for primary conditions which are *psychiatric in nature*, or for patients who in addition to their physical problems have a *SECONDARY PSYCHIATRIC DIAGNOSIS.*

Observation & Assessment

- Psychiatric Diagnoses
  - These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which requires skilled observation and assessment for indications of suicidal or hostile behavior.
  - The purpose of nursing observation and assessment in these psychiatric cases is to *IDENTIFY THE POTENTIAL FOR HARMFUL BEHAVIORS*

Teaching & Training

- Care Plan teaching/training programs
- Use a flow sheet or MAR to document when teaching occurred
- Document response to teaching/training
- Include return demonstrations, if applicable

Teaching & Training

- Self-catheterization
- Self- administration of G-tube feeding
- Brace, splint, orthotic and associated skin care
- Care of specialized dressings or skin treatments
- Self-injection of medications
- Self-administration of medical gases
- Ostomy care
- Central Venous Line maintenance (Hickman Cath)

Nursing Services – Not Skilled

- Oral medications
- Maintenance of colostomy or ileostomy – unless new
- Dressing changes for uninfected post-operative or chronic conditions
- Prophylactic and palliative skin care

Rehabilitation Services

- When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether non-skilled personnel can carry out the services.

Admission Criteria

Physician Orders

- CMS State Operational Manual states
  - "there must be discharge orders from acute care services…. and subsequent admission orders to a swing-bed status regardless of whether the patient stays in the same facility".

Physician Certification

- Initial certification
  - Must be obtained upon admission or as soon thereafter as, reasonable and practical
  - Routine admission orders are not sufficient
  - Must be a separate signed statement indicating the need for daily skilled care.

Physician Certification

- Who may sign
  - Attending physician
  - Physician on staff with knowledge of the case
  - Physician Assistant
  - Nurse practitioner
    - With no direct or indirect employment relationship
  - Clinical nurse specialist
    - With no direct or indirect employment relationship

Re-certification Requirements

- Recertification statement must contain
  - Reason for continued need for skilled services
  - Estimated period of time
  - Post SNF discharge plans
  - Physician attestation that skilled care continues for a condition that was treated in the hospital.
  - First re-certification no later than day 14
  - Subsequent re-certifications not to exceed 30 days


Sample
Physician Certification and Recertification Form

- Physician Certification

Example: Recertification

Signature of Physician — Date

First RECERTIFICATION of SNF inpatient care following the initial certification on or before the 14th day after admission.

March 17, 2017
Date

I certify that continued SNF inpatient care is necessary for the following reason(s):

Skilled PT and OT 5 x week for gait and ADL decline related to fractured hip and skilled Nursing for surgical incision care

I estimate that the additional period of SNF inpatient care will be 30 days (or weeks). Plans for post-SNF care are:

☒ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☒ Yes ☐ No

Dr. Oaks — 3/16/17
Signature of Physician — Date

Physician Services

Physician Involvement

- Physicians need to understand;
  - Benefits of the Swing Bed to patient, community and hospital
  - Admission criteria
  - Documentation needed
  - There role in promoting the Swing Bed program

Physician Documentation

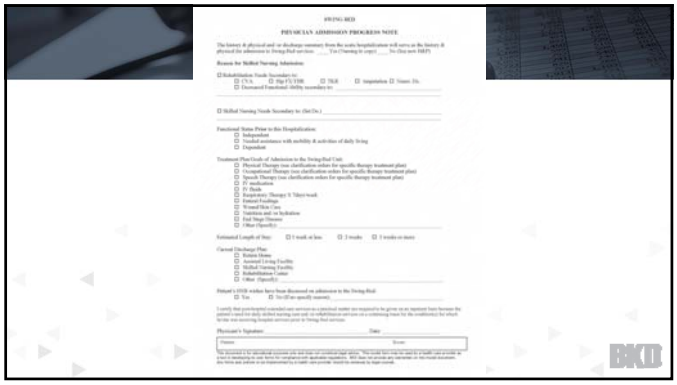
- Certification and recertifications for skilled care
- Orders
- History and Physical
- Admit/Discharge Summaries

Physician Documentation

- Reason for Swing Bed admission can be found in any of the following;
  - Acute discharge summary
  - Swing bed H&P
  - Hospital H&P
  - Swing Bed admission progress note
  - On-going progress notes for need of continued swing bed services

Physician Documentation

- The Admission Progress Note or admitting information should include the following:
  - Systems Review
  - Impressions/Diagnosis
  - Plan of Care (Clinical or Rehab)
  - Anticipated Progress
  - Anticipated Discharge Plans
  - Estimated Length of Stay (LOS)



Physician Visits

- Swing-bed patients do not require that same level of intense oversight by physician – usually expected to see patient less frequently
- Continuing care is assumed by nursing personnel with the help of the rehabilitative & social services

Physician Visits

- How often can a physician bill for a skilled bed patient visit**?**
  - **A**: According to CMS, a physician must see a skilled patient at least every 30 days but may see and bill for his/her visits as frequently as he/she feels it is necessary
- **Note**: Encourage physician to have good documentation and appeal denials

Physician Visits

- Swing Bed visits should be billed using nursing facility CPT codes:
  - Admission (99304-99306)
  - Subsequent Nursing Facility Care (99307-99310)
  - Nursing Facility Discharge Services (99315-99316)
  - Annual Nursing Facility Reassessment (99218)

Swing Bed Documentation

The Importance of Documentation

- The link between care delivery and payment for care provided
- Supports the need for and delivery of skilled services provided

" if the patient does not change facilities, the same chart can be utilized but the swing-bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents".

CMS STATE OPERATIONS MANUAL

The Swing Bed Medical Record

- New Documentation that will need to be completed specific to the swing-bed stay includes:
  - Medication Administration Records
  - Therapy Evaluation
  - Assessment and Care Plan related to Activities
    - Can be done by OT as part of the Activities program
- Case management and social services notes:
  - No need for a new evaluation
  - Continue the care path established on admission to the acute stay.

Skilled Nursing Documentation

- Nursing staff caring for a patient admitted to swing-bed will need to switch the focus of nursing documentation from charting by exception to **charting to support skilled care** provided.

Skilled Nursing Documentation

- Admission Assessment
- Nursing Notes
  - Medicare regulations once every 24 hours
  - Recommend every shift
- Nursing Documentation
  - Needs to clearly support the skilled need
  - All UR meetings should be documented in patient medical record with a synopsis of progress

Skilled Nursing Documentation

- Admission Note
  - Medicare Part A coverage
  - Reason for coverage
  - Prior Level of Function (PLOF)
  - Current Level of Function (CLOF)

PLOF Assessment

- Can be located anywhere in the medical record. Usually found in various locations.
- Establishes a “baseline” for the patient prior to acute admission.
- Once it is established that their has been a decline in the patients function, this allows for therapy services to evaluate for needed services.

PLOF Assessment

- Some important information (not exhaustive):
  - Where were they living?
  - What was their ADL status?
  - What was their ambulatory status? Any Assistive Devices?
  - Were they driving?
  - Were they doing their own shopping?
  - Were they paying their own bills?
  - How was their intake of nourishment and hydration?
  - Were there any cognition issues? Confusion?

Skilled Nursing Documentation

- If Rehabilitation primary skilled services, Nursing documentation needs to address;
  - Patient **Participation** in Therapy
  - Patient **Tolerance** of Therapy
  - Patient **Progress** in Therapy
- Nursing documentation should not conflict with therapy

Electronic Medical Records

- Only as good as the processes that is supports and the people who use it
- Pros and Cons to use
- Increased risk for HIPAA violations
- Doesn't replace a good narrative note
- Not defensible in court

Rehabilitation Documentation

- Evaluation
- Certification & Recertification of Plan of Care
- Treatment notes
- Progress notes
- Discharge note or summary

CMS IOM Publication 100-02, chapter 15, Section 220.3

Rehabilitation Documentation

- Physician Order Required
  - For Evaluation and Treatment
- Physician Signature on Plan of Care
  - Signature must be obtained in a reasonable amount of time.
  - Signature must be obtained prior to filing Medicare claim.
  - Faxed signatures are acceptable

Rehabilitation Documentation

- Evaluation
  - Presenting complaint or condition
  - Date of onset
  - Date services started
  - Prior therapy
  - Prior/current level of function
    - Objective
    - measurable

Rehabilitation Documentation

- Plan of Care (POC)
  - Diagnoses
  - Treatment goals
  - Therapy services
    - Modality
    - Frequency
- May be combined with the evaluation

Rehabilitation Documentation

- Treatments must be:
  - Reasonable and necessary
  - Within acceptable standards of practice to be a specific and effective treatment of the patient's condition
  - Services provided must be at the level of complexity and sophistication that only a licensed therapist can perform.
  - Amount, frequency, and duration of treatment must be reasonable
  - Therapist should regularly re-evaluate the condition and adjust the treatment plan as needed.

Skilled Rehabilitation - Example

An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had 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 to restore lost functions, those services are reasonable and necessary.

Rehabilitation Documentation

- Progress Notes
  - Once every 10 treatment days
    - More frequent notes are allowed
  - Written by therapist
    - At least one per period
  - Objective and measurable data

Ancillary Care

- Respiratory care
- Nutritional therapy
- Case management/Social work
- Include:
  - Screening tools, Assessments
  - Plans of care
  - Notes

Swing Bed Documentation

- Think Skilled not Acute
- Encourage participation in Activities and Therapy
- Encourage to wear personal clothing
- The goal is discharge to home or a lower level of care

Non-Coverage Notices

Providing Notice of Non-Coverage

- Medicare beneficiaries who are discharged from one level of care to a lower level of care must be notified of their right to appeal the change in care level as well as financial responsibility.

CMS Approved Notices

- Swing-Bed Programs
  - Hospital-Issued Notice of Non-coverage (HINN) 1 or Preadmission/Admission HINN
  - Expedited Determinations (EDs)
    - **Notice of Provider Non-Coverage (Generic Notice or NOMNC Letter – form CMS-10123)**
    - **Detailed Notice (DENC – form CMS-10124)**

Expedited Review Process

- CMS provides both PDF & Word versions of NOMNC on BNI webpage;

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html

- There is a parallel expedited process for Medicare Advantage
  - See Chapter 13 of Medicare Managed Care Manual (CMS Pub.100-16)

http://new.cms.hhs.gov/BNI/06_FFSEDNotices.asp#TopOfPage

HINN 1

- Issued before providing non-covered inpatient hospital and /or swing bed services that:
  - Are not reasonable and necessary
  - Could be safely provided in another setting
  - Constitute custodial care
- Beneficiary is liable, if admitted for customary charges for all services furnished during the stay
- Must be issued before 3pm for charges that day

NOMNC

- Notice of Medicare Provider Non-Coverage (NOMNC)
  - Expedited Determination (ED)
  - Effective October 1, 2005
  - Must be given 2 days before the last day Medicare services will be provided

Expedited Review Process

- Clarification on use of NOMNC
  - Not provided for reduction of services but when Medicare coverage of all services will end
  - Not required for transfer to more intense level of care (acute hospital) or to another SNF for skilled services
  - Given even when Medicare is secondary payer
  - If beneficiary incompetent, deliver to individual authorized under State law to make health care decisions on behalf of beneficiary

Expedited Review Process

- Clarification on use of NOMNC
  - Not required when beneficiary exhaust benefits
  - Not required when the beneficiary ends care on own initiative
  - Not required when Provider discontinues care for business reasons

Expedited Review Process

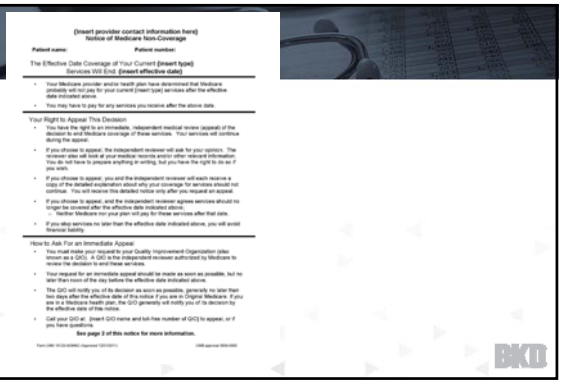
- Alterations to the NOMNC
  - Replications of notice must mirror notice posted on BNI website, including structure, wording & font size
  - Handwriting is permitted so long as it is legible & approximately as large as 12-point font
  - NOMNC must remain two pages
  - Providers may customize with business logo and contact information

Expedited Review Process

- Completing the NOMNC
  - Type or write the following information in the corresponding blanks on NOMNC;
    - Resident name
    - Resident identification number (not Medicare number)
    - Type of coverage (Swing Bed, Part A)
    - Effective date (last day of coverage)

Expedited Review Process

- Delivering the NOMNC
  - Providers must deliver to all eligible beneficiaries at least two days prior to last covered day of Medicare services
  - Must be delivered even if beneficiary agrees with the termination of services
  - Delivery should occur during normal operating hours
  - The provider must ensure the beneficiary or representative signs and dates the NOMNC



(Insert provider contact information here)
Notice of Medicare Non-Coverage

Patient name: Patient number:

The Effective Date Coverage of Your Current (insert type)
Services Will End: (insert effective date)

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current (insert type) services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

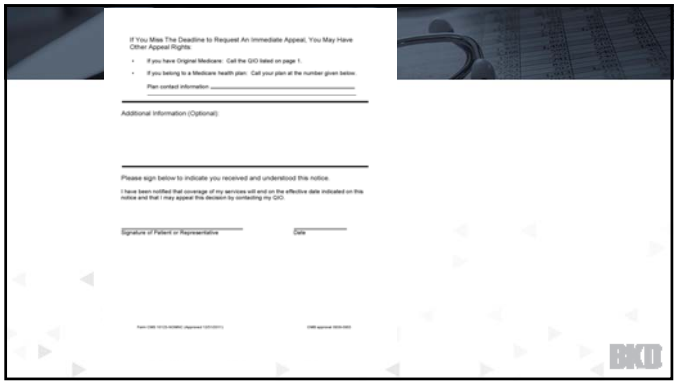
Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at (insert QIO name and toll-free number of QIO) to appeal, or if you have questions.

See page 2 of this notice for more information.


If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative _____ Date _____

Expedited Review Process

- If a beneficiary refuses to sign the NOMNC, the Provider should annotate the notice and indicate date of refusal on the notice
- The date of refusal is considered the date of notice receipt
- Beneficiaries who refuse to sign remain entitled to an expedited determination

Expedited Review Process

- Appealing to BFCC-QIO

  If beneficiary disagrees with Hospital's determination that Medicare coverage of services will end, whether beneficiary remains in Swing Bed or is discharged home, he/she has access to expedited review by Beneficiary and Family Care Center-Quality Improvement Organization (BFCC-QIO). The BFCC-QIO is independent reviewer authorized by Medicare to review the decision to end Medicare services

BFCC-QIO

- Texas Region 3
- KEPRO

  5700 Lombardo Center Dr., Suite 100
  Seven Hills, OH 44131

  Toll-free phone number: 844-430-9504
  Fax number: 844-878-7921

Phone Notification of NOMNC

- Calls to representative at least two days prior to end of covered services
- Inform of beneficiary's right to appeal and telephone number of BFCC-QIO
- How to appeal and the deadline to request an appeal

Phone Notification of NOMNC

- Document on NOMNC;
  - Name of staff initiating contact
  - The name of representative contacted and telephone number
  - Date, time and method of contact
  - A copy of the annotated NOMNC should be mailed the day telephone contact is made
  - The original should be retained in the medical record.

Phone Notification of NOMNC

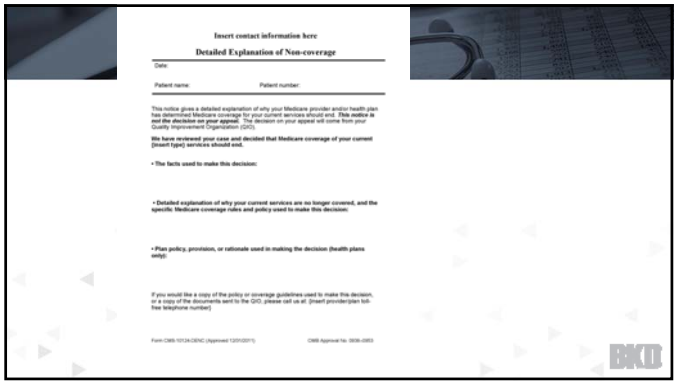
- BKD recommends all NOMNC communication be sent certified mail, return receipt requested.

Expedited Review Process

- A beneficiary
  - Who disagrees with the termination of services may request the expedited determination
  - Must contact the BFCC-QIO by noon of the day before the effective date on the NOMNC in order to receive a review within 72 hours.
  - If the request is untimely the BFCC-QIO is not required to meet the 72 hour deadline.

Expedited Review Process

- BFCC-QIO notifies Swing Bed that beneficiary has requested expedited determination
- Swing Bed must provide beneficiary with Detailed Explanation of Non-Coverage (DENC), referred to as "Detailed Notice"
- Detailed Notice should be provided to beneficiary by no later than close of business on day BFCC-QIO notifies Swing Bed of requested expedited determination



Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current [insert type] services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: [insert provider/plan toll-free telephone number]

Form CMS-10124-DENC (Approved 12/01/2011) CMB Approval No. 0938-0963

Expedited Review Process

- BFCC-QIO is responsible for establishing contact with Swing Bed so beneficiary's medical records can be used in making determination
- Swing Bed must provide BFCC- QIO with copies of both notices provided to beneficiary (NOMNC & DENC)
- QIO makes decision on coverage & informs involved parties generally within 72 hours

Expedited Review Process

- Beneficiary may request reconsideration of BFCC-QIO decisions by Qualified Independent Contractor (QIC) under similar process
- When QIO/QIC makes decision at end of review, Swing Bed can then bill for period that was reviewed in accordance with QIO/QIC decision on coverage for that period
- Standard claim appeal rights still apply to these claims

Swing Bed Payment

CAH – Swing Bed

- Cost-based paid at 101% of reasonable cost.
- Coinsurance and deductible are applicable for inpatient CAH payment.
- Bill Type 18X or 21X
- All charges are included on the claim

Swing Bed Services

- Routine Services
  - Room and board
  - Nursing care
  - Medical Social Services
  - Minor medical supplies
  - Psychiatric social services

Swing Bed Services

- Ancillary
  - Rehabilitation therapy
  - Physician monitoring
  - Laboratory services
  - Diagnostic services
  - Medication

Optimizing the Swing Bed Program

Inquiry/Initial Pre-Assessment Process

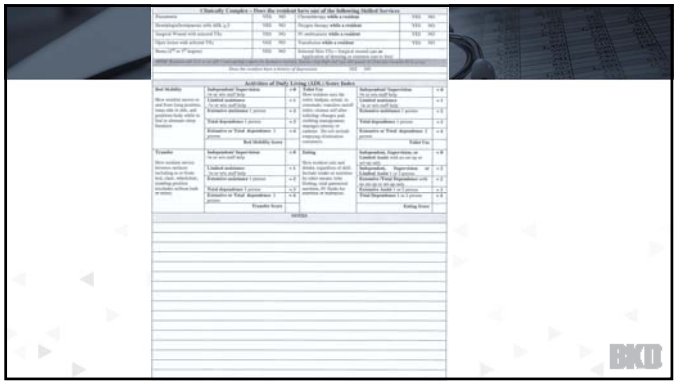
- Process should begin day **1** of acute hospital stay.
- Hospital discharge planner, along with UR committee, review all acute patients-daily
- Identify patients eligible for SB
- Notify Physician of SB eligibility
- Notify Patient or Representative

Patients in ER/Observation

- Utilizing the 30 Day Transfer Rule
  - Has the patient been in the hospital or received skilled care in the past 30 days?
  - Is the reason for ER/Observation related to the most recent hospital stay?
- **Admit to Swing Bed**

Case Management

- Review of all inpatient Medicare Part A or Managed Care patients for Swing Bed placement.
- Use a Pre-Screening form
- Look at inpatient admit dates and length of stay
- Look at diagnosis and discuss plan of care with physician



Case Management

- **Recommendation:**
  - Develop a "**Patient Swing Bed Admission Packet**" to include:
    - Welcome to your skilled level of care….
      - Includes purpose and expected outcome
    - Medicare Coverage – Medicaid contact info
    - Expectations

Case Management

- What Patients should expect on Swing Bed
  - Sample of day
    - Treatments
    - Therapy
    - Street clothing expected
  - Visiting hours
  - Patient Rights

Case Management

- Case Manager/Social Services
  - Give and explain the packet to patient when discussing the change in the level of care
  - Note the review of the packet and the discussion of advance directives in the initial SB progress note
  - Act as liaison between patient/family and team and document conversations

Case Management

- Manage care needs
- Ensure stability prior to discharge
- Monitoring acute stay for 96 hour requirement or GMLOS of diagnosis
- Look at length of stay
  - Typically less than 5 days
  - Increase to 7-10 days for safe and sustainable discharge

Swing Bed Financial Utilization Results

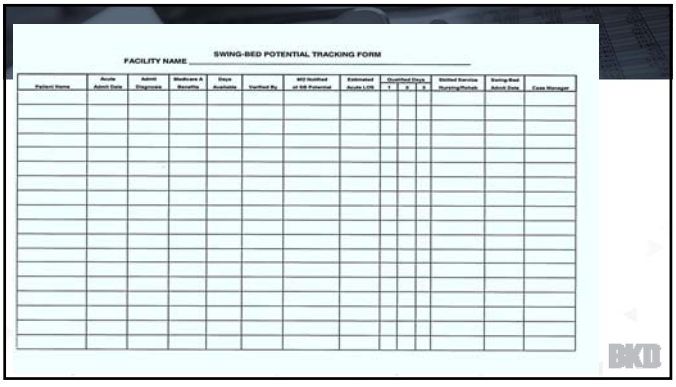
	Medicare Days	Medicare Discharges	Medicare ALOS	Total Days	Medicare Days	Medicare Discharges	Medicare ALOS	Total Days
Acute/ICU	1,754	483	3.63	3,464	1,754	483	3.63	3,464
Swing Bed - SNF	557	93	5.99	557	929	93	10	929
Swing Bed - NF	-			-	-			-
Observation	-			528	-			528
Total Days	2,311			4,549	2,683			4,921
Total Routine Cost				4,879,006				4,879,006
Less: Swing Bed - NF Costs				-				-
Adjusted Total Routine Cost				4,879,006				4,879,006
Total Days (Less Swing Bed - NF)				4,549				4,921
Total Routine Cost Per Day				1,072.54				991.45
Medicare Days				2,311				2,683
Medicare Acute & Swing Bed SNF Cost				2,478,651				2,660,136
Medicare Routine Cost Reimbursement %				51%				55%
								181,485

Swing Bed Tracking Form

- Recommend use of;
  - Tracking form
    - Good way to determine why patients are not being admitted
    - Great for marketing

Tracking Log

- Include;
  - All referrals in house and from outside sources
  - Patient zip code
  - Diagnosis
  - Where to be admitted from
  - Referral source
  - Admitted or not
  - Reason if not
  - Physician


SWING-BED POTENTIAL TRACKING FORM

FACILITY NAME _____

Tracking Log

- Review monthly and quarterly
- Determine percentage of admissions
- Review all patients not admitted
  - Look at reason/causal factors
  - Determine if improvement is needed
  - Determine if education of staff needed

Summary

- Risk management is essential for effective utilization of Swing Beds
  - Verify all eligibility criteria is met
  - Documentation to Support Skilled Care – Nursing &/or Rehab
  - Manage the patient stay
  - Ensure safe and sustainable discharge
  - Increase length of stay as appropriate to prevent re-hospitalizations

Questions?

Resources

- The policies for extended care services in a Swing-Bed are the same as a SNF.
- Medicare General Information, Eligibility and Entitlement Manuals
  - Chapter 3, Section 10.4
  - Chapter 4, Section 40
- Medicare Benefit Policy Manual
  - Chapter 8, Sections 10,20,& 30
  - Chapter 15, Section 220
- State Operations Manual
  - Appendix W

Thank You!

BKD Thoughtware®

- Webinars, seminars & articles
- Many are CPE-eligible
- PDMs – Populate bullets with most relevant webinars, articles, videos, etc.

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