

Oregon State Office of Rural Health

CAH Swing Bed Q&A Webinar

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Objective & Agenda Items

- ❖ **The participants will have an opportunity to update their SB knowledge based on questions that were sent to the presenter prior to the webinar and on questions during the webinar based on time availability.**
- ❖ **Pre-sent questions topic items:**
 - **Medicare End of Life Benefits**
 - **Where can we admit a SNF patient when...**
 - **Nursing Care Plan/IDT Documentation**
 - **Therapy Skilled Needs**
 - **Wound and Infusion Clinic**
 - **Transportation Billing**
 - **Other based on time available**

End of Life

□ End of Life

- Although there isn't any direct end-of-life benefit under Medicare Part A in a SNF, there are many times when a person who is at end-of-life receives Medicare benefits in a SNF:
 - The beneficiary can elect their Medicare Hospice benefit, which provides some benefits in the SNF (but not room and board) – hospice pays hospital based on contract
 - If a beneficiary, even at the end of life, requires skilled care or services and meets all the requirements (e.g., 3-day hospital stay, treatment within 30 days of the hospital stay, has a skilled therapy need that would benefit from skilled care, etc), then that person would be entitled to the skilled care under Medicare in addition to the hospice benefit. The skilled service is not related to the end of life necessarily, just to the need of the patient/resident.

End of Life

- ❑ There are some pretty clear examples of when a beneficiary can receive both hospice and a SNFPPS benefit. A patient that has elected their hospice benefit due to end stage lung CA may also fall and fracture a hip. If the hip fracture has no direct relationship to the end stage diagnosis, the patient may also be entitled to receive therapy even though he is a hospice patient. There is a special condition code that must be on the UB-04 to indicate this situation and documentation should be clear.
- ❑ “Skilled therapy may be needed, and improvement in a patient’s condition may occur, even where a chronic or terminal condition exists. The fact that a full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient’s condition. <Medicare Benefit Policy Manual, Chapter 15 § 220.2 (C)>”
- ❑ Lastly, the Medicare HMO may have their own rules that are specified in the contract between the SNF and the Medicare HMO, so that is a very different issue. (HMO is under Medicare C)

SNF Bed Availability

- ✓ The swing-beds in a hospital or CAH **do not have to be separated from the acute patients** although the facility may choose to do so. The patients do not have to move to a different location in the facility when changing from acute care status to swing-bed status unless the facility requires it.
- ✓ There is no length of stay restriction for a swing-bed patient whether they are in a hospital or a CAH **(must have Medicare skilled days left if hospital wants to get paid though)**
- ✓ **There is no more required discharge to a nursing home even if they have beds available and no transfer agreement are required.**

SNF Bed Availability

- ✓ **Patients may be discharged to a nursing home from SB** as part of discharge planning, but it is not required.
- ✓ **A medical order in the chart by the physician is required** to change status from acute care to swing-bed because the patient is being discharge from acute care status and admitted to swing-bed status. This is necessary for reimbursement purposes because the billing and reimbursement changes to “swing.”
- ✓ Accordingly, the facility is given a **sub-provider number** for billing swing-bed services.
- ✓ All CAH SNF-like swing bed bills should have a “z” in the third position of the provider number

Nursing Care Plan

- An inpatient **nursing care plan** is required for both acute and skilled level of care
- The nursing care plan consists of a nursing diagnosis or may be medical diagnosis (based on hospital's policy) with defining characteristics (subjective and objective data that support the diagnosis), related factors or risk factors, expected outcomes/goals, and nursing interventions.
- Care plans outlines the nursing care to be provided to a patient during his/her stay
- It is a set of actions the nursing staff will implement to resolve/support a medical or nursing diagnosis based on the admitting assessments and on-going assessments
- It is to serve as a care map to guide the staff in the ongoing provision of nursing care and assists in the evaluation of that care.

Nursing Care Plan

- Discussion regarding the following:
 - Nursing care plan dos and don't.....
 - Discipline specific care plan.....
 - Interdisciplinary care plan.....
 - Interdisciplinary team documentation..

Therapy Skilled Needs

Q: Can a patient stay in a skilled bed if they live alone and have needs they can't manage (meds, specific diet etc...)?

A: No – that is considered custodial care and not skilled care. – discussion.....

Q: If a patient is not improving with therapy and even declining, can we still keep them with a skilled therapy need?

A: Most likely not but it depends – let's discuss....

Therapy Skilled Needs

Q: Is therapy required b.i.d or is the # of sessions based on the patient's condition?

A: Therapy is ALWAYS based on patient's needs and their tolerance level – let's discuss.....

Wound & Infusion Clinic

Q: Can we bill for assessments and treatments provided by those clinics when a patient is in a swing bed?

A: Wound care and IV is considered an inclusion under SNF regulations therefore those services should be billed as you do for IP.

Transportation Billing

❑ Ambulance services **are not covered when**

- ✓ Other means of transportation could be utilized without endangering the individual's health, whether or not such other transportation is actually available
- ✓ If it fails to meet the reasonableness requirement even if it meets medical necessity requirements
- ✓ Transportation from a hospital to a radiation oncology office and return
- ✓ Transportation to a funeral home
- ✓ Transportation to a physician's office or physician directed clinic for emergency treatment without continuing on to the hospital immediately thereafter
- ✓ Transportation from SNF to SNF before midnight of the discharge date

Transportation Billing

- ❑ Ambulance services are not covered when
 - ✓ Transport for patient or family convenience
 - ✓ Transportation for those patients receiving diagnostic and/or therapeutic services which could have been reasonably brought to the beneficiary's bedside at less cost than transporting the beneficiary for services

- ❑ *Roundtrip to a Physician's Office*
 - If a SNF's Part A patient requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF

Transportation Billing

- ❑ Noncovered transportation may be billed directly to the patient (see: MLN Matters Special Edition SE0433: Revised – page 5 under “*Noncoverage of Transportation by Any Means Other Than Ambulance* “ <https://www.cms.gov/MLN MattersArticles/downloads/SE0433.pdf>)
- ❖ *As with any noncovered service for which a resident may be financially liable, the SNF must provide appropriate notification to the patient/resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to “. . . inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate.*

Transportation Billing

Other questions?

