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| Subject: Admission & Continued Stay Criteria | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
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DEFINITION:

Swing Bed is a hospital-based skilled care program located in a Critical Access Hospital (CAH) with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish swing bed services, where they may use up to 25 of their beds as needed to furnish either acute or Skilled Nursing Facility (SNF) level care.

Swing Bed may also be found in Rural delineated PPS Acute Hospitals, provided under a Medicare Agreement, but limited to a specific number of swing beds.

POLICY:

It is the policy of [Hospital Name/Program Name] to have standardized criteria for “swinging” a patient from an acute care bed to a skilled level of care along with continued stay. These criteria will be applied equally to all who are referred for skilled care in a “Swing Bed”.

PROCEDURE:

Admission Criteria:

# A physician’s order prior to the admission is required for an admission to the swing bed.

# The acute hospitalization should have been medically necessary.

# The patient shall be medically stable sufficient to prevent readmission to acute as much as possible.

# The services to be provided in the swing bed must be related to:

## A hospital-related medical condition that they were admitted with and treated during the qualifying inpatient hospital stay or

## A skilled need that developed while hospitalized, even if it was not the reason they were admitted to the hospital for and

## The patient’s physician has decided that the patient needs daily skilled inpatient care which must be given by, or under the supervision of, skilled nursing and/or therapy staff.

# Medicare patients must have a 3-day qualifying stay (defined as 3 consecutive midnights) in an acute care bed. (Observation day is not counted in the 3-day stay)

## This qualifying stay must have occurred within the last 30 days.

## Patients may be admitted to SB/SNF and readmitted to a SB/SNF within the last 30 days of discharge without a new 3-day acute stay if reason for admission is related to the original acute or SB/SNF stay.

## Patients may have a Physician Hold / Deferred Covered Treatment which allows an exception to the “within 30 days of hospitalization”.

### When the physician writes an order to start therapy when the patient is able to do weight bearing therapy within 4 to 6 weeks. Once the patient is able to start the therapy then the Medicare 100-day count will start the first day that the patient is able to start therapy services or will start from where you left off if less than 60 days since last SNF stay if applicable.

### In this case, the patient may be discharged to home or LTC from acute care during the wait period or at a custodial level of care which will change to SB/SNF when patient is ready to start therapy.

## Non-Medicare payors may have same or different rules such has only one day required in an acute care bed and usually require a pre-authorization from the payor.

## Patients with Medicaid as primary payor are not covered unless the program is licensed as a LTC facility.

# The deciding factor for admission based on therapy needs is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel.

# 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. The skilled service is not related to the end of life necessarily, just to the need of the patient.

# Medical needs or 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.

# Due to the short stay nature of the program, discharge disposition plan is discussed during the pre-admission phase to ensure that the short-term skilled program is appropriate for each patient.

# Patients in an acute care bed immediately prior to the swing bed admission must be discharged from acute and admitted to skilled care even when the transfer occurs from the acute to swing in the same hospital.

# Admissions from other than the hospital (such as home, assisted living, LTC…) can be admitted directly to the skilled bed if the acute discharge was within the last 30 days and the re-admit reason is clearly associated to the initial hospital stay.

# A direct admission from home, LTC, Assisted Living can also occur with Physician Hold / Deferred Covered Treatment which is an elapsed period of more than 30 days. Such is permitted for SNF/SB admissions where the patient’s condition makes it medically inappropriate to begin an active course of treatment in a SNF/SB immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period.

# The attending physician must certify the need for skilled care on admission and recertify at day 13 or 14 if IP skilled is still needed and every 30 days thereafter until discharge or Medicare days have been used up.

# The attending physician must have privileges at the hospital where the skilled bed patient is admitted.

# Internal and external referrals (from other hospitals) must be reviewed for appropriateness.

## Medicare skilled needs,

## qualifying stay,

## able to meet needs,

## discharge plan,

## physician with admitting privileges is willing to follow the inpatient care (may be PCP or hospitalist or another willing provider).

# No patient shall be denied admission on the basis of sex, race, religion, ancestry, national origin, age, handicap, or sexual orientation.

Limitations:

# No patient with a primary psychiatric or mental retardation diagnosis shall be admitted to the swing bed.

# Patient with secondary psychiatric or mental retardation diagnosis shall be evaluated on a case-by-case basis for swing bed admission based on whether their needs can be met.

# External referrals of patients with a communicable disease or diagnosis will be evaluated on the basis of diagnosis type, specific care requirements, availability of correct room to manage isolation if needed and as directed by the hospital’s policy on communicable disease.

# Patients on ventilators [will or will not] be considered for admission to the swing bed.

# External referrals will be considered for admission to the swing bed based on the program’s capability to meet their medical and rehab needs but also on bed availability which is first kept for acute patients.

Continued Stay Criteria and/or Discharge Criteria:

# Patients must exhibit continued need for nursing skilled care or physical rehab and/or continued progress except in the situation of “terminal care.”

## Patient may not remain in a skilled bed while billing Medicare part A for maintenance level of care.

# The decision to transfer or discharge is determined appropriate if one of the following criteria exists.

## Patient’s health has sufficiently improved and the services are no longer needed.

## Patient is at a custodial care level and waiting for nursing home placement.

## Patient’s welfare is endangered.

## Staff unable to meet patient’s needs.

## Health or safety of individuals in the facility is endangered.

## Patient leaves against medical advice.

# If a patient remains in a skilled bed after no longer meeting criteria, the patient and/or responsible party must be given a letter of denial making them responsible for the cost of the stay.

## They may choose to appeal but they will be responsible if the QIO or FI/MAC agrees with the hospital’s assessment.

## Patients remaining in a hospital bed as a private pay may meet criteria for Medicare part B services for certain ancillaries as if they were home or in a nursing home.

# A patient who still meets criteria for skilled needs but has used all of his Medicare days for the spell of illness, must be discharged for Medicare purpose (no longer billing Medicare part A) but as above, the hospital may bill Medicare part B as appropriate.